

2025 Benefits Enrollment Guide



 **BROWN EDWARDS**

certified public accountants

Helping You Understand
Your Benefit Choices

This is a high-level benefits guide of certain benefits your employer offers. The information in this booklet is intended as a general outline of the benefits offered under your employers benefits program and should not be considered legal, investment or other benefits advice. Specific details and plan limitations are provided in the Summary Plan Descriptions (SPD), which is based on the official Plan Documents that may include policies, contracts and plan procedures. The SPD and Plan Documents contain all the specific provisions of the plans. In the event that the information in this brochure differs from the Plan Documents, the Plan Documents will prevail. Benefit plans are subject to change, amendment, or termination without notice to or the agreement of any employee/participant. All protected health information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see the "Notices" Section in the back of this benefits booklet.

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WELCOME

BENEFITS MENU | ENROLLMENT GUIDE

BENEFITS OFFERED

MY HEALTH

Medical | **Anthem**

Dental | **Delta Dental**

Vision | **VSP**

Health Savings Accounts | **Wex**

Flexible Spending | **Wex**

Accident | **Aflac**

Critical Illness | **Aflac**

Hospital Indemnity | **Aflac**

MY LIFE

Life and AD&D | **Sun Life**

Disability | **Sun Life**

InsurChoice Personal Solutions

Your Benefit Period

JANUARY 1, 2025 - DECEMBER 31, 2025

ENROLLMENT

All team members have access to our online benefits enrollment platform, ADP, 24/7 where you have the ability to enroll, select or change your benefits online during the annual open enrollment period, new hire orientation, and for qualifying events.

- ✓ Accessible 24/7;
- ✓ View all benefit plan options and your elections;
- ✓ View important carrier forms and links;
- ✓ Report a qualifying life event; and
- ✓ Make changes to beneficiary designations and more.

READY TO ENROLL?

Go to <https://workforcenow.adp.com>

This is an Active Open Enrollment. You will need to log into ADP and verify your information as well as your dependent information for 2025.

We are requiring employees to make beneficiary assignments in ADP to complete open enrollment for the Group Life and Supplemental Life coverages.



Helpful Tips To Consider Before You Enroll

1. Do you plan to enroll an *eligible dependent(s)*?

If so, make sure to have their social security numbers and birthdates available. You cannot enroll your dependent(s) without this information.

2. Have you recently been *married/divorced or had a baby*?

If so, remember to add or remove any dependent(s) and/or update your beneficiary designation.

3. Did any of your covered children reach their *26th birthday this year*?

If so, they may no longer be eligible for benefits, unless they meet specific criteria.

ELIGIBILITY

RULES | REQUIREMENTS

EMPLOYEE ELIGIBILITY

You are eligible to participate if you work an average of 25 hours per week. Your coverage will be effective 1st of the month following your date of hire.

If you are a New Hire, you will have 30 days in which to make your elections online.

DEPENDENT ELIGIBILITY

You may also enroll eligible dependents for benefits coverage. A **'dependent'** is defined as the **legal spouse** and/or **'dependent child(ren)'** of the plan participant or the spouse.

The term 'child' refers to any of the following:

- A natural (biological) child;
- A stepchild;
- A legally adopted child;
- A foster child;
- A child for whom legal guardianship has been awarded to the participant or the participant's spouse; or
- Disabled dependents may be eligible if requirements set by the plan are met.



Qualifying Life Events

If you have a Qualifying Life Event and want to request a mid-year change, you must notify Human Resources and complete your election changes within 30 days following the event. Be prepared to provide documentation to support the Qualifying Life Event.

Common life events include; Marriage, Divorce, New Dependent, Loss/gain of available coverage by you or any of your dependents.

Please note: Not every change in status permits a change in benefit plan elections.

A change in election is permitted only when it is determined that the change in status affects eligibility for coverage of the employee, a spouse or a dependent under a benefit plan.

IMPORTANT

You cannot make changes to these elections during the year unless you experience a qualified family status change, which must be reported to Human Resources within 30 days of the event.

If you separate from employment, COBRA continuation of coverage may be available as applicable by law.

HEALTH

INSURANCE TERMS | ANTHEM

COMMON INSURANCE TERMS

A **PREMIUM** is the amount you pay for insurance, using pre-tax or post-tax dollars.

A **COPAYMENT (COPAY)** is a fixed amount you pay to receive services. Your copayment(s) will count towards your out-of-pocket maximum but not your deductible. (e.g., \$30 for every visit to the doctor), while your insurance company pays the rest.

A **DEDUCTIBLE** is the amount of money you are responsible for paying each year before the plan begins to pay for covered services, with the exception of preventive care services, which are covered at 100% In-Network.

COINSURANCE This is your share of the expense of covered services after your deductible has been paid when the company plan is paying a percentage. The coinsurance rate is usually a percentage.

OUT-OF-POCKET (OOP) MAXIMUM is the most you pay per Plan Year for health care expenses and applies to deductibles, flat-dollar copays and coinsurance for all covered services – including cost-sharing amounts for prescription drugs. Once this limit is met, the plan will cover all in-network services at 100% until the end of the plan year.

***OUT-OF-NETWORK** charges in the above plans are subject to reasonable and customary limitations, which means you are responsible for charges over this amount in addition to separate deductible and coinsurance.

PPO | In-Network & Out-of-Network* Benefits Available

The PPO option offers the freedom to see any provider when you need care. When you use providers from within the PPO network, you receive benefits at the discounted network cost. Most expenses, such as office visits, emergency room and prescription drugs are covered by a copay. Other expenses are subject to a deductible and coinsurance.

HDHP HSA | In-Network & Out-of-Network* Benefits Available

The HDHP is similar to the PPO Plan in that you have the option to choose any provider when you need care. However, in exchange for a lower per-paycheck cost, you must satisfy a higher deductible that applies to almost all health care expenses, including those for prescription drugs.

All expenses are your responsibility until the deductible is reached, with the exception of preventive care, which is covered at 100% when you visit a physician in the network. Once the deductible is met, you are responsible for coinsurance for medical expenses and a copay for prescription drug expenses.

Enrolling in this plan allows you to contribute tax free dollars to a health savings account (HSA). Any dollars that you (and your employer) wish to contribute can be used towards any eligible medical, Rx, dental and vision expenses that you may incur while covered under the plan. See HSA section of this guide for additional details.



[Click the image to access the hyperlink to view a short video for more information.](#)



Did You Know?

