

Benefits Guide



2026

January 1 – December 31, 2026

WELCOME

We are pleased to offer a comprehensive array of valuable benefits to protect your health, family and way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

You are eligible for benefits if you work 30 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your registered domestic partner (RDP) and/or their children, where applicable by state law
- Your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

Coverage Begins

- **New Hires:** You must complete enrollment within 30 days of your date of hire. If you enroll on time, coverage is effective on the first of the month following 30 days. If you fail to enroll on time, you will NOT have benefits coverage (except for company-paid benefits) until you enroll during our next annual Open Enrollment period.
- **Open Enrollment:** Changes made during Open Enrollment are effective January 1 – December 31, 2026.

Choose Carefully

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualifying life event during the year. Following are examples of the most common qualifying life events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse, RDP or child
- Lost coverage under your spouse's/RDP's plan
- You gain access to state coverage under Medicaid or The Children's Health Insurance Program

Making Changes

To change your benefit elections, you must contact Human Resources within 31 days of the qualifying life event. Be prepared to show documentation of the event, such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to change your elections.

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ENROLLMENT

Go to <https://access.paylocity.com/>

There you will find detailed information about the plans available to you and instructions for enrolling.

Required Information—You will be required to enter a Social Security number (SSN) for all covered dependents when you enroll. The Affordable Care Act (ACA) requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.

OPEN ENROLLMENT DETAILS

Remember, Open Enrollment is an opportunity to make changes to your benefits without a qualifying life event. During this time, you can:

- Add, cancel or change your coverage
- Add or remove eligible family members
- Elect your 2026 HSA contributions
- Enroll in the health care and/or dependent care FSAs
(**Note:** The IRS requires you to re-enroll in the FSAs each year)

IMPORTANT REMINDERS



Open Enrollment is ACTIVE:

- You must log in to Paylocity to confirm or elect benefits, even if you are not making any changes.
- You must actively re-enroll in the health care and dependent care FSAs to participate in 2026.

New Hires: you must enroll in benefits within 30 days of your date of hire or you will have to wait until the next Open Enrollment period or experience a Qualifying Life Event

Important Changes

Each year Zak Designs reviews our benefits program to ensure our partners provide comprehensive and affordable coverage. This year, we're pleased to announce new offerings for our employees to help you better manage your health and well-being in the new year.

2026 Updates At-a-Glance

- There are a few changes to our medical plan designs.
- New carrier for Voluntary Life/AD&D, Principal.
- Voluntary Life/AD&D – this is the one-time you can enroll and elect up to \$150,000 of coverage without Evidence of Insurability (Health Questionnaire).
- There will be a modest increase in how much you pay out of your paycheck for health insurance, also known as your premiums.



[Click here](#) to watch a video about Open Enrollment.

MEDICAL COVERAGE

PPO 800

The Preferred Provider Organization (PPO) plan, provided through Cigna, gives you the freedom to seek care from any provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the network.

A PPO plan relies on a network of health care clinics, hospitals and professionals who have agreed to provide their services at discounted rates. These preferred providers are considered “in-network.” In general, you will pay less for in-network services than you would were you to seek care outside the network.

How You Pay for Services

- You pay a flat dollar amount—or copay—for covered health care treatments and services, such as doctor’s office visits and prescription drugs.
- Once you satisfy your annual deductible, you will pay a percentage—or coinsurance—of the cost of the visit, and the plan will cover the rest.
- Once you hit your annual out-of-pocket maximum, the plan will cover 100% of the cost of covered services for the rest of the year.

To find an in-network provider, login to your MyCigna account:
www.myCigna.com



[Click here](#) to watch a video about
comparing medical plan types.



MEDICAL COVERAGE

HDHP HSA 2000

The HDHP HSA (High-Deductible Health Plan + Health Savings Account), provided through Cigna, gives you the freedom to seek care from the provider of your choice. You will maximize your benefits and reduce your out-of-pocket costs by choosing an in-network provider. In addition, the HDHP comes with a health savings account (HSA) that allows you to save pre-tax dollars¹ to pay for any qualified health-related expenses as defined by the IRS, including most out-of-pocket medical, prescription drug, dental and vision expenses. For a complete list of qualified health-related expenses, visit [Publication 502](#)

How You Pay for Services

- Routine preventive care is covered at 100%. The deductible does not need to be met first for most in-network preventive care services.
- You pay the full cost of non-preventive health care services and prescription drugs until you meet the annual deductible.
- Once you meet the annual deductible, you pay a percentage of your health care expenses (coinsurance), and the plan pays the rest.
- Once your deductible and coinsurance add up to the out-of-pocket maximum, this plan pays the full cost of all qualified health care services for the rest of the year.

¹ Tax free under federal tax law; state taxation rules may apply.

