EMPLOYEE MANAGEMENT SERVICES

Benefit Election Form 2020 - 2021

☐ NEW HIRE ☐ CHANGE (Must be submitted within 30 Days of Qualifying Event) ☐ OPEN ENROLLMENT

Social Security #: _____ **Date of Hire:** _____

Employee Name: _____ **Classification:** *Union Employees*

Client Name: *Alpha & Omega* **Pay Frequency:** *Weekly*

Please review plans in Option 1 and Option 2. Please choose plans in only one of the options then sign and date the bottom of page 2.
***** Plans in separate options cannot be mixed.**
Please mark the plan you would like (and the number of people you would like to have covered by the plan) and follow the instructions under each plan.
If you do not want coverage under the plan, please mark waive and follow the instructions below each section.

Option 1

If you choose any plans in Option 1, you cannot choose any plans in Option 2

Medical

Amalgamated

Effective Date: _____

☐ *PRE-TAX*
☐ *WAIVE*

	Tier	Employee Per Pay	Dependent Per Pay	Total Per Pay
		9.78% up to:		
☐	Single	$73.27	$0.00	$73.27
☐	Employee + Spouse	$73.27	$180.46	$253.73
☐	Employee + Child	$73.27	$51.69	$124.96
☐	Employee + Child(ren)	$73.27	$124.85	$198.12
☐	Family	$73.27	$268.38	$341.65

****If you do not want or need the insurance:**
On the Application, check the box "I do not wish to pay for coverage under the plan" then sign and date

****If you want UHC insurance:**
Complete the Application, then sign and date

Dental *Plan 1C*

UHC Dental

Effective Date: _____

☐ *PRE-TAX*
☐ *WAIVE*

	Tier	Employee Per Pay
☐	Single	$6.12
☐	EE + Spouse	$12.25
☐	EE + Children	$15.30
☐	Family	$23.17

Vision *Plan 1D*

UHC Vision

Effective Date: _____

☐ *PRE-TAX*
☐ *WAIVE*

	Tier	Employee Per Pay
☐	Single	$1.48
☐	EE + Spouse	$2.81
☐	EE + Children	$3.30
☐	Family	$4.64

****If you do not want or need the dental or vision insurance:**
Check the WAIVE box above for the plan(s) you do not want

****If you want dental or vision insurance:**
Complete each application you are requesting coverage for

If you waived all plans in Option 1, please go to Option 2 at the top of page 2.
If you elected any plans in Option 1, you must skip Option 2 and sign and date the bottom of page 2.

Option 2

If you choose any plans in Option 2, you cannot choose any plans in Option 1

Medical ***Plan 2A*** ***CHC Base Plan*** ***Effective Date:*** _____

☐ ***PRE-TAX***
☐ ***WAIVE***

	Tier	Employee Per Pay	Dependent Per Pay	Total Per Pay
☐	Single	$7.52	$0.00	$7.52
☐	EE + Spouse	$7.52	$13.53	$21.05
☐	EE + Child(ren)	$7.52	$8.42	$15.94
☐	Family	$7.52	$20.53	$28.05

Medical ***Plan 2B*** ***CHC Buy Up Plan*** ***Effective Date:*** _____

☐ ***PRE-TAX***
☐ ***WAIVE***

	Tier	Employee Per Pay	Dependent / Buy Up Per Pay	Total Per Pay
☐	Single	$7.52	$11.26	$18.79
☐	EE + Spouse	$7.52	$39.01	$46.53
☐	EE + Child(ren)	$7.52	$28.60	$36.12
☐	Family	$7.52	$55.18	$62.70

Dental ***Plan 2C*** ***CHC Dental*** ***Effective Date:*** _____

☐ ***PRE-TAX***
☐ ***WAIVE***

	Tier	Employee Per Pay
☐	Single	$2.55
☐	EE + Spouse	$4.46
☐	EE + Child(ren)	$5.88
☐	Family	$7.78

Vision ***Plan 2D*** ***CHC Vision*** ***Effective Date:*** _____

☐ ***PRE-TAX***
☐ ***WAIVE***

	Tier	Employee Per Pay
☐	Single	$2.32
☐	EE + Spouse	$3.79
☐	EE + Child(ren)	$3.78
☐	Family	$6.10

****If you do not want or need the CHC insurance:**
On the Century HealthCare Application, check the box on the second page "Refusal of Coverage"
Sign and date right under the "Refusal of Coverage" box and DO NOT write anything on the third page

****If you want CHC insurance:**
On the Century HealthCare Application, check the box of the Benefit Plan Selection that you want
Fill out those sections and sign and date

