Eagle KMC,LLC

BENEFITS BOOKLET

2025 Core Benefits Enrollment

* BC/BS: Medical Plan
* EAGLE KMC HRA Plan
* SecureCare: Dental & Vision Plans

Presented By:

CAPITOL INSURANCE
BROKERS INC. / BENEFIT CONSULTANTS

JEFFREY WM. GENNARO
PRESIDENT

Enrollment Call Center - 833-781-7575
MONDAY - FRIDAY 9:00 A.M. - 5:00 P.M. PST

Enrollment Portal to Login:
www.eaglekmc.ease.com

The information in this Enrollment Guide is presented for illustrative purposes. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your guide contact HR - Cole Jenner at 520-574-4325

The information provided in this summary is for comparative purposes only. Actual claims paid are subject to the specific terms and conditions of each contract. This benefit summary does not constitute a contract.
The information in this booklet is proprietary. Please do not copy or distribute to others.

OPEN **ENROLLMENT** Call Center - 833-781-7575

Monday - Friday 9:00am to 5:00pm PST

Call to enroll by phone, or for assistance with your online enrollment.

MEDICAL BENEFITS

WHO IS ELIGIBLE?

Benefit eligible employees of Eagle KMC, LLC, and Hawk KMC, LLC, are eligible for the new fully insured medical plans effective January 1, 2025

Review both BCBS and the Eagle KMC HRA plan to determine the full scope of the Medical benefits plan offered.

HOW TO ENROLL/RE-ENROLL

Open Enrollment will begin when you receive your Login Email.

This is your opportunity to elect Medical, Dental & Vision Benefits.
You can login to EASE and self enroll. The step by step process is easy to complete or you can call an enrollment advisor for assistance.
If you have pre-tax elections, you will not be able to change them until the 2025 open enrollment, unless you have a qualified life event change in status.

QUALIFIED CHANGES FOR 2025

Qualified changes in status 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, or termination of adoption proceedings, or change in spouse's benefits or employment status.
When you decide to enroll in the plan with a life event change, you will be required to do so within 30 calendar days of the event.

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MEDICAL & PRESCRIPTION DRUG

	BCBS Plan	Eagle KMC HRA Plan Included Max after HRA Reimbursement
Deductible In Network	$6,000 Single $12,000 Family	HRA reimburses 70% of last $3,000 of 6K Ded. Max reimbursed - $2,100 pcm / $4,200 Fam.
Coinsurance Max OOP- In Net	70 / 50 $ 8,150 Single $ 16,250 Family	70 % In-Network $ 6,050 Single after reimbursement $12,100 Family after reimbursement
Office Visit Copay	$25 PCP $75 Non- PCP $ 0 Telehealth	
Preventive Office Copay	Covered at 100%	
Emergency Room Urgent Care	$450 Copay then 30% coins after ded. $75 Copay	.
Prescription Drug	$15/$55/$85/$150 SP $60/$110/$160/$210	

Please review BCBS SBC and the Eagle KMC HRA plan provided below to understand the combined medical plan offered. contact the CIB Team for additional information. Eagle KMC HRA is provided at no additional premium to the Employee.

Coverage Level Weekly deductions	Plan 1 with Eagle KMC HRA Plan	
Single	$66.92	
Single + Spouse	$227.96	
Single + Child(ren)	$187.70	
Family	$362.15	

* Note: The plan illustrations above do not represent the complete Coverage and limitations, terms and conditions of the policy. Refer to the plan document for a complete review

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Call to enroll by phone, or for assistance with your online enrollment.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit azblue.com/benefit2025jan. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-877-475-8440 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$6,000**/individual or **$12,000**/family Out-of-network: **$12,000**/individual or **$24,000**/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Unless a copay, fee, or other percent is shown, the coinsurance percent of the allowed amount that you pay for most services is 30% in-network and 50% out-of-network.
Are there services covered before you meet your deductible?	Yes. In-network primary care and specialist visits, certain in-network preventive services, in-network imaging services, prescription drugs, specialty drugs, emergency room care, in-network urgent care visits, in-network mental health visits, and hospice services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: **$8,150**/individual or **$16,300**/family Out-of-network: **$16,300**/individual or **$32,600**/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, out-of-network prior authorization charges, balance-bills, and costs for health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.azblue.com or call 1-877-475-8440 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/provider/day, deductible does not apply	50% coinsurance & balance bill	Specialist copay for most chiropractic services. $500 charge if no prior authorization for out-of-network services. No charge for medical telehealth consultations through BlueCare Anywhere℠.
	Specialist visit	$75 copay/provider/day, deductible does not apply		
	Preventive care/screening/ immunization	No charge		Preventive services not required to be covered by state or federal law are not covered. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.

* For more information about limitations, exceptions, and prior authorization, see the plan or policy document at azblue.com/benefit2025jan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	Office visit copay (deductible does not apply) or 30% coinsurance.	50% coinsurance & balance bill may apply	Cost share varies based on place of service and provider's network status and type. $500 charge if no prior authorization for out-of-network services.
	Imaging (CT/PET scans, MRIs)	$300 copay/procedure type/member/provider/day (deductible does not apply) for CT, MRI, MRA & PET scans		Cost share varies based on place of service and provider's network status and type. $500 charge if no prior authorization for out-of-network services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.azblue.com	Tier 1	$15 copay/30 day supply, deductible does not apply	$15 copay/30 day supply & balance bill, deductible does not apply	Some drugs require prior authorization and won't be covered without it. 90-day supply costs 2.5 copays (retail pharmacy) and 2 copays (mail order). Mail order not covered out-of-network. If a generic drug is available, pay the generic cost share + the price difference between the allowed amount for the brand and generic drugs.
	Tier 2	$55 copay/30 day supply, deductible does not apply	$55 copay/30 day supply & balance bill, deductible does not apply	
	Tier 3	$85 copay/30 day supply, deductible does not apply	$85 copay/30 day supply & balance bill, deductible does not apply	
	Tier 4	$150 copay/30 day supply, deductible does not apply	$150 copay/30 day supply & balance bill, deductible does not apply	
	Specialty drugs	Copays (deductible does not apply): Tier A: $60 Tier B: $110 Tier C: $160 Tier D: $210	Not covered	Specialty copay covers up to a 30-day supply. Some drugs require prior authorization and won't be covered without it.

