

Winning Wheels, Inc,

Comprehensive Employment Benefits

*** *Benefits in Italics are company paid/free to the team member*

Group Health Insurance

Plan Tier	Monthly Premium
Employee	\$150.00
Employee + Spouse	\$750.00
Employee + Child	\$750.00
Family	\$1150.00
Eligibility	Full-time team members
Effective	First of the month following hire date
Provider	Blue Cross/Blue Shield of Illinois

Dental Insurance

Plan Tier	Monthly Premium
<i>Employee</i>	<i>Company Paid (free)</i>
Employee + Spouse	\$30.47
Employee + Child	\$30.54
Family	\$60.71
Eligibility	Full-time team members
Effective	First of the month following hire date
Provider	United HealthCare

Vision Insurance

Plan Tier	Monthly Premium
<i>Employee</i>	<i>Company Paid (free)</i>
Employee + Spouse	\$4.66
Employee + Child	\$4.92
Family	\$12.69
Eligibility	Full-time team members
Effective	First of the month following hire date
Provider	United HealthCare

Life Insurance

Amount of Coverage	\$50,000.00 per year
Premium	<i>Company Paid (free)</i>
Eligibility	Full-time team members
Effective	First of the month following hire date
Provider	United HealthCare

Short Term Disability

Amount of Coverage	Based on individual income
Premium	Company Paid (free)
Eligibility	Full-time team members
Effective	First of the month following hire date
Provider	United HealthCare

Supplemental Coverage

Coverage Available	Supplemental Life Accident Critical Illness Medical Bridge
Premium	Dependent upon coverage elected
Effective	First of the month following hire date
Provider	Colonial Life

Retirement Savings

Premium	Team member chooses contribution amount
Effective	First of the month following hire date
Provider	Illinois Secure Choice

Things to Note

Under the "125 Cafeteria" Flex Plan, team member contributions to dental, supplemental, limited medical and vision plans are made pre-tax, which allows team members to save money on income and social security taxes
Insurance premiums are prepaid by Winning Wheels, Inc. and final payroll deductions may need to be adjusted accordingly
Once enrolled, you may only make changes during the designated annual enrollment period or in the event of a qualifying event.
New team member enrollment paperwork must be completed within 14 days of hire.
Full time status is 30 hours + per week

Child Care

Amount of Benefit	75% discount at the Lyndon Play and Learn Center
Eligibility	<i>All team members</i>
Effective	Upon hire and based on service availability and openings
Provider	Lyndon Play and Learn Center

Employee Assistance Program

Premium	<i>Company Paid (free)</i>
Eligibility	All team members and their dependents
Effective	Upon hire
Provider	Deer Oaks EAP Services 888-993-7650 www.deeroakseap.com
Confidential services for team members and their dependents to help with stress, anxiety, depression, workplace difficulties, substance abuse, marital problems, family or parenting conflicts, grief, violence and unhealthy life styles. The EAP will also provide additional assistance, tools and referrals for work/life resources, financial and legal issues, and interactive online simple will and trust.	

Education Assistance

Amount of Benefit	Reimbursement of up to \$500.00 per semester
Eligibility	Full-time team members
Effective	First of the month following 90 days of employment

Professional Licenses and Membership Dues

Amount of Benefit	Up to \$250.00 per year
Eligibility	Professionally licensed team members and memberships to professional associations
Effective	Upon Hire

Certified Nurse Aide Training Program

Eligibility	All team members
Effective	Upon Hire, must be successfully completed within 120 days of hire

Shift Differential

Nursing staff receive \$3.00 per hour in addition to their regular rate of pay for 2 nd and 3 rd shifts.
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RN/LPN Bonus Holiday

Full Time RNs and LPNs (minimum 72 hours per pay period) receive 8 hours of holiday pay each pay period.
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Paid Time Off

Vacation Time	<ul style="list-style-type: none"> - Accrues as you work - Up to 40 hours per year during 1st year of service - Up to 80 hours per year 2-4 years of service - Up to 120 hours per year after 5 years of employment - Up to 160 hours per year at 15 years of employment - Benefit time accrues and is banked - Full and part-time team members are eligible after 90 days of service
Personal Time	<ul style="list-style-type: none"> - 8 hours after 90 days of service - 16 hours after 1 year of service - 24 hours after 2 years of service - 32 hours after 5 years of service - Benefit time does not bank and expires after one year - Team members are eligible after 90 days of service - Part-time team members receive 50% of the benefit - Renews annually upon employment anniversary date
Sick Time	<ul style="list-style-type: none"> - First year of service: 50% of hourly rate with a 2 day waiting period, 40 hour maximum benefit - After first year of service: 75% of hourly rate with a 1 day waiting period, 80 hour maximum benefit - Benefit time does not bank and expires upon employment anniversary date - Team members are eligible after 90 days of service - Part-time team members receive 50% of the benefit - Renews annually upon employment anniversary date
Bereavement	<ul style="list-style-type: none"> - 3 days immediate family member - 1 day for non-immediate family member - 10 days for a child
Jury Duty	<ul style="list-style-type: none"> - Reimbursement for service during scheduled work time
Holidays	<ul style="list-style-type: none"> - 6 paid holidays annually: New Year's Day Memorial Day Labor Day Thanksgiving Day Independence Day Christmas Day - Team members working the actual holiday will be paid at time and a half of their regular pay rate - Part-time team members receive 50% of the benefit


For assistance with any of our employment benefits or programs, please contact Human Resources at 815-778-3683 extension 305 or aschaefer@aheinco.com

Detailed plan summaries, current benefit information and employment resources are available at www.wwihub.com



 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbsil.com/member/policy-forms/2023 or by calling 1-800-541-2768. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: Participating \$1,500; Non-Participating \$3,000 Family: Participating \$4,500; Non-Participating \$9,000	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care services and services with a copayment are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. Out-of-Network Inpatient \$300. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Individual: Participating \$3,500; Non-Participating \$10,500 Family: Participating \$10,500; Non-Participating \$31,500	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com or call 1-800-541-2768 for a list of Participating Providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30/visit; deductible does not apply	40% coinsurance	Virtual Visits: No Charge; deductible does not apply. See your benefit booklet* for more details.
	Specialist visit	\$50/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Primary Care: \$30/visit Specialist: \$50/visit; deductible does not apply	40% coinsurance	Preauthorization may be required; see your benefit booklet* for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbsil.com/rx-drugs/drug-lists/drug-lists	Preferred generic drugs	Retail: Preferred - No Charge Non-Preferred - \$10/prescription Mail: No Charge; deductible does not apply	Retail: \$10/prescription; deductible does not apply	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. The applicable <u>cost-sharing</u> (by tier) and the cost difference between the generic and brand will never exceed the overall price of the drug. All Out-of-Network prescriptions are subject to a 50% additional charge after the applicable copayment/coinsurance. Additional charge will not apply to any deductible or out-of-pocket amounts.
	Non-preferred generic drugs	Retail: Preferred - \$10/prescription Non-Preferred - \$20/prescription Mail: \$20/prescription; deductible does not apply	Retail: \$20/prescription; deductible does not apply	
	Preferred brand drugs	Retail: Preferred - \$50/prescription Non-Preferred - \$70/prescription Mail: \$100/prescription; deductible does not apply	Retail: \$70/prescription; deductible does not apply	The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$100, when obtained