- ✓ **Preventive Services** are covered at **100% In-Network** and copays & deductibles do not apply.
- ✓ You **pay less** out of pocket if you receive care from an **In-Network provider**.
- ✓ **Anthem's National PPO network is part of the BlueCross BlueShield network.**

How do I find an In-Network Provider?

Find Care

In-Network providers can be found on your provider's website (www.Anthem.com) under "Find Care."

Click on the "FIND CARE" Green button

Prior to receiving your Anthem ID card, select "Basic Search as a Guest"

- Select Medical Plan or Network
- Select Virginia (regardless of your home state)
- Select Medical (Employer Sponsored)

For network –

- Select KeyCare PPO for providers located in Virginia
- Select National PPO (BlueCard PPO) for all other locations

MEDICAL

HEALTH | PLAN COMPARISON | ANTHEM

IN-NETWORK BENEFITS	5000 HDHP Plan	3300 HDHP Plan	4000 PPO Traditional Plan
DEDUCTIBLE	In-Network / Out of Network	In-Network / Out of Network	In-Network / Out of Network
Single Deductible	\$5,000 / \$7,500	\$3,300 / \$6,600	\$4,000 / \$7,000
Family Deductible	\$10,000 / \$15,000	\$6,600 / \$13,200	\$8,000 / \$14,000
OUT OF POCKET MAXIMUM			
Single Maximum	\$6,250 / \$15,000	\$4,500 / \$9,000	\$5,000 / \$10,500
Family Maximum	\$12,500 / \$30,000	\$9,000 / \$18,000	\$10,000 / \$21,000
MEMBER RESPONSIBILITY	In-Network / Out of Network	In-Network / Out of Network	In-Network / Out of Network
Preventive Services: Well-Child Care, Annual Physical Exams	100% covered / 20% after deductible	100% covered / 20% after deductible	100% covered / 40%
Primary Care (PCP) - Office Visit	0% / 20%	10% / 20%	\$30 copay / 40%
Specialist - Office Visit	0% / 20%	10% / 20%	\$50 copay / 40%
Virtual Visits	0% / 20%	10% / 20%	\$10 copay / N/A
Urgent Care Facility	0% / 20%	10% / 20%	\$50 copay / 40%
Emergency Room Visit	0%	10%	20% / 40%
Inpatient Services	0% / 20%	10% / 20%	20% / 40%

Percentage of coverage above, coinsurance, applies after deductible is met.

Copays do not go toward the deductible.



[Click the image to access the hyperlink to view a short video for more information](#)

Your Care Options and When to Use Them

Primary Care Physician (PCP)

For routine, primary/preventive care, or non-urgent treatment, we recommend going to your doctor's office for medical care. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out-of-pocket when you receive care in your doctor's office.

Urgent Care Centers vs. Freestanding Emergency Rooms

Freestanding emergency rooms look a lot like the urgent care centers you are likely used to, but the costs and services are drastically different. In general, consider an urgent care center as an extension of your PCP, while freestanding emergency rooms should be used for health conditions that require a high level of care. Research the options in your area and determine which ones are covered by your insurance plan's network; note that balance billing may apply. Choosing an urgent care center for everyday health concerns could save you hundreds of dollars.

PRESCRIPTION DRUGS

Rx | PLAN COMPARISON | ANTHEM

TRADITIONAL DRUGS

TIER 1 (GENERIC) | Lowest copay: Most drugs in this category are generic drugs. Members pay the lowest copay for generics, making these drugs the most cost-effective option for treatment.

TIER 2 | Higher copay: This category includes preferred, brand name drugs that don't yet have a generic equivalent. These drugs are more expensive than generics, and a higher copay.

TIER 3 | Highest copay: In this category are nonpreferred brand name drugs for which there is either a generic alternative or a more cost-effective preferred brand. These drugs have the highest copay. **Make sure to check for mail order discounts that may be available.**

SPECIALTY DRUGS

TIER 4 | Lowest specialty drug copay: Tier 4 specialty drugs are generally more effective and less expensive than nonpreferred specialty drugs in tier 5.

In-Network Rx Copays	5000 HDHP Plan	3300 HDHP Plan	4000 PPO Traditional Plan
TIER 1 (Value / Generic)	\$10 copay after deductible	\$10 copay after deductible	\$10 copay
TIER 2	\$35 copay after deductible	\$35 copay after deductible	\$35 copay
TIER 3	\$60 copay after deductible	\$60 copay after deductible	\$60 copay
TIER 4	20% up to a maximum of \$150 after deductible	20% up to a maximum of \$150 after deductible	20% up to a maximum of \$150

WHERE CAN I FIND A DRUG LIST?

Typically, a full listing of covered drugs is found on your provider's website. A drug list, also called a formulary, is a list of generic and brand-name drugs covered by a health plan. Although a drug may be on the drug list, it might not be covered under every plan. Review the plan materials for details on specific benefits.

You can use drug lists to see if a medication is covered by your health insurance plan. You can also find out if the medication is available as a generic, needs prior authorization, has quantity limits and more.

To see if your medication is covered, go to www.Anthem.com under "Find Care."

- Scroll down until you see Medication Search under Health Resources
- Then Scroll down to the formulary list, under National Drug List and select [National Drug List 4-Tier \(Searchable\)](#)

Find Care



Save Money With Generic (Tier 1) Drugs

Ask your doctor if it's appropriate to use a generic drug rather than a brand.

Generic drugs are less expensive, and according to the FDA, they contain the same active ingredients and are identical in dose, form and administrative method as a brand name.

Helpful Rx Cost Savings Tools & Tips:

MAIL ORDER - Many drugs are available in a 90-day supply, rather than the 30-day retail supply. Typically, you will pay less if you choose to get a mail order 90-day supply.

GOOD Rx - There are many tools online that you can use in order to save on prescription costs. One being GoodRx.com, an online Rx database that allows you to find what pharmacy is the cheapest for your specific prescription. Additionally, you may be able to find a coupon that will greatly reduce your cost. It is important to remember that many of the coupons can only be used outside of your plan (will not count towards your maximums).

ASK YOUR DOCTOR - Make sure to ask if there are cost savings alternatives to the prescription they are providing. Many times, there are generic or different manufacturers that will save you money at the pharmacy.

COST OF COVERAGE

HEALTH | COST COMPARISON | ANTHEM

Below is your 2025 cost for coverage. Brown Edwards contributes a significant amount towards the cost of your insurance program. All costs for coverage listed are shown as a semi-monthly payroll contribution.

