



Eleos Property Management

2024-2025 Benefit Guide

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal Law gives you choices about your prescription drug coverage.

Letter from the Benefits Department

As consumers of health care, we have many choices on how and where we receive care. Although health care costs continue to rise, your employer is committed to offering a benefits plan that is valuable and accessible to you and your family.

Eleos Property Management has been diligent in searching for benefits that help our employees and their families satisfy their insurance needs. A brief overview of the providers and the benefits offered by each are listed below. For more detailed information on a specific benefit, please refer to the full plan documents.

NOTE: The plan year is November 1st-October 31st. However, the benefits run on a calendar year which means the deductible and out of pocket start over January 1st.

- ◆ **BlueCross and BlueShield of Oklahoma** - Medical and Prescription Drug plan
- ◆ **Delta Dental of Oklahoma** - Dental plan
- ◆ **VSP** - Vision plan
- ◆ **SunLife** - Group Life/ Accidental Death & Dismemberment
- ◆ **Colonial** - Accident, Critical Illness and Medical Bridge

Eligibility

Employees and your dependents are eligible for Eleos Property Management benefits on the first of the month following 60 days continuous employment.

It is wise to remember that the health care choices we make when visiting our physician, purchasing prescription drugs at the pharmacy, or utilizing one of the benefits offered by our plan, impacts both our health and our financial well-being. As smart consumers, we should ask about generic drugs and talk to our doctors about treatment options. Taking care of yourself can positively impact your quality of life.

After you review the enclosed information, please choose the coverage that is best for you and your family. Your employer will provide you with payroll deduction information to aid you in making your decisions.

Please complete all paperwork provided to you by your employer indicating your coverage election decisions. Be sure to provide all forms back to your employer by the date they indicate.

Sincerely,

Your Benefits Team

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

BCBSOK Medical Plan Options

	P8E1ADT Blue Advantage Platinum PPO	G740ADT Blue Advantage Gold PPO
	In-Network	In-Network
Calendar Year Deductible	\$750 Individual / \$2,250 Family	\$2,000 Individual / \$6,000 Family
Out-of-Pocket Maximum (includes deductible)*	\$2,000 Individual / \$6,000 Family	\$5,000 Individual / \$15,000 Family
Coinsurance	10%	30%
OFFICE VISITS		
Preventive Care	Covered 100%	Covered 100%
Primary Care Physician	\$25 copay / visit	\$45 copay / visit
Specialist	\$45 copay / visit	\$65 copay / visit
EMERGENCY MEDICAL SERVICES		
Urgent Care	\$50/visit	\$50/visit
Emergency Room	\$300/visit plus 10% coinsurance (Copayment waived if admitted)	\$650/visit plus 30% coinsurance
Outpatient Surgery	\$100/visit plus 10% coinsurance	\$300/visit plus 30% coinsurance
Inpatient Surgery	\$150/visit plus 10% coinsurance	\$300/visit plus 30% coinsurance
PHARMACY BENEFIT		
Retail (30 Days)		
Preferred Generic	\$0 / \$10	\$10 / \$20
Non-Preferred Generic	\$10 / \$20	\$20 / \$30
Preferred Brand	\$35 / \$55	\$50 / \$70
Non-Preferred Brand	\$75 / \$95	\$100 / \$120
Preferred Specialty	\$150	\$150
Non-Preferred Specialty	\$250	\$250
Mail Order (90 days)		
	\$0 / \$30 / \$105 / \$225	\$30 / \$60 / \$150 / \$300

*Copayments, coinsurance and deductibles accumulate toward the out-of-pocket maximum.

>Per BCBSOK: Allowable charge for non-contracting providers for covered services will be the lesser of the provider's billed charges or the plan's non-contract acting allowable charge. The non-contracting allowable charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the plan. Such factor will not be less than 100% of the base Medicare reimbursement rate.

What is Insure Oklahoma?

Insure Oklahoma is an Employer Sponsored Insurance plan that helps employers provide eligible employees with affordable health care insurance.

What Can IO Do For Me?

What Every Employee Should Know About the IO Program

- ◆ Employees who participate in Insure Oklahoma save on health insurance premiums provided by their employer by receiving subsidies through Insure Oklahoma.
- ◆ The qualified employee pays no more than 15% of the premium.
- ◆ The employer pays 25% and Insure Oklahoma pays the remaining 60%.
- ◆ If the spouse is eligible for subsidy and enrolled in the health insurance plan, Insure Oklahoma will subsidize 85% of their premium.
- ◆ Insure Oklahoma IS NOT AN INSURANCE COMPANY. Insure Oklahoma is administered by the Oklahoma Health Care Authority.

Employee Qualifications

To qualify, an employee should:

- ✓ Be between the ages of 19 and 64.
- ✓ Be an Oklahoma resident and meet citizenship requirements.
- ✓ Not be enrolled in any other state program like SoonerCare (Family Planning, BCC) or Medicare.
- ✓ Be able to provide SSN for all household members.
- ✓ Have an annual household income at or below the Income Guidelines.