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Non-preferred brand drugs	Retail: Preferred - \$100/prescription Non-Preferred - \$120/prescription Mail: \$200/prescription; deductible does not apply	Retail: \$120/prescription; deductible does not apply	from a Preferred Participating or Participating Pharmacy.
	Preferred specialty drugs	\$150/prescription; deductible does not apply	\$150/prescription; deductible does not apply	
	Non-preferred specialty drugs	\$250/prescription; deductible does not apply	\$250/prescription; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	\$150/visit; deductible does not apply	\$150/visit; deductible does not apply	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	\$300/visit plus 40% coinsurance	Preauthorization required. Preauthorization penalty: \$1,000 or 50% of the eligible charge. See your benefit booklet* for details.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
	Outpatient services	\$30/office visit; 20% coinsurance for other outpatient services	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Inpatient services	20% coinsurance	\$300/visit plus 40% coinsurance	Preauthorization required.
	Office visits	Primary Care: \$30/visit Specialist: \$50/visit; deductible does not apply	40% coinsurance	
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	20% coinsurance	\$300/visit plus 40% coinsurance	

SBC IL Non-HMO LG-2022

*For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/member/policy-forms/2023

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Habilitation services	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Skilled nursing care	20% coinsurance	\$300/visit plus 40% coinsurance	Preauthorization may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Benefits are limited to items used to serve a medical purpose. DME benefits are provided for both purchase and rental equipment (up to the purchase price).
If your child needs dental or eye care	Hospice services	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)			
• Acupuncture	• Long-term care	• Weight loss programs	
• Dental care (Adult)	• Routine eye care (Adult)		
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)			
• Bariatric surgery	• Hearing aids (for children 1 per ear every 24 months, for adults up to \$2,500 per ear every 24 months)	• Private-duty nursing	• Routine foot care (only in connection with diabetes)
• Chiropractic care (Chiropractic and Osteopathic manipulation limited to 30 visits per calendar year)	• Infertility treatment (4 in vitro attempt maximum with special approval up to 6 per benefit period)		
• Cosmetic surgery (only for correcting congenital deformities or conditions resulting from accidental injuries, scars, tumors, or diseases)	• Non-emergency care when traveling outside the U.S.		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-541-2768, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccoio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Blue Cross and Blue Shield of Illinois at 1-800-541-2768 or visit www.bcbstl.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at (877) 527-9431 or visit <http://insurance.illinois.gov>.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-541-2768.

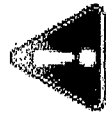
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-541-2768.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-541-2768.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-541-2768.

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

About these Coverage Examples:



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

Peg is Having a Baby

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$400
Coinsurance	\$1,600
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,560

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$1,100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,920

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$300
Coinsurance	\$40
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,840

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



BlueCross BlueShield of Illinois

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6384.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>



BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To talk to an interpreter, call 855-710-6984.

Spanish Español	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Arabic العربية	إن كان لديك أي شيء بخصوص تأمينك، يمكنك الاتصال بالخدمة اللغوية المجانية من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل بالرقم 855-710-6984.
Chinese 繁體中文	如果您，或您正在協助的對象，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
Gujarati ગુજરાતી	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. પ્રવૃત્તિઓ બદલે પ્રશ્ન હોય, તો તમને તેની ભરે, તમારે ભાષામાં મદદ અને માહિતી મેળવવાની હક છે. દુભાવિયા સાથે વાત કરવા માટે અહીં 855-710-6984 પર કોલ કરો.
Hindi हिंदी	यदि आपको, या आप जिसकी सहायता कर रहे हैं उसने, प्रश्न हू, तो आपके अपनी भाषा में निशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनचाहक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
Korean 한국어	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움을 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984로 전화하십시오.
Diné Navajo	T'áá n, éí doodagó la' da bááa anánil'wó'ígíí, na' ídilk'idgo, ts'ída bee ná áhóódi'í' t'áá n'íik'e n'íáa a'dool'woł dóó bina'í'idilk'idgíí bee ná h' o'doonih. Áta' áhah'ne'ígíí bich'í' hodíílnih kwe' é 855-710-6984.
Persian فارسی	اگر شما یا کسی که شما به او کمک می کنید سوالاتی داشته باشید، حق این را دارید که به زبان خود، به صورت رایگان کمک و اطلاعات دریافت کنید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس بگیرید.
Polish Polski	Jesli Ty lub osoba, której pomagasz, masz jakiekolwiek pytania, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Russian Русский	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulongan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wikang nang wawang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
Urdu اردو	اگر آپ یا کسی جس کو آپ مدد کر رہے ہیں، تو آپ کے آپنی زبان میں مفت مدد اور معلومات کی ضرورت ہے۔ اگر آپ کو فوری مترجم کی ضرورت ہے، تو 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một người dịch viên, gọi 855-710-6984.

bcbstl.com



BlueCross BlueShield of Illinois



Take Charge of Your Health

Get information about the cost of procedures, find a doctor or request an ID card. You can do it all – simply and securely – on Blue Access for MembersSM (BAMSM).

With BAM, you can:

- Find In-network doctors and hospitals.
- View your digital member ID, or order new or replacement IDs.
- Review your benefits and dependent coverage.

Covered dependents age 18 and over can have their own BAM accounts.



Scan this QR code to visit bcbsil.com.

Let's get started

1. Go to bcbsil.com.
2. Under Member Log in, use your member ID card to complete your registration.

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

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EspañolLanguage AssistanceMessaging PPO v My Account ▾

1

DASHBOARD

2

CLAIMS

3

COVERAGE ▾

4

SPENDING

5

FIND CARE

6

WELLNESS

Hello, Alexandria!

[Member ID card](#)
[Contact us](#)

Recent Claims <p>Aug 24, 2021</p> <p>Your Hospital</p> <p>Member: Alex Roberts</p> <p>Aug 24, 2021</p> <p>Your Medical Treatment Center</p> <p>Member: Chris Roberts</p> <p>Aug 24, 2021</p> <p>Your Pharmacy</p> <p>Member: Alex Roberts</p>	<div>Claim status:</div> Paid <div>You may owe:</div> \$0.00 Details >
--	--

Claim status:

 Processed

You may owe:

 \$239.99
 Details >

Claim status:

 Not Paid

You may owe:

 \$10.00
 Details >

View all claims >

 Find Care **Medical** Doctors and hospitals, nurseline, hearing aids > **Pharmacies** Pharmacies > **Dental Care** Dentists of America > **Vision Care** Eyemed > |