Anthem Medical Plans Semi-Monthly Payroll Deductions			
Without Wellness Incentive			
Coverage Tier	5000 HDHP Plan	3300 HDHP Plan	4000 PPO Traditional Plan
Employee Only	\$31.77	\$89.73	\$108.26
Employee & Spouse	\$210.55	\$320.99	\$352.26
Employee & Child(ren)	\$93.69	\$179.66	\$203.15
Employee & Family	\$254.51	\$462.32	\$514.95

HSA Employer Contributions
 If you are elect one of the HDHP/HSA Plans, Brown Edwards will contribute \$500 for employee only coverage or employee/spouse coverage, \$1,000 for employee/child(ren) coverage or \$1,500 for family coverage for 2025!

WELLNESS INCENTIVE

At Brown Edwards, we care about our employees and want to encourage you to live a healthy lifestyle so you can be your best at work and at home. A couple of steps you can take to be in better health are being tobacco free and having regular preventative exams to identify risk factors before they lead to a chronic, and sometimes debilitating illness.

Employees (and their applicable spouses) who have had their annual physical will receive a Wellness Incentive of \$10 per pay period (per person). Attestations indicating that you have had an annual physical in 2024 (or will prior to 12/31/2024) are due by 12/31/2024. Please visit the benefit section of the intranet to obtain a copy of this form for your provider to complete. A missing record of this information will result in loss of the Wellness Incentive.

Employees (and their applicable spouses) who use tobacco products will be assessed a surcharge of \$40 per pay period (per person). During open enrollment you will need to attest to being tobacco free. This will be done through your online ADP enrollment.

Brown Edwards is committed to helping you achieve your best health. If you think you might be unable to meet a standard for a Wellness Incentive under this program, you might qualify for an opportunity to earn the same incentive by different means. Contact HumanResources@becpas.com and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same Wellness Incentive that is right for you in light of your health status.

SPOUSAL SURCHARGE

If you are enrolling your spouse in a Brown Edwards medical plan and they have access to PPACA qualified health coverage with their employer, you will be assessed a spousal surcharge of \$75.00 per pay period. If you are enrolling your spouse in medical coverage and they DO NOT have access to medical benefits through their employer, or they ARE NOT employed, you will not incur the surcharge. Please complete the attestation in ADP during open enrollment if you are enrolling your spouse in your medical plan.

ONLINE HEALTHCARE

24/7 | VIRTUAL DOCTOR VISITS | ANTHEM

**No crowded
waiting rooms.**
No Driving.
**See a doctor when
you need a doctor.**

A virtual care visit lets you see and talk to a doctor from your computer or mobile device (using Anthem's Sydney mobile app). Virtual options include both routine/primary care as well as urgent care services. Costs must be paid by you at the time of the virtual visit based on the Anthem benefit plan you choose for 2025.

For questions regarding online health care, contact:
1-833-592-9956 or
www.anthem.com

WHEN CAN I USE A VIRTUAL VISIT?

When you have a non-emergency condition and:

- your doctor is not available;
- you become ill while traveling;
- When you are considering visiting a hospital emergency room for a non-emergency health condition.

**Your covered children may also use Virtual Visits when a parent or legal guardian is present for the visit.*

Examples of Non-Emergency Conditions:

- | | |
|---------------------|----------------|
| ✓ Bladder infection | ✓ Rash |
| ✓ Bronchitis | ✓ Seasonal flu |
| ✓ Diarrhea | ✓ Sinus |
| ✓ Fever | ✓ Sore throat |
| ✓ Pink eye | ✓ Stomach |

Visit with a doctor at your convenience

Accessing the care you need, when you need it, matters. That's why our Sydney Health mobile app connects you to a team of doctors ready to help you on your time. There are two secure ways to find low-cost care through our app:

Chat with a doctor 24/7 without an appointment

- Urgent care support for health issues, such as allergies, a cold, or the flu.
- New prescriptions for concerns such as a cough or a sinus infection.

Schedule a virtual primary care appointment

- Routine care, including virtual annual preventive care (wellness) visits and prescription refills. Personalized care plans for chronic conditions, such as asthma or diabetes.

Assess your symptoms with the Symptom Checker

When you're sick, you can use the Symptom Checker on Sydney Health to answer a few questions about how you're feeling. That information is run against millions of medical data points to provide care advice tailored to you.

Save money and time with virtual care

Sydney Health brings care to you anywhere, anytime. The Symptom Checker is always free to use, while virtual primary care visits and on-demand urgent care through the app are available at low cost. Virtual care options are also available for behavioral health and dermatology services.

DOWNLOAD THE APP

Get the information you need on the go by downloading the Anthem Sydney App from the App Store for AppleSM products or on the Google PlayTM Store for Android products.



FLEXIBLE SPENDING ACCOUNT

FSA | TAX SAVING VEHICLE | WEX

Flexible Spending Accounts (FSA) allow you to reduce your taxable income by setting aside pre-tax dollars from each paycheck to pay for eligible out-of-pocket health care and dependent care expenses* for yourself, your spouse and your dependent children.

In order to participate in the FSA, you must enroll each year. Your annual contribution stays in effect during the entire year (**January 1st through December 31st**). The only time you can change your election is during the enrollment period or if you experience a change-in-status event. Also, you must elect this benefit within **30 days** of your hire date or first date of benefits eligibility.

ELIGIBLE EXPENSES

- A full list of qualified FSA expenses can be found in IRS Publication 502 at www.irs.gov.
- You can learn more about FSA qualified expenses and also make purchases by visiting the FSA Store at www.fsastore.com.

HEALTH CARE & LIMITED PURPOSE FSA

MAXIMUM ANNUAL CONTRIBUTION | \$3,300

All eligible health care expenses – such as deductibles, medical and prescription copays, dental expenses, and vision expenses – can be reimbursed from your general-purpose FSA account.

With the Health Care FSA or Limited Purpose FSA, you can spend up to the full amount of your annual election as soon as your account has been set up.

LIMITED PURPOSE FSA | ADDITIONAL REQUIREMENTS

- If you open or contribute to a Health Saving Account (HSA), you may only enroll in a Limited Purpose FSA.
- If you enroll in a HDHP (High Deductible Health Plan) and elect a Health FSA, you will automatically be enrolled in the Limited Purpose FSA.
- A limited purpose FSA will reimburse you for dental and vision expenses, but you cannot claim the same expense on both the FSA and HSA Accounts.

DEPENDENT CARE FSA

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax-free dollars so that you and your spouse can work or attend school FT.

Unlike the Health Care FSA, funds in a Dependent Care FSA are only available once they have been deposited into your account and you cannot use the funds ahead of time.