To find an in-network provider, login to your MyCigna account:
www.myCigna.com



MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	Cigna HDHP HSA 2000		Cigna PPO 800	
	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Deductible (Individual/Family)	\$2,000 / \$4,000 ²	\$3,200 / \$6,400 ²	\$800 / \$1,600	\$1,800 / \$3,600
Out-of-Pocket Max (Individual/Family)	\$4,500 / \$9,000 ³	\$12,000 / \$24,000 ³	\$4,000 / \$8,000	\$12,000 / \$24,000
Office Visits (physician/specialist)	20%*	50%*	\$30 copay	50%*
Virtual Visits	20%*	50%*	\$30 copay	50%*
Routine Preventive Care	Covered in full	50%*	Covered in full	Not covered
Diagnostics (Lab/X-ray)	20%*	50%*	20%*	50%*
Complex Imaging	20%*	50%*	20%*	50%*
Chiropractic	20%*	50%*	20%, deductible waived	50%*
Ambulance	20%*		20%*	
Emergency Room	20%*		\$200 copay + 20%*	
Urgent Care Facility	20%*	50%*	\$40 copay	50%*
Inpatient Hospital Stay	20%*	50%*	20%*	50%*
Outpatient Surgery	20%*	50%*	20%*	50%*
Retail Pharmacy (30-day)	\$10* / \$35* / \$60* / 30%*	Not covered	\$10 / \$35 / \$60 / 30%	Not covered
Mail Order (90-day)	\$20* / \$70* / \$120* / 30%*	Not covered	\$20 / \$70 / \$120 / 30%	Not covered

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.

*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. The deductible is aggregate. With an aggregate deductible, the full family deductible must be met before coinsurance applies to any individual.
3. The out-of-pocket maximum is aggregate. With an aggregate out-of-pocket maximum, the full family out-of-pocket maximum must be met before an individual's expenses are covered at 100%.

DENTAL COVERAGE

Willamette Dental Group DHMO

With the dental Health Maintenance Organization (HMO) plan, provided through Willamette Dental, you choose a primary dental provider to manage your care. There are no charges for most preventive services, no claim forms and no deductibles. Reduced, pre-set charges apply to other services.

Delta Dental of Washington DPPO

The dental Preferred Provider Organization (PPO) plan, provided through Delta Dental of Washington, offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a dentist who participates in the Delta Dental network.

Following is a high-level overview of your dental plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	Willamette DHMO	Delta Dental of WA DPPO	
	In-Network	In-Network	Out-of-Network ¹
Deductible (Individual/Family)	None / None	\$50 / \$150	\$50 / \$150
Annual Benefit Maximum (per person)	None	\$1,500	\$1,500
Preventive Services	\$15	0%	20%*
Basic Services	See schedule	20%*	30%*
Major Services	See schedule	50%*	50%*
Orthodontic Services (Child & Adult)	See schedule	50% up to \$1,000	50% up to \$1,000

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.