2024 ESI Income Guidelines		
Family Size	Max Monthly Income	Annual Income
1	\$2,849	\$34,188
2	\$3,869	\$46,428
3	\$4,886	\$58,632
4	\$5,902	\$70,824
5	\$6,922	\$83,064
6	\$7,939	\$95,268
7	\$8,956	\$107,472
8	\$9,975	\$119,700

Income guidelines are effective April 1, 2024 - March 31, 2025

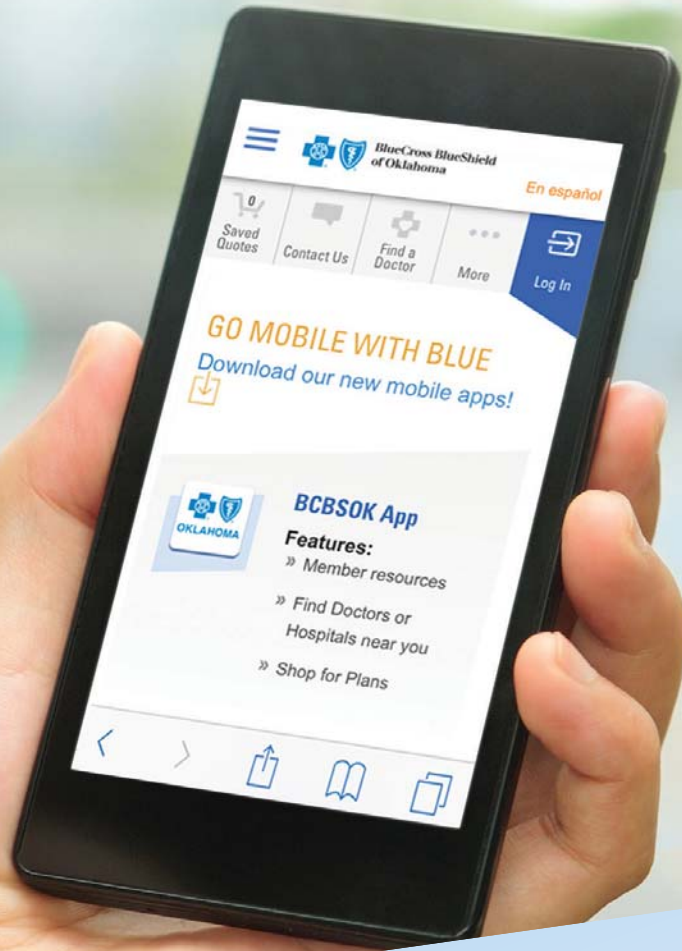
* To qualify, the applicant's household must have a modified gross income (MAGI) at or below the guidelines noted above. Visit www.insureoklahoma.org for information on how MAGI is determined. Dependent children may count toward household size and may be eligible for Insure Oklahoma.

Coverage for spouses and dependents may be available through Insure Oklahoma.

Spouses may be approved for benefits if the spouse:

- Is not employed, or
- Works full-time for an employer that would qualify for IO but is not participating, or
- Works less than 29 hours per week for any size employer.

To see if your children qualify for Insure Oklahoma, please call 888-365-3742 or visit www.insureoklahoma.org.



Blue Access MobileSM allows you to conveniently and securely access your health coverage and wellness information via your mobile devices anywhere, anytime.



Learn more about Blue Access Mobile at bcbsok.com/mobile or text* **OKGO to **33633**.**

*Message and data rates may apply. Terms and conditions and privacy policy at bcbsok.com/mobile/text-messaging.



BCBSOK App and Mobile Website:

- Find a doctor, hospital or urgent care facility or search for Spanish-speaking providers
- Register or log in to Blue Access for MembersSM
 - View coverage details
 - Check claims status
 - Access ID card information



Centered App for iPhone[®]:

- Promote wellness through mindful meditation and activity
 - Set a daily steps goal and a weekly meditation goal
 - Choose from three meditation sessions - short, mindful or body awareness
 - Record activity automatically



Text Messaging:

- Set up personalized, daily reminders to take your prescriptions, multi-vitamins or check your blood glucose
- Get weekly diet, exercise and fitness tips
- Send texts to BCBSOK when you need instant account information



Looking for the right doctor?

Provider Finder[®] is the quick and easy way to make better health care decisions for you and your family.



Provider Finder from Blue Cross and Blue Shield of Oklahoma (BCBSOK) is an innovative tool for helping you choose a provider, plus estimate and manage health care costs.

By logging in to Blue Access for MembersSM (BAM) you can use Provider Finder to:

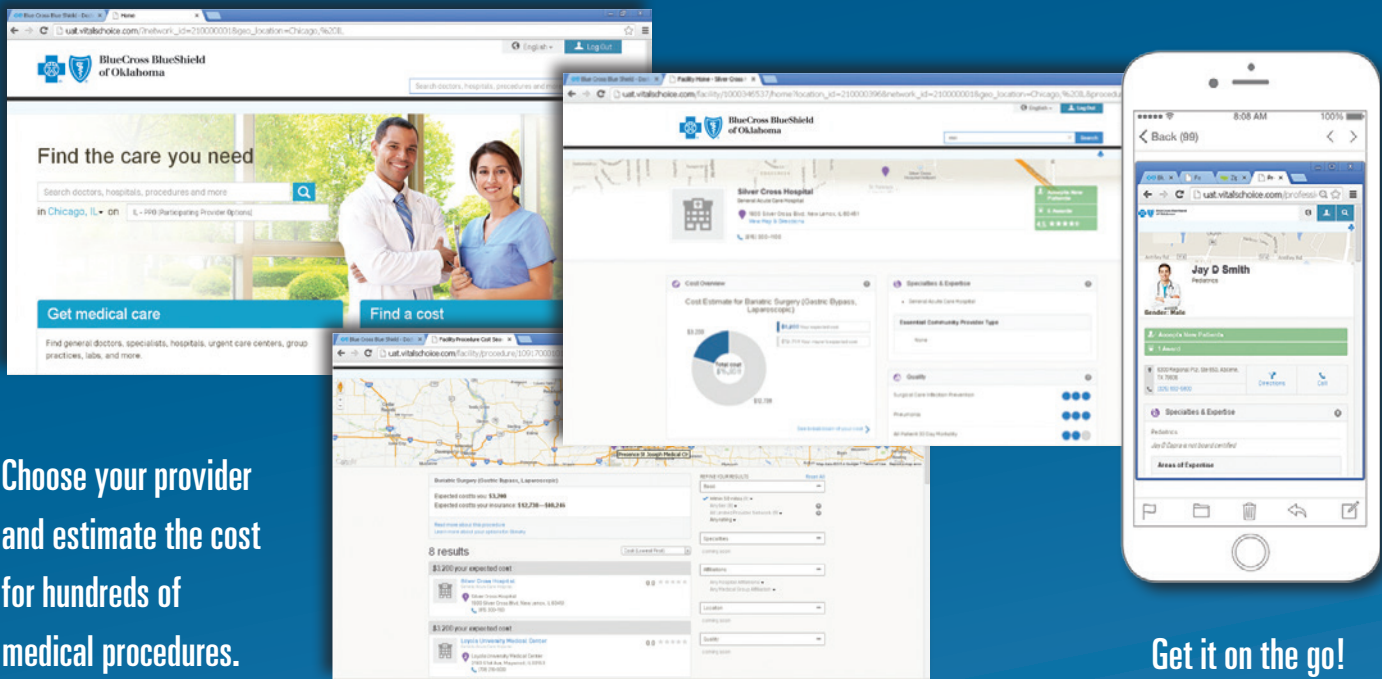
- Find a network primary care physician, specialist or hospital.
- Filter search results by doctor, specialty, ZIP code, language and gender – even get directions.
- Estimate the cost of hundreds of procedures, treatments and tests and your out-of-pocket expenses.
- Determine if Blue Distinction Center[®] (BDC), BDC+ or Blue Distinction Total Care is an option for treatment.
- View patient feedback or add your review for a provider.
- Review providers' certifications and recognitions.