- You may set aside up to **\$5,000** annually in pre-tax dollars, or **\$2,500** if you are married and file taxes separately from your spouse.
- If you participate in a Dependent Care FSA, you cannot apply the same expenses for a dependent care tax credit when you file your income taxes.

ELIGIBLE DEPENDENT CARE EXPENSES INCLUDE:

1. 'Care' for your dependent child who is under the age of 13 that you can claim as a dependent on your federal tax return;
2. 'Care' for your dependent child who resides with you and who is physically or mentally incapable of caring for themselves; or
3. 'Care' for your spouse, parent or grandparent who is physically or mentally incapable of caring for themselves and spends at least eight hours a day in your home.

'Care' is defined as: *In-home baby-sitting services (not by an individual you claim as a dependent); care of a preschool child by a licensed nursery or day care provider; before and after-school care; summer day camp (provided it is not overnight); and in-home dependent day care.*

IMPORTANT FSA RULES

HEALTH CARE FSA ROLLOVER

At the end of each plan year, you may use these funds left over from the current year FSA balance to pay for eligible expenses incurred in the first 2 ½ months of the following year. Any Unused funds beyond the 2 ½ month grace period will be forfeited.

“USE IT” OR “LOSE IT”

“Unused” FSA funds do not roll over from year to year. If you don't use the funds in your account before the end of the grace period, you'll lose them.

Both the Health Care and Dependent Care FSA have a 2½ month “grace period”. This means that you have until March 15, 2025, to incur your eligible expenses and until March 30, 2025, to submit your claims.

ELIGIBLE HEALTH FSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Artificial teeth/dentures
- Blood pressure monitors
- Braces
- Braille-books & magazines
- Breast pumps & lactation supplies
- Chiropractors
- Co-insurance, co-pay & deductibles
- Cost of operations & related treatments
- Crutches
- Diabetic supplies
- Drug addiction treatment
- Eye exams, eye glasses, contacts
- Hearing devices & batteries
- Hospital services
- Operations
- Pregnancy tests
- Radial keratotomy & lasik eye surgery
- Smoking cessation programs
- Speech therapy
- Surgical fees
- Vaccines
- Walkers & wheelchairs
- X-rays and more.

**A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.*

HEALTH SAVINGS ACCOUNT

HSA | TAX SAVING VEHICLE | WEX

HSA ELIGIBILITY REQUIREMENTS

To have an HSA and make contributions to the account, you must meet several basic qualifications.

- ✓ To be eligible to open and contribute to an HSA, you must have coverage under a qualified High Deductible Health Plan (HDHP).
- ✓ Participants cannot be covered by any other health insurance plan (this exclusion does not apply to certain other types of insurance, such as dental, vision, disability or long-term care coverage);
- ✓ Participants cannot participate in a Healthcare FSA or spouse/domestic partner's Healthcare FSA or Health Reimbursement Account (HRA).
- ✓ Participants cannot be enrolled in Medicare or Medicaid.
- ✓ You cannot be eligible to be claimed as a dependent on someone else's tax return.
- ✓ You have not received Department of Veterans Affairs Medical benefits in the past 90 days, unless the Veteran has a disability rating. *(There may be additional special circumstances, check with your tax preparer).*

Why choose an HSA?

- You don't lose it if you don't spend it. The HSA, including all the money in the account, is yours. You take the account with you when you change jobs, retire, or leave your qualified health plan.
- You don't have to pay taxes on withdrawals for eligible medical expenses.
- Contributions can be made via pre-tax payroll deduction and are put directly into the account.
- You can invest your contributions and/or use a debit card through Wex Health

Employer Contributions

If you are enrolled in one of the HDHP/HSA Plans, Brown Edwards will contribute \$500 for employee only coverage or employee/spouse coverage, \$1,000 for employee/child(ren) coverage or \$1,500 for family coverage for 2025!

2025 IRS HSA Contribution Limits *	
Individual	Family
\$4,300	\$8,550
Age 55+ Catch-Up Contribution:	
\$1,000	

*These limits are based on your medical plan coverage level, and they do not include any contributions from Brown Edwards.

Employees will have access to their HSA fund through a Debit card, or claims can be submitted to Wex Health for reimbursement. You can do this, as well as check your balance through your online Wex Health account or mobile app 24/7.

Wex Health Participant Services team is available 6 a.m. to 9 p.m. Central time, Monday through Friday. Access all of our participant service options at: wexinc.com/contact/health or through the mobile app.

ELIGIBLE HSA EXPENSES*

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limb
- Automobile modifications for a physically handicapped person
- Birth control pills
- Blood pressure monitoring device
- Braille books & magazines
- Chiropractic care
- Christian science practitioner
- COBRA premiums
- Contact lenses & related materials
- Crutches
- Dental treatment
- Dentures
- Diagnostic services
- Drug addiction treatment
- Eye examination
- Eyeglasses & related materials
- Fertility treatment
- Flu shot
- Guide dog or other animal aide
- Hearing aids
- Hospital services
- Immunization
- Insulin
- Laboratory fees
- Laser eye surgery
- Long-term care premiums or expenses
- Medical testing device
- Nursing services
- Obstetrical expenses
- Organ transplant
- Orthodontia (not for cosmetic reasons)
- Oxygen
- Physical exam
- Physical therapy
- Prescription drugs
- Psychiatric care
- Retiree medical insurance premiums
- Smoking cessation program
- Surgery
- Transportation for medical care
- Weight loss program
- Wheelchairs and more*.

***A full list of qualified expenses can be found in IRS Publication 502 at www.irs.gov.**

DENTAL

COVERAGE OVERVIEW | DELTA DENTAL

COMMON TERMS

PRE-TREATMENT ESTIMATE

If your dental care is extensive and you want to plan ahead for the cost, you can ask your dentist to submit a pre-treatment estimate. While it is not a guarantee of payment, a pre-treatment estimate can help you predict your out-of-pocket costs.

DUAL COVERAGE

You might have benefits from more than one dental plan, which is called dual coverage. In this situation, the total amount paid by both plans can't exceed 100% of your dental expenses. And in some cases, depending on the specifics of the plans, your coverage may not total 100%.

LIMITATIONS AND EXCLUSIONS

Dental plans are intended to cover part of your dental expenses, so coverage may not extend to your every dental need. A typical plan has limitations such as the number of times you can receive a cleaning each year. In addition, some procedures may be not be covered under your plan, which is referred to as an exclusion.

PREVENTION FIRST!

Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits.

Preventive care services are covered at 100% if you visit an In-Network provider. They are also not subject to the annual deductible.