*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

VISION COVERAGE

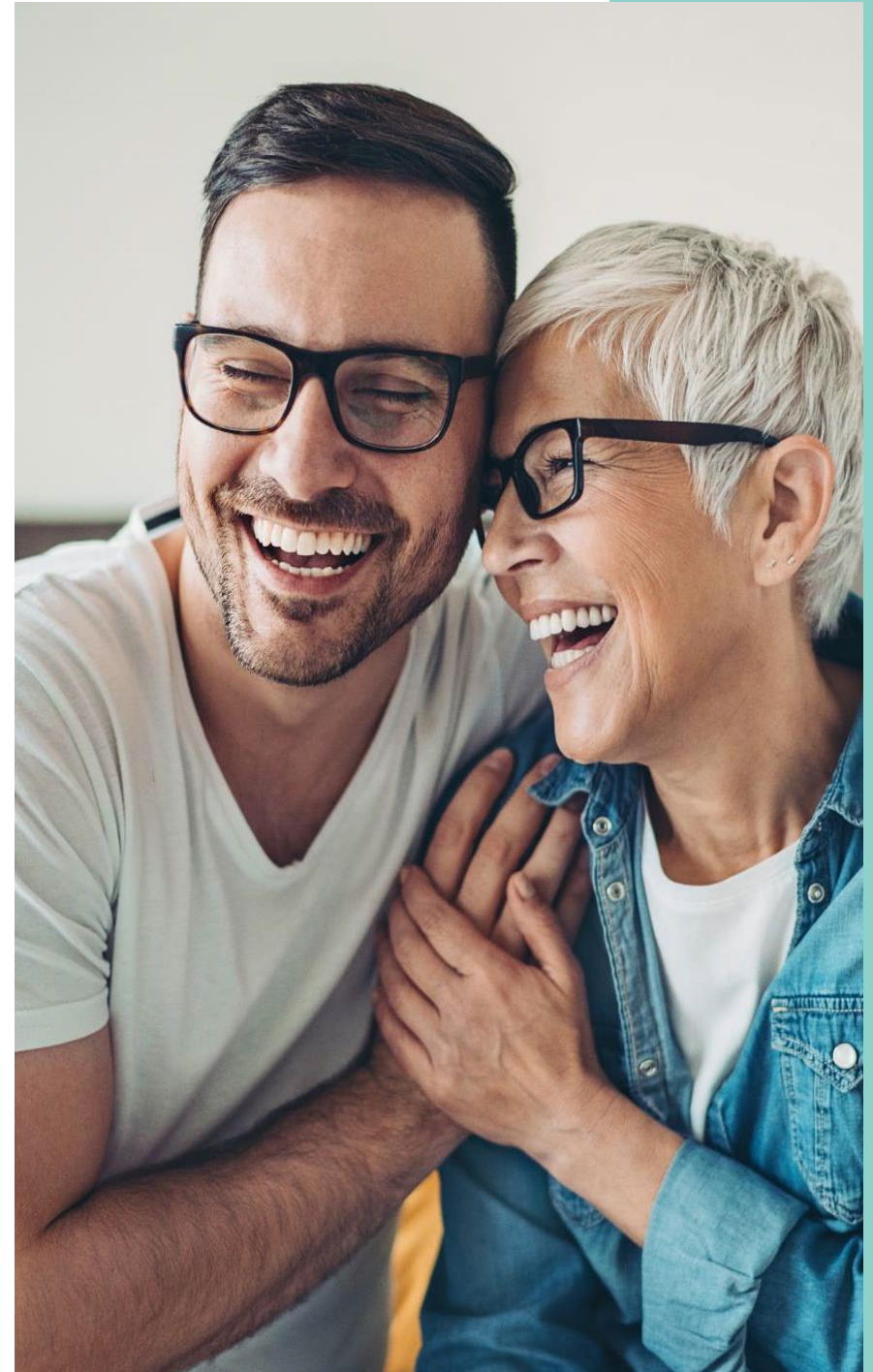
Vision Plan

Your eyesight is an integral part of your overall health and a key component of safety. This plan, provided through Cigna, gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the EyeMed network. If you decide to use an out-of-network provider, you will pay the provider in full at the time of your appointment and submit a claim form for reimbursement up to the amount allowed by the plan.

Following is a high-level overview of your vision plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	Cigna EyeMed Vision	
	In-Network	Out-of-Network Reimbursement
Exam (once every 12 months)	No charge	Up to \$45
Frames (once every 24 months)	Up to \$200 allowance	Up to \$110 allowance
Lenses (once every 12 months)		
Single Vision	No charge	Up to \$32
Bifocal		Up to \$55
Trifocal		Up to \$65
Contact Lenses (in lieu of glasses; once every 12 months)	Up to \$200 allowance	Up to \$160 allowance

To find an in-network provider, login to your MyCigna account:
www.myCigna.com



HEALTH SAVINGS ACCOUNT (HSA)

The HDHP HSA 2000 features an HSA provided through Cigna. The HSA lets you set aside pre-tax dollars to help offset your annual deductible and pay for qualified health care expenses.

How the HSA Works

- You contribute pre-tax dollars through automatic payroll deductions or make after-tax contributions that are deductible when you file your taxes.
- The Zak Designs contributes the following amounts annually to your HSA account to help it grow:
 - Employee only coverage: \$780
 - Employee + dependent(s) coverage: \$1,200
- You may change your contributions at any time throughout the year.
- You can withdraw HSA funds tax free to pay for current qualified health care expenses, or save them for the future, also tax free. Unused funds roll over from year to year and are yours to keep, even if you change medical plans or leave your employer.

Contribution Limits

Coverage Tier	2026
Individual	\$4,400
Family (Employee + 1 or more)	\$8,750
Catch-up Contributions (age 55+)	\$1,000

Note: Contribution limits include both Employer and Employee contributions.



[Click here](#) to watch a video about HSA limits.



HEALTH SAVINGS ACCOUNT (HSA)

Key Features of the HSA

Triple-Tax Advantage

- You contribute funds pre-tax through convenient payroll deductions. This means the money comes out of your paycheck before income tax is calculated. So, you get to keep a bigger portion of your paycheck.
- HSA funds grow tax free, and unused funds roll over year to year. So, the more you save, the more your account will grow—just like a bank savings account.
- If you need to use your HSA funds, you can withdraw them tax free to pay for qualified health care expenses now and in the future—even in retirement.

Control

You own and control the money in your HSA. You decide how or whether you want to spend it. You can use it to pay for doctor's visits, prescriptions, braces, glasses—even laser vision correction surgery.

Investment Opportunities

Once you reach and maintain a minimum threshold, you can make investments to help your money grow tax free.

Savings Potential

Your HSA is like a “health care 401(k).” There is no “use it or lose it” rule. Your account grows over time as you continue to roll over unused dollars from year to year.

Portability

Your HSA is yours for life. The money is yours to spend or save, even if you change health plans,¹ retire or leave the organization.

Preventive Medications List

If you are enrolled in an HSA-compatible medical plan, you may be able to access a range of preventive medications for a copay or coinsurance before meeting your deductible. These medications are contained in the HSA Preventive Drug List provided by your employer.