It's easy, immediate, secure – and available at bcbsok.com.

You're in charge with more information.

- Do you want to know more about the providers who take care of you or your family?
- Do you need to know the estimated cost of a medical service?
- Do you want to know what feedback other patients had on a provider?

Informed Choice. Cost Management. More Options.



Choose your provider and estimate the cost for hundreds of medical procedures.

Get it on the go!

Screen shots are for illustrative purpose only.

It's easy to get started with Provider Finder by registering for Blue Access for MembersSM (BAM):

- 1 Go to **bcbsok.com**.
- 2 Click the **Log In** tab, and then click the **Register Now** link.
- 3 Use the information on your BCBSOK ID card to complete the process.
- 4 Then, log in to BAM. Provider Finder is located under the **Doctors & Hospitals** tab.

You can also call a BCBSOK Customer Service Advocate at the toll-free telephone number on the back of your member ID card for help in locating a provider.



Get assistance while you're away from home.

Go to bcbsok.com and register or log in to BAM. You can stay connected to your claims activity, member ID card and coverage details – you can also receive prescription reminders and health tips via text messages.

Blue365[®]

A Discount Program for Your Employees



Blue365 is just one more advantage your employees have by being a Blue Cross and Blue Shield of Oklahoma (BCBSOK) member. With this program, your employees may save money on health and wellness products and services from top retailers not covered by insurance. There are no claims to file and no referrals or preauthorizations.

Once employees sign up for Blue365 at blue365deals.com/bcbsok, weekly “Featured Deals” will be emailed to them. These deals offer special savings for a short period of time.

Below are some of the ongoing deals offered to Blue365 members.

EyeMed | Davis Vision

Members can save on eye exams, eyeglasses, contact lenses and accessories. They have access to national and regional retail stores and local eye doctors. Members may also qualify for savings on laser vision correction.

TruHearing[®] | Beltone[™] | American Hearing Benefits

Members (and possibly their immediate family members) could get savings on hearing tests, evaluations and hearing aids.

Dental SolutionsSM

Members may get dental savings with Dental Solutions. They may receive a dental discount card that provides access to discounts of up to 50% at more than 70,000 dentists and more than 254,000 locations.*

Jenny Craig[®] | Sun Basket | Nutrisystem[®]

Members can work toward reaching their weight loss goals with savings from leading programs. They may save on healthy meals, membership fees (where applicable), nutritional products and services.

See all the Blue365 deals and learn more at blue365deals.com/bcbsok.

Fitbit®

Your employees can customize their workout routines with Fitbit's family of trackers and smartwatches that can be employed seamlessly with your lifestyle, your budget and your goals. Members receive a 20% discount on Fitbit devices plus free shipping.

Reebok | SKECHERS®

Reebok, a trusted brand for more than 100 years, makes top athletic equipment for all people, from professional athletes to kids playing soccer. Your employees get 20% off select models. SKECHERS, an award-winning leader in the footwear industry, offers exclusive pricing on select men's and women's styles. Your employees can get 30% off plus free shipping on their online orders.

InVite® Health

InVite Health offers quality vitamins and supplements, educational resources and a team of healthcare experts for guidance to select the correct product at the best value. Members get 50% off the retail price of non-genetically modified microorganism (non-GMO) vitamins and supplements and a free Midnight Bright Black Coconut Charcoal Tooth Polish with a \$25 purchase.

Livekick

Livekick is the future of private fitness. Your employees can choose from training or yoga over live video with a private coach. They can get fit and feel healthier with action-packed 30-minute sessions that they can do from home, their gym or hotel while traveling. They'll also get a free two-week trial and 20% off a monthly plan on any Live Online Personal Training.



eMindful

A 25% discount is available on any of eMindful's live streaming or recorded premium courses. Members can apply mindfulness into their lives including Stress Reduction, Mindful Eating, Chronic Pain Management, Yoga, Qigong Movement and more.

For more great deals or to learn more about Blue365, visit blue365deals.com/bcbsok.

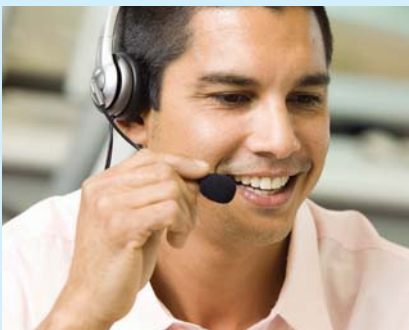
The relationship between these vendors and Blue Cross and Blue Shield of Oklahoma (BCBSOK) is that of independent contractors. BCBSOK makes no endorsement, representations or warranties regarding any products or services offered by the above-mentioned vendors.