Spending

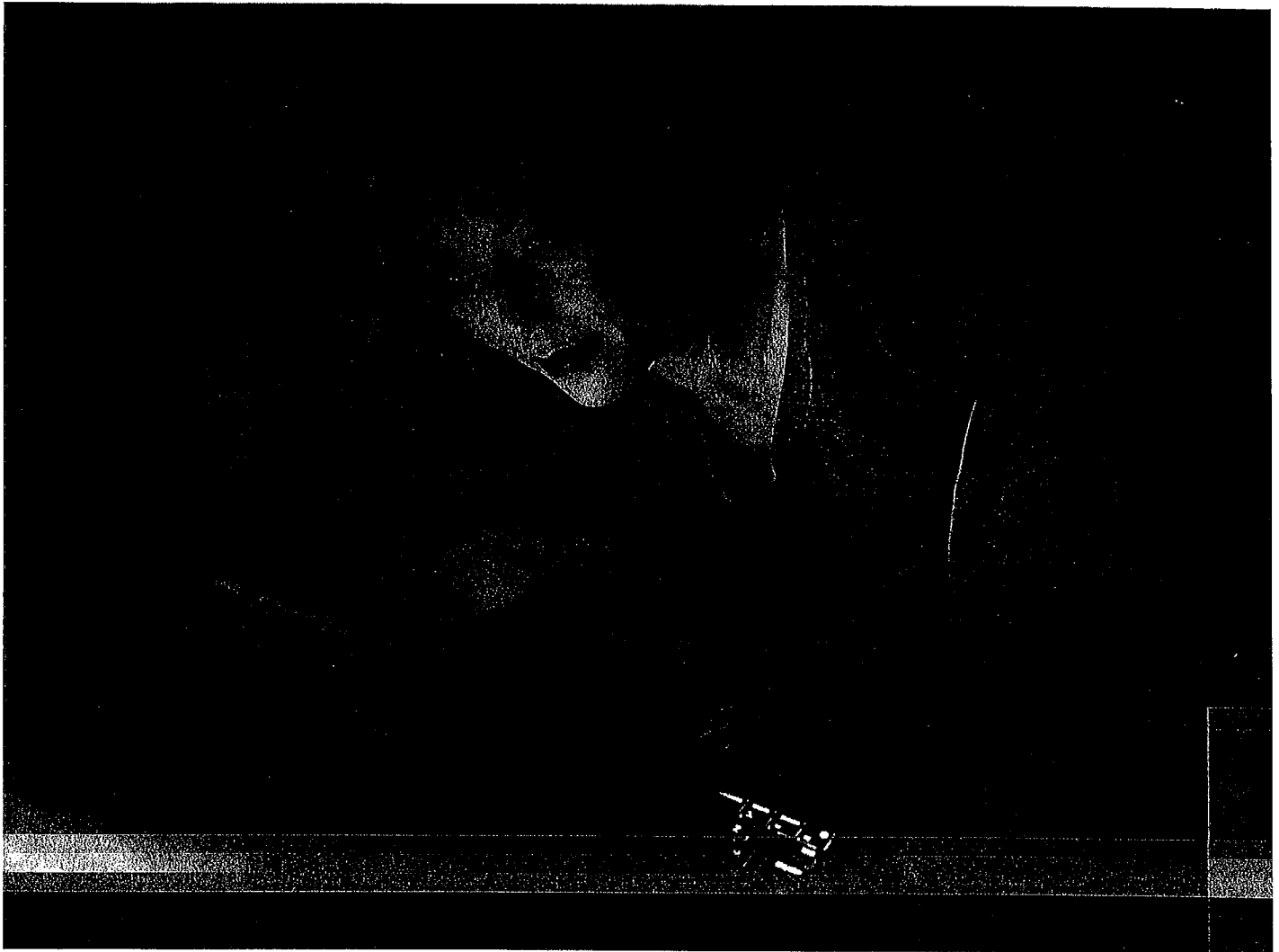
Deductible	Out-of-Pocket
\$625.00 / \$1,000 limit	\$1,250.00 / \$5,000 limit
<div style="width: 100%; height: 10px; background-image: linear-gradient(to bottom, transparent 49%, black 49% 51%, black 51%);"></div>	<div style="width: 100%; height: 10px; background-image: linear-gradient(to bottom, transparent 49%, black 49% 51%, black 51%);"></div>
\$375.00 remaining	\$3,750.00 remaining

View all spending >

- This material is only for illustration purposes. Your group's coverage types and benefits may be different.**



BlueCross BlueShield of Illinois



Virtual Visits: **Get Cost-Effective, 24/7 Care**

With Virtual Visits powered by MDLIVE®, the doctor is always in. This Blue Cross and Blue Shield of Illinois (BCBSIL) benefit gives you access to 24/7 non-emergency care from a board-certified doctor or therapist by phone, online video or mobile app from almost anywhere.

Skip expensive ER bills and waiting to see a doctor. You can speak with a Virtual Visits doctor within minutes.

Services are available in both English and Spanish with translation services available in other languages.

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

Powered by
MDLIVE

Why Virtual Visits?

- 24/7 access to an independently contracted, board-certified doctor or therapist
- Access via phone, online video or mobile app from almost anywhere
- Average wait time of less than 20 minutes
- Doctors can send e-prescriptions to your local pharmacy

The Virtual Visits benefit is a convenient alternative for treatment of more than 80 health conditions, including:

- Allergies
- Cold/Flu
- Fever
- Headaches
- Nausea
- Sinus Infections

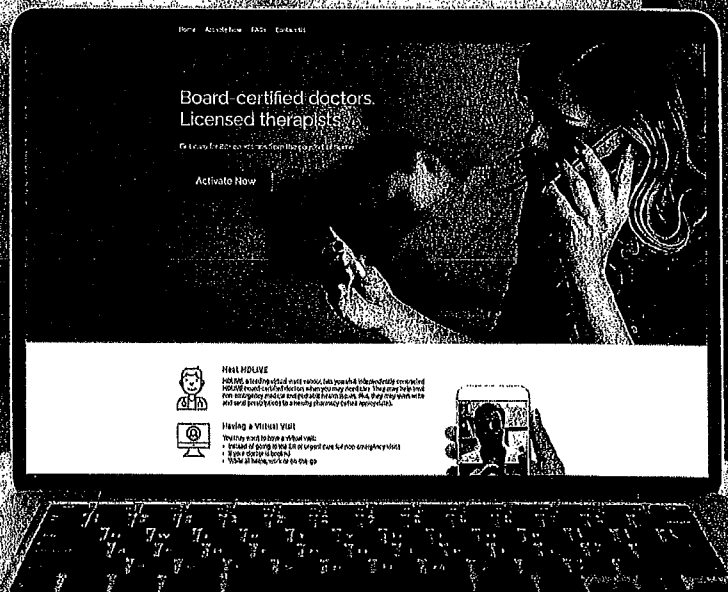
Virtual Visits sessions with licensed behavioral health therapists are available by appointment. Get virtual care for:

- Depression
- Eating disorders
- ADHD
- Substance use disorders
- Trauma and PTSD
- Autism spectrum disorder

First, call your doctor's office; they may also offer telehealth consultations by phone or online video. If you have any questions about this or any other BCBSIL benefit, please call the number on the back of your ID card.

Activate your Virtual Visits account today:

- Call 888-676-4204
- Go to MDLIVE.com/bcbsil
- Text BCBSIL to 635-483
- Download the app



Virtual Visits may not be available on all plans. Non-emergency medical service in Montana and New Mexico is limited to Interactive online video. Non-emergency medical service in Arkansas and Idaho is limited to Interactive online video for initial consultation.

MDLIVE is a separate company that operates and administers Virtual Visits for Blue Cross and Blue Shield of Illinois. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

Blue Cross®, Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.



BlueCross BlueShield of Illinois

Blue Access for MembersSM

Health care at your fingertips.

Blue Cross and Blue Shield of Illinois (BCBSIL) helps you get the most from your health care benefits with Blue Access for Members (BAMSM). You and all covered dependents age 18 and up can create a BAM account.

With BAM, you can:

- Find care – search for in-network doctors, hospitals, pharmacies and other health care providers
- Get your digital member ID card
- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Sign up for text or email alerts

It's easy to get started.

Use your member ID card to create a BAM account at bcbsil.com, or text* **BCBSILAPP** to **33633** to download our mobile app.



Scan this QR code to visit bcbsil.com.

*Message and data rates may apply.