Qualified Health Care Expenses

- Qualified medical, dental and vision expenses not covered by the plans, as defined by the IRS in [Publication 502](#)
- COBRA premiums
- Qualified long-term care insurance and expenses
- Health insurance premiums when receiving unemployment compensation
- Medicare and retiree health insurance premiums (not Medicare Supplement premiums)
- Medigap insurance premiums

Important Notes

- You must meet certain eligibility requirements to have an HSA: You a) must be at least 18 years old, b) must be covered under a qualified HDHP, c) must not be enrolled in Medicare and d) cannot be claimed as a dependent on another person's tax return. For more information, please refer to IRS [Publication 969](#).
- Adult children must be claimed as dependents on your tax return for their medical expenses to qualify for payment or reimbursement from your HSA.

1. You must be enrolled in an IRS-qualified high-deductible health plan to contribute to an HSA.



[Click here](#) to watch a video about how an HSA works.



FLEXIBLE SPENDING ACCOUNTS (FSAs)

The flexible spending accounts (FSAs), provided through Rehn & Associates, are tax-advantaged accounts that can help you cover certain qualified out-of-pocket expenses. Each account works in much the same way but has different eligibility requirements, list of qualified expenses and contribution limits. You may choose to enroll in the following accounts.

	Health Care FSA (HCFSA)	Dependent Care FSA (DCFSA)
Eligibility Requirements	You must be benefits eligible; enrollment in an HCFSA disqualifies you from making or receiving HSA contributions	Available to all eligible employees
Examples of Qualified Expenses	<ul style="list-style-type: none"> • Coinsurance • Copayments • Deductibles • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia • Prescriptions 	<ul style="list-style-type: none"> • Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or daycare centers • Care of household members who are physically or mentally incapable of caring for themselves and who qualify as your federal tax dependent
Annual Contribution Limit	\$3,400	\$7,500 per family (or \$3,750 each if you are married and file separate tax returns)

Important FSA Rules

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

- **You must enroll each year to participate.**
- **HCFSA:** Unused funds will **not** be returned to you or carried over to the following year. There is 2.5-month grace period during which you can continue to use your remaining health care and limited-purpose FSA balance in the next plan year. This grace period ends on March 15, and you must submit expenses for reimbursement by March 31. Any funds in your account after this date will be forfeited.
- **DCFSA:** Unused funds will **NOT** be returned to you or carried over to the following year.



[Click here](#) to watch a video about how an FSA works.



[Click here](#) to watch a video comparing an HSA and an FSA.

LIFE INSURANCE

Life insurance, provided through Principal, provides your named beneficiaries with a benefit following your death, while accidental death and dismemberment (AD&D) insurance provides a benefit to you following a covered accident that leads to dismemberment (such as the loss of a hand, foot or eye). Should your death occur due to a covered accident, both the life benefit and the AD&D benefit would be payable.

Basic Life and AD&D (employer-paid)

Coverage Tier	Benefit Amount
Employee	Full-Time Employees: \$50,000 Executives/Full-Time Managers: 2x annual salary up to \$200,000

Supplemental Life and AD&D (employee-paid)

If you determine you need more than the basic coverage, you may purchase additional insurance for yourself and your eligible family members.

Coverage Tier	Benefit Amount	Guaranteed Issue Amount
Employee	\$10,000 increments up to \$500,000	Under age 70: \$150,000
Spouse	\$10,000 increments up to \$200,000	Under age 70: \$30,000
Child(ren)	\$5,000 or \$10,000 age 14-days and older \$1,000 14-days and under	

Note: During your initial eligibility period, you can secure coverage up to the Guaranteed Issue limits without the need for Evidence of Insurability (EOI, or information about your health). Please note that coverage amounts requiring EOI will only go into effect once the insurance carrier approves them.



DISABILITY INSURANCE

Disability insurance, provided through Principal, provides benefits that replace part of your lost income when you cannot work due to a covered illness or injury.

Voluntary Short-Term Disability

Provided at an affordable group rate.

Benefit	60% of base salary
Maximum weekly benefit	\$2,500
When benefit begins	After 7th day of disability
When benefit ends	12 weeks