* Dental Solutions requires a \$9.95 signup and \$6 monthly fee.

Blue365 is a discount program only for BCBSOK members. This is NOT insurance. Some of the services offered through this program may be covered under the health plan you choose to offer. Employees should check their benefit booklet or call the customer service number on the back of their ID card for specific benefit facts. Use of Blue365 does not change monthly payments, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors that take part in this program and may be subject to change. BCBSOK does not guarantee or make any claims or recommendations about the program's services or products. Members should consult their doctor before using these services and products. BCBSOK reserves the right to stop or change this program at any time without notice.



**BlueCross BlueShield
of Oklahoma**



83% of members who participated in the Condition Management program remained stable or improved.*

* Internal data analysis: Condition Management severity level measured initially in January 2013, final severity level measured June 2014

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Rather do it online? No problem! Visit careontarget.com.

Care onTarget®, our condition management website, is available whenever you are. It provides you with these tools to try to help you better manage your chronic condition:

Take a Condition Assessment: Just answer some basic questions about your health. You can take assessments for asthma, coronary artery disease (CAD), diabetes, depression and more.

Watch Online Health Tutorials: Based on your assessment answers, Care onTarget will suggest online tutorials that may help you better understand your health needs and take a more active role in your care.

Find Health Resources: This section can help you access useful information from well-known sources such as the National Institutes of Health and the Centers for Disease Control and Prevention.

Live Chat with a Clinician: Have a question about your health? Chat with a clinician Monday through Friday, 8:30 a.m. to 5 p.m. Central time (excluding holidays).

Getting your chronic condition under control may help you be healthier in the years to come. Call 866-670-6681 and select "Blue Care Connection" today to join the Condition Management program, or visit careontarget.com and start a live chat with a clinician.

Blue Care Connection

Dental Benefits

Insured by Delta Dental of Oklahoma

Good oral care enhances overall physical health, appearance, and mental well-being. Problems with the teeth and gums are common and easily treated. Keep your teeth healthy and your smile bright with the Eleos Property Management dental benefit plan.

Base Plan

Buy-Up Plan

	Select PPO In-Network Benefits	Plus Premier In-Network Benefits
Annual Deductible	\$50 per person / \$150 per family	\$50 per person / \$150 per family
Annual Maximum	\$1,500	\$1,500
Preventive Services	100%	100%
Deductible Waived	Yes	Yes
Basic Services	80% after deductible	80% after deductible
Endodontics	80% after deductible	80% after deductible
Periodontics	80% after deductible	80% after deductible
Major Services	50% after deductible	50% after deductible
Orthodontia Services Lifetime Maximum	50% \$1,500 per child	50% \$1,500 per child



Voluntary Vision Benefits

Insured by Vision Service Plan (VSP)

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

In-Network (Member Cost)

Exam Frequency	Every 12 months
Eye Exam	\$20 copay
Frame Frequency	Every 24 months
Frames	\$130 allowance for wide selection; \$150 allowance for featured frame; plus 20% savings over allowance (Walmart / Costco Frames: \$70 allowance)
Lenses Frequency	Every 12 months
Single Vision Lenses	\$20 copay
Bifocal Lenses	\$20 copay
Trifocal Lenses	\$20 copay
Contacts Frequency (in lieu of lenses & frames)	Every 12 months
Contacts Exam (fitting & evaluation)	\$60 copay
Contact Lenses	\$130 allowance (copay does not apply)
Medically Necessary	\$20 copay then Paid in full



Life and Accidental Death & Dismemberment

Insured by SunLife Financial

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Eleos Property Management. The company provides basic life insurance of \$25,000 at no cost to you.

Accidental Death and Dismemberment (AD&D)

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Eleos Property Management provides basic AD&D insurance of \$25,000 at no cost to you.

If the employee is dismembered (such as loss of an eye or limb), benefits will be paid to the employee as a percentage of the AD&D amount.

Age Reduction

Beginning at age 65, your life coverage will reduce to 65% of the amount in force. At age 70, your life coverage will reduce to 50%. Please refer to the Sun life benefit summary for further information regarding the reduction schedule and any other benefit limitations.

Your Responsibility

You should verify that all beneficiary information is up to date annually.

Additional Voluntary Accident, Critical Illness, Medical Bridge

Insured by Colonial

Worksite Insurance

Eleos Property Management has partnered with Colonial to offer you the option to customize your insurance coverage to what best fits your personal situation.

Available options include the following:

Accident Insurance: Accidents by nature are a surprise. This plan helps to offset unexpected medical expenses for covered accidents such as sprains, broken bones, and burns.

Critical Illness Insurance: Should you be diagnosed with a covered illness, this plan helps to provide a financial cushion with a lump sum cash benefit of either \$10,000 or \$20,000.

Medical Bridge: This plan can help with medical costs associated with a hospital stay or other covered events.

Should you elect to enroll in the offered Colonial plans, it is important to note that you are able to enroll in most plans without answering health questions.

IMPORTANT: This Employee Benefits Guide is an outline of the coverages proposed by the carrier(s). It does not include all of the terms, coverages, exclusions, limitations, and conditions of the actual contract. The policy and contract documents must be read for complete details. Policy information will be made available upon request.

ADDITIONAL SERVICES

COLONIAL ACCIDENT

COLONIAL CRITICAL ILLNESS

COLONIAL MEDICAL BRIDGE

Group Accident Insurance

Preferred Plan



For more information,
talk with your
benefits counselor.

ColonialLife.com

Group accident insurance can help with medical or other costs associated with a covered accident or injury that your health insurance may not cover. With this coverage you may not need to use your savings or secure a loan to help pay those unexpected out-of-pocket expenses. Coverage options are available for you, your spouse and eligible dependent children.