I understand that my portion of the monthly premium elected will be deducted from my paycheck on scheduled paydays. I understand that my deductions will begin on the first check of the month in which I am eligible. Should I have a pay period without earnings or deductions, I understand that make-up deductions will be taken. If I leave employment prior to the end of the benefit month, the balance of my portion will be deducted from my final paycheck. I further understand that my benefit coverage will end according to the plan design. **I understand this will be my only notice of eligibility and election, as it is my responsibility to be aware of eligibility dates/elections, and to notify EMS within 30 days of eligibility regarding any inconsistencies that appear after review of my deductions on the first check after deductions start/change. Retro changes, refunds, etc. will not be considered beyond this time.**

By checking the Pre-Tax boxes, I request that my benefit premiums will be deducted from my earnings before Federal taxes are withheld. In addition, I understand by checking Pre-Tax boxes, I will not be able to cancel the particular benefit(s) until "open enrollment" or if I have a "qualifying event" (i.e. birth of a child, marriage, divorce, etc.) Supporting documentation is required within 30 days of a qualifying event.

By checking the Waive boxes, I do not wish to participate in the plan(s) at this time. I understand that I will not be eligible to enroll in the plan(s) until the next open enrollment period, unless I have a "qualifying event" (i.e. birth of child, marriage, divorce, etc.). Supporting documentation is required within 30 days of the qualifying event.

Employee Signature **Date**

Alpha & Omega Building Services

Employee Enrollment Form

Enrollment Date		Work Location
Enrollment Reason		

Section 1)

Employee Last Name	First Name	M	Social Security Number

Address	Apt	City	State	Zip	Date of Birth

Phone # Home or Cell	Marital Statue	Do You Use Tobacco?	Male of Female

Section 2) Fill in Family Information if you want Dependents Coverage (THIS WILL BE AT 100% YOUR COST)

Last Name	First Name	M	Social Security Number

Date of Birth	Marital Statue	Do You Use Tobacco?	Male of Female

Last Name	First Name	M	Social Security Number

Date of Birth	Marital Statue	Do You Use Tobacco?	Male of Female

Last Name	First Name	M	Social Security Number

Date of Birth	Marital Statue	Do You Use Tobacco?	Male of Female

Last Name	First Name	M	Social Security Number

Date of Birth	Marital Statue	Do You Use Tobacco?	Male of Female

Section 3) Please note below the Product Plan / Plans you want to be enrolled in:

Person	**Medical**	**Dental**	**Vision**
EE			
EE+ Spouse			
EE+ Child(Ren)			
EE+ Family			

Section 4)	(LIFE INSURANCE ONLY IF TAKING MEDICAL COVERAGE) Beneficiary Full Name & Address	**Relationship**
Primary		
Secondary		

Section 5) EMPLOYEE INITIAL BOXES IF WAIVING COVERAGES

Person	**Medical**	**Dental**	**Vision**	**Declining Coverage due to existence of other coverage**
EE				Insert reason from choice of 9 see note
EE+ Spouse				Insert reason from choice of 9 see note
EE+ Child(Ren)				Insert reason from choice of 9 see note
EE+ Family				Insert reason from choice of 9 see note

Section 6)

Date	Employee Signature for all applying or waiving	Spouse Signature (if applying for coverage)

NOTE IF YOU WAIVE COVEAGE AT THIS TIME, YOU WILL NOT BE ALLOWED TO PARTICIPATE UNLESS YOU QUALIFY FOR A SPECIAL ENROLLMENT PERIOD OR AS A LATE ENROLLEE, IF APPLICABLE, OR AT THE NEXT OPEN ENROLLMENT PERIOD.

AliCare™
Third-Party Administration

BENEFIT ENROLLMENT/CHANGE FORM

COMPLETE ALL SECTIONS BELOW

(FOR PROPER PROCESSING OF YOUR ENROLLMENT, PLEASE PRINT CLEARLY USING A BLACK BALLPOINT PEN)

REASON FOR SUBMISSION (CHECK ALL THAT APPLY): ☐ Open Enrollment ☐ New Hire ☐ Change Coverage Selection ☐ Add Dependents listed Below
☐ Change of Beneficiary ☐ Change of Address ☐ Change of Marital Status ☐ Change of Name (Former Name _____)

PLEASE SELECT YOUR HEALTHCARE COVERAGE UNDER THE PLAN (PLEASE CHECK ONE BOX ONLY)