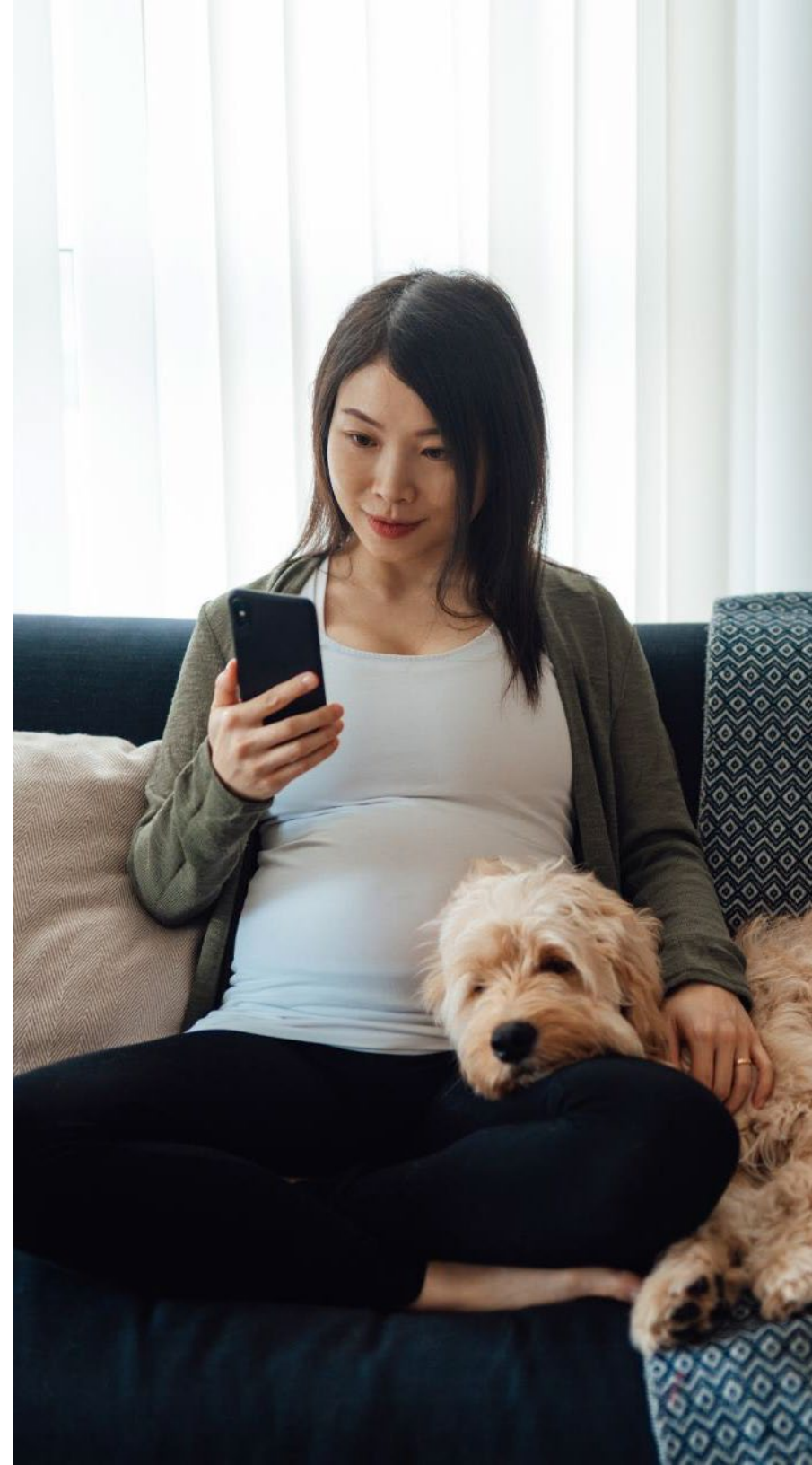
Voluntary Long-Term Disability

Provided at an affordable group rate.

Benefit	60% of base salary
Maximum monthly benefit	\$6,000
When benefit begins	After 90 day of disability
When benefit ends	To age 65 or Social Security Retirement Age



[Click here](#) to watch a video about how disability insurance works.





EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life is full of challenges and sometimes balancing them all can be difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families. The Employee Assistance Program (EAP) is provided at NO COST to you through Resources for Living.

The EAP can help with the following issues, among many others:

- Mental health
- Relationships
- Substance use
- Child and eldercare
- Grief and loss
- Legal or financial issues

EAP Benefits

- Assistance for you and your household members
- Up to six (6) in-person or virtual sessions with a counselor per event, per year, per individual
- Unlimited toll-free phone access and online resources

EAP ACCESS

Visit: www.resourcesforliving.com

Or call: (888)-238-6232

Username: zakdesigns

Password: eap



[Click here](#) to watch a video about how an EAP works.



VOLUNTARY BENEFITS



Pet Insurance

Your pet is a member of your family, and they deserve to be covered as one. You have access to discounted rates on pet insurance to help cover the costs of veterinary services.

Pet insurance, provided through Pets Best, reimburses all or part of the cost of covered veterinary expenses, either as a percentage of your cost or based on a schedule of set dollar amounts. You can visit any vet of your choice and customize coverage to meet your needs.

What's Covered?

Coverage varies based on the plan you select. Below are examples of services that may be covered (check plan details to verify).

Preventive Care:

- Routine exams and immunizations
- Preventive medication
- Spay/neuter surgery
- Teeth cleaning

Accidents, Illness and More:

- Hospitalization and surgery
- Emergency care
- Prescription pet medications
- Disaster response

ENROLL ONLINE

www.petsbest.com/zakpet

Or call: 888-984-8700





VALUABLE EXTRAS

Blue Cross Blue Shield Global Solutions (GeoBlue)

GeoBlue will be re-branded to Blue Cross Blue Shield Global Solutions. New Electronic ID cards will be available starting November 2025.