Benefits are per covered person per covered accident unless stated otherwise

Accident emergency treatment \$150

One visit per covered person per covered accident and
Up to four visits per covered person per calendar year

Accident follow-up doctor visit \$50

Up to four visits per covered person per covered accident and
Up to 16 visits per covered person per calendar year

Accidental death

Per covered person

	Accidental death	Accidental death common carrier
■ Named insured	\$50,000	\$200,000
■ Spouse	\$50,000	\$200,000
■ Dependent child(ren)	\$10,000	\$40,000

Examples of common carriers are mass transit trains, buses and planes

Accidental dismemberment

Loss or loss of use

■ One hand, arm, foot, leg or sight of an eye	\$9,000
■ Both hands, arms, feet, legs or the sight of both eyes; or any combination	\$18,000
■ One finger or one toe	\$1,050
■ Two or more fingers; two or more toes; or any combination	\$2,100

Air ambulance \$1,500

Transportation to or from a hospital or medical facility

Ambulance (ground)..... \$300

Transportation to or from a hospital or medical facility

Appliance aid in personal locomotion or mobility \$100

Walking boot, neck brace, back brace, leg brace, cane, crutches, walker and wheelchair

Blood/plasma/platelets \$400

Required during treatment of a covered accident

Burn

■ 2nd-degree burns (covering at least 36% of the body's surface)	\$1,000
■ 3rd-degree burns (based on size)	\$2,000 – \$15,000

Burn-skin graft..... 50% of applicable burn benefit

As a result of 2nd-degree or 3rd-degree burns

Alex was cleaning out the gutters when he fell.

EMERGENCY ROOM VISIT

Alex was taken by ambulance to the nearest emergency room and received immediate care.

DIAGNOSTIC PROCEDURE

The doctor ordered an X-ray and discovered Alex had fractured his leg.

HOSPITAL CONFINEMENT

Alex was admitted to the hospital for surgery on his leg. He was confined for three days.

APPLIANCE FOR MOBILITY

Alex used crutches.

PHYSICAL THERAPY

Alex had eight sessions of PT to help him regain the strength in his leg.

DOCTOR'S OFFICE VISIT

Over the next several weeks, he had three follow-up appointments with his doctor.

ALEX'S OUT-OF-POCKET EXPENSES

When Alex totaled up the bills, he had to pay his annual deductible, as well as co-payments for the ambulance, emergency room, hospital, surgery, physical therapy and follow-up visits. Luckily, Alex had accident coverage to help with these expenses.

ALEX'S BENEFITS	
Ambulance	\$300
Emergency room visit	\$150
X-ray	\$60
Hospital admission	\$1,000
Hospital confinement	\$750
Leg fracture (surgical)	\$3,600
Physical therapy	\$360
Appliance (crutches)	\$100
Doctor's follow-up office visit	\$150
	\$6,470

Catastrophic accident

Total and irrecoverable loss or loss of use

- Both hands, arms, feet, legs or the sight of both eyes; or any combination; or
- Loss of hearing in both ears or loss of ability to speak

Subject to a 365-day elimination period; payable once per lifetime per covered person

- Named insured.....\$50,000
- Spouse.....\$50,000
- Dependent child(ren).....\$25,000

Coma.....\$10,000

Lasting for 14 or more consecutive days

Concussion.....\$375

Dislocation (separated joint)	Non-surgical	Surgical
■ Hip.....	\$3,000	\$6,000
■ Knee (except patella).....	\$1,500	\$3,000
■ Ankle, bone or bones of the foot (other than toes).....	\$1,200	\$2,400
■ Collarbone (sternoclavicular).....	\$800	\$1,600
■ Collarbone (acromioclavicular and separation).....	\$200	\$400
■ Lower jaw.....	\$720	\$1,440
■ Shoulder (glenohumeral).....	\$1,200	\$2,400
■ Elbow.....	\$450	\$900
■ Wrist.....	\$600	\$1,200
■ Bone(s) of the hand, (other than fingers).....	\$810	\$1,620
■ Finger, toe.....	\$200	\$400
■ Incomplete dislocation or dislocation reduction without anesthesia.....	25% of the applicable non-surgical amount	

Emergency dental work

- Dental crown or denture.....\$300
- Dental extraction.....\$100

Eye injury.....\$300

With surgical repair or removal of a foreign object

Fracture (broken bone)	Non-surgical	Surgical
■ Skull, depressed fracture (except face/nose).....	\$3,750	\$7,500
■ Skull, simple non-depressed fracture (except face/nose).....	\$1,800	\$3,600
■ Hip, thigh (femur).....	\$3,150	\$6,300
■ Body of vertebrae (excluding vertebral processes).....	\$2,700	\$5,400
■ Pelvis.....	\$2,400	\$4,800
■ Leg (tibia and/or fibula).....	\$1,800	\$3,600
■ Bones of the face or nose (except mandible or maxilla).....	\$910	\$1,820
■ Upper jaw, maxilla, upper arm between elbow and shoulder.....	\$1,050	\$2,100
■ Lower jaw, mandible.....	\$1,200	\$2,400
■ Kneecap, ankle, foot.....	\$1,200	\$2,400
■ Shoulder blade, collarbone.....	\$1,200	\$2,400
■ Vertebral processes.....	\$630	\$1,260
■ Forearm, hand, wrist.....	\$1,200	\$2,400
■ Rib.....	\$375	\$750
■ Coccyx.....	\$320	\$640
■ Finger, toe.....	\$200	\$400
■ Chip fracture.....	25% of the applicable non-surgical amount	

For illustrative purposes only.

Benefit amounts may vary and may not cover all expenses. The certificate has exclusions and limitations.