You have the freedom to select the dentist of your choice; however, when you visit a participating in-network dentist, you will have lower out-of-pocket costs, no balance billing, and claims will be submitted by your dentist on your behalf.

	Low Plan	High Plan
PLAN FEATURES		
Benefit Period	Calendar Year	
DEDUCTIBLE		
Single	\$50	\$50
Family	\$150	\$150
When does it apply?	When receiving Basic or Major services (Does not apply for Preventive services)	
COVERED SERVICES		
CLASS I: Preventive Services <i>Routine oral exams and cleanings, x-rays (bitewing), sealants & fluoride treatments</i>	Covered at 100%, not subject to deductible	Covered at 100%, not subject to deductible
CLASS II: Basic Services <i>(Covered services include fillings and extractions)</i>	Covered at 80%, after deductible	Covered at 80%, after deductible
CLASS ii: Basic Services <i>(Endodontics, periodontics and complex oral surgery)</i>	Not covered	Covered at 50%, after deductible
CLASS III: Major Services <i>(covered , crowns, inlays/onlays, Dentures & bridges</i>	Not covered	Covered at 50%, after deductible
Orthodontia	Not covered	50% up to a lifetime maximum of \$1,500. Benefit covers both adults and dependents
ANNUAL MAXIMUM		
Maximum Benefit <i>Allowed per Benefit Period</i>	\$1,500 per covered individual	\$1,500 per covered individual



How do I find an In-Network Provider?

This dental plan offers deeper discounts when you visit a provider that is In-Network. In-Network providers can be found on www.deltadental.com "Find a Dentist". Choose the network based on the plan type you are choosing.

Delta Dental Plans Semi-Monthly Payroll Deductions		
Coverage Tier	Low Plan	High Plan
Employee Only	\$12.21	\$21.66
Employee & Spouse	\$24.39	\$43.31
Employee & Child(ren)	\$25.78	\$45.61
Employee & Family	\$38.88	\$58.71

*Note: If health insurance is waived, the firm will pay 100% of the premium for either Dental plan elected.

VISION

COVERAGE OVERVIEW | VSP*

*Brown, Edwards & Company will be transitioning to VSP directly for January 1, 2025

Under this plan, you may use the eye care professional of your choice. However, when you visit a participating in-network provider, you receive higher levels of coverage. If you choose to receive services from an out-of-network provider, you will be required to pay that provider at the time of service and submit a claim form for reimbursement.

Core Plan

Buy Up Plan

PLAN FEATURES		
Vision Exam (once every 12 months)		\$10 copay
COVERED SERVICES – LENSES / FRAMES		
Materials	Not covered; 20% discount	\$30 copay (lenses and frame)
Frame Allowance (once every 24 months)	Not covered; 20% discount	\$150 retail frame allowance
<ul style="list-style-type: none"> - Single Vision - Bifocal-lined - Trifocal-lined - Lenticular - Progressive 	Not covered; 20% discount	Single, Lined Bifocal, Lined Trifocal, Lenticular and Standard Progressive lenses are covered in full, after \$30 material copay Premium Progressive - \$80 - \$90 copay Custom Progressive - \$120 - \$160 copay
COVERED SERVICES		
Contact Lenses - Elective	Not covered; 15% discount	\$150 elective contact lens allowance Exam, fitting & evaluation service 15% discount and capped at \$60
Contact Lens - Necessary	Not covered; 15% discount	Covered if full, after \$30 material copay
Frames	Frequency limits to not apply	Once every 24 Months
Contacts	Frequency limits to not apply	Once every 12 Months

Vision Plans Semi-Monthly Payroll Deductions		
Coverage Tier	Core Plan	Buy up Plan
Employee Only	No Cost (if enrolled in Brown Edwards Health Insurance)	\$3.84
Employee & Spouse		\$6.46
Employee & Child(ren)		\$6.59
Employee & Family		\$10.63

Need to locate a participating In-Network provider? Get easy access to manage your benefits, claims, and more.
Sign in or register at VSP.com by clicking the image below or by going to www.vsp.com

Sign in

Register



Did you know your eyes can tell an eye care provider a lot about you?

In addition to eye disease, a routine eye exam can help detect signs of serious health conditions like diabetes and high cholesterol. This is important, since you won't always notice the symptoms yourself and since some of these diseases cause early and irreversible damage.

BASIC LIFE & AD&D INSURANCE

COVERAGE OVERVIEW | SUN LIFE

BENEFICIARY(IES)

It's very important to designate beneficiaries. Taking a few minutes to designate your beneficiaries now will help ensure that your assets will be distributed according to your direction.

A **Beneficiary** is the person you designate to receive your life insurance benefits in the event of your death. It is important that your beneficiary designation is clear so there is no question as to your intentions.

It is also important that you name a **Primary** and **Contingent Beneficiary**. A contingent beneficiary will receive the benefits of your life insurance if the primary beneficiary cannot. You can change beneficiaries at any time.

You should review your beneficiary elections on a regular basis to ensure they are updated as life changes. Even if you are single, your beneficiary can use your Life Insurance to pay off your debts, such as: credit cards, mortgages, and other expenses.

**You designate your beneficiary(ies) when enrolling for your benefits.*

BASIC LIFE INSURANCE

Brown Edwards provides benefit eligible employees with Basic Term Life and Accidental Death & Dismemberment (AD&D) Insurance. This benefit will be through **Sun Life**. The Employee Life and AD&D benefit amount is 3 times your salary, up to a maximum of \$1,000,000. Brown Edwards also offers Basic Life and AD&D to spouses and dependent children. Spousal coverage is provided at a flat amount of \$25,000, and children are provided with a \$10,000 policy. **Please make sure to make your beneficiary assignments in ADP.**

Benefit Detail

Employee Amount	3 times salary, up to a maximum of \$1,000,000
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Spouse Amount	Flat \$25,000
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Child(ren) Amount	Flat \$10,000
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ADDITIONAL PLAN PROVISIONS

Portability	If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.
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Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.
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WHAT WILL MY BENEFICIARY RECEIVE?

In The Event That Death Occurs:

- Your Basic Life insurance is paid to your beneficiary.
- **If death occurs from an accident:** 100% of the AD&D benefit would be payable to your beneficiary(ies) in addition to your Basic Life insurance.

SUPPLEMENTAL LIFE

COVERAGE OPTIONS FOR YOU & THE FAMILY | SUN LIFE

SUPPLEMENTAL LIFE INSURANCE

Employees have the opportunity to enroll in supplemental Life insurance. If you choose to enroll in employee coverage, this will be in addition to your employer provided Basic Life coverage. Coverage is also available for your spouse and/or child dependents. It is typically required that you elect coverage for yourself in order to be eligible for coverage on your dependents.