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

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UnitedHealthcare Insurance Company (30100)®			Dental Plan	
Contributory Options PPO 30 / covered dental services			New Standard/25P14/U90	
	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Deductible	\$50	\$50	\$0	\$0
Family Annual Deductible	\$150	\$150	\$0	\$0
Maximum (the sum of all Network and Non-Network benefits will not exceed Annual Deductible)	\$1,000 per person per Calendar Year	\$1,000 per person per Calendar Year	\$1,000 per person per Lifetime	\$1,000 per person per Lifetime
New member waiting period	None			
Annual deductible applies to preventive and diagnostic services			No (In Network)	No (Out Network)
Annual deductible applies to orthodontic services			No	
Orthodontic Eligibility Requirement			Adult & Child	
COVERED SERVICES *	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES	
DIAGNOSTIC SERVICES				
Periodic Oral Evaluation	100%	100%	See Exclusions and Limitations section for benefit guidelines.	
Radiographs	100%	100%		
Lab and Other Diagnostic Tests	100%	100%		
PREVENTIVE SERVICES				
Prophylaxis (Cleaning)	100%	100%	See Exclusions and Limitations section for benefit guidelines.	
Fluoride Treatment (Preventive)	100%	100%		
Sealants	100%	100%		
Space Maintainers	100%	100%		
RESTORATIVE SERVICES				
Restorations, Amalgams or Composite (Anterior & Posterior)	80%	80%	See Exclusions and Limitations section for benefit guidelines.	
Emergency Treatment/General Services	Split Class	Split Class		
General Services - Adjunctive Occlusal Guard	80%	80%		
General Services - Adjunctive Emergency Treatment	80%	80%		
General Services - Adjunctive Other	80%	80%		
Simple Extractions	80%	80%		
Oral Surgery (incl. surgical extractions)	80%	80%		
Periodontics	80%	80%		
Endodontics	80%	80%		
MAJOR SERVICES				
Emergency Treatment/General Services	Split Class	Split Class	See Exclusions and Limitations section for benefit guidelines.	
General Services - Adjunctive Anesthesia	50%	50%		
Inlays/Onlays/Crowns	50%	50%		
Dentures and Removable Prosthetics	50%	50%		
Fixed Partial Dentures (Bridges)	50%	50%		
ORTHODONTIC SERVICES				
Diagnose or correct misalignment of the teeth or bite	50%	50%		

* 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 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 fees negotiated with the provider.

***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

Veneers are only covered when a filling cannot restore a tooth. For a complete description and coverage levels for Veneers, please refer to your Certificate of Coverage. Cone Beams are limited to combined captured and interpretation treatment codes only. For a complete description and coverage levels for Cone Beams, please refer to your Certificate of Coverage.

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 table 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 of 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.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.

UnitedHealthcare/Dental Exclusions and Limitations

Dental Services described in this section are covered when such services are:

- A. Necessary;
- B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
- C. The least costly, clinically accepted treatment, and
- D. Not excluded as described in the Section entitled, General Exclusions.

GENERAL LIMITATIONS

- 1 PERIODIC ORAL EVALUATION Limited to 2 times per consecutive 12 months.
- 2 COMPLETE SERIES OR PANOREX RADIOGRAPHS Limited to 1 time per consecutive 36 months.
- 3 BITEWING RADIOGRAPHS Limited to 1 series of films per calendar year.
- 4 EXTRAORAL RADIOGRAPHS Limited to 2 films per calendar year.
- 5 DENTAL PROPHYLAXIS Limited to 2 times per consecutive 12 months.
- 6 FLUORIDE TREATMENTS Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
- 7 SPACE MAINTAINERS Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
- 8 SEALANTS Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
- 9 RESTORATIONS (Amalgam or Composite) Multiple restorations on one surface will be treated as a single filling.
- 10 PIN RETENTION Limited to 2 pins per tooth; not covered in addition to cast restoration.
- 11 INLAYS, ONLAYS, AND VENEERS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
- 12 CROWNS Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
- 13 POST AND CORES Covered only for teeth that have had root canal therapy.
- 14 SEDATIVE FILLINGS Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
- 15 SCALING AND ROOT PLANING Limited to 1 time per quadrant per consecutive 24 months.
- 16 ROOT CANAL THERAPY Limited to 1 time per tooth per lifetime.
- 17 PERIODONTAL MAINTENANCE Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
- 18 FULL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- 19 PARTIAL DENTURES Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
- 20 RELINING AND REBASING DENTURES Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
- 21 REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
- 22 PALLIATIVE TREATMENT Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
- 23 OCCLUSAL GUARDS Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
- 24 FULL MOUTH DEBRIDEMENT Limited to 1 time every consecutive 36 months.
- 25 GENERAL ANESTHESIA Covered only when clinically necessary.
- 26 OSSEOUS GRAFTS Limited to 1 per quadrant or site per consecutive 36 months.
- 27 PERIODONTAL SURGERY Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.
- 28 REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
- 29 CONE BEAM Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

The following are not covered:

- 1 Dental Services that are not Necessary.
- 2 Hospitalization or other facility charges.
- 3 Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
- 4 Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
- 5 Any Dental Procedure not directly associated with dental disease.
- 6 Any Dental Procedure not performed in a dental setting.
- 7 Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
- 8 Placement of dental implants, implant-supported abutments and prostheses.
- 9 Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
- 10 Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
- 11 Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
- 12 Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
- 13 Services related to the temporomandibular joint (TMJ), either bilateral or unilateral, Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
- 14 Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
- 15 Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
- 16 Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
- 17 Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
- 18 Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
- 19 Oculusal guards used as safety items or to affect performance primarily in sports-related activities.
- 20 Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
- 21 Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups situated in the state of Arizona, in order to comply with state regulations.
- 22 Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
- 23 Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
- 24 Orthodontic service Coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, or a surgical procedure to correct a malocclusion, replacement of retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan.
- 25 Foreign Services are not Covered unless required as an Emergency.
- 26 Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- 27 Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the Covered Person by any municipality, county, or other political subdivision. Covered Person by any municipality, county, or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.



Winning Wheels, Inc

Vision Benefit Summary

Powered by UnitedHealthcare Vision Network

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.

Exam with Materials	
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Eyeglass Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses instead of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	\$ 10.00
Eyeglasses (lenses and frame)	\$ 25.00
Contact lenses instead of Eyeglasses	\$ 25.00
Retinal Screening	\$ 39.00
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.	
Contact Lens Benefit² (Formulary contact lenses refer to contact lenses available on our formulary contact list. Contact lenses not on this list are referred to as Non-Formulary. A copy of the list can be found at myuhcvision.com).	
Formulary contact lenses The fitting/evaluation fees, contact lenses, and up to two follow-up visits are covered in full after copay.	If you choose disposable contacts, up to 4 boxes are included when obtained from an In-network provider.
Non-Formulary contact lenses An allowance is applied toward the purchase of contact lenses outside the Formulary. Contact lens copay is waived.	\$130.00
Necessary contact lenses³	Covered in full after copay (if applicable).
Children's and Maternity Eye Care Benefit	
Members age 0-12 and members pregnant or breastfeeding are eligible for a 2nd exam. Members age 0-12 and members pregnant or breastfeeding 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.	
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 and Progressive Lenses	Up to \$60.00
Lined Trifocal Lenses	Up to \$80.00
Lenticular Lenses	Up to \$80.00
Elective Contacts instead of Eyeglasses ²	Up to \$130.00
Necessary Contacts instead of Eyeglasses ³	Up to \$210.00

UnitedHealthcare

Discounts

Laser vision

UnitedHealthcare has partnered with QualiSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction providers. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at \$945 per eye for Traditional LASIK and \$1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. 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.

¹30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.

