CARRELL CLINIC

A DIVISION OF OrthoLoneStar

2023 Employee Benefits

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We recognize that OrthoLoneStar is built by and dependent on our collective efforts to create the highest quality orthopedic outcomes at the best value across Texas. Those efforts are provided by each and every one of our team members, every day. In recognition of your importance to our mission, OrthoLoneStar is invested in providing benefit options to you that enhance and improve your well-being and your security. This guide provides an overview on benefit details for 2023; we hope that you find them comprehensive and caring. If you should have any questions, please don't hesitate to ask your Human Resources representative or your Supervisor manager. Thank you for all you do!

Info on the Go!

Scan with Your Smartphone to Access Enrollment Materials Online Anytime.

See **page 30** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to OrthoLoneStar, LLC. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Eligibility & Enrollment

OrthoLoneStar offers a variety of benefits to support you and your family's needs. Choose options that cover what's important to you.

Eligibility

If you are a full-time employee of Carrell Clinic who is regularly scheduled to work a minimum of 30 hours a week, you are eligible to participate in the medical, dental, vision, life and disability plans, and additional benefits.

When Does Coverage Begin?

New employees will be eligible for coverage on the first of the month following 30 days. You won't be able to change your benefits until the next enrollment period unless you experience a qualifying life event.

Eligible Dependents

Dependents eligible for coverage in the OrthoLoneStar benefits plans include:

- Your legal spouse (or common-law spouse).
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility is required upon enrollment.

Thoughts & Tips: You cannot change your benefit selections during the plan year unless you have a qualifying life event, such as marriage and/or the birth or adoption of a child.

Electing or Changing Benefits: Open Enrollment and Qualifying Life Events

What are Qualifying Life Events?

Most people know you can change your benefits when you start a new job or during Open Enrollment. But did you know that changes in your life may permit you to update your coverage at other points in the year? Qualifying Life Events (QLEs) determined by the IRS could allow you to enroll in health insurance or change your elections outside of the annual time.

Common qualifying events include:

- A change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- A change in your legal marital status (marriage, divorce or legal separation)
- Entitlement to Medicare or Medicaid
- A change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Eligibility for coverage through the Marketplace
- A change in your spouse's employment status (resulting in a loss or gain of coverage)
- Changes in your address or location that may affect the coverage for which you are eligible

Some lesser-known qualifying events are:

- Turning 26 and losing coverage through a parent's plan
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)
- Death in the family (leading to change in dependents or loss of coverage)

When a Qualifying Life Event occurs, you have **31 days to request changes** to your coverage. Keep in mind your change in coverage must be consistent with your change in status.

Questions regarding specific life events and your ability to request changes should be directed to your Human Resources Manager. Don't miss out on a chance to update your benefits!

Medical Benefits

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your per pay period contributions. A $100 monthly Tobacco/Nicotine surcharge will be assessed on employees participating in the medical plans who use tobacco or nicotine. This surcharge may be avoided by completing approved cessation efforts, including physician care. Please contact HR for more information on eligibility to avoid the Tobacco/Nicotine surcharge. Medical premium costs and contributions are shown in the table below.

	PPO				$3,000 HDHP				$5,000 HDHP			
	MONTHLY			PER PAY PERIOD	MONTHLY			PER PAY PERIOD	MONTHLY			PER PAY PERIOD
	TOTAL PREMIUM	EMPLOYER COST	EMPLOYEE COST	EMPLOYEE COST	TOTAL PREMIUM	EMPLOYER COST	EMPLOYEE COST	EMPLOYEE COST	TOTAL PREMIUM	EMPLOYER COST	EMPLOYEE COST	EMPLOYEE COST
EMPLOYEE ONLY	$730.55	$480.00	$250.55	$115.64	$651.50	$586.36	$65.14	$30.06	$586.36	$586.36	$0.00	$0.00
EMPLOYEE + SPOUSE	$1,412.14	$480.00	$932.14	$430.22	$1,259.32	$586.36	$672.96	$310.60	$1,133.38	$586.36	$547.02	$252.47
EMPLOYEE + CHILD(REN)	$1,355.13	$480.00	$875.13	$403.91	$1,208.52	$586.36	$622.16	$287.15	$1,087.65	$586.36	$501.29	$231.36
EMPLOYEE + FAMILY	$2,096.61	$480.00	$1,616.61	$746.13	$1,869.78	$586.36	$1,283.42	$592.35	$1,682.81	$586.36	$1,096.45	$506.05

Medical Plan Summary

This chart summarizes the 2023 medical coverage provided by Blue Cross Blue Shield. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations. If you enroll in one of the two HDHP options, you may be eligible to open a Health Savings Account (HSA). Please see pages 12-13 for additional detail.