PLAN OPTIONS

Cost of Coverage	Premiums are based on age-rated tables and paid by the employee every pay period through a payroll deduction. These premiums are post-tax and benefits payable are tax-free.		
Coverage Options	<p>Employee Coverage Choose in \$10,000 increments up to the lesser of 5x your annual salary or \$500,000</p>	<p>Spouse Coverage Choose in \$5,000 increments up to the lesser of 100% of the amount you elect for yourself or \$250,000</p>	<p>Dependent Coverage \$5,000, \$10,000 or \$20,000 14 days to 6 months \$500</p>
Do I have to take a health exam to get coverage?	If you and your dependents enroll in coverage at your initial eligibility date, you may apply for up to the Guaranteed Issue amounts without medical questions.		
Guaranteed Issue	Employee \$250,000	Spouse \$100,000	

PLAN PROVISIONS

Cost Calculation	Age Rated Benefit (Spouse Life based on employee's age)		
Benefit Reduction Schedule	<p>Employee Coverage Will Reduce To:</p> <ul style="list-style-type: none"> 65% of the original amount at age 70 50% of the original amount at age 75 	<p>Spouse Coverage Will Reduce By:</p> <p>The same amount and at the same time your coverage reduces</p>	
Portability	If your employment ends or you retire, you may be eligible to continue your term insurance at group rates.		
Conversion	When coverage ends under the plan, you can convert to an individual permanent life policy without evidence of insurability.		

Employee/ Spouse Age	Employee Monthly Premiums (per \$1,000)	Spouse Monthly Premiums (per \$1,000)
Under age 20	\$0.044	\$0.105
20-24	\$0.044	\$0.105
25-29	\$0.044	\$0.105
30-34	\$0.044	\$0.105
35-39	\$0.057	\$0.130
40-44	\$0.083	\$0.183
45-49	\$0.136	\$0.302
50-54	\$0.197	\$0.445
55-59	\$0.312	\$0.710
60-64	\$0.479	\$1.094
65-69	\$0.726	\$1.609
70-74	\$1.445	Spouse termination age 70
75-79	\$3.136	
80-84	\$6.290	
85 and over	\$12.560	
AD&D per \$1,000	\$0.020	\$0.036
Dependent Rate	Life Rate: \$0.205 per \$1,000 Child AD&D Rate: \$0.053 per \$1,000	



*Guaranteed Issue (GI) and Evidence of Insurability (EOI)

When you are first eligible (at hire) for Voluntary Life and AD&D, you may purchase up to the Guaranteed Issue (GI) for yourself and your spouse without providing proof of good health (EOI). Annually, you are able to increase elections 1 increment up to GI without proof of good health.

Any amount elected over the GI will require EOI. If you elect optional life coverage, and are required to complete an EOI, it is your responsibility to complete the EOI and send to the provider (address will be listed on your form). In addition, your spouse will need to provide EOI to be eligible for coverage amounts over GI, or if coverage is requested at a later date.

DISABILITY

LONG-TERM | SUN LIFE

LONG-TERM DISABILITY (LTD)

Serious illnesses or accidents can come out of nowhere. They can interrupt your life, and your ability to work for months – even years.

Long Term Disability provides financial protection for you by paying a portion of your income, so you have financial support to manage your disability and your household.

Brown Edwards provides benefit eligible employees with Long-Term Disability (LTD) benefits. This benefit will be administered by **Sun Life**. This benefit is 100% paid for by Brown Edwards. In the event you become disabled due to a qualified injury or sickness, disability income benefits are there to help provide a source of income. See below for a brief summary of benefits.

Benefit Detail	Long-Term Disability
Elimination Period	90 days
Benefit Duration	Benefits are paid to the later of either age 65 or Social Security Normal Retirement Age (SSNRA)
Percentage of Income Replaced	60% of salary to a monthly maximum of \$10,000
Pre-Existing Condition	You may not be eligible for benefits if you have received treatment for a condition within 3 months prior to your effective date under this policy until you have been covered under the policy for 12 months.

Please note that if the employer pays the entire premium for the coverage and does not include the cost of the of the coverage in the employee’s gross income, the premiums are considered to be paid on a pre-tax basis. This being said, should you ever receive long-term disability benefits, the benefit would be subject to tax because the premiums were pre-tax.

Brown Edwards also provides the option to have the taxes on your long-term disability coverage premiums that are paid by the employer deducted semi-monthly on an after-tax basis and therefore any long-term disability benefits that you receive would not be subject to tax.

VOLUNTARY BENEFITS

ACCIDENT | AFLAC

*Brown, Edwards & Company will be transitioning to Aflac for January 1, 2025

Brown Edwards offers various Voluntary Benefits you may purchase to enhance your overall benefits package. These benefits are standalone products, that work independently of the medical and other benefits and pay cash directly to you in the event of a claim. Aflac elections will be payroll deducted.

Accident Insurance

A serious injury can cost you a lot of money – not only in medical bills but in things like income from lost work hours. Some injuries are minor, but others are debilitating and require significant medical care. If you get hurt, accident insurance pays you money that you can use to cover personal expenses, bills, and out-of-pocket medical costs.

Who Gets Paid?

You get paid. When you have a covered accident or injury, your health insurance company pays your doctor or hospital, but your accident insurance company pays you.

What's Covered?

Not all accidents are “qualifying injuries.” The kinds of accidents that are covered can vary by plan, but accident insurance plans typically cover things like:

- Emergency Room Visits
- Ambulance Transportation
- Hospital Admissions & Per Diem Charges
- Intensive Care & Rehabilitation Unit Care
- Diagnostic Exams
- Follow-up Treatments
- Physical Therapy

What is the Cost of Accident Insurance?

Cost will vary depending on if you cover yourself and/or other dependents, as well as which plan you elect. Payroll deduction will be provided through ADP.

What it Doesn't Cover

Accident insurance will not typically cover things like check-ups or hospitalization due to illness. Accident insurance will not cover you for injuries suffered before you purchased the plan.



Scan the QR Code or visit your Aflac [benefits page](#) for more information.