²Contact lenses are instead of eyeglass lenses and/or eyeglass frames. Coverage for Formulary contact lenses does not apply at all in-network providers. The allowance for Non-Formulary contact lenses applies to materials. No portion will be exclusively applied to the fitting and evaluation.

³Necessary 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, anisokonia, 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.
- Your participating provider will help you determine which contact lenses are available in the UnitedHealthcare Formulary.
- Patient lens options 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.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., UnitedHealthcare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher than if you had received only covered vision services and you may incur additional out-of-pocket expenses. Eyewear materials may be ordered through our national lab network.

UnitedHealthcare



**United
Healthcare**

Vision Benefit Card

Winning Wheels, Inc

Copays

Exam(s)	\$10.00		
Eyeglasses	\$25.00	Retinal Screening	\$ 39.00
Contacts	\$25.00		

Powered by UnitedHealthcare Vision Network



**United
Healthcare**

myuhcvision.com

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

TDD for Hearing Impaired: (877) 735-2929

To print a personalized ID card, please log on to our website and select 'Group/Plan' then select 'Print ID card' from the member benefits page.

Winning Wheels, Inc.
Summary of Benefits
Short Term Disability Insurance



Effective Date	January 1, 2022
Eligibility	All Active Full Time Administrator Employees working a minimum of 30 Hours per week.
Non-Contributory STD Benefit	86.67% of your weekly Earnings to a maximum of \$1,000 per week. Minimum Benefit: \$15 Earnings are defined in the UnitedHealthcare contract with your employer.
Elimination Period	Short Term Disability Insurance benefit begins on the 15th day after your accident or 15th day of sickness.
Benefit Duration	Up to 11 weeks*
Lump Sum Survivor Benefit	Lesser of \$3,000 or 3 weeks Gross
Offsets	As described later in this summary, your weekly Short Term Disability benefit may be reduced by other income you receive.
Other limitations to enrollment	You must be Actively at Work with your employer on the day your coverage takes effect.

Important Details

This Summary of Benefits sheet is an overview of the Short Term Disability Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Summary of Benefits sheet and the insurance policy, the terms of the insurance policy apply.

Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

Exclusions:

You cannot receive Short Term Disability Insurance benefit payments for disabilities that are caused or contributed to by*:

- War or act of war (declared or not)
- The commission of, or attempt to commit a felony
- An intentionally self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability
- Sickness or injury for which Workers' Compensation benefits are paid, or may be paid, if duly claimed
- Any injury sustained as a result of doing any work for pay or profit for another employer

You must be under the regular care of a physician to receive benefits.*

Your benefit payments **will be reduced** by other income you receive or are eligible to receive due to your disability, including but not limited to*:

- Social Security Disability Insurance
- Workers' Compensation
- Other employer-based insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (such as a pension plan)
- Employer's sick leave or salary continuation plan.
- Loss of time or lost wages from no-fault motor vehicle insurance plan.

** Some state variations may apply*

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company, and certain products in California by Unimerica Life Insurance Company. Texas coverage is provided on Form LASD-POL-TX (05/03), Form UHCLD-POL 2/2008-TX, or UICLD-POL-TX 4/5.

UnitedHealthcare Insurance Company is located in Hartford, CT; Unimerica Insurance Company and Unimerica Life Insurance Company in Milwaukee, WI.



Disability insurance

How to file a short-term disability claim



UnitedHealthcare Specialty Benefits is committed to supporting you during your period of disability and helping you achieve a timely and healthy return to work.

An important first step is providing you with information on how to file a short-term disability (STD) claim, what you can expect during the claim review process, and what benefits and services are available once your claim is approved.

Claim filing.

You, your employer and your attending physician(s) must complete various claim forms. In some cases, you must provide additional information so we can begin to review your claim.

As an employee, you must submit the following forms and information:

- **Employee short-term disability statement:**

This form includes the information we need to initiate your claim. You may be required to provide additional information, such as copies of other income entitlement awards and/or denials you have received from such sources as workers' compensation, retirement, state disability or others, including those you have applied for but not yet been awarded. (If you receive an award or denial after submitting your claim, please forward this information immediately)

Financial Protection

- **Authorization for the Release of Information:** This form gives us permission to gather additional information we need to properly administer your claim
- **Authorization of Personal Representation:** This form is optional. If you would like us to discuss your claim with anyone, we need your prior authorization. If you do not complete the form now, you can request it directly from us after your claim for benefits has been submitted

Your employer must submit the following forms and information:

Your employer can submit these completed materials to us on your behalf, or they can give them to you, and you can send the materials to us with your completed forms.

- **Employer's Report of Claim:** This form includes information we need to initiate your claim

Your employer may be required to provide the following additional information:

- Job description (detailed duties)
- Copy of enrollment card (if employees contribute to plan premium)
- Copy of approved Evidence of Insurability form (if required at plan enrollment)
- Documentation of earnings, including prior year's W-2
- First Report of Accident form and decision (if a workers' compensation claim was filed)
- Copies of other source(s) of benefits awarded or applied for, but not yet approved (such as Social Security, workers' compensation, retirement, state disability or others)
- Copy of your employment application or resumé, if available

Your attending physician must submit the following forms:

- **Attending Physician's Statement:** Provide this form to your physician to complete. This form includes information necessary to initiate your claim. In addition, your physician(s) may be required to provide information such as medical records, physician notes, test results and so forth. This information will be requested by UnitedHealthcare on your behalf

Claim review.

When all necessary information has been received, a claims specialist will be assigned to review your claim and make a determination. The claims specialist will:

- Acknowledge by phone or letter that your claim has been received and is in review
- Request any additional information needed for a claim determination
- Contact your employer to confirm any outstanding information and discuss return-to-work plans, if appropriate
- Contact your employer and/or attending physician(s) to clarify your condition, discuss potential for recovery and determine a plan for your return to work
- Make a determination on your claim as soon as possible
- Ensure that your claim receives thorough, fair and objective evaluation

We appreciate your prompt response to any requests the claims specialist makes for information, which will help us make a timely determination of benefits available to you under your plan. If a claim decision is delayed while awaiting information, the claims specialist will provide you with a written or verbal status of your claim every 30 days.

We encourage you to complete and submit the necessary materials in a timely manner so your claim can be processed without delay. When you file promptly, a claims specialist can initiate the claims process and begin communicating with all parties, which ultimately helps facilitate a timely determination of your claim. Forms must be complete and all forms must be received before the claims review process can begin.

Mail or fax completed forms and supporting documentation to:

UnitedHealthcare Specialty Benefits
P.O. Box 7466
Portland, ME 04112-7466
Fax: 1-888-505-8550

Claim determination.

If your claim is approved, you will receive a weekly benefit payment to help you meet your ongoing financial obligations. In addition, your claims specialist will assist you throughout your recovery and return to work.

- **Income replacement benefits:** The weekly benefit amount paid to you will be equal to a percentage of your pre-disability earnings, up to a maximum amount stated in your benefit plan for each day you remain disabled as defined by your plan

- **Timing:** You will begin receiving the weekly benefit when you have completed the Elimination Period, which begins the day you became disabled as defined by your benefit plan and ends after a period of time determined by your benefit plan. Your weekly benefit will be paid in arrears. For example, if your disability occurred on January 1 and the Elimination Period ended January 7, the first eligible benefit period would be January 8 to January 15 (7 days). The first weekly benefit check would be payable for the period January 8 to January 15, and the check would be released on January 12.
- **Benefit reductions:** Your weekly benefit amount will be reduced by legally required taxes or deductions, as well as other sources of income outlined in your Certificate of Coverage, such as sick pay, vacation pay, workers' compensation, state disability or other sources outlined in your benefit plan.
- **Claim management services:** Your claims specialist will maintain contact with you, your employer and your physician(s) for the duration of your claim. This individual will monitor your recovery process for the duration of your claim and assist you with next steps.