* For more information about limitations, exceptions, and prior authorization, see the plan or policy document at azblue.com/benefit2025jan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance & balance bill	Additional $1,000 access fee for all bariatric surgeries. $500 charge if no prior authorization for out-of-network services.
	Physician/surgeon fees		50% coinsurance & balance bill may apply	
If you need immediate medical attention	Emergency room care	$450 copay/facility/day, deductible does not apply		If admitted to hospital, copay is waived and you pay inpatient deductible for facility and ancillary services. Out-of-network providers can't balance bill for the difference between the allowed amount and the billed charge.
	Emergency medical transportation	30% coinsurance		None.
	Urgent care	$75 copay/provider/day, deductible does not apply	50% coinsurance & balance bill	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance & balance bill	Additional $1,000 access fee for all bariatric surgeries. $500 charge if no prior authorization for out-of-network services.
	Physician/surgeon fees	30% coinsurance	50% coinsurance & balance bill may apply	
	Long-term acute care (LTAC)	30% coinsurance days 1-100 and 50% coinsurance days 101-365	50% coinsurance & balance bill	$500 charge if no prior authorization for out-of-network services. Limit of 365 total LTAC days per member.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Copay applies to office, home, walk-in clinic visits (deductible does not apply). Amount varies based on PCP/Specialist. 30% coinsurance applies to all other locations.	50% coinsurance & balance bill may apply	Cost-share varies based on place of service and provider's network status and type. $500 charge if no prior authorization for out-of-network services. $20 copay for counseling or $45 copay for psychiatric telehealth consultations through BlueCare Anywhere℠.
	Inpatient services	30% coinsurance		$500 charge if no prior authorization for out-of-network services.

* For more information about limitations, exceptions, and prior authorization, see the plan or policy document at azblue.com/benefit2025jan.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office Visits	Office visit copay (deductible does not apply) or 30% coinsurance	50% coinsurance & balance bill	Only one copay is collected for services included in delivering physician's global charge. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for in-network preventive services.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance & balance bill may apply	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance & balance bill	
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	30% coinsurance	50% coinsurance & balance bill	$500 charge if no prior authorization for out-of-network services. Limit of 42 visits (of up to 4 hours)/calendar year.
	Rehabilitation services • PT/OT/ST = Physical Therapy, Occupational Therapy, Speech Therapy	30% coinsurance except 50% coinsurance for: ▪ days 61-120 of EAR ▪ days 91-180 of SNF	50% coinsurance & balance bill	$500 charge if no prior authorization for out-of-network services. Limit of 120 days/calendar year for Extended Active Rehabilitation Facility (EAR) and 180 days/calendar year for Skilled Nursing Facility (SNF). *Limited coverage available for habilitation services to treat autism spectrum disorder for groups of 51 or more eligible employees.
	Habilitation services	Not covered*	Not covered*	
	Skilled nursing care	30% coinsurance	50% coinsurance & balance bill	
	Durable medical equipment	Office visit copay (deductible does not apply) or 30% coinsurance	50% coinsurance & balance bill	Cost share varies based on place of service and provider's network status and type. $500 charge if no prior authorization for out-of-network services.
	Hospice services	No charge	No charge except balance bill	Deductible and coinsurance waived. $500 charge if no prior authorization for out-of-network services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Excluded
	Children's glasses	Not covered	Not covered	Excluded
	Children's dental check-up	Not covered	Not covered	Excluded

* For more information about limitations, exceptions, and prior authorization, see the plan or policy document at azblue.com/benefit2025jan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care except as stated in plan
- DME rental/repair charges that exceed DME purchase price
- Experimental and investigational treatments except as stated in plan
- Eyewear except as stated in plan
- Fertility and infertility medication and treatment
- Flat feet treatment and services
- Genetic and chromosomal testing, except as stated in plan
- Habilitation services, except certain autism services
- Hearing aids
- Home health care and infusion therapy exceeding 42 visits (of up to 4 hours)/calendar year
- Homeopathic services
- Inpatient EAR treatment exceeding 120 days per calendar year and inpatient SNF treatment exceeding 180 days per calendar year
- Long-term care, except long-term acute care up to a 365 days benefit plan maximum
- Massage therapy other than allowed under evidence-based criteria
- Naturopathic services
- Out-of-network Mail Order and out-of-network Specialty
- Private-duty nursing
- Respite care, except as stated in plan
- Routine foot care
- Routine vision exams
- Sexual dysfunction treatment and services
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Non-emergency care when travelling outside the U.S.

* For more information about limitations, exceptions, and prior authorization, see the plan or policy document at azblue.com/benefit2025jan.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact the Arizona Department of Insurance (602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area) regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- For group health coverage subject to ERISA, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.
- For non-federal governmental group health plans and church plans that are group health plans, contact Blue Cross Blue Shield of Arizona at 1-877-475-8440. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area or https://difi.az.gov/consumer/i/health.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

* For more information about limitations, exceptions, and prior authorization, see the plan or policy document at azblue.com/benefit2025jan.

Multi-language Interpreter Services

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hólǫ́ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą́ doo bą́ąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíilnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب 877-475-4799.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید .877-475-4799 تماس حاصل نمایید.

Assyrian:
ܐܢ ܐܢܬ، ܐܘ ܚܕ ܐܢܫܐ ܕܩܐ ܡܥܕܪܝܬ ܠܗ، ܐܝܬ ܠܗ ܫܘܐܠܐ ܒܘܬ Blue Cross Blue Shield of Arizona، ܐܝܬ ܠܘܟ ܙܕܩܐ ܕܗܘܝܬ ܡܩܒܠܢܐ ܕܥܘܕܪܢܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟ ܡܢ ܕܠܐ ܦܪܥܬܐ ܕܡܐ. ܠܡܡܠܠܐ ܥܡ ܡܬܪܓܡܢܐ، ܩܪܝ ܥܠ 877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคำถามเกี่ยวกับ Blue Cross Blue Shield of Arizona
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.