☐ **EMPLOYEE ONLY** (9.5% OF EMPLOYEE'S WAGES AS NEGOTIATED BY YOUR EMPLOYER)
☐ **EMPLOYEE & SPOUSE** (9.5% OF EMPLOYEE'S WAGES + FULL COST FOR DEPENDENT COVERAGE AS NEGOTIATED BY YOUR EMPLOYER)
☐ **EMPLOYEE & CHILD** (9.5% OF EMPLOYEE'S WAGES + FULL COST FOR DEPENDENT COVERAGE AS NEGOTIATED BY YOUR EMPLOYER)
☐ **EMPLOYEE & CHILDREN** (9.5% OF EMPLOYEE'S WAGES + FULL COST FOR DEPENDENT COVERAGE AS NEGOTIATED BY YOUR EMPLOYER)
☐ **FAMILY** (9.5% OF EMPLOYEE'S WAGES + FULL COST FOR DEPENDENT COVERAGE AS NEGOTIATED BY YOUR EMPLOYER)
☐ **I DO NOT WISH TO PAY FOR COVERAGE UNDER THE PLAN (INCLUDING LIFE INSURANCE COVERAGE)**

EMPLOYEE SOCIAL SECURITY NUMBER | SEX (M F) | EMPLOYEE BIRTHDATE (MM DD YYYY) | MARITAL STATUS (Circle One) M / S / W / D / SP / CL | EMPLOYMENT DATE (MM DD YYYY)

EMPLOYEE NAME: LAST (AS SHOWN ON YOUR PAY STUB) | FIRST | MI

HOME ADDRESS (STREET, APARTMENT NUMBER)

CITY | STATE | ZIP CODE | HOME PHONE NUMBER

CELL PHONE NUMBER | EMAIL ADDRESS

UNLESS YOU REQUEST OTHERWISE, ALL COMMUNICATION TO THE PARTICIPANT & BENEFICIARIES WILL BE SENT TO THE ABOVE ADDRESS

SPOUSE NAME (LAST, FIRST, MI) | SEX (M F) | SPOUSE SOCIAL SECURITY NUMBER | SPOUSE BIRTHDATE (MM DD YYYY)

DOES YOUR SPOUSE HAVE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO
DOES YOUR CHILD(REN) AGE 19-26 HAVE OTHER GROUP HEALTH INSURANCE COVERAGE? ☐ YES ☐ NO
NAME OF OTHER INSURANCE CARRIER: _____

NAME (LAST, FIRST, MI) OF DEPENDENT CHILDREN	DEPENDENT SOC. SEC. NO.	RELATIONSHIP	1-Natural 2-Adopted 3-Stepchild	SEX	BIRTHDATE (MM DD YYYY)
		S D	1 2 3	M F	
		S D	1 2 3	M F	
		S D	1 2 3	M F	

YOU MUST INCLUDE COPIES OF DOCUMENTATION THAT SUPPORT YOUR DEPENDENT RELATIONSHIP (I.E. – MARRIAGE, BIRTH, ADOPTION, ETC.) AS WELL AS A PHYSICIAN STATEMENT FOR CHILDREN LISTED AS MENTALLY OR PHYSICALLY HANDICAPPED.. FAILURE TO PROVIDE COMPLETE SUPPORTING DOCUMENTATION CAN RESULT IN A DELAY OR A DENIAL OF ELIGIBILITY. ATTACH ADDITIONAL COPIES OF THIS FORM FOR MORE DEPENDENTS.

BENEFICIARY INFORMATION (FOR GROUP LIFE INSURANCE)

NAME (LAST,FIRST,MI)	RELATIONSHIP	%	ADDRESS (NUMBER AND STREET)	CITY	STATE	ZIP

ATTACH ADDITIONAL COPIES OF THIS FORM FOR MORE BENEFICIARIES – ON ADDITIONAL COPIES PRINT **ONLY** EMPLOYEE SOCIAL SECURITY # AND NAME.

AUTHORIZATION: I hereby authorize my employer to make payroll deductions in the amount indicated above which I am obligated to pay to the Amalgamated National Health Fund for coverage.

ENROLLMENT/ELECTION: I understand that I am obligated to pay the amount checked off above as long as I am otherwise eligible for coverage as defined by the Plan. I understand I can only change my election during the open enrollment period or in the case of a Life Event as defined by the Plan.

EMPLOYEE SIGNATURE: | **DATE SIGNED:**

Email or Mail Completed Enrollment Form To:
Amalgamated National Health Fund, Plan Participation Dept.
333 Westchester Avenue, White Plains, NY 10604
Email: enrollments@alicare.com

ALPHA AND OMEGA BUILDING SERVICES, INC.
EMPLOYER NAME

2012690
ACCOUNT NO

Your Plan At A Glance

Health Care Coverage

By using the Network of Hospitals, doctors and other health care providers, you will be entitled to maximum healthcare coverage for yourself and your family. The chart below summarizes your full managed care coverage and is included here as a "quick reference."