If your claim is denied, you will receive an explanation, along with instructions on how to appeal the decision.

If you have questions about the claims process, please call us at 1-888-299-2070.



For specific information about your Short-Term Disability insurance plan, please refer to your Certificate of Coverage.

This is intended to provide general information and does not change any terms of the STD Certificate of Coverage or Summary Plan Description. In the event of a conflict between the language in this brochure and your STD Certificate of Coverage or Summary Plan Description, the STD Certificate of Coverage and Summary Plan Description will prevail. Please refer to your Certificate of Coverage or contact UnitedHealthcare Specialty Benefits for information regarding exclusions and limitations under your policy and the terms under which your policy may be continued in force or discontinued.

Please note: Any person who knowingly, and with intent to injure, defraud or deceive an insurance company, files a statement of claim containing any false, incomplete or misleading information, may be guilty of a felony, and may be subject to imprisonment, fines and civil damages. In certain states, other consequences may apply.

UnitedHealthcare Disability products are provided by UnitedHealthcare Insurance Company; and in California by Unimerica Life Insurance Company; and in New York by Unimerica Life Insurance Company of New York. UnitedHealthcare Insurance Company is located in Hartford, CT; Unimerica Life Insurance Company is located in Milwaukee, WI; and Unimerica Life Insurance Company of New York is located in New York, NY.

Specialty benefits and programs may not be available in all states or for all group sizes. Components are subject to change.

Winning Wheels, Inc.
Summary of Benefits
Basic Life and AD&D Insurance



Effective Date	January 1, 2022
Eligibility	All Active Full Time Administrator and All Other Employees working a minimum of 30 hours per week.
Non-Contributory Basic Employee Life and AD&D Benefit	\$50,000
	Guarantee Issue Limit: \$50,000
Additional Benefits	<i>Please see the certificate of coverage for the complete Benefit Schedule.</i>
Waiver of Premium	If you become totally disabled your life insurance premium may be waived. See the certificate of coverage for details
Accelerated Death Benefit	If you are diagnosed as terminally ill you may receive payment of a portion of your Life Insurance. The remaining amount of your Life Insurance would be paid to your beneficiary when you die.
Conversion	Included. Please see the certificate of coverage for provision details.
Benefit Reductions	<i>Initial benefit age reduction is the percent of the face amount, any subsequent benefit age reductions are the percent of the original amounts.</i>
Basic EE Life and AD&D	65% at age 65, 40% at age 70, 25% at age 75, 15% at age 80
	Coverage terminates at employee's retirement
Evidence of Insurability Requirements	Late Entrant (did not enroll within 31 days of eligibility): For Employee coverage, evidence of good health/insurability is required for any requested amount.

Important Details

This Summary of Benefits sheet is an overview of the Life Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Summary of Benefits sheet and the insurance policy, the terms of the insurance policy apply.

Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

You must be Actively at Work with your employer on the day your coverage takes effect.

This coverage, like most group benefit insurance, requires that a certain percentage of eligible employees participate. If that group participation minimum is not met, the insurance coverage that you have elected may not be in effect.

Annual Earnings are defined in UnitedHealthcare's contract with your employer.

Benefit Reduction Examples:

- 65% at age 65, 60% at age 70: Coverage reduces to 65% of the face amount at age 65; to 60% of the original amount at age 70.

- 65% at age 65, 45% at age 70, 25% at age 75: Coverage reduces to 65% of the face amount at age 65; to 45% of the original amount at age 70; to 25% of the original amount at age 75.

Exclusions:

AD&D insurance does not cover losses caused by or contributed by:

Disease, bodily or mental infirmity, suicide or intentionally self-inflicted injury, commission of an assault or felony, war, use of any drug unless prescribed by physician, driving while intoxicated, engaging in any hazardous activities, or travel in a private aircraft.*

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

Value-Added Services (All features may not apply. Some states may have restrictions.)

Beneficiary Services: Provides beneficiaries with services for grief consultation, financial/legal assistance and referral to community resources. For more information, call 866-302-4480.

* Toll-free line available 24/7 as well as referrals for face-to-face counseling. Specialists provide in-depth consultation, information and referral to community resources such as grief support groups. Includes access to a national network of credentialed clinicians for grief and loss counseling. Beneficiaries receive two complimentary sessions.**

* Financial and Legal Services. Telephonic access to financial consultants for assistance with financial decision-making. Includes access to a network of 22,000 attorneys for either a 30-minute telephonic or an in-person consultation. Clients may retain the same attorney for representation at a discounted rate. CLC, Inc. provides access to legal services.

* Communication Support. We provide a "Beneficiary Kit" with informational resources to help beneficiaries with the emotional and financial process that follows the loss of a loved one.

Wealth Management Account: An enhanced benefit payment process. Life claim proceeds in excess of \$5,000 will automatically be deposited into an OptumBank Wealth Management Account (WMA). Beneficiaries receive an FDIC-insured, beneficiary-owned, interest earning account with convenient access to their claim proceeds via debit card or checkbook.***

**Beneficiary Services offered through United Behavioral Health, a company of UnitedHealth Group.

***Eligibility for automatic deposit into an OptumHealth Bank Wealth Management Account is subject to qualifying conditions evaluated by OptumHealth Bank and UnitedHealthcare Specialty Benefits at the time of claim review to include limited availability in certain states. For more information please contact your Specialty Benefits representative. OptumHealth Bank, Member FDIC, is part of the financial services unit of OptumHealth, a health and wellness company serving more than 60 million people. OptumHealth is a UnitedHealth Group (NYSE:UNH) company.

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company, and certain products in California by Unimerica Life Insurance Company. Texas Coverage is provided on Form LASD-POL-TX (05/03), Form UHCLD-POL 2/2008-TX, or UICLD-POL-TX 4/6.

UnitedHealthcare Insurance Company is located in Hartford, CT; Unimerica Insurance Company and Unimerica Life Insurance Company in Milwaukee, WI.



Group Term Life

Plan Effective Date: 2/1/2022

Proposal Prepared for: Winning Wheels
Number of employees: 193
City, State: Lyndon, IL

Prepared by: Vicki Lynn

Plan Selected: Group Term Life, Spouse Coverage, Dependent Children Coverage, AD&D, Waiver of Premium

Date Prepared: 1/18/2022
Quote Expires: 4/18/2022

Rate Information

Voluntary Coverage

All Rates listed are Monthly per \$1,000 of coverage

Age-band	Employee		Spouse	Dependent Children
	Non-tobacco	Tobacco	Unit-tobacco	Unit
0-24	0.037	0.047	0.112	0.358
25-29	0.053	0.066	0.111	0.358*
30-34	0.082	0.102	0.139	*Dependent children coverage is available up to age 26.
35-39	0.131	0.170	0.190	
40-44	0.195	0.269	0.284	
45-49	0.294	0.405	0.449	
50-54	0.425	0.624	0.668	
55-59	0.591	0.784	1.005	
60-64	0.733	0.940	1.419	
65-69	1.075	1.330	1.998	
70-74	2.031	2.492	3.781	Suite coverage not available for spouse and dependent children.
75+	6.345	7.251	11.686	
Ad&D	0.025		0.027	0.031
with Family Suite	0.028		Suite coverage not available for spouse and dependent children.	