<u>PRA Disclosure Statement:</u> According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About These Coverage Examples

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$6,000**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$6,000
Copayments	$430
Coinsurance	$1,080
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$7,560**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$6,000**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,070**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$6,000**
- **Specialist copayment** **$75**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,940
Copayments	$510
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,450**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to enable people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call 602-864-4884 for Spanish and 1-877-475-4799 for all other languages and other aids and services.

Blue Cross, Blue Shield, the Cross and Shield Symbols, and BluePreferred are registered service marks, and BlueCare Anywhere is a service mark, of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Eagle KMC HRA Plan

Section 105 – Health Reimbursement Arrangement (HRA) Plan Highlight Your employer has established a Section 105, Health Reimbursement Arrangement (HRA) Plan. This Summary Plan description describes the benefits, terms and conditions of the Plan as it applies to eligible employees on or after the plan year dates.

PLAN BENEFITS (Benefit(s) allowed per covered member (PCM) for reimbursement under the Plan)

	EMPLOYEE (Member) PAYS	HRA REIMBURSES
DEDUCTIBLE REIMBURSEMENT	The first $6,000.00 of Employee DEDUCTIBLE expenses. (2X Family)	**Buy-Up Plan** - Once the member has met his/her DEDUCTIBLE responsibility, he/she will receive reimbursement for 70% of the last $3,000.00 of incurred **IN-NETWORK** DEDUCTIBLE expenses. The maximum CALENDAR YEAR reimbursement is $2,100.00 pcm and $4,200 with Dependent (s)
REIMBURSEMENT INFORMATION	T ◆ The eligible HRA OUT-OF-POCKET expenses include only IN-NETWORK Deductibles ◆ Copays and Out of network expenses are excluded from reimbursement ◆ RX copays are excluded from reimbursement ◆ **COMBINED ANNUAL MAXIMUM -** **B**uy up Plan = $2,100 pcm with a max of $4,200 w Dep (s).	

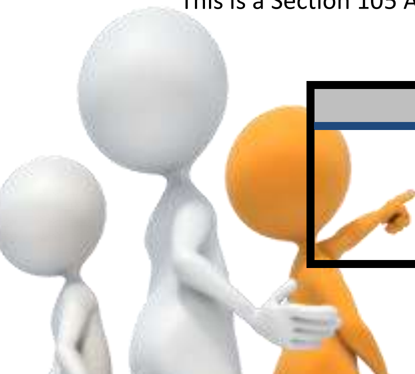
REIMBURSEMENT PROCESS

Once, you (an eligible member) have reimbursable expenses; please submit your Explanation of Benefits, or EOB, (provided by the insurance company – A sample EOB is included for your reference) or proof of the expense, plus a Reimbursement Request to:

MAILING ADDRESS FOR Administrator	CLAIM CONTACT RE: REIMBURSEMENTS	ONLINE REIMBURSEMENTS
Davis Flex Spending Solutions, Inc. P.O.Box 20211 Boulder, CO 80308	(866) 607-9750 Ext 801	dfss.summitfor.me

PLAN DEFINITION AND FUNDING

This is a Section 105 Accident and Health Plan, as classified by the Internal Revenue Code. This benefit plan is classified as a welfare plan by the Department of Labor. The Employer funds this Plan.



PLAN ADMINISTRATOR/EMPLOYER	ADMINISTRATION AGENT
Eagle KMC, LLC 850 W Silverlake Rd Tucson, Arizona 85713 Tel. 520-574-4325	Davis Flex Spending Solutions, Inc. P.O.Box 20211 Boulder, CO 80308 (866) 607-9750 Ext 801

TAX ID NUMBER	ERISA NUMBER
On file at the Employer's office	510
PLAN YEAR DATES	
The 2025 Plan Year will begin 01/01/2025 and ends 12/31/2025. The HRA Plan Year will auto renew thereafter, unless otherwise notified.	
CLAIM RUN OUT DATES	
The member has until 3/30/2026 to turn in a claim after the 2025 Calendar Year has ended.Terminated employees who have not chosen to extend their HRA benefit through COBRA, have from the end of the month that they are terminated, plus 90 days to submit claims for reimbursement.	

ELIGIBILITY REQUIREMENTS Eligibility requirements include participation in the group medical plan.

EMPLOYEE TERMINATION

You will automatically cease to be a participant on the earliest of the following dates:

1. Your death;
2. The date the Plan terminates;
3. The your employment with the employer is terminated for whatever reason;
4. The date the sponsor determines you made fraudulent or improper use of a plan, certificate or identification.

CONTINUATION OF COVERAGE, COBRA (applicable to employers with 20 or more employees)

Continuation Coverage means your right, or your spouse and dependents' right to continue to be covered under this Medical Expense Reimbursement Plan if participation by you (including your spouse and dependents) otherwise would end due to the occurrence of a "Qualifying Event." Duration of coverage will depend upon the qualified event, and will be either 18, 29 or 36 months. Qualifying Event is:

1. Termination of your employment (other than for gross misconduct), or reduction of your work hours below eligibility requirements;
2. Your death;
3. Your divorce or legal separation from your spouse;
4. Your becoming eligible to receive Medicare benefits;
5. Your dependent ceases to be a dependent.

It will be your obligation to inform the Plan Administrator of the occurrence of any Qualifying Event within 60 days of the occurrence, other than a change in your employment status. The Plan Administrator, in turn, has a legal obligation to furnish you, or your spouse, as the case may be, with separate, written options to continue the coverage provided through this Plan at stated premium costs for the remainder of the Plan Year. The notification you will receive will explain other terms and conditions of the continued coverage.

PLAN TERMINATION

The Plan or any portion of the Plan can be amended or terminated, in whole or in part at any time, by your employer in the same manner as the plan was adopted. Consent of any Participant, employee or any other person referenced in the Plan is not required to terminate the Plan.

CLAIM APPEALS

If you believe you are entitled to a benefit under the Plan that is different from the amount that has been paid, you may file an appeal with the Plan Sponsor. Such an appeal must be made in writing and must contain the following information: the reason for the appeal; the facts supporting the appeal; the amount claimed; and the name and address of the person filing the appeal. The Plan Sponsor will generally make a decision within 90 days after receipt of the appeal. If an appeal is denied, the claimant may seek to review the Plan Sponsor's decision. The request must be submitted in writing within 60 days of the date of denial. Unless special circumstances arise, a written decision will be given to the claimant within 60 days of the review request.