Hospital admission	\$1,000
Per covered person per covered accident	
Hospital confinement	\$250 per day
Up to 365 days per covered person per covered accident	
Hospital intensive care unit admission	\$1,750
Per covered person per covered accident	
Hospital intensive care unit confinement	\$400 per day
Up to 15 days per covered person per covered accident	
Knee cartilage (torn)	\$750
Laceration (no repair, without stitches)	\$50
Laceration (repaired by stitches)	
■ Total of all lacerations is less than two inches long	\$150
■ Total of all lacerations is at least two but less than six inches long	\$300
■ Total of all lacerations is six inches or longer	\$600
Lodging (companion)	\$200 per day
Up to 30 days per covered person per covered accident	
Medical imaging study (CT, CAT scan, EEG, MR or MRI)	\$200
One benefit per covered person per covered accident per calendar year	
Occupational or physical therapy	\$45 per day
Up to 10 days per covered person per covered accident	
Pain management for epidural anesthesia	\$150
Prosthetic device/artificial limb	
One benefit per covered person per covered accident	
■ One	\$1,250
■ More than one	\$2,500
Rehabilitation unit confinement	\$150 per day
Immediately after a period of hospital confinement due to a covered accident; up to 15 days per covered person per covered accident, not to exceed 30 days per covered person per calendar year	
Ruptured disc with surgical repair	\$900
Surgery	
■ Cranial, open abdominal and thoracic	\$1,500
■ Hernia with surgical repair	\$300
Surgery (exploratory and arthroscopic)	\$225
Tendon/ligament/rotator cuff	
■ One with surgical repair	\$900
■ Two or more with surgical repair	\$1,800
Transportation for hospital confinement	\$600 per round trip
Up to three round trips for more than 50 miles from home per covered person per covered accident	
X-ray	\$60



For more information,
talk with your
benefits counselor.

Group Critical Illness Insurance

Plan 2 Full



If you're diagnosed with a covered critical illness or cancer, group critical illness insurance* from Colonial Life can help with your expenses, so you can concentrate on what's most important – your treatment, care and recovery.

*The policy name is Critical Illness and Cancer Group Specified Disease Insurance.

Face amount: \$_____

Critical illness benefit

For the diagnosis of this covered critical illness condition: ¹	This percentage of the face amount is payable:
Heart attack (myocardial infarction)	100%
Stroke	100%
End-stage renal (kidney) failure	100%
Major organ failure	100%
Coma	100%
Permanent paralysis due to a covered accident	100%
Blindness	100%
Occupational infectious HIV or occupational infectious hepatitis B, C or D	100%
Coronary artery bypass graft surgery/disease ²	25%

For more information,
talk with your
benefits counselor.

ColonialLife.com

Subsequent diagnosis of a different critical illness³

If you receive a benefit for a critical illness, and later you are diagnosed with a different critical illness, the original percentage of the face amount is payable for that particular critical illness.

Subsequent diagnosis of the same critical illness³

If you receive a benefit for a critical illness, and later you are diagnosed with the same critical illness, 25% of the original face amount is payable. Critical illness conditions that do not qualify are: coronary artery bypass graft surgery/coronary artery disease² and occupational infectious HIV or occupational infectious hepatitis B, C or D.

Diagnosis of cancer benefit

Covered cancer benefits	
For this condition: ¹	The amount payable is:
Diagnosis of cancer (internal or invasive)	100% of the face amount
Diagnosis of carcinoma in situ	25% of the face amount
Skin cancer	\$500

Cancer vaccine benefit: \$50

This benefit is payable if you or your covered family members incur a charge for any FDA-approved cancer vaccine while your certificate is in force.



ColonialLife.com

1 Please refer to the certificate for complete definitions of covered conditions.

2 Benefit for coronary artery disease applicable in lieu of benefit for coronary artery bypass graft surgery when health savings account (HSA) compliant plan is selected.

3 Dates of diagnoses of a covered critical illness must be separated by at least 180 days.

THIS POLICY PROVIDES LIMITED BENEFITS.

Insureds in MA must be covered by comprehensive health insurance before applying for this coverage.

EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS

We will not pay the Critical Illness Benefit or Benefit Payable Upon Subsequent Diagnosis of a Critical Illness that occurs as a result of a covered person's: alcoholism or drug addiction; felonies or illegal occupations; intoxicants and narcotics; psychiatric or psychological conditions; suicide or injuries which any covered person intentionally does to himself; war or armed conflict; or pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a critical illness.

EXCLUSIONS AND LIMITATIONS FOR CANCER

We will not pay the Diagnosis of Cancer Benefit, Diagnosis of Carcinoma in Situ Benefit, the Cancer Treatment and Care Benefit or the Skin Cancer Benefit for a covered person's cancer (internal or invasive), carcinoma in situ or skin cancer that: is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico; is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is initially diagnosed as having cancer (internal or invasive), carcinoma in situ or skin cancer. No pre-existing condition limitation will be applied for dependent children who are born or adopted while you are covered under the policy, and who are continuously covered from the date of birth or adoption.

This is not an insurance contract and only the actual certificate provisions will control. Applicable to certificate form GCC1.0-C (including state abbreviations where used, for example: GCC1.0-C-TX). The certificate or its provisions may vary or be unavailable in some states. Please see your Colonial Life benefits counselor for details.

Hospital Indemnity Insurance



How will you pay for what your health insurance won't cover?

No matter how well you plan, you can't predict when sudden medical expenses could impact your way of life. If you're admitted to the hospital for a covered accident or covered sickness, Group Medical Bridge,SM Colonial Life's hospital indemnity insurance, could help pay for out-of-pocket costs.

One family's journey

Nathan was doing yard work with his wife when his chest pains began. After an emergency room visit, the couple was relieved to learn it was a false alarm. A few weeks later, Nathan had a follow-up appointment with his family doctor.

Nathan's Group Medical Bridge benefits helped pay for the out-of-pocket expenses associated with his medical care.

NATHAN'S OUT-OF-POCKET EXPENSES	
Emergency room co-pay	\$100
Deductible	\$1,500
Doctor's visit co-pay	\$25
Coinsurance	\$1,800
	\$3,425

NATHAN'S BENEFITS	
Emergency room visit	\$100
Diagnostic procedure	\$250
Hospital confinement	\$1,500
Doctor's office visit	\$25
	\$1,875



Only 37% of Americans would have enough savings to pay an unexpected expense of around \$1,000.