	Coverage When A Network Provider Is Used	Coverage When A Network Provider Is NOT Used[1]
Annual Maximum	None.	None.
Annual Deductible	$500 per person, $1,000 per family.	$1,000 per person, $2,000 per family.
Out of Pocket Maximum	$6,350 per person, $12,700 per family.	Unlimited.
Hospital Coverage		
Hospital Inpatient Room, Board and Ancillary, Skilled Nursing or Acute Rehabilitation Facility, Birthing Center	60% of the network rate for up to 120 days per calendar year. Includes coverage for mental health and substance abuse admissions.	50% of reasonable billed charges for up to 120 days per calendar year. Includes coverage for mental health and substance abuse admissions.[2]
Hospice	60% of the network rate for up to a maximum period of six months and three bereavement counseling sessions per calendar year.	50% of reasonable billed charges for up to a maximum period of six months and three bereavement counseling sessions per calendar year.[2]
Hospital Outpatient		
Emergency Accident, Emergency Illness	60% of the network rate.	60% of reasonable billed charges.[2]

[1] For services where you have no control in selecting an in network provider (e.g. you used an in network provider but there were professional components that may have resulted in billing by non-network professionals such as an emergency room physician, anesthesiology, assistant surgeon, diagnostic interpretations such as radiology & pathology and ambulance) coverage will be provided at the in-network level of coinsurance based on usual and customary charges for the service provided.

[2] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

	Coverage When A Network Provider Is Used	Coverage When A Network Provider Is NOT Used
Hospital Coverage (continued)		
Hospital Outpatient (continued)		
Non-emergency hospital, clinic, urgent care, or diagnostic only facility services	60% of the network rate. $35 co-payment per urgent care facility visit.	50% of reasonable billed charges.[1]
Ambulatory or Outpatient Surgery, Chemotherapy, Radio-therapy, and Pre-admission testing (within 7 days from admission)	60% of the network rate.	50% of reasonable billed charges.[1]
Major Medical Coverage		
Surgery **Maternity, Assistant Surgeon, Second Surgical Opinion**	60% of the network rate.	50% of reasonable billed charges.[1]
Organ Transplants	60% of the network rate.	Not covered.
Anesthesiology	60% of the network rate.	50% of reasonable billed charges.[1]
Physician Hospital Inpatient Visits	60% of the network rate.	50% of reasonable billed charges.[1]
Physician Office Visits	100% of the network rate, after a $25 primary care physician co-payment per visit and a $35 specialist co-payment per visit.	50% of reasonable billed charges.[1]
Home Health Care	60% of the network rate.	50% of reasonable billed charges.[1]
Diagnostic Imaging, X-Ray and Laboratory Testing (includes MRI, CT Scans, etc.)	60% of the network rate.	50% of reasonable billed charges.[1]

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

	Coverage When A Network Provider Is Used	Coverage When A Network Provider Is NOT Used
Major Medical Coverage (continued)		
Therapeutic Professional Services (chemotherapy, radiation therapy, infusion therapy, dialysis, electroshock therapy)	60% of the network rate.	50% of reasonable billed charges.[1]
Physical Therapy	100% of the network rate, after a $35 co-payment, for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Speech Therapy	100% of the network rate, after a $35 co-payment, for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Occupational Therapy	100% of the network rate, after a $35 co-payment, for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Respiratory Therapy	60% of the network rate for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Cardiac Rehabilitation	60% of the network rate for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Allergy Testing and Treatment	60% of the network rate.	50% of reasonable billed charges.[1]
Injections/Immunizations	60% of the network rate (some immunizations may be covered at 100% of the network rate).	50% of reasonable billed charges.[1]
Accidental Injury To Sound Natural Teeth	60% of the network rate.	50% of reasonable billed charges.[1]
Durable Medical Equipment, Prosthetics, & Orthotics (includes medical supplies essential to DME, e.g. oxygen)	60% of the network rate. Shoe inserts are covered for up to a maximum payment of $500 every 2 years.	50% of reasonable billed charges.[1] Shoe inserts are covered for up to a maximum payment of $500 every 2 years.
Ambulance	60% of the network rate.	50% of reasonable billed charges.[1]