ERISA RIGHTS

As a participant in the welfare benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan Documents including insurance contracts, and to obtain copies of all Plan Documents and other Plan information upon written request to the Plan Administrator. The Administrator in turn may apply a reasonable charge for copies. You are also entitled to receive a summary of the Plan's financial report, if applicable. Finally, the Plan Administrator is required by law to furnish each participant with a copy of the summary annual report, with certain expectations. You are entitled to continue health care coverage under the Plan for yourself, spouse or dependents if there is a loss of health insurance coverage as a result of a qualifying event.

ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your plan - called fiduciaries of the plan - have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or from exercising your rights under ERISA. If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, and must receive a written explanation of the reason for denial. You have the right to have the Plan Administrator review and reconsider your claim.

Under ERISA, you can take steps to enforce the above rights. For instance, if you require materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in state or federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for assuming your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in state or federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay the costs and fees. If you have any questions about your Plan, you should contact the Plan Sponsor. If you have questions about this statement or about your rights under ERISA, you may also obtain certain publications with your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administrator, or by contacting the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor (listed in your telephone directory), or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administrator, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210.

Eagle KMC, LLC

The Eagle KMC HRA Plan

In-Network Deductible - 3K PLAN

- Employee pays the first $3,000 of the IN-Network deductible per covered member up to $6,000 CY Max.
- The employee is responsible for the next $3,000 per covered member. The Eagle KMC HRA will reimburse the employee 70% of this $3,000 of deductible to a maximum of $2,100 pcm up to $4,200 maximum.
- To put this another way, for the first $6,000 deductible the employee is responsible for $3,900 per covered member up to $7,800 maximum after receiving the HRA reimbursement.

The Total Deductible Annual Maximum reimbursement for a Covered member is $2,100

The Total Deductible Annual Maximum reimbursement for a Covered member and dependents is $4,200.

BC/BS Preferred - $6,000 Ded –70/50 Coins PPO Plan HRA Illustration: 70% of last $3,000 of In-Net. Deductible

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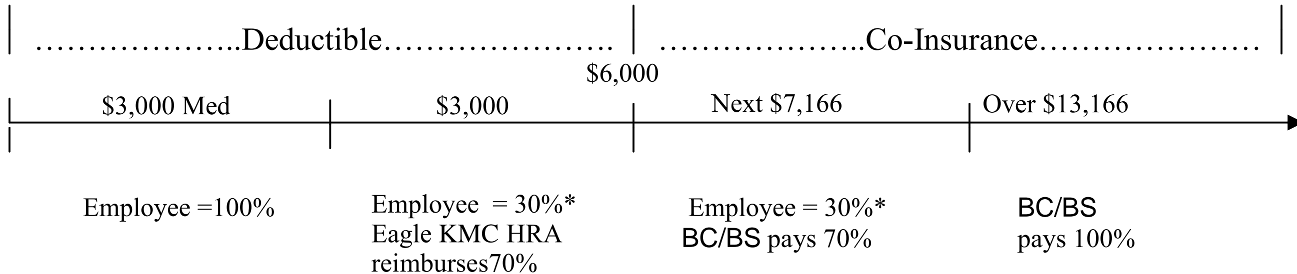


Employee Pays up to after reimbursement:

$3,000	+	$900	+	$2,150	+	0	=	$6,050 **

Eagle KMC HRA reimburses up to:

$ 0	+	$2,100	+	0	+	0	=	$2,100 **

Out of Pocket Maximum $8,150

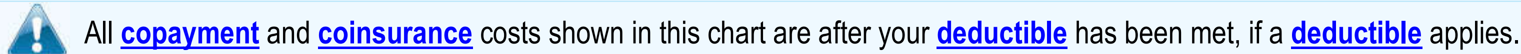
* Net Employee cost after Eagle KMC HRA Reimbursement.

**Illustration is based on HRA reimbursement of 70% of remaining Deductible after the first $3,000.

(Since Copays also count against the OOP Maximum they can change the illustrated numbers shown above.)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	You pay the first: **$3000.00** Single You pay the first: **$3000.00** first person, **$3000** for remaining family members	See the chart starting on page 2 for your costs for services this plan covers. If you participate in your employer's HRA, the HRA will pay for or reimburse you for certain, qualified medical expenses for amounts under the deductible, up to the balance available in your HRA.
Are there services covered before you meet your deductible?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	This plan has no out-of-pocket limit.	There is no limit on how much you could pay during a coverage period for your share of the cost of covered services, except as shown in the health plan which is described in a separate SBC
What is not included in the out-of-pocket limit?	Not Applicable	Not applicable because there's no **out-of-pocket** limit on your expenses under this HRA plan, but see the health plan SBC for an **out-of-pocket** limit under that plan.
Will you pay less if you use a network provider?	Yes. Only in-network providers are covered.	This plan treats **providers** the same in determining payment for the services, however the amount paid by this plan will depend on amount you owe under the health plan. This amount may vary depending on whether you use a **network provider**.
Do you need a referral to see a specialist?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.


All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$3000 Employee Only Coverage Deductible + 30% of Remaining Health Plan Deductible (max $3900) $3000 First Family Member +30% of Remaining Health Plan Deductible, $3000 Remaining Family Members + 30% of Remaining Health Plan (max $7800)	N/A Out of Network Expenses Are Not Covered Prescription drug expenses subject to deductible are not reimbursable under the HRA.	Coverage is limited to individual's HRA account balance.
	Specialist visit			
	Preventive care/screening/ immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)			
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care			
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)			
	Physician/surgeon fees			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$3000 Employee Only Coverage Deductible + 30% of Remaining Health Plan Deductible (max $3900) $3000 First Family Member +30% of Remaining Health Plan Deductible, $3000 Remaining Family Members + 30% of Remaining Health Plan (max $7800)	N/A Out of Network Expenses Are Not Covered	
	Inpatient services			
If you are pregnant	Office visits			
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			Coverage is limited to individual's HRA account balance.
If you need help recovering or have other special health needs	Home health care			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice services			
If your child needs dental or eye care	Children's eye exam			
	Children's glasses			
	Children's dental check-up			