The rates above are for the plan(s) described in this proposal, subject to the conditions specified. Rates are based on information entered on the quote input screen and final rates may differ if the information changes.

Proposed Plan - Voluntary

Employee Coverage - Benefits available in \$1,000 increments from a minimum of \$10,000 to a maximum of \$500,000, subject to an individual's maximum of 5.0x salary.

Spouse Coverage - Benefits available in \$1,000 increments from a minimum of \$5,000 to a maximum of 100% of the employee amount.

Dependent Children Coverage - Benefits available in \$1,000 increments to a maximum of \$10,000. The maximum benefit payable to children less than 6 months of age is \$1,000 regardless of the benefit amount purchased. One rate covers all children in the same family.

Waiver of Premium - Based on employee's total disability that occurs before age 65, lasts to age 65 or retirement with a 270 day elimination period. Total disability means unable to perform any occupation.



Accidental Death and Dismemberment (AD&D) - Available at the same face amount of Life coverage. Will be provided for all covered persons (employee, spouse and dependent children) receiving Life coverage. Must have Life coverage to receive AD&D coverage.

Employees can select the following Suite which covers accidental bodily injury and/or accidental death to the employee only.

Family Suite

- Child Care Benefit
- Career Adjustment for Spouse Benefit

Built-in Benefits

Three Year Rate Guarantee

Employee Assistance Program

- Provides professional counseling and referral services to help employees with personal and family issues and work/life balance to all employees with GTL coverage. Also includes Life Planning Financial and Legal Services to a terminally ill employee or spouse or designated beneficiaries of an employee or spouse.

Portability

- Employees and their spouse and dependent children may continue coverage when the employee leaves his job, reduces hours below the minimum required or retires.
- All ported insurance will move to special ported rate tables.
- Evidence of insurability is not required at time of port.

Conversion

- Right to convert to an individual level premium whole life plan then in use by us without proof of good health.

Accelerated Death Benefit

- An insured can advance up to 75% of their death benefit to a maximum of \$150,000 if diagnosed with a terminal illness and given 24 months or less to live.
- Benefit amount discounted for 12 months.

Eligibility Guidelines

All active employees working a minimum of 20 hours or more per week on a regular basis.

Eligible spouses and dependent children (up to age 26) also qualify for coverage if employee purchases coverage.

Coverage may be delayed for spouses and dependent children if they are totally disabled. Being totally disabled includes being unable to perform activities of daily living, being cognitively impaired, confined in a hospital or similar institution, or the existence of any life threatening conditions.

Participation Requirements: Greater of 10 lives or 20%. For 193 eligible lives, the minimum participation is 39 enrolled employees. This participation requirement must be maintained to keep the plan in force.



Guaranteed Issue at Initial Enrollment only

\$125,000 for Employees

\$25,000 for Spouses

\$10,000 for Dependent Children

Amounts above Guaranteed Issue, up to the plan maximum, are available with evidence of insurability.

AD&D Benefit Schedule

Full Benefit for the loss or loss of use of any of the following

- | | |
|--|--------------------------------|
| •Life | •One hand and sight of one eye |
| •Both hands or both feet or sight of both eyes | •One foot and sight of one eye |
| •One hand and one foot | •Speech and hearing |

Half Benefit for the loss or loss of use of any of the following

- One hand or one foot
- Sight of one eye
- Speech or hearing loss

One-Quarter Benefit for the loss or loss of use of thumb and index finger on the same hand

Seatbelts and Airbags Benefit

AD&D Exclusions

Suicide or Intentional self-inflicted Injury

Active participation in a riot

Commission of a felony or engaging in an illegal occupation

Use of controlled substances, except drugs prescribed by a physician and taken as prescribed

Disease of the body, mental infirmity or diagnostic, medical or surgical treatment

Presence of that percentage of alcohol in the blood which raises a presumption the individual was under the influence of alcohol

Exposed to war or any act of war

Serving in the armed forces of any country or authority

Investigational or experimental medical procedures

Travel in any experimental or test device for aerial navigation

Group Term Life Exclusions

Insurance delayed for employees not in active employment because of injury, sickness, temporary layoff, or leave of absence on date of insurance otherwise effective.

24 month suicide exclusion applies to initial amounts of insurance and any increases.

Spouses and dependent children are eligible to apply for coverage under guaranteed issue at the initial enrollment, but their coverage will not be effective if they are totally disabled. Being totally disabled includes the inability to perform activities of daily living, being cognitively impaired, confined in a hospital or similar institution, or the existence of any life threatening conditions. The inability to work does not determine total disability. The employee can pay premiums on insurance for their dependents with no health questions asked; however coverage is not effective until they are no longer totally disabled.

Benefit Reduction Due to Age

When an employee turns 70, coverage reduces to 65% of the face amount in effect just prior to age 70.

When an employee turns 75, coverage reduces to 50% of the face amount in effect just prior to age 70.

Policies issued to individuals over age 70 initially are automatically reduced in accordance with the schedule above.

Spouses experience the same reduction schedule, but it is based on the spouse's age.

Premiums

Employee and spouse initial premiums are based on current age and will change as the insureds age, based on five-year age bands. Dependent children premiums are based on the cost of coverage for one child, regardless of the number of children insured.

Annual Earnings

Annual earnings means your gross annual income from your employer in effect just prior to the date of loss. It includes your total income before taxes, but does not include deductions made for pre-tax contributions to a qualified deferred compensation plan, Section 125 plan, or flexible spending account. It does not include income received from commissions, bonuses, overtime pay, any other extra compensation from this employer, or income received from sources other than your employer.

Important Notice

This quote is based on the data provided and is guaranteed for 90 days. If the ZIP code, industry or case size is different at enrollment time, these rates may not apply. Cost and rates for the employees to be insured under this plan on the effective date must be approved and accepted by Colonial Life's home office.

The proposal is intended to explain the Group Term Life plan. It does not constitute the contract. If this proposal is accepted, a contract outlining the coverage will be issued. Any discrepancies between this proposal and the contract will be resolved by the wording contained in the contract.

Provisions shown are based on the home office state of the employer (IL). Applicable to policy form GTL1.0-P-IL and certificate GTL1.0-C-IL. If any differences are required, the insureds' certificates will be based on the state in which they work.

Where used, the term spouse also includes a legally separated spouse. You may not cover your spouse if your spouse is enrolled for coverage as a named insured.

This quote tool is intended for proposal use with employers. Colonial Life products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand. Colonial Life is a registered service mark of Colonial Life & Accident Insurance Company.

Colonial Life is committed to helping working Americans and their families minimize personal financial risk with a comprehensive offering of voluntary benefits through the workplace. Colonial Life compensates producers to facilitate the sale and delivery of these valuable benefits. This compensation might include commissions as well as various incentives and awards.

We support disclosure of compensation programs for our products, and your benefits counselor can provide you with complete information about these programs. You may also learn additional information about our compensation programs by contacting our Plan Administrator Service Center at 1-800-256-7004.

Plan Effective Date – Actively at Work Employees – Existing coverage is transferred on a "no loss – no gain" basis. This means that an employee or participant will not be penalized or lose the benefits/provisions already attained before switching insurance carriers, nor will they gain any additional benefits/provisions for which they have not yet satisfied the requirements or are not yet eligible for.

**Important Notice, cont.**

Plan Effective Date – Disabled Employees – Employees who are away from work due to a disability who are not covered under a prior carrier's premium waiver feature may have existing coverage transferred on a "no loss – no gain" basis. To do this Colonial Life requires the receipt of a list of disabled employees. This list should include life coverage amount, date of birth, sex and disability reason. Based on the review of this list Colonial Life reserves the right to make adjustments to the proposal.