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

	Coverage When A Network Provider Is Used	Coverage When A Network Provider Is NOT Used
Major Medical Coverage (continued)		
Blood	60% of the network rate.	50% of reasonable billed charges.[1]
Outpatient Psychotherapy	100% of the network rate, after a $35 co-payment per visit.	50% of reasonable billed charges.[1]
Outpatient Substance Abuse Therapy	100% of the network rate, after a $35 co-payment per visit.	50% of reasonable billed charges.[1]
Chiropractic Visits	100% of the network rate, after a $35 co-payment, for up to 30 visits per calendar year.	50% of reasonable billed charges, for up to 30 visits per calendar year.[1]
Preventive Services	Certain preventive services are covered in full. Refer to your Summary Plan Description for details. When a network provider is not used, preventive services are covered at 50% of reasonable billed charges.[1]	

Medical Certification Program — The Medical Certification Program requires that you call Alicare Medical Management at 1-800-332-5426 to obtain the Fund's certification before you or one of your covered dependents use any of the following services or procedures:

- If you are going into the hospital.
- If you are having any surgery.
- If you are having any high cost diagnostic or therapeutic treatment (over $500) such as Magnetic Resonance Imaging (MRI), CAT Scans, Dialysis or Infusion Therapy.
- If your doctor is planning to admit you to a skilled nursing facility, an acute rehabilitation facility or order home health care services.
- If you are going to have hospice care.
- If you are pregnant, you must call Alicare Medical Management if your physician or midwife has recommended a hospital length of stay for more than 48 hours following a normal vaginal delivery or more than 96 hours following a Caesarean Section. In addition, when you are in the hospital at the time of delivery, you must call Alicare Medical Management if it is determined that your stay will be longer than what is outlined above. Additional days that are not precertified may not be covered.
- If you are planning to participate in an approved experimental and/or clinical trial with respect to the treatment of cancer or another life-threatening disease or condition.

If you do not notify Alicare Medical Management when required, your claims for those services will not be covered, or will not be covered in full. The toll free telephone number to call Alicare Medical Management is 1-800-332-5426.

The 24-Hour Nurse HelpLine

The 24-Hour Nurse HelpLine is a service that allows you and your family to call registered nurses, toll free, 24 hours a day, who will assist you with your health questions. This is a completely voluntary program of health education, support and counseling. In addition to speaking with a nurse, callers may choose to listen to any of over 1000 pre-recorded tapes dealing with a wide range of medical topics such as allergies, diet, children's health and development, HIV/AIDS, cancer, exercise, dental health, drug abuse, and many other topics. Close to 600 of these tapes are also available in Spanish. Call the Nurse HelpLine at **1-888-557-6796**.

[1] The reasonable billed charges are either the usual and customary charges for the service provided, the network rate, or the Fund's schedule.

Prescription Drug Coverage

Covered through a card program for up to a 34 day supply, after a $15 co-payment for generic drugs, a $30 co-payment for formulary brand name drugs, and a $45 co-payment for non-formulary brand name drugs.

Also covered through a maintenance mail order program for up to a 90 day supply after a $30 co-payment for generic drugs, and a $60 co-payment for formulary brand name drugs, and an $90 co-payment for non-formulary brand name drugs.

Vision Care Coverage

Covered up to $200 per person each 24 months for eyeglasses or contact lenses and/or an eye examination.

Affordable Care Act

The benefits summarized in this Summary Plan Description are intended to comply with the Patient Protection and Affordable Care Act (the Affordable Care Act). Any further modifications required by the Affordable Care Act will be made as necessary at the appropriate time.

PLAN 1 C WEEKLY RATES

Employee $ 6.12 | Employee + Spouse $12.25
Employee + Child(ren) $15.76 | Employee + Family $23.17

UnitedHealthcare®

FlexAppeal Enhanced dental plan

Consumer MaxMultiplier Voluntary National Options PPO 20

X9197 /MAC

Network/covered dental services

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50	$0	$0
Family Annual Deductible	$150	$150	$0	$0
Annual Maximum Benefit* *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$1000 per person per Calendar Year	$1000 per person per Calendar Year	$1000 per person per Lifetime	$1000 per person per Lifetime
Annual Deductible Applies to Preventive and Diagnostic Services	No			
Annual Deductible Applies to Orthodontic Services	No			
Waiting Period	No waiting period			
Orthodontic Eligibility Requirement	Child Only Up to Age 19			