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Amounts in excess of HRA account balance.
- Expenses not subject to deductible.
- Rx deductible expenses

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Out of network expenses

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying

individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? [N/A]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? [N/A]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$3000**
- **Specialist *[cost sharing]*** **$N/A**
- **Hospital (facility) *[cost sharing]*** **30%**
- **Other *[cost sharing]*** **30%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3000.00*
Copayments	100%
Coinsurance	30%
What isn't covered	
Limits or exclusions	$*
The total Peg would pay is	**$***

***$3000, plus coinsurance and amount in excess of individual's account balance.**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$3000**
- **Specialist *[cost sharing]*** **$N/A**
- **Hospital (facility) *[cost sharing]*** **30%**
- **Other *[cost sharing]*** **30%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3000
Copayments	100%
Coinsurance	30%
What isn't covered	
Limits or exclusions	$*
The total Joe would pay is	**$***

***$3000, plus coinsurance and amount in excess of individual's account balance.**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$3000**
- **Specialist *[cost sharing]*** **$N/A**
- **Hospital (facility) *[cost sharing]*** **30%**
- **Other *[cost sharing]*** **30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$3000
Copayments	100%
Coinsurance	30%
What isn't covered	
Limits or exclusions	$*
The total Mia would pay is	**$***

***$3000, plus coinsurance and amount in excess of individual's account balance.**

The plan would be responsible for the other costs of these EXAMPLE covered services.

SECURECARE GROUP INSURANCE

EAGLE KMC LLC
Dental Benefits Summary

Group ID: 10006564
Effective: 01/01/2025

EMPLOYEE **PLAN OPTIONS**	**THE COPAY PLAN**		**THE PPO MAC PLAN**	
(Employee may select one of the two plans)	Network	Non-Network [2]	Network	Non-Network[2]
Office Visit Copay	None		None	
Type I: Diagnostic and Preventive[1]	See Schedule AZ500	See Schedule AZ500	100%	80%
Type II: Basic [1]			80%	60%
Type III: Major [1]			50%	40%
Endodontic & Periodontic Services [1]	See Schedule AZ500		Type II: Basic	
Deductible	None		$50 per person; $150 per family; Calendar year (Type II, & III Services)	
Calendar Year Maximum	None		$ 1,500 per person	
Type I Waiting Period[4]	None	None	None	None
Type II Waiting Period [4]	None	None	None	None
Type III Waiting Period[4]	None	12 months	None	None
Discount Orthodontic Fee Program[3]	Included	Not Included	Included	Not Included
Insured Orthodontic Coverage	None		50%, up to $750/12 months; $1,500 lifetime	
Insured Orthodontic Waiting Period	None		12 Months	

Weekly Premium Rates		THE COPAY PLAN	THE PPO MAC PLAN
	Employee	$ 3.81	$ 7.38
	Employee + Spouse	$ 7.29	$ 14.02
	Employee + Child(ren)	$ 8.45	$ 20.24
	Employee + Family	$ 10.94	$26.22
Plan Code		A5C1	2MCG

[1] **SUMMARY OF COVERED SERVICES** (The Certificate of Coverage will include a complete list of Covered Services)	
Type I: **Diagnostic & Preventive**	Oral Examinations (2 per calendar year) * Routine Cleanings (2 per calendar year) * Topical fluoride up to age 16 (1 per calendar year) * Diagnostic x-rays, full or panoramic (1 in any 3-year period) * Bitewing x-rays (2 per calendar year) * Emergency palliative treatment to relieve pain * Space maintainers (for premature loss of primary tooth).
Type II: **Basic**	Fillings using amalgam, silicate, acrylic, synthetic porcelain and composite filling materials * Simple extractions * Antibiotic injections administered by Dentist * Oral Surgery, including customary postoperative treatment. * Endodontics - root canal therapy, pulpotomy * Periodontics - treatment of gum disease.
Type III: **Major**	Restorative - implants, inlays, onlays, crowns (5-year waiting period for replacement) * Prosthodontics - full or partial dentures or bridges (5-year waiting period for replacement)* Endodontics - root canal therapy, pulpotomy * Periodontics - treatment of gum disease.

NOTES: Pre Treatment Review recommended for services or supplies over $300. **ELIGIBILITY:** Full-time Employees working at least 30 hours per week, and their dependents. See page 2 for details.

2-For PPO MAC plans, non-network benefits are paid on a Maximum Allowable Charge (MAC) basis. For PPO, Indemnity & SecureFlex UCR plans, non-network benefits are paid on a Usual, Customary, and Reasonable (UCR) basis. The employee is responsible for non-network balance billing that may result.

4-Replacement Benefits: Time periods satisfied under the employer's prior qualifying group dental plan (without coverage gap) will reduce Type I, II, III Waiting Periods.

For customer service, please call (602) 241-0914 (toll free at 1-888-429-0914), or visit www.mysecurecare.com for additional contact information.

Insured benefits under the SecureCare Dental Insurance Plan are provided under the Master Policy. This brochure is a summary of the SecureCare Dental benefits. It is not a contract and not part of the policy, but simply an outline of benefits provided under the Master Group Policy. For complete details consult the Certificate of Coverage.

SecureCare Dental Plan Information

Eligibility for Enrollment

You may enroll yourself for coverage if you (1) are an active employee; (2) meet your employer's eligibility criteria (e.g., number of work hours, job classification); and (3) have completed any applicable waiting period for coverage.

An employee may also enroll (1) his/her lawful spouse; (2) his/her child (natural, legally-adopted, step, or foster) who is under age 26. (3) his/her grandchild who is under age 19, and whom the employee can claim as an exemption on his/her federal income tax return; and (4) his/her handicapped child or grandchild older than the maximum age limit, who receives at least 50% support and care from the employee.

Effective Date of Coverage

Your coverage will begin on the first day of the month following your completed enrollment, provided (1) you are Actively At Work on such date; and (2) your first premium has been paid by you, or on your behalf. (Actively At Work means you are performing all customary job duties of your occupation, at your usual place of employment [or would be able to do so if it is a regular paid vacation day, or a regular non-working day, provided you are at work on the last preceding regular work day].)