New Website: <https://bcbsglobalsolutions.com/>. Your login information remains the same.

Benefits and processes will not change.

Business Travel Coverage is your primary medical insurance when you travel outside of your home country. It provides coverage for accidental injury and illness if you are traveling outside of your home county for up to 180 consecutive days. This plan does not cover routine preventive care vision or dental services.

ACCESS

Visit: <https://bcbsglobalsolutions.com/>

Or call: 610-254-5830

Group Access Code: QHG999999ZAK

NOTE: Please notify HR if you will be traveling internationally on business

PLAN CONTRIBUTIONS

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members.

Medical

Coverage Tier	Bi-Weekly Contributions	
	HDHP HSA 2000	PPO 800
Employee Only	\$0.00	\$42.50
Employee + Spouse	\$225.00	\$375.00
Employee + Child(ren)	\$117.50	\$212.50
Employee + Family	\$325.00	\$535.00

Dental

Coverage Tier	Bi-Weekly Contributions	
	Willamette DHMO	Delta Dental of WA DPPO
Employee Only	\$0.00	\$0.00
Employee + Spouse	\$20.30	\$20.50
Employee + Child(ren)	\$20.30	\$23.50
Employee + Family	\$38.14	\$41.00

Vision

Coverage Tier	Bi-Weekly Contributions
	Cigna EyeMed Vision
Employee Only	\$0.00
Employee + Spouse	\$4.61
Employee + Child(ren)	\$3.78
Employee + Family	\$8.39

Voluntary Life/AD&D

Age-Bands	Monthly Rate, Per \$1,000 of Benefit	
	Employee	Spouse
29 & under	\$0.126	\$0.126
30 - 34	\$0.154	\$0.154
35 - 39	\$0.168	\$0.168
40 - 44	\$0.181	\$0.181
45 - 49	\$0.251	\$0.251
50 - 54	\$0.363	\$0.363
55 - 59	\$0.642	\$0.642
60 - 64	\$0.962	\$0.962
65 - 69	\$0.213	\$0.213
70 +	\$2.915	\$2.915
Child(ren)	\$5,000 benefit	\$1.00
	\$10,000 benefit	\$2.00

Voluntary Disability

Coverage Tier	Monthly Rate
Short-Term Disability	\$0.13 per \$10 of weekly benefit
Long-Term Disability	\$0.42 per % of covered earnings

IMPORTANT CONTACTS

Coverage	Carrier	Phone #	Website
Medical	Cigna	(800) 244-6224	www.cigna.com
Dental DPPO	Delta Dental of WA	(800) 554-1907	www.deltadentalwa.com
Dental DHMO	Willamette Dental	(855) 433-6825	www.willamettedental.com
Vision	Cigna EyeMed	(800) 244-6224	www.eyemedvisioncare.com
Flexible Spending Account (FSA)	Rehn & Associates	(800) 872-8979	www.rehnonline.com
Life and AD&D	Principal	(800) 247-4695	www.principal.com
Disability	Principal	(800) 247-4695	www.principal.com
Employee Assistance Program (EAP)	Resources for Living	(888) 238-6232	www.resourcesforliving.com Username: zakdesigns Password: eap
Pet Insurance	Pets Best	(888) 984-8700	www.petsbest.com/zakpet
Business Travel Coverage	Blue Cross Blue Shield Global Solutions (GeoBlue)	(610) 254-5830	www.bcbsglobalsolutions.com Group Access Code: QHG999999ZAK

BENEFITS WEBSITE

Go to <https://access.paylocity.com/>

There you will find detailed information about the plans available to you and instructions for enrolling.

QUESTIONS?

If you have additional questions, you may also contact:

Melissa Kuntzmann
(509) 244-1248
kuntzmann@zak.com

Daniel Stoick
(509) 244-6334
HR@zak.com





RESOURCES



CIGNA & EYEMED RESOURCES

Through your MyCigna.com or MyCigna App you have access to several tools to help you navigate your health journey.



Register & Create your online account by visiting www.myCigna.com



Access Virtual Care provided by MDLive Urgent Care, Primary Care, Dermatology and Behavioral Health

MDLive: 888-726-3171 or click on “Talk to a doctor” from your MyCigna.com account.



Locate in-network providers.

Medical: Cigna Open Access Plus network

Vision: EyeMed network



Recovery One for Cigna:

Virtual physical therapy at no additional cost.



Identity Theft Protection provided by IdentityForce, at no cost to you.

Register by visiting:

<https://cigna.identityforce.com/starthere>

Call: 833-580-2523



Download the myCigna App on your mobile device



Cigna One Guide can help resolve health care issues, get cost estimates, understand your bills, navigate the health care system and more.



Case Management will connect you to a Case Manager who will work closely with you and your providers. You can get support for conditions and illnesses such as cancer, or pain management.