COVERED SERVICES**	NETWORK PLAN PAYS***	NON-NETWORK PLAN PAYS****	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs - Bitewing	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Radiographs - Intraoral/Extraoral	100%	100%	Limited to 2 films per calendar year.
Lab and Other Diagnostic Tests	100%	100%	
Dental Prophylaxis (Cleanings)	100%	100%	Benefit is not to exceed in combination with periodontal maintenance 4 per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations; Amalgam or Composite (Anterior & Posterior)	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services - Emergency Treatment	80%	80%	Covered as a separate benefit only if no other service was done during the visit other than X-rays.
General Services - Occlusal Guards	80%	80%	Limited to 1 guard every consecutive 36 months.
General Services - Anesthesia	80%	80%	When clinically necessary.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
MAJOR DENTAL SERVICES			
Oral Surgery - Brush Biopsy	50%	50%	
Oral Surgery - Surgical Extractions	50%	50%	
Oral Surgery - Partial/Bony	50%	50%	
Oral Surgery - Other	50%	50%	
Endodontics - Pulpotomy	50%	50%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
Endodontics - Other	50%	50%	
Periodontal Maintenance	50%	50%	Benefit is not to exceed in combination with dental prophylaxis 4 per consecutive 12 months.
Periodontics - Non Surgical	50%	50%	Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months.
Periodontics - Surgical	50%	50%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
Periodontics - Osseous Surgery	50%	50%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
Inlays/Onlays/Crowns**	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)**	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Implant Services	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	

* This plan includes a maximum benefit award program. Some of the unused portion of your annual maximum benefit may be available in future benefit periods.

** Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

*** The network percentage of benefits is based on the discounted fee negotiated with the provider.

**** The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

Plan 1 D

Plan S109V

Employee	$1.48
Employee + Spouse	$2.81
Employee + Child(ren)	$3.30
Employee + Family	$4.64

UnitedHealthcare

Vision Benefit Summary

Customer Service and Provider Locator: (800) 638-3120

myuhcvision.com

UnitedHealthcare vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.
In-network, covered-in-full benefits (up to the plan allowance and after applicable copay) include a comprehensive exam, eyeglasses with standard single vision, lined bifocal, lined trifocal, or lenticular lenses, standard scratch-resistant coating and the frame, or contact lenses in lieu of eyeglasses. Members age 0-12 are eligible for a 2nd exam. Members age 0-12 are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame and lens benefits.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Comprehensive Exam(s) for diabetics only	Twice every 12 months
Spectacle Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses in Lieu of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 10.00
Materials	$ 25.00
Retinal Screening for Diabetics	$ 0.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[1]	
Private Practice Provider	$130.00 retail frame allowance
Retail Chain Provider	$130.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating,Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full. Other optional lens upgrades may be offered at a discount. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details. The Lens Options list can be found at myuhcvision.com.	
Contact Lens Benefit[2]	
Elective contact lenses Allowance is applied toward the purchase of contact lenses. Materials copay is waived.	$125.00
Elective contact lens fitting and evaluation Allowance is applied toward the contact lens fitting/evaluation fees.	$30.00
Necessary contact lenses[3]	Covered in full after copay (if applicable).
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to $40.00
Frames	Up to $45.00
Single Vision Lenses	Up to $40.00
Lined Bifocal Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Lenticular Lenses	Up to $80.00
Elective Contacts in Lieu of Eyeglasses[2]	Up to $100.00
Contact Lens Fitting and Evaluation	Up to $0.00
Necessary Contacts in Lieu of Eyeglasses[3]	Up to $210.00

Discounts	
	Laser vision UnitedHealthcare offers members access to discounted laser vision correction providers. Members can receive discounts on laser vision correction procedures. For more information, visit myuhcvision.com.
	Additional Material At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.
	Hearing Aids As a UnitedHealthcare vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to UHCHearing.com. When placing your order use promo code MYVISION to get the special price discount.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[2]Contact lenses are in lieu of eyeglass lenses and/or eyeglass frames.
[3]Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: Following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with eyeglass lenses and/or frames; with certain conditions such as anisometropia, keratoconus, irregular corneal/astigmatism, aphakia, pathological myopia, aniseikonia, aniridia, facial deformity, or corneal deformity. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Patient options such as UV coating, progressive lenses, etc., which are not covered-in-full, may be available at a discount at participating providers. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details. The Lens Options list can be found at myuhcvision.com.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
Retain this UnitedHealthcare vision benefit summary which includes detailed benefit information and instructions on how to use the program. Please refer to your Certificate of Coverage for a full explanation of benefits.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

This Benefit Summary is intended only to highlight your benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your healthcare expenses. More complete descriptions of benefits and the terms under which they are provided are contained in the certificate of coverage that you will receive upon enrolling in the plan. If this Benefit Summary conflicts in any way with the Policy issued to your employer, the Policy shall prevail.

2020 Benefits Enrollment Guide

Alpha & Omega Building Services

Effective Date: April 1, 2020

OVERVIEW & ELIGIBILITY

We are happy to announce that **Century Healthcare** has joined **The American Worker** family. Effective **April 1, 2020**, your current benefit plan will transition to The American Worker. To make this transition easy for our employees, all current members and their dependents will have coverage rolled over to similar benefits with The American Worker.