If you enroll for dependent coverage, such coverage will begin the same day your coverage begins. If you enroll for dependent coverage at a later date, coverage on such eligible dependent(s) will begin on the first day of the month following completed enrollment, and payment of premium. If a dependent is Disabled (hospital confined; or unable to perform the regular and customary activities of a person in good health, and of the same age) on the date their coverage is to begin, coverage on that dependent will be delayed until the first of the month coincident with, or next following, the date Disability no longer exists.

End of Coverage

Your coverage will end on the earliest of (1) the date the policy ends; (2) the date you enter the Armed Forces of any country; (3) the end of the month during which you cease eligibility; or (4) the end of the last period for which premium payment has been made by you or on your behalf. Coverage on your dependents will end on the earliest of (1) the date your coverage ends; (2) the date your dependent no longer meets eligibility requirements; (3) the date your dependent enters the Armed Forces of any country; or (4) the end of the last period for which premium payment has been for dependent coverage.

Expenses Not Covered

No benefits are payable for, and any applicable Deductible amount may not be reduced by, any of the following:

- any service or supply (a) not listed as a Covered Service within the Schedule of Benefits, (b) payable under any medical expense plan, or (c) rendered by someone who is related to the covered person by blood, marriage, or adoption; or is normally a member of the covered person's household;
- any procedure (a) begun, but not completed; (b) begun before insurance begins; or (c) begun after insurance ends;
- any prosthetic appliance (a) for which the impression (for new or modified device) was made before insurance begins; (b) installed before insurance begins; or (c) finally installed or delivered more than 30 days after insurance ends;
- any treatment which is elective, or primarily cosmetic in nature, and/or not recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
- any procedure that (a) is determined to be not Medically Necessary, (b) does not offer a favorable prognosis, (c) does not have uniform professional endorsement, or (d) is experimental in nature;
- the correction of congenital malformations, including anodontia and cleft palate;
- the replacement of lost, discarded, or stolen appliances; or any duplicate device or appliance;
- cast restorations, inlays, onlays, and crowns for teeth that are not broken down by extensive decay or accidental injury, or for teeth that can be restored by other means (such as an amalgam or composite filling);
- restoration of third molars, except fillings;
- crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology;
- replacement of (a) bridges, (b) full or partial dentures, (c) crowns, inlays or onlays, or (d) occlusal guards (night guards, except for bruxism); unless such item is more than five years old and cannot be made serviceable;
- appliances, services, or procedures relating to: (a) the change or maintenance of vertical dimension; (b) correction of attrition, abrasion, erosion, or abfraction; (c) biteregistration; (d) bite analysis; or (e) splints, other than provisional splints;
- Procedures related to implants (other than what is listed as covered in COVERED DENTAL SERVICES, CLASS/TYPE III Major Services, item 11.), and any complications as of the result of implants; removal of implants; precision or semi-precision attachments; denture duplication; overdentures and surgery; or other customized services or attachments
- services provided for any type of (a) temporomandibular joint (TMJ) dysfunction; (b) muscular or skeletal deficiencies involving TMJ or related structures; or (c) myofascial pain;
- orthognathic surgery;
- orthodontic treatment, unless stated otherwise;
- treatment of malignancies;
- general anesthesia and intravenous sedation (regardless of the age of the patient), except in conjunction with covered oral surgery procedures;
- hospital services, or services of anesthetists or anesthesiologists;
- prescribed drugs;
- any instruction for diet, plaque control, or oral hygiene;
- dental disease, defect, or injury caused by a declared or undeclared war, or any act of war;
- charges for failure to keep a scheduled visit, or for the completion of any claim forms;
- expenses compensable under Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No Fault" coverage);
- expenses provided, or paid for, by any governmental program or law, except as to charges which the person is legally required to pay;
- services for which there would be no charge in the absence of insurance, or for any service or treatment provided without charge;
- Interpretation of a diagnostic image by a practitioner not associated with the capture.

Coordination of Benefits

Other coverage you have may affect benefits payable under the policy, to ensure that the total benefits from all plans will not exceed 100% of eligible expenses.

Administered by:
Southwest Preferred Dental Organization

Underwritten by:
American National Life Insurance Company of Texas
Galveston, TX

SECURECARE GROUP INSURANCE

DAVIS VISION EYECARE REFRAMED℠

Group Name: Eagle KMC LLC

Effective Date: 01/01/2025

Group ID: 10006564

Premier Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. Your vision plan helps you care for your eyes while saving you money by offering:

Paid-in-full eye examinations, eyeglasses and contacts!

Frame Collection: Your plan includes a selection of designer, name brand frames that are completely covered in full[1]

One-year eyeglass breakage warranty included on plan eyewear at no additional cost!

How to locate a Network Provider...
Just visit us at www.mysecurecare.com and click "Look for a Vision Provider" to locate a provider near you including:

Weekly Premium	Premier Plan
Employee	$ 1.53
Employee plus Spouse	$ 2.80
Employee plus Children	$ 2.60
Employee plus Family	$ 4.00
Vision Plan Code	**V103**

Contact your Human Resources department today to enroll.

For more information about the plan, visit us at www.mysecurecare.com or call: **1 (888) 429-0914.**

IN-NETWORK BENEFITS	
Eye Examination[6]	Every 12 months, Covered in full after $10 copayment
Eyeglasses	
Spectacle Lenses	Every 12 months, Covered in full For standard single-vision, lined bifocal, or trifocal lenses after $10 copayment
Frames	Every 24 months, Covered in full Any Premier frame from the Davis Vision Collection[1] (value up to $225) OR $150 retail allowance toward any frame from provider, plus 20% off balance[2] OR $200 allowance, plus 20% off balance to go toward any frame from a Visionworks family of store locations[9]
Contact Lenses [3 7]	
Contact Lens, Evaluation, Fitting & Follow Up Care	Every 12 months Davis Collection Contacts: Covered in full after $10 copay. Non Davis Collection Contacts: Standard: Covered in full after $10 copay Specialty: $60 allowance with 15% off the balance, after $10 copay
Contact Lenses (in lieu of eyeglasses)	Every 12 months Any contact lenses from Davis Vision's Contact Lens Collection[1] OR $150 retail allowance toward provider supplied contact lenses, plus 15% off balance[2]