MEMBER DISCOUNTS

Provided by Principal

Laser Vision Correction

Save up to \$800 with featured providers LasikPlus, TLC Laser Eye Centers or the LASIK Vision Institute. Or receive 15% off standard pricing or 5% off promotional pricing on Lasik through the National Lasik Network's 600 locations. Administered by LCA Vision. www.principallasik.com | 888-647-3937

Hearing Aid Program:

Receive up to 48% off hearing aids, including rechargeable and Bluetooth options. You can also receive a free hearing consultation at any of the 3,000+ locations nationwide. Administered by Start Hearing. www.starthearing.com/partners/principallife | 877-890-4694

Available with Life Insurance Coverage

Identity Theft Kit:

Be proactive in protecting one of your most important assets – your identity. Provided by ARAG. www.principal.araggroup.com
Enter group number: 1182831

Beneficiary Support:

Beneficiaries receive access to comprehensive support system after a loved one dies. Services include care human support and helpful technology from Empathy. Spouses and dependents receive three months of free online will preparation services provided by ARAG. Information is provided after the loss of a loved one.



BENEFIT TERMINOLOGY

Allowed amount

This is the amount agreed upon between the provider and the insurance company for the service provided. It is almost always less than the billed amount, which is why enrollees see different amounts on their Explanation of Benefit statements (EOBs). For example, a provider may charge \$120 per hour of psychotherapy, but the insurance company pays them \$95—the allowed amount for that service.

Balance billing

When an out-of-network provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. An in-network provider cannot balance bill you for the covered services.

Beneficiary

A person who is designated as the recipient of proceeds from an insurance policy.

Coinsurance

Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Consider an example in which the medical plan's allowed amount for a medical service is \$100 and you've met your deductible. If your plan pays 70%, then you are responsible for the remaining 30%, which is \$30.

Copayment

Oftentimes referred to as a “copay,” this is the amount you are responsible for paying when seeing a doctor, picking up a prescription, or visiting an urgent care facility or emergency room.

Deductible

The amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. For example, if your individual deductible is \$1,500, your plan will not pay anything for certain medical services until you have paid \$1,500. The deductible may not apply to all services, such as services that are covered by a copay.

Dependent

Dependents are usually an immediate relative, such as a spouse or child (up to age 26, as per the ACA), who is eligible to be included on your health insurance policy. The Company also allows domestic/civil union partners to be listed as dependents.

Dependent care FSA

A flexible spending account (FSA) is designed to provide tax-exempt funds that can be used to offset qualifying expenses for children and elderly dependents. Eligible dependent care expenses include daycare, before- and after-school care, summer day camps and eldercare for dependents claimed on your income taxes. Funds deposited in an FSA must be spent in the same year in which they are set aside, or they are forfeited. This rule is often referred to as “use it or lose it.”

Diagnostic test

Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.



BENEFIT TERMINOLOGY

Durable medical equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs or crutches.

Eligible expense

Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “payment allowance” or “negotiated rate.” If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. See balance billing.

Embedded deductible

Once a person covered under a family plan reaches the individual embedded deductible, all covered expenses for that individual will be paid at the coinsurance amount even when the family deductible may not have been satisfied. For example, PPO 800 features an in-network family deductible of \$1,600. If one member of the family satisfies the individual \$800 deductible, the medical carrier will pay 80% of the remaining in-network expenses. Once another person or a combination of persons meet the remaining \$800, the embedded family deductible is considered satisfied.

Embedded out-of-pocket maximum

Once a person covered under a family plan reaches the individual embedded out-of-pocket maximum, all covered expenses for that individual will be paid at 100% even when the family out-of-pocket maximum may not have been satisfied. For example, PPO 800 features a family out-of-pocket maximum of \$8,000. If one member of the family satisfies the individual out-of-pocket maximum of \$4,000, the medical carrier will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the embedded family out-of-pocket maximum is considered satisfied.

Employee contribution

The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

Excluded services

Medical services that your medical plan doesn't pay for or cover.

Explanation of benefits

Every time you use your health insurance, your health plan sends you a record called an “explanation of benefits” (EOB) or “member health statement” that explains how much you may owe. The EOB also shows the total cost of care, how much your plan paid, and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the “allowed amount”). An EOB is generated for every single health claim, including prescriptions. It is not a bill, but rather a tool members can use to make sure they're not paying more than their insurer expects them to for services rendered.

Health care FSA

Funded through pre-tax payroll deductions, a health care flexible spending account (FSA) is a cost-savings tool that allows you to pay for qualified health care-related expenses with pre-tax dollars.

Generic drugs

Medications that are comparable to brand-name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand-name counterparts. (These are typically “Tier 1” drugs in the Company's medical plans.)



BENEFIT TERMINOLOGY

High-Deductible health plan (HDHP)

A HDHP is a type of health insurance plan that typically offer lower premiums in exchange for higher deductibles. The deductible, which is the amount you must pay out of pocket for covered medical expenses before your insurance begins to pay, is higher for HDHPs compared to traditional PPO plans. These plans allow individuals to pay a lower monthly premium and instead cover more of their medical expenses through out-of-pocket deductibles.