Alpha & Omega Building Services values the contributions of our employees. In appreciation of your dedicated service, we are pleased to offer The American Worker program. Please carefully review this enrollment guide so you understand the benefits being provided and can make the right choices for you and your family.

About Your Coverage

FIXED INDEMNITY BENEFITS

- First dollar coverage for Doctor Office Visits, Diagnostic X-Rays and Lab Work, Hospital Stays and more
- Key features include no deductibles, copays, pre-existing condition limitations or waiting periods
- Prescription Drugs
- National PPO Network, PHCS

FREESTANDING COVERAGE OPTIONS

- Dental Benefit
- Vision Coverage

Take The Next Step

For your convenience, you can enroll in coverage online or by phone. If you are newly eligible for benefit coverage and do not enroll in coverage now, you will not be able to enroll until the next Open Enrollment period, unless you have a Qualifying Life Event.

Effective Date: April 1, 2020

Online: Visit www.TheAmericanWorker.com
Available anytime, day or night

Phone: Call (888) 798-9480
Available Monday - Friday, 7:00 AM - 7:00 PM CST

FIXED INDEMNITY

Companion Life

The American Worker Fixed Indemnity Plans provide affordable, first dollar coverage. The plans offer coverage for basic healthcare services and prescription drug coverage.

The Fixed Indemnity Plans are underwritten by Companion Life Insurance Company. The plans include Accident Medical, AD&D, Pharmacy Benefits and PHCS PPO Network, which are provided by separate vendors. **All benefits pay on a calendar year basis per person, unless stated otherwise.**

	PLAN 2 A	PLAN 2 B
Services	Value	Premier
Physician's Office Visit	$50 per day; 3 days per year	$70 per day; 4 days per year
Outpatient Diagnostic X-Ray & Lab	$65 per testing day; 3 days per year	$75 per testing day; 3 days per year
Preventive Care	$50 per day; 1 day per year	$70 per day; 1 day per year
Outpatient Surgical Outpatient Minor Surgical Outpatient Anesthesia	N/A $50 per day; 1 day per year N/A	$2,000 per day; 1 day per year $70 per day; 1 day per year $500 per day; 1 day per year
Inpatient Surgical Inpatient Anesthesia	N/A N/A	$2,000 per day; 1 day per year $500 per day; 1 day per year
Hospital Indemnity	$150 per day; 10 days per year	$300 per day; 10 days per year
Intensive Care	$300 per day; 3 days per year	$600 per day; 3 days per year
Substance Abuse	$75 per day; 3 days per year	$150 per day; 3 days per year
Mental Illness	$75 per day; 3 days per year	$150 per day; 3 days per year
Skilled Nursing Facility	$75 per day; 6 days per year	$150 per day; 6 days per year
Life Insurance (Employee Only)	$10,000	$10,000
*Accident Medical Expense	$5,000 maximum benefit per injury	$5,000 maximum benefit per injury
*Accidental Death & Dismemberment Employee / Spouse / Child	$15,000 / $7,500 / $3,000	$15,000 / $7,500 / $3,000
*Prescription Benefits	Discount Rx Plan	Copay Rx Plan
*PHCS Network	Physician and Hospital	
Weekly Rates	Value	Premier
Employee Only	$7.52	$18.78
Employee + Spouse	$21.05	$46.53
Employee + Child(ren)	$15.94	$36.12
Family	$28.05	$62.70

***Services not underwritten by Companion Life Insurance Company.**
Plans are not available to residents of NH.

The Fixed Indemnity Plan is (a) not a substitute for minimum essential health coverage under the Affordable Care Act (ACA); and (b) does not qualify as minimum essential coverage under the ACA.

PHCS PPO Limited Benefit Network

All plan designs provide covered individuals access to a PPO Network that allows them to take advantage of network negotiated rates.

Discount Rx Plan

Employees and their dependents pay the lesser of the pharmacy's usual and customary fee or the contract rate. Discounts are available on both generic and brand name drugs. Contraceptive drugs are included. Receive instant savings of up to 85% based on all FDA approved drugs (brand & generic) at the pharmacy filling the claim. No claim forms required. Prescriptions for 30-day supplies can be filled at more than 58,000 participating pharmacies nationwide including all of the national chains and over 90% of independent pharmacies.

Your discount may also apply to certain over-the-counter medications, diabetic supplies that have an NDC (National Drug Code), and even for certain pet medications that have human equivalent medications. For additional savings, you may also utilize our mail order pharmacy for 90 day supplies.