ADDITIONAL DISCOUNTED LENS OPTIONS & COATINGS		
MOST POPULAR OPTIONS Savings based on in network usage and average retail values	Without SecureCare	With SecureCare
Scratch Resistant Coating	$40	$0
Polycarbonate Lenses[4]	$64	Included
Standard AntiReflective (AR) Coating	$62	$35
Standard Progressive (no line bifocals)	$154	$0
Plastic Photosensitive (Transitions)[5]	$123	$65

Insured and Underwritten by:

American National Life Insurance Company of Texas

Galveston, Texas

SC-Vis-P-0814-SB.25000

SECURECARE
GROUP INSURANCE

SECURECARE VISION PLANS OFFER

Value for our Members
A comprehensive benefit ensuring low out-of- pocket cost to members and their families. Our goal is 100% member satisfaction.

Convenient Network Locations
A national network of credentialed preferred providers throughout the 50 states.

Freedom of Choice
Access to care through either our network of independent, private practice doctors (optometrists and ophthalmologists) or select retail partners.

Value-Added Features:
Replacement contacts through LENS123® mail-order contact lens replacement service, saving both time and money.
laser Vision Correction discounts of up to 25% off the provider's Usual & Customary fees, or 5% off advertised specials, whichever is lower.

Contact SecureCare Vision
For more details about the plan visit us at: www.mysecurecare.com or call:
1 (888) 429-0914

Out-of-Network Benefits
You may receive services from an out-of-network provider, however you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Out-of-network Reimbursement Schedule
Eye Examination up to $40 | Frame up to $50
Spectacle Lenses (per pair) up to: Single Vision $40,
Bifocal / Progressive $60, Trifocal $80, Lenticular $100
Elective Contacts up to $105
Medically Necessary Contacts up to $225

Insured and Underwritten by:
American National Life Insurance Company of Texas
Galveston, Texas

Lower costs and more benefits! ***See the savings!***

Service	Without SecureCare	With SecureCare
Eye Examination	$100	$10
Lenses		
Bifocals	$80	$10
Scratch Resistant Coating	$40	$0
Transitions[5]	$123	$65
Frame	$150	$0
Total	$493	$85
Savings up to $408		

Additional Options	Without SecureCare	With SecureCare
FRAMES (from Davis Vision Collection)		
Fashion Frame	$125	$0
Designer Frame	$175	$0
Premier Frame	$225	$0
LENSES		
All ranges of perscriptions and sizes	$90	$0
Plastic Lenses	$33	$0
Oversized Lenses	$20	$0
Tinting of Plastic Lenses	$20	Included
Scratch Resistant Coating	$40	$0
Polycarbonate Lenses[10]	$64	Included
Ultraviolet Coating	$28	Included
Standard AntiReflective (AR) Coating	$62	$35
Premium AR Coating	$80	$48
Ultra AR Coating	$113	$60
Standard Progressive Lenses [8]	$154	$0
Premium Progressives (Varilux®) [8 11]	$248	$40
Ultra Progressives (Varilux®) [8 11]	$430	$90
High Index Lenses	$120	$55
Blue Light Filtering	$30	$15
Polarized Lenses	$103	$75
Plastic Photosensitive Lenses	$123	$65
Scratch Protection Plan (Single vision & Multifolcal Lenses)		$20 / $40

1 The Davis Vision Collection is available at most participating independent provider locations. Collection is subject to change. Davis Vision is the national eyecare network used by SecureCare Vision.
2 Additional discounts not applicable at Walmart, Sam's Club or Costco locations.
3 Including, but not limited to toric, multifocal and gas permeable contact lenses.
4 For dependent children, monocular patients and patients with prescriptions of 6.00 diopters or greater.
5 Transitions® is a registered trademark of Transitions Optical Inc.
6 Routine eye examinations do not include professional services for contact lens evaluations.
7 If contact lenses are selected and fitted, they may not be exchanged for eyeglasses
8 Progressive lenses: If you are unable to adapt to progressive addition lenses you have purchased, conventional bifocals will be supplied at no additional cost; however, your copayment is nonrefundable above the evaluation and fitting allowance are the responsibility of the member.
9 Enhanced frame allowance available at all Visionworks Locations nationwide.
10 Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions 6.00 diopters or greater.
11 Varilux® is a registered trademark of Societe Essilor International

SecureCare Vision has made every effort to correctly summarize your vision plan features. In the event of a conflict between this information and your organization's contract with SecureCare Vision, the terms of the contract or insurance policy will prevail. 5/25/14

SC-Vis-P-0814-SB.25000

SUMMARY PLAN DESCRIPTION (SPD)

Note: BGA does not currently offer SPD services, but can refer you to a company that does. See Fact Sheet.

ERISA requires a Summary Plan Description (SPD) to be distributed to each plan participant and to each beneficiary receiving benefits under the plan as follows:
For existing plans, a new participant must receive a copy of the SPD within 90 days after becoming a participant and a beneficiary must receive a copy within 90 days after their first receiving benefits. For newly created plans, a SPD must be distributed to participants and beneficiaries within 120 days after the plan is first instituted. Additionally, a plan sponsor must provide a SPD within 30 days of it being requested by a plan participant.

SUMMARY OF MATERIAL MODIFICATIONS (SMM)
SUMMARY OF MATERIAL REDUCTION IN COVERED SERVICES OR BENEFITS

Note: BGA does not currently offer SMM services, but can refer you to a company that does. See Fact Sheet. Screen Shot 1

Under the Employee Retirement Income Security Act of 1974 (ERISA), pension providers must provide a summary of material modifications any time a change is a material modifications to the policy. Material modifications include plans to reduce or remove benefits, changes to the responsibilities on individuals enrolled in the scheme and changes to the eligibility criteria.

SUMMARY ANNUAL REPORT (SAR)

Benefit plans subject to ERISA are required to distribute SARs. If a plan is not required to file a Form 5500, then a SAR is not required. Under the Department of Labor's (DOL) SAR regulations, a totally unfunded welfare plan, regardless of size, does not need to provide SARs (even though large, unfunded welfare must file a Form 5500). In contrast, large insured plans are subject to the SAR requirement.