Bankrate.com, Survey: How Americans Contend with Unexpected Expenses (Jan. 6, 2016)

This is an example and does not represent your actual plan benefits. Cost of treatment benefits and benefit amounts may vary. Benefits may not cover all expenses. The policy has exclusions and limitations.

Teal Ridge Assisted Living

To learn more, contact:

ColonialLife.com

Hospital Indemnity Insurance

These benefits are available for you, your spouse and eligible dependent children.

This brochure provides an overview of the plan. For complete details, refer to your certificate.



There are approximately 36 million hospital stays in the U.S. each year.

Agency for Healthcare Research and Quality, "Overview of Hospital Stays in the United States," 2012, HCUP Statistical Brief #180, 2014

Basic benefits

Hospital confinement	\$1,500 per day	Maximum of one day per covered person per calendar year
Waiver of Premium	Available after 30 continuous days of a covered confinement of the named insured	

Additional benefits

Daily hospital confinement	\$100 per day	Maximum of 365 days per covered person per confinement
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Specified critical illness

This benefit can help pay for expenses related to a covered critical illness, including child care, home health care and travel expenses to and from treatment centers.

Specified critical illness	\$2,500 per day	The specified critical illness benefit amount will reduce by 50% on the first policy anniversary date after the named insured attains age 75
Initial diagnosis and subsequent diagnosis benefit¹	- End-stage renal (kidney) failure - Heart attack - Stroke	Maximum of one day per covered person per diagnosis (for any covered person)
Additional specified critical illness		
Initial diagnosis benefit	- Cerebral palsy - Cleft lip or cleft palate - Cystic fibrosis - Down syndrome - Spina bifida	Maximum of one day per covered dependent child per lifetime (for covered dependent children)

Medical treatment package

This package can help pay for out-of-pocket expenses related to the treatment of a covered accident or covered sickness.

Air ambulance	\$1000 per day	Maximum of one day per covered person per calendar year
Ambulance	\$100 per day	
Appliance	\$100 per day	
Emergency room visit	\$100 per day	Maximum of two days per covered person per calendar year
X-ray	\$25 per day	
Doctor's office visit/telemedicine	\$25 per day	Maximum of three days per calendar year for named insured coverage or maximum of five days per calendar year for all covered persons combined

EXCLUSIONS AND LIMITATIONS

THIS POLICY PROVIDES LIMITED BENEFITS.

¹ Subsequent diagnosis for a different specified critical illness: If a covered person receives a benefit for a specified critical illness, and later is diagnosed with a different specified critical illness, we will pay an additional specified critical illness benefit. The date of diagnosis must be separated by at least 180 days.

PRE-EXISTING CONDITION LIMITATION

We will not pay benefits for Hospital Confinement or any of the following benefit(s) for any covered person when such loss results from a pre-existing condition as defined in this certificate, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule:

- Rehabilitation Unit Confinement
- Specified Critical Illness
- Daily Hospital Confinement
- Outpatient Surgical Procedure
- Inpatient Mental and Nervous
- Diagnostic Procedure

GENERAL EXCLUSIONS

We will not pay any benefits for injuries received in accidents or for sicknesses which are caused by, contributed to by or occur as a result of the covered person's:

- Addiction to alcohol or drugs, except for drugs taken as prescribed by his physician.
- Treatment for dental care or dental procedures, unless treatment is the result of a covered accident.
- Undergoing elective procedures or cosmetic surgery. This includes procedures or hospital confinement for complications arising from elective or cosmetic surgery. This does not include congenital birth defects or anomalies of a child, or reconstructive surgery.
- Committing or attempting to commit a felony, or engaging in an illegal occupation.
- Having a disorder including but not limited to affective disorders, neurosis, anxiety, stress and adjustment reactions. Alzheimer's Disease and other organic senile dementias are not considered mental or nervous disorders. This exclusion does not apply to the Inpatient Mental and Nervous benefit, if included.

- Dependent child's pregnancy, including services rendered to her child after birth. Complications of pregnancy including Cesarean births, will be covered to the same extent as any other covered sickness.
- Committing or trying to commit suicide or his injuring himself intentionally, whether he is sane or not.
- Being exposed to war or any act of war, declared or undeclared, while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer. Losses as a result of acts of terrorism or nuclear release committed by individuals or groups will not be excluded from coverage unless the covered person who suffered the loss committed the act of terrorism or nuclear release.

HOSPITAL CONFINEMENT LIMITATIONS

We will not pay benefits for hospital confinement or daily hospital confinement due to any covered person giving birth within the first nine (9) months after the coverage effective date of the certificate as a result of a normal pregnancy, including cesarean. Complications of pregnancy will be covered to the same extent as any other covered sickness.

WELL BABY CARE LIMITATION

We will not pay benefits for hospital confinement or daily hospital confinement, if included, of a newborn child following his birth unless he is injured or sick.

This information is not intended to be a complete description of the insurance coverage available. This coverage has exclusions and limitations that may affect benefits payable. For cost and complete details, see your Colonial Life benefits counselor. This brochure is applicable to policy form GMB7000-P.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC

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The average expense for a hospital stay ranges from \$9,100 for a medical stay to \$22,700 for a surgical stay.

Agency for Healthcare Research and Quality
Healthcare Cost and Utilization Project,
Trends in Hospital Inpatient Stays in the United States, 2005–2014 (2017).

CARRIER CONTACTS

Contact Information

If you have specific questions during the plan year about a Eleos Property Management benefit plan, there are many resources at your disposal. The carrier contacts listed can assist you with many types of issues. Please see below for day to day services they can provide.