Copay Rx Plan

- **Tier 1 (Most Generics):** $10 Co-Pay
- **Tier 2 (Some Generics & Preferred/Formulary Brand Name):** $50 or 50%; whichever is greater
- **Tier 3 (Non-Preferred / Non-Formulary Brand Name):** Employees pay 100% of the cost after pharmacy discounts

Mail Order option available for 90 day prescription supply.

- **Tier 1:** $25 copay
- **Tier 2:** $125 or 50%
- **Monthly Maximum:** $200 Employee / $400 Family
- No Deductible

Ameritas.

Dental Insurance

Keep a bright, healthy smile while supporting your overall well-being with affordable dental coverage.

LOCATE NETWORK PROVIDERS

Visit www.Ameritas.com
- Select **"FIND A PROVIDER"**
- Select **"DENTAL"**
- Select **"NETWORK PROVIDER"**
- Select **"CLASSIC PPO" network.**

Call (800) 659-2223
- Select **option 3**

	PLAN 2 C
Calendar Year Maximum	Up to $1,000 per Covered Member
Deductible	$0 per Visit
Covered Services	Maximum Covered Expense*
Type 1 - No Waiting Period	
Comprehensive Oral Evaluation	$13.00
Bitewing - Single Radiographic Image	$4.00
Prophylaxis - Adult	$18.00
Sealant - Per Tooth	$10.00
Intraoral - Complete Series of Radiogrpahic Images	$27.00
Panoramic Radiographic Image	$22.00
Space Maintainer - Fixed - Unilateral	$64.00
Type 2 - No Waiting Period	
Amalgam - One Surface, Primary or Permanent	$26.00
Resin-based Composite - One Surface, Anterior	$32.00
Resin-based Composite - One Surface, Posterior	$35.00
Endodontic Therapy - Anterior Tooth	$160.00
Periodontal Scaling & Root planing - Four or More Teeth per quadrant	$54.00
Extractions	$29.00
Protective Restoration	$19.00
Type 3 - 12 Month Waiting Period	
Resin-based Composite - Crown, Anterior	$52.00
Prefabricated Porcelain/Ceramic - Crown - Primary Tooth	$48.00
Prefabricated Stainless Steel - Crown - Primary Tooth	$44.00
Prefabricated Resin Crown	$52.00
Inlay - Metallic - One Surface	$137.00
Onlay - Metallic - Two Surfaces	$178.00
Crown Resin-based Composite (indirect)	$78.00
Complete Denture - Maxillary	$222.00
Orthodontia - 12 Month Waiting Period	
Plan Benefit	50%
Lifetime Maximum (per person)	$500.00**
Coverage for Adults	No
Weekly Rates	
Employee Only	$2.55
Employee + Spouse	$4.46
Employee + Child(ren)	$5.88
Family	$7.78

***Maximum Covered Expense** is the maximum amount considered per procedure.
**Maximum not reduced by prior carrier payment.

Ameritas.

Vision Insurance

A regular eye exam won't just help you see better, it can also detect the first signs of serious health conditions. Visit a VSP Choice provider to get the most benefit from the plan.

LOCATE NETWORK PROVIDERS

Call (800) 877-7195

Visit www.Ameritas.com

- Select **"FIND A PROVIDER"**
- Select **"VISION: VSP"**
- Select **"LOOK UP VSP PROVIDERS"**

	PLAN 2 D	
Deductible	$10 Exam, $10 Eye Glass Lenses or Frames[1]	
Covered services	VSP Choice Network	Out-of-Network
Annual Eye Exam	Covered in Full	Up to $45
Lenses (per pair) Single Vision Bifocal Trifocal Lenticular	Covered in Full	 Up to $30 Up to $50 Up to $65 Up to $100
Frame Allowance	$150[2]	Up to $75
Contact Lenses Fit and Follow Up Exams Elective Medically Necessary	 Member cost up to $60 Up to $150 Covered in Full	 No Benefit Up to $120 Up to $210
Frequency Exam / Lens / Frames	Based on Date of Service 12 Months / 12 Months / 24 Months	
Lens Options[3]		
Std. Polycarbonate	Covered in full for dependent children $33.00 for Adults	No Benefit
Scratch Resistant Coating	$17.00 - $33.00	No Benefit
Anti-Reflective Coating	$43.00 - $85.00	No Benefit
Ultraviolet Coating	$16.00	No Benefit
Weekly Rates		
Employee Employee + Spouse Employee + Child(ren) Family	$2.32 $3.79 $3.78 $6.10	

[1]Deductible applies to a complete pair of glasses or to frames, whichever is selected.

[2]The Costco allowance will be the wholesale equivalent.

[3]Lens Option member costs vary by prescription, option chosen and retail locations.