Generally, the responsibility rests with a plan administrator who contracts with your company to provide pension or other benefit plans.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. If you offer more than one plan to your employees, only the SBC specific to the plan for which an employee is eligible must be provided to that employee at renewal.

Insurers are required to provide an SBC to the employer that sponsors the group health plan, and the insurer is jointly responsible with the plan's administrator for furnishing the SBC to participants and beneficiaries. Accordingly, employers who sponsor fully insured health plans should coordinate with their carriers to determine when the carrier will be providing SBCs, and if the carrier will be furnishing them directly to participants and beneficiaries.

Summary of Benefits and Coverage Regulations and Guidance
SBC Template

SCHEDULE A FORM 5500

Note: A group health plan with fewer than 100 participants that is either fully insured or self-funded (or both) is generally not required to file Form 5500.

All qualified retirement plans, 403(b) plans subject to ERISA, and health and welfare plans with more than 100 participants will be subject to the new filing requirements. Employers sponsoring qualified plans or 403(b) plans with more than 100 participants, subject to audit, will also be required to electronically file the audited financial statement along with Form 5500.

IRS Form 5500 must be filed each year for every pension benefit plan or entity that participates as a Direct Filing Entity (DFE) in certain trusts, accounts, or other arrangements.

Form 5500 Series

Generally, the responsibility to fill out and file IRS forms rest with a plan administrator who contracts with your company to provide pension or other benefit plans.

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)

This act establishes employees' rights with regard to their personal health information. Employers should make employees aware of all the aspects of HIPAA privacy regulations, including penalties for committing privacy breaches. HIPAA requires employers to adhere to strict privacy guidelines.

Notice of Privacy Practices for Protected Health Information

General Notice/Individual Notice of Preexisting Condition Exclusion, Special Enrollment Rights, Wellness Program Disclosure

Note: Group health plans with two or more participants who are current employees must supply notices.

HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. Employers may implement the HIPAA guidelines using one of two approaches: "Hands-On" and "Hands-Off" of employees' personal health information. An employer who adopts a Hands-On approach is granted access to all of their employees' personal health information, and accordingly is required to adhere to all of the HIPAA privacy rules. An employer who adopts a Hands-Off approach chooses to not have access to its employees' personal health information, and is thus required to follow only a limited portion of the HIPAA privacy rules.

Model Notices of Privacy Practices

NOTICE REGARDING AVAILABILITY OF HEALTH INSURANCE EXCHANGES

This notice must be provided in the plan's Summary Plan Description (SPD) or other description of benefits given to participants.

To satisfy the content requirements, model language is available at www.dol.gov/ebsa/healthreform. You may also review, Notice Regarding Availability of Health Insurance Exchanges. There are two models; employers may use one of those models as applicable.

Model Notice for Employers who Offer a Health Plan

Model Notice for Employers who DO NOT Offer a Health Plan

Note: Employers must provide all new hires and current employees with an exchange notice at the time of hiring.

COBRA (CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT) NOTICES

Employers with 20 or more employees are usually required to offer COBRA coverage and to notify their employees of the availability of such coverage. COBRA applies to plans maintained by private-sector employers and sponsored by most state and local governments.

General Notice of COBRA Rights

COBRA Election Notice Model

Additional Information

Note: Notices must be provided by employers with 20 or more employees at time of hire and at time of termination or a qualifying event.

AZ Mini-COBRA

Pursuant to ARS § 20-2330, a health benefits plan issued or renewed after December 31, 2018, must allow an enrollee and any qualified dependent to continue coverage after a qualifying event. The law requires a small employer (with an average of at least 1 but fewer than 20 employees) to notify an enrollee in writing of the right of the enrollee and any qualified dependents to continue coverage under the employer's health benefits plan upon an enrollee's qualifying event.
Mini-COBRA Election Model Notice

MEDICARE PART D CREDITABLE COVERAGE DISCLOSURES

Employers must provide creditable or non-creditable coverage notice to all Medicare eligible individuals who are covered under, or who apply for, the entity's prescription drug plan (Part D eligible), whether active employees or retirees, at least once a year.
Medicare Part D Creditable Coverage Disclosures

Note: The Centers of Medicare and Medicaid Services(CMS) Creditable Coverage website provides complete text of the guidance and model disclosure templates published by CMS.

DISCLOSURE OF GRANDFATHER STATUS (GRANDFATHERED PLANS ONLY)

To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement that the plan or coverage believes it is a grandfathered health plan. This can be located in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage.

Disclosure of Grandfather Status

Note: This notice must be provided in each plan year in which grandfathered status is maintained.

SPECIAL HEALTH CARE NOTICES

The Patient Protection Portability Care Act (PPACA) require the distribution of certain notices describing changes that take effect for plan years beginning on or after September 23, 2010. The DOL has published model notices that may be used to make these disclosures.
Women's Health and Cancer Rights Act (WHCRA) Notices
Mental Health Parity and Addiction Equity Disclosure (MHPAEA)
Employer CHIP (Children's Health Insurance Program) Notice
Notice Regarding Newborns' and Mothers' Health Protection Act
Patient Protection Model Notice
Surprise Billing Notice
HIPAA Notice of Special Enrollment Rights
GAG Clause Prohibition

Note: These notices must be delivered in accordance with the Department of Labor's disclosure regulations applicable to furnishing summary plan descriptions. The notices may be provided by first class mail or any other means of delivery prescribed in the regulation.

OTHER POSSIBLE COMPONENT DOCUMENTS

FMLA (Family Medical Leave Act)
ERISA (Employee Retirement Income Security Act)
USERRA (Uniformed Services Employment and Re-employment Rights Act)
GINA (Genetic Information Nondiscrimination Act)
HITECH (The Health Information Technology for Economic and Clinical Health Act)

***This checklist is designed to help companies review the key notice requirements that may apply to their employer-sponsored group health plans under ERISA. Please note that this list is for general reference purposes only and is not all-inclusive.**

**** If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor.**

*****For more detailed information, please review the Reporting and Disclosure Guide for Employee Benefit Plans provided by the United States Department of Labor.**

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

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

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

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

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

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