- Helping you understand the benefits
- Providing assistance with claim questions
- Helping you understand your EOB's (Explanation of Benefits)
- Providing assistance with ordering ID cards (as applicable)

Benefit	Administrator	Phone	Website/Email
Medical	BlueCross BlueShield	800.942.5837	www.bcbsok.com
Pharmacy Prescription	Prime	877.546.2779	www.primetherapeutics.com
Pharmacy Mail Order (Home Delivery)	AllianceRX Walgreens Prime	800.354.1985	www.alliancerxwp.com
Pharmacy Specialty Prescriptions	AllianceRX Walgreens Prime	877.627.6337	www.alliancerxwp.com
Dental	Delta Dental of Oklahoma	800.522.0188	www.deltadentalok.org
Vision	VSP	800.877.7195	www.vsp.com
Life and AD&D	SunLife	800.247.6875	www.sunlife.com
Accident/Critical Illness/Bridge	Colonial	800.325.4368	www.coloniallife.com

If the carrier contacts are unable to assist you, please reach out to the local Human Resources Department.

Eleos Property Management	Melissa Mahaffey	405.608.8020	mmahaffey@tealridge.com
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NOTICES

PATIENT PROTECTIONS DISCLOSURE

The Eleos Property Management Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, BlueCross BlueShield designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the BlueCross BlueShield at 800.942.5837 or www.bcbsok.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from BlueCross BlueShield or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the BlueCross BlueShield at 800.942.5837 or www.bcbsok.com.

WOMEN'S HEALTH & CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: P8E1ADT Blue Advantage Platinum PPO (Individual: 10% coinsurance and \$750 deductible; Family: 10% coinsurance and \$2,250 deductible)

Plan 2: G740ADT Blue Advantage Gold PPO (Individual: 30% coinsurance and \$2,000 deductible; Family: 30% coinsurance and \$6,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 405.608.8020 or mmahaffey@tealridge.com.

HIPAA SPECIAL ENROLLMENT RIGHTS

Eleos Property Management Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Eleos Property Management Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children’s Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan’s special enrollment provisions, contact Melissa Mahaffey - Executive Director at 405.608.8020 or mmahaffey@tealridge.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children’s health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan’s annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan.

MICHELLE’S LAW

Michelle’s Law requires group health plans to provide continued coverage for a dependent child covered under the plan if the child loses eligibility under the Group Health Medical Plan because of the loss of student status resulting from a medically necessary leave of absence from a post- secondary educational institution. If your child is covered under the Group Health Medical Plan, but will lose eligibility because of a loss of student status caused by a medically necessary leave of absence, your child may be able to continue coverage under our plan for up to one year during the medically necessary leave of absence. This coverage continuation may be available if on the day before the medically necessary leave of absence begins your child is covered under the Group Health Medical Plan and was enrolled as a student at a post-secondary educational institution.

A “medically necessary leave of absence” means a leave of absence from a post-secondary educational institution (or change in enrollment status in that institution) that (1) begins while the child is suffering from a serious illness or injury, (2) is medically necessary, and (3) causes the child to lose student status as defined under our plan.

If your child is eligible for this coverage continuation and loses coverage under the plan at the end of the continuation period, COBRA continuation may be available at the end of the Michelle’s Law coverage continuation period.

If you have any questions concerning this notice or your child’s right to continued coverage under Michelle’s Law, please contact Human Resources

NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN’S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Service
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights (For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA **

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

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

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

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Melissa Mahaffey.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, [Children's Health Insurance Program \(CHIP\)](#), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov/.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Eleos Property Management
Melissa Mahaffey - Executive Director
5124 Keystone Cir
Edmond, Oklahoma 73025-9633
United States
405.608.8020

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>

NOTICE OF CREDITABLE COVERAGE

Important Notice from Eleos Property Management About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Eleos Property Management and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Eleos Property Management has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Eleos Property Management coverage will be affected. You can or keep this coverage if you elect Part D, but the group health plan will not coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Eleos Property Management coverage, be aware that you and your dependents will be able to get this coverage back only during open enrollment or a special enrollment event.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Eleos Property Management and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Eleos Property Management changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov/
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227) (TTY users should call 1-877-486-2048).

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: November 01, 2024
Name of Entity/Sender: Eleos Property Management
Contact—Position/Office: Melissa Mahaffey - Executive Director
Office Address: 5124 Keystone Cir
Edmond, Oklahoma 73025-9633
United States
Phone Number: 405.608.8020

MARKETPLACE NOTICE

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1 2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

²An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by [HealthCare.gov](https://www.healthcare.gov) and either- submit a new application or update an existing application on [HealthCare.gov](https://www.healthcare.gov) between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Melissa Mahaffey.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Eleos Property Management		4. Employer Identification Number (EIN) 47-3752143
5. Employer address 5124 Keystone Cir		6. Employer phone number 405.608.8020
7. City Edmond	8. State Oklahoma	9. ZIP code 73025-9633
10. Who can we contact about employee health coverage at this job? Melissa Mahaffey		
11. Phone number (if different from above)		12. Email address mmahaffey@tealridge.com

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

- As your employer, we offer a health plan to:
 - All employees. Eligible employees are:
 - Some employees. Eligible employees are: As defined in the plan document.

- With respect to dependents:
 - We do offer coverage. Eligible dependents are: As defined in the plan document.
 - 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.

Disclaimers

This booklet gives you an overview of the main features of your benefit plans. The plans are administered according to legal plan documents and insurance contracts. Although we have tried to summarize the provisions of these legal documents clearly and accurately, if any information contained herein conflicts with the legal documents, the legal documents will govern. For more detailed information on the plans and your legal rights under the plans, be sure to read the summary plan descriptions or request a copy of the plan documents. All benefits are subject to change from time to time and Eleos Property Management reserves the right to amend or cancel any benefits described in this booklet, with or without notice.

This booklet is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This benefit summary prepared by



Gallagher

Insurance | Risk Management | Consulting