Health savings account (HSA)

An employer- and employee-funded savings plan that reimburses you for qualified out-of-pocket medical expenses. Funded through pre-tax payroll deductions by the employer and employee, HSAs are only available to people enrolled in a qualified high-deductible health plan. Unspent balances aren't forfeited; they roll over and accumulate over time.

In-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network coinsurance costs you less than out-of-network coinsurance payments.

In-network provider

The facilities, providers and suppliers our health insurance carrier has contracted with to provide medical services. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Mail order Rx

The Company's medical carrier offers this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can obtain a 90-day supply at one time versus a 30-day supply at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your copay is cheaper through mail order.

Medically necessary

Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, and that meet accepted standards of medicine.

Member health statement

Every time you use your health insurance, your health plan sends you a record called a "member health statement" or an "explanation of benefits" (EOB) that explains how much you may owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount").

Negotiated rate

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.



BENEFIT TERMINOLOGY

Network

The facilities, providers and suppliers a health insurance carrier has contracted with to provide medical services at a pre-negotiated discount. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Non-preferred brand-name drugs

Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand-name drug or a generic. (These are typically “Tier 3” drugs in the Company’s medical plans.)

Open Enrollment

A period during which a health insurance company is required to accept applicants without regard to health history.

Out-of-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network coinsurance costs you more than in-network coinsurance. An out-of-network provider can balance bill you for charges over the allowed amount.

Out-of-network provider

A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see an out-of-network provider.

Out-of-pocket maximum

The most you pay during a policy period (a calendar year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-counter drug

A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Preauthorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn’t a promise your medical plan will cover the cost.

Preferred/brand-name drug

These are medications for which generic equivalents are not available. They have been on the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs. (These are typically “Tier 2” drugs in the Company’s medical plans.)

Prescription drugs

Medications you can only obtain with a prescription from your doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor, Vicodin and Albuterol can only be obtained with a prescription. The opposite of an over-the-counter drug.



BENEFIT TERMINOLOGY

Prescription drug coverage

Coverage that helps pay for prescription drugs and medications covered under a health insurance carrier's formulary. A formulary is the list of FDA-approved drugs covered under a medical plan. Each drug is classified into a tier and each tier determines the copayment you will pay for the drug. These tiers typically, but not always, are: Generic (Tier 1), Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty.

Your cost will depend on the level of drug specified by your doctor. A generic drug is a medication whose active ingredients, safety, dosage, quality and strength are identical to that of its brand-name counterpart. Preferred brand-name drugs generally do not have a generic equivalent, while those listed as non-preferred brand-name drugs generally do have a generic or preferred brand-name equivalent.

Your copay for preferred brand-name drugs is less than the copay for non-preferred brand-name drugs because you don't have the generic option available to you.

Premium (Insurance)

The fees paid to an insurance carrier to provide coverage. These fees are usually shared between you and the Company, though there are insurance benefits the Company pays for entirely, while there are others that you pay for yourself.

Pre-tax deduction

Payments deducted from your gross pay before Medicare, federal, and state taxes are calculated, thus reducing your taxable wages and tax liability.

Post-tax deduction

Payments deducted from your net pay after Medicare, federal and state taxes are calculated, thereby having no impact on your taxable wages and tax liability.

Preventive care

Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventive.

Primary care physician (PCP)

A physician who directly provides or coordinates a wide range of medical services for a patient. Primary care physicians include medical doctors, doctors of osteopathic medicine, internists, family practitioners, general practitioners, OB/GYNs and pediatricians. The opposite of a specialist.

Provider

A physician, health care professional or health care facility, certified or accredited as required by state law.

Qualifying life event (QLE)

QLEs are major events in an enrollee's life that allow them to make specific changes to their insurance policy outside of an annual Open Enrollment period. This usually includes the birth or adoption of a child, marriage, divorce, death of a spouse or change in the spouse's employment or insurance status. These changes must typically be made within 31 days of the QLE.

Special enrollment period

Special enrollment periods allow you to make changes to your insurance plan or sign up for a new policy outside of Open Enrollment. They're almost always triggered by QLEs.

Specialist

A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a primary care physician. For example, a dermatologist is considered a specialist.



BENEFIT TERMINOLOGY

Specialty drugs

Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

Telehealth

Telehealth is the use of telecommunication technologies through which you and your personal physician, who is treating you and knows your health history, can talk live over the phone or video chat, by appointment, during regular office hours. Services such as medication management, regular visits and online counseling are particularly well suited to Telehealth, since consistent and regular visits with your physician typically improve outcomes.

Telemedicine

Telemedicine is the use of telecommunication technologies where you and an on-call physician can talk live (24/7/365) over the phone or video chat. Services that are particularly well-suited to telemedicine include the discussion of symptoms, receiving a diagnosis, learning your treatment options and minor health issues such as pink eye or sore throat. Prescription can also be facilitated through telemedicine. Please note that each time you reach out for telemedicine services, you might speak with a different physician.

Urgent care

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

Wellness

Wellness refers to a healthy state of being.



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