Benefits:	Low Plan	High Plan
Concussion	\$150	\$300
Dental Work	\$50 extraction / \$200 crown	\$100 extraction / \$400 crown
Doctor's Office Initial Visit	\$150(without x-ray)/\$200(with x-ray)	\$300(without x-ray)/\$400(with x-ray)
Emergency Room Treatment	\$150(without x-ray)/\$200(with x-ray)	\$300(without x-ray)/\$400(with x-ray)
Eye Injury	\$65	\$100
Fractures	\$120-\$3,000	\$240-\$6,000
Dislocations	\$160-\$4,000	\$200-\$5,000
Coma	\$5,000	\$10,000
Lacerations	\$20 - \$500	\$35 - \$1000
Burns	\$200 - \$10,000	\$200 - \$10,000
Follow-up Treatment	\$50-\$500(second degree) \$500-\$10,000(third degree)	\$100-\$1,000(second degree) \$1,000-\$20,000(third degree)
Physical Therapy	\$50, up to 10 visit per accident	\$50, up to 10 visit per accident
Ambulance	\$200 (ground); \$750 (air)	\$300 (ground); \$1,500 (air)
Transportation	\$300/trip, 100+ miles, 3/accident	\$600/trip, 100+ miles, 3/accident
Blood/Plasma	\$200	\$500
Lodging	\$50/night, 30 days max	\$100/night, 30 days max
Ruptured Disc	\$25-\$125(outpat surg) \$500(inpat surg)	\$50-\$250(outpat surg) \$1,000(inpat surg)
Tendon/Ligament/ Rotator Cuff	\$25-\$125(outpat surg) \$500(inpat surg)	\$50-\$250(outpat surg) \$1,000(inpat surg)
Surgery Benefit	\$25-\$125(outpat surg) \$500(inpat surg)	\$50-\$250(outpat surg) \$1,000(inpat surg)
Wellness	\$150 per year	\$150 per year
Hospital Admission	\$1,200 (\$1,200 ICU)	\$2,000 (\$2,000 ICU)
Hospital Confinement	\$150/day, 365 max	\$250/day, 365 max
Hospital Intensive Care	\$300/day, 14 days max	\$500/day, 14 days max
Portability	Included	Included
Knee Cartilage	\$25-\$125(outpat surg) \$500(inpat surg)	\$50-\$250(outpat surg) \$1,000(inpat surg)
Accidental Death	\$25,000	\$25,000
Accidental Death (Common Carrier)	\$100,000	\$100,000
Pre-existing Condition	None	None



\$150 WELLNESS BENEFIT
Per Covered Individual

For Screenings such as: blood tests, Chest X-rays, Stress tests, Colonoscopies, Mammograms, and other tests listed in your policy.

VOLUNTARY BENEFITS

CRITICAL ILLNESS | AFLAC

*Brown, Edwards & Company will be transitioning to Aflac for January 1, 2025

Brown Edwards offers various Voluntary Benefits you may purchase to enhance your overall benefits package. These benefits are standalone products, that work independently of the medical and other benefits and pay cash directly to you in the event of a claim.

AFLAC elections will be payroll deducted.

Critical Illness Insurance

How would you pay your bills if you were suddenly diagnosed with cancer and couldn't work? Critical illness insurance doesn't pay your medical bills. It pays you if you're diagnosed with a covered illness. The benefit is paid directly to you and is your choice how to spend it.

What's Covered?

Critical illness can vary widely from one another. Some may focus on a single specific diagnosis, while others may provide you with coverage for a range of possible diagnoses, such as:

What is the Cost of Critical Illness Insurance?

Depending on your age, and how much coverage you want, the cost of critical illness insurance can vary significantly. Payroll deduction will be provided through ADP.

More Details

Pre-Existing Condition Limitation: Benefits for a pre-existing condition (defined as a sickness or injury, or symptoms of one, whether diagnosed or not, for which you received medical treatment, consultation, care or services, including diagnostic measures, took prescribed drugs or medicine, or had been prescribed medicine or drugs to be taken in the 12 months prior to your effective date) will not be paid during the first 12 months the policy is in force.



Scan the QR Code below or visit your Aflac [benefits page](#) for more information.



	Benefit
Employee	\$10,000 increments; up \$40,000
Employee Guarantee Issue Amount	\$40,000
Spouse	\$10,000 increments; up \$40,000; not to exceed 100% of the Employee Election
Spouse Guarantee Issue Amount	\$40,000
Dependent Child	\$5,000 increments; up \$20,000; not to exceed 50% of the Employee Election
Dependent Child Guarantee Issue Amount	\$20,000



\$150 WELLNESS BENEFIT
Per Covered Individual

For Screenings such as: blood tests, Chest X-rays, Stress tests, Colonoscopies, Mammograms, and other tests listed in your policy.

VOLUNTARY BENEFITS

HOSPITAL INDEMNITY | AFLAC

*Brown, Edwards & Company will be transitioning to Aflac for January 1, 2025



Hospital Indemnity Standard Plan	Low	High	Covered confinements
First Day Hospital – 1 day per year	\$500	\$1,500	<ul style="list-style-type: none"> • Accident and Sickness • Routine Pregnancy • Complications of Pregnancy • Newborn complications • Mental Nervous Disorder • Substance Abuse
Hospital Confinement – Up to 30 days per year	\$100/day	\$200/day	
ICU Confinement – Up to 10 days per year	\$100/day	\$200/day	
Rehabilitation Unit – Up to 60 days per year ¹	\$100/day	\$200/day	

IMPORTANT: THE AFLAC VOLUNTARY HOSPITAL INDEMNITY PLAN IS A FIXED INDEMNITY POLICY, NOT HEALTH INSURANCE.

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

QUESTIONS ABOUT THIS POLICY?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Scan the QR Code below or visit your Aflac [benefits page](#) for more information.



\$150 WELLNESS BENEFIT
Per Covered Individual

For Screenings such as: blood tests, Chest X-rays, Stress tests, Colonoscopies, Mammograms, and other tests listed in your policy.

GETTING STARTED WITH AFLAC

*Brown, Edwards & Company will be transitioning to Aflac for January 1, 2025

Managing your coverage has never been easier

To access and manage your coverage online, visit aflac.com/login and register your account.

Once registered, you can take advantage of these features, available 24/7:



Set up direct deposit

Add your banking information and get paid fast.

Submit a claim and track the status:

Simply select new claim, answer a few questions about what happened and upload your supporting documents.

Once submitted, you can track your claim status as it is processing.

Manage your plans

Update your contact information, assign beneficiaries and more.



Have questions? Connect whenever you need us 24/7 by scanning the QR code on the left, logging in to your account or chatting with us at aflacgroupinsurance.com.



To submit your claim by mail, send your completed forms and supporting documents to P.O. Box 84075 Columbus, GA 31993, Attn: Claims Department.