Newly Eligible Employees – If Ill or Injured, and away from work on the date that coverage would become effective, the effective date of coverage is delayed until the employee returns to full-time work for one full day.

Home Office Notes

Industry Selection:	Health Care	Nursing Facilities
ZIP Code	61261	INTERMEDIATE CARE FACILITIES
Case Size	193	8052



Invest in your future.
ilsecurechoice.com

Benefits:

Illinois Secure Choice is a transparent, convenient, and voluntary way for Illinoisans to save for retirement.

Your employer has registered with the Illinois Secure Choice program. You are invited to set up your account or opt out at this time.

Illinois Secure Choice is a program that allows you to automatically save for retirement through payroll deductions at work. Amounts you save in this account are always your money. Your account is in your control and goes with you from job to job. Every little bit you save now can potentially make a difference in retirement.

30 Days to Decide:

Option One:

Start saving

- Set up your account now
 - Establish online access and update your savings choices
- Set up your account later
 - Your savings will start automatically based on the standard savings choices

OR

Option Two:

Opt out

- Opt out of participating to avoid saving through payroll deductions
 - You can opt back in
- Consider smaller contribution rates
 - A great alternative to opting out entirely

Decide ☐ online at saver.ilsecurechoice.com, by ☐ phone at 855-650-6914, or by ☒ filling out a form.

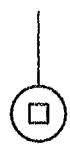
Standard Savings Choices:

30 days after receiving the invitation, **you will be automatically enrolled in the program** and start saving part of each paycheck into your own Roth Individual Retirement Account (IRA) (unless you opt out within the 30 day window).

5% of your gross pay (wages before taxes and other deductions) will be contributed to your Roth IRA.

Your account will be a Roth IRA. Contributions into a Roth IRA are made after-tax and not taxable when you remove them from your account. Any earnings on those contributions could be tax free if you meet certain IRS criteria.

The only administrative charge for Illinois Secure Choice is in the form of an annual asset-based fee of approximately .75%, which means **you will pay approximately \$0.75 per year for every \$100 in your account.** You will not get a bill. This cost is automatically taken out of your Illinois Secure Choice balance on a regular basis to help pay for the administration of the program.



Set Up Your Account:

- Verify your contact information
- Accept the account documents
- Add beneficiaries (who will inherit your Roth IRA in the event of your death)
- You can also:
 - Change your contribution rate
 - **minimum = 1%, maximum = 100% up to IRS limits for Roth IRAs**
 - Change your investment choices. Available options include:
 - Illinois Secure Choice Capital Preservation Fund: 100% invested in the State Street Institutional Liquid Reserves Fund (Ticker: SSHXX)
 - Illinois Secure Choice Target Date Retirement Funds: 100% invested in the BlackRock LifePath Index Target Date Retirement Funds. Choose your fund based on your target retirement date.
 - Illinois Secure Choice Growth Fund: 100% invested in the Schwab S&P 500 Index Fund (Ticker: SWPPX)
 - Illinois Secure Choice Conservative Fund: 100% invested in the Schwab U.S. Aggregate Bond Index Fund (Ticker: SWAGX)

*The default investment is the Illinois Secure Choice Target Date Retirement Fund

Learn more about Illinois Secure Choice at saver.ilsecurechoice.com.

The Illinois Secure Choice Savings Program ("IL Secure Choice") is overseen by the Illinois Secure Choice Savings Board ("Board"). Ascensus College Savings Recordkeeping Services, LLC ("ACSR") is the program administrator. ACSR and its affiliates are responsible for day-to-day program operations. Participants saving through IL Secure Choice beneficially own and have control over their Roth IRAs, as provided in the program offering set out at saver.ilsecurechoice.com.

IL Secure Choice's Portfolios offer investment options selected by the Board. For more information on IL Secure Choice's Portfolios go to saver.ilsecurechoice.com. Account balances in IL Secure Choice will vary with market conditions and are not guaranteed or insured by the Board, the State of Illinois, the Federal Deposit Insurance Corporation (FDIC) or any other organization.

IL Secure Choice is a completely voluntary retirement program. Saving through a Roth IRA will not be appropriate for all individuals. Employer facilitation of IL Secure Choice should not be considered an endorsement or recommendation by your employer of IL Secure Choice, Roth IRAs, or these investments. Roth IRAs are not exclusive to IL Secure Choice and can be obtained outside of the program and contributed to outside of payroll deduction. Contributing to an IL Secure Choice Roth IRA through payroll deduction offers some tax benefits and consequences. You should consult your tax or financial advisor if you have questions related to taxes or investments.



saver.ilsecurechoice.com



855-650-6914



Mon - Fri 8 a.m. - 8 p.m. CT

Marketplace (exchange) Notice PART A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the ACA Health Insurance Marketplace (the "exchange") and employment based health coverage offered.

What is the Government-run Health Insurance Marketplace (exchange)?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage occurs on an annual basis, and Special enrollment Periods are available throughout the year to those with a qualifying life event such as marriage, divorce, birth or adoption of a child, loss of a job and other events.

Can I save money on my health insurance premiums in the Marketplace?

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

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium and a reduction in plan cost-sharing if your employer a) does not offer coverage to you at all or b) does not offer coverage that meets certain standards. Specifically, if your cost for SELF-ONLY coverage on a plan offered to you by your employer is more than 9.5% of your household income for the year (plus all applicable adjustments for inflation), OR if the coverage your employer provides does not meet the "Minimum Value (MV) Standard" set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: There may be some disadvantages if you purchase a health plan through the Marketplace instead of accepting coverage offered by your employer. First, current regulations generally prohibit employers from contributing funds toward non-group health premiums. This means that you will lose any employer premium contributions that would have otherwise been payable. Second, the costs paid toward employer-offered health coverage are generally excluded from income for Federal and State income tax purposes. However, payments for coverage through the Marketplace are made on an AFTER-tax basis.

How can I get more information?

For more information about your coverage offered by your employer, please check your coverage materials or contact Amber Schaefer at (815) 778-3683, ext. 304 or aschaefer@ahelnco.com.

The Marketplace or a licensed insurance broker can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov to find more information.

¹ An employer-sponsored health plan meets the "Minimum Value (MV) 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 and meets other requirements.

PART B: General Information

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 Winning Wheels, Inc.		4. Employer Identification Number 23-7136038	
5. Employer address 701 E Third St		6. Employer phone number (815) 778-3683, ext. 304	
7. City Prophetstown	8. State IL	9. Zip code 61277	
10. Who can we contact about employee health coverage at this job? Amber Schaefer			
11. Phone number (if different from above) (815) 778-3683, ext. 304		12. Email address aschaefer@ahcinc.com	

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

As your employer, we offer a health plan to:

All employees we deem eligible for health coverage under the plan's eligibility rules. Generally speaking, coverage is offered to full-time employees working at least 30 hours per week, but other criteria may apply based on employment class and other facts and circumstances.

With respect to dependents:

All eligible spouses and dependents under the age of 26, as well as others who meet specified criteria (e.g. those who meet disabled dependent definitions). Please contact the individual listed in Box 10 (above) with any questions.

☒ If checked, this coverage meets the minimum value standard and the cost of this coverage is intended to be affordable under one of the §4980H Affordability Safe Harbors.

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

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. You may need to get information from your employer, about their coverage, in order to find out if you qualify for a tax credit to lower your monthly premiums.