*Registration of a new MyAflac account can take up to 24 hours to take effect.

Aflac herein means Aflac and/or Aflac of New York and/or Continental American Insurance Company and/or Continental American Life Insurance Company

INSURCHOICE

Personal Insurance Solutions. Digitally.



InsurChoice offers you the ability to personalize your own protection – bringing you quick, convenient, holistic coverage with incredible cost-saving discounts across a variety of top-rated insurance products and carriers.

- **Competitive pricing:** One size doesn't fit all, so you can match yourself with the best rates and coverages from multiple insurance companies.
- **Custom-tailored coverage:** Select the products that meet YOUR needs & YOUR schedule.
- **Stability:** We have relationships with key national carriers who have a proven track record of rate and coverage stability.
- **Innovation:** With our innovative digital product platform, we are constantly striving to add more benefits and improve your experience.



Auto Insurance



Home Insurance



Pet Insurance



Medicare Advantage



Discount Program



Mental Wellness



Renters Insurance



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Or email us at InsurChoice@nfp.com

GLOSSARY OF TERMS

Dependent Verification Services (DVS) – Service used to verify dependent proof of relationship when adding dependents to benefit plans.

Beneficiary – A person designated by you, the participant of a benefit plan, to receive the benefits of the plan in the event of the participant's death.

- **Primary Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the participant's death
- **Contingent Beneficiary** – A person who is designated to receive the benefits of a benefit plan in the event of the Primary Beneficiary's death

Charges – The term “charges” means the actual billed charges. It also means an amount negotiated by a provider, directly or indirectly, if that amount is different from the actual billed charges.

Coinsurance – The percentage of charges for covered expenses that an insured person is required to pay under the plan (separate from copayments)

Deductible – The amount of money you must pay each year to cover eligible expenses before your insurance policy starts paying.

Dependents – Dependents are your:

- Lawful spouse through a marriage that is lawfully recognized.
- Dependent child (married or unmarried) under the age of 26 including stepchildren and legally adopted children.

Proof of relationship documentation will be required in order to add dependents to your plan(s). Employees will receive request for documentation.

Emergency Services – Medical, psychiatric, surgical, hospital, and related health care services and testing, including ambulance service, that are required to treat a sudden, unexpected onset of a bodily injury or serious sickness that could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones.

The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the hospital, or the final diagnosis – whichever reasonably indicated an emergency medical condition – will be the basis for the determination of coverage provided such symptoms reasonably indicate an emergency.

Evidence of Insurability (EOI) – Proof that you are insurable based on the requirements of the insurance carrier. *For example, the results of a blood test or a doctor's signature on a form may be required for you to be covered by/for Optional Life insurance.*

Explanation of Benefits – The health insurance company's written explanation of how a medical claim was paid. It contains detailed information about what the company paid and what portion of the costs are your responsibility.

Health Reimbursement Account (HRA) – The Health Reimbursement Account (HRA) is an employer-funded account that reimburses you for eligible out-of-pocket medical expenses. The HRA is only available to employees who are enrolled in the HRA Plan.

In-Network – The term “in-network” refers to health care services or items provided by your Primary Care Physician (PCP) or services/items provided by another participating provider and authorized by your PCP or the review organization. Authorization by your PCP or the review organization is not required in the case of mental health and substance abuse treatment other than hospital confinement solely for detoxification.

Emergency Care that meets the definition of “emergency services” and is authorized as such by either the PCP or the review organization is considered in-network.

Out-of-Network - The term “out-of-network” refers to care that does not qualify as in-network.

Maximum Out of Pocket – The most money you will pay during a year for coverage. It includes deductibles, copayments and coinsurance, but is in addition to your regular premiums. Beyond this amount, the insurance company will pay all expenses for the remainder of the year.

Medically Necessary/Medical Necessity – Required to diagnose or treat an illness, injury, disease, or its symptoms; in accordance with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site, and duration; not primarily for the convenience of the patient, physician, or other health care provider; and rendered in the least intensive setting that is appropriate for the delivery of the services and supplies.

Participating Provider – A hospital, physician, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Post-Tax – An option to have the payment to your benefits deducted from your gross pay after your taxes have been withheld. Therefore, your tax contributions will be calculated based on a higher amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a higher amount.

Pre-Tax – An option to have the payment to your benefits deducted from your gross pay before your taxes have been withheld. Therefore, your tax contributions will be calculated based on a lesser amount. Your statutory deductions (federal income tax, Social Security, Medicare) will be calculated based on a lesser amount.

Primary Care Dentist (PCD) – The term “Primary Care Dentist” means a dentist who (a) qualifies as a participating provider in general practice, referrals, or specialized care; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for dental care for you or any of your insured dependents.

Primary Care Physician (PCP) – The term “Primary Care Physician” means a physician who (a) qualifies as a participating provider in general practice, obstetrics/gynecology, internal medicine, family practice, or pediatrics; and (b) has been selected by you, as authorized by the provider organization, to provide or arrange for medical care for you or any of your insured dependents.

Proof of Relationship Documentation – Documents that show a dependent is lawfully your dependent. Documents can include marriage certificates, birth certificates, adoption agreements, previous years' tax returns, court orders, and/or divorce decrees showing your or your spouse's responsibility for the dependent.

Contact Information

If you have any questions regarding any of the benefits mentioned, please contact your HR team at HumanResources@becpas.com.

For questions regarding your **Medical**, call **Anthem** at 1-833-592-9956 or visit www.Anthem.com



For questions regarding your **FSA, HSA**, call **Wex** at 866-451-3399 or visit www.wexinc.com/contact/health/



For questions regarding your **Dental**, call **Delta Dental** at 800-587-9514 or visit www.deltadental.com



For questions regarding your **Vision**, call **VSP 1800-877-7195** at or visit www.vsp.com



For questions regarding your products, **Basic Life, Supplemental Life, LTD**, call **Sun Life** at 800-247-6875 or visit www.Sun Life.com/us



For questions regarding your products, **Accident, Critical Illness and Hospital Indemnity coverages**, call **Aflac** at 800-433-3036
Visit <https://mylogin.aflac.com/>



For questions regarding **InsurChoice** email InsurChoice@nfp.com or visit https://digital.nfp.com/pc/BEBDO_IC_MP



To access the ADP website, go to:
<https://workforcenow.adp.com>

This is an Active Open Enrollment. You will need to log into ADP and verify your information as well as your dependent information for 2025.

We are requiring employees to make beneficiary assignments in ADP to complete open enrollment for the Group Paid Life and Supplement Life coverages.



BROWN EDWARDS

certified public accountants