	PPO	$3,000 HDHP	$5,000 HDHP
CALENDAR YEAR DEDUCTIBLE			
	IN-NETWORK	IN-NETWORK	IN-NETWORK
INDIVIDUAL	$1,500	$3,000	$5,000
FAMILY	$3,000	$6,000	$10,000
COINSURANCE (PLAN PAYS)	80%*	80%*	80%*
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)			
INDIVIDUAL	$6,600	$5,000	$6,350
FAMILY	$13,200	$10,000	$12,700
COPAYS/COINSURANCE			
PREVENTIVE CARE	Covered at 100%; No Copay	Covered at 100%; No Copay	Covered at 100%; No Copay
PRIMARY CARE	$30	80%*	80%*
SPECIALIST SERVICES	$60	80%*	80%*
URGENT CARE	$60	80%*	80%*
EMERGENCY ROOM	$250 Copay then Plan Pays 80%*	80%*	80%*

*After Deductible

Out-of-Pocket Costs

Know Before You Go: Paying for Services

Deductible

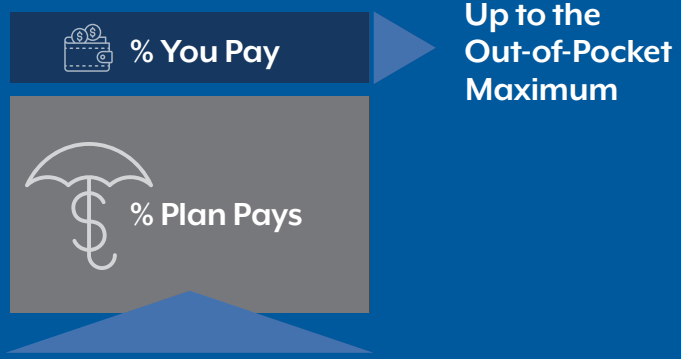
The amount you must pay for covered services before your insurance starts paying its portion.

Copay

The fixed amount you pay for healthcare services at the time you receive them.

Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.



Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

The individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a "per individual" deductible amount will also be applied toward the "per family" deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the "per family" deductible amount. The same typically applies for the out-of-pocket maximum.

Healthcare Cost Transparency

With options like High Deductible Health Plans, your healthcare spending is in your control. But with so many providers and varying costs for services, how do you decide where to go? Healthcare cost transparency tools are online services available through most health insurance carriers that allow consumers to compare costs for medical services, from prescriptions to major surgeries, to make choices easier. To learn more, visit www.bcbstx.com.

Rising Costs of Healthcare

The cost of healthcare in the U.S. has been steadily growing each year. Why? Some of the factors include an aging population, increased demand for care (resulting in higher prices for premiums and prescription drugs) and an increase in chronic illnesses. Make sure you're informed about your options so you can make the best healthcare choices for you and your family. Placing an importance on preventive care, making healthy choices, and managing costs will help keep your health — and wallet — in control in the long run.

How to Pick a Plan

Which plan is right for you? When deciding, consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

How does a PPO (Preferred Provider Organization) work?

You'll pay more in premiums out of your paycheck, but perhaps less at the time of service.

You're able to choose from a network of providers who offer a fixed copay for services.

If you expect to need more medical care this year or you have a chronic illness, the PPO may be the right choice for you to ensure your healthcare needs are covered.

How does an HDHP (High Deductible Health Plan) work?

You'll pay less in premiums. (Think less money from your paycheck.)

You'll pay for the full cost of non-preventive medical services until you reach your deductible.

You can also use a Health Savings Account in conjunction, which provides a safety net for unexpected medical costs and tax advantages.

If you expect to mostly use preventive care (which is covered), this plan could be for you.

Preventive Care

Most health plans are required to cover a set of preventive services — at no cost to you!

Screening tests and routine checkups are considered preventive, which means they're often paid at 100%. Keep up to date with your primary care physician to save time and money and keep yourself healthier in the long run. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

- Wellness visits, physicals and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity and diabetes
- Pediatric screenings for hearing, vision, obesity and developmental disorders
- Anemia screenings, breastfeeding support and pumps for pregnant and nursing women
- Iron supplements (for children ages 6 to 12 months at risk for anemia)

Take advantage of these covered services. However, remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. This means if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

Where To Go For Care

You think you may be sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new medication, but the pharmacy is closed. Instead of immediately choosing an expensive trip to the emergency room or relying on questionable information from the internet, take a look below at various care centers and resources and the types of care they provide.

PRIMARY CARE CENTER

When would I use this?
You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

What type of care would they provide?*
- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

What are the costs and time considerations?**
- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

TELEMEDICINE

When would I use this?
You need care for minor illnesses and ailments, but would prefer not to leave home. These services are available by phone and online (via webcam).

What type of care would they provide?*
- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

What are the costs and time considerations?**
- There is usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- Access to care is usually immediate.
- Some states may not allow for prescriptions through telemedicine or virtual visits.

DO YOUR HOMEWORK

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

URGENT CARE CENTER

When would I use this?
You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

What type of care would they provide?*
- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

What are the costs and time considerations?**
- Often requires a copay and/or coinsurance that is usually higher than an office visit.
- Walk-in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first.

EMERGENCY ROOM

When would I use this?
You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

What type of care would they provide?*
- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

What are the costs and time considerations?**
- Often requires a much higher copay and/or coinsurance.
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first.

*This is a sample list of services and may not be all-inclusive. **Costs and time information represent averages only and are not tied to a specific condition or treatment.

Virtual Medicine

When you're sick, the last thing you want to do is leave the cozy comfort of your home. Or sometimes you're just too on the go to pop in for a visit. Virtual medicine is a convenient and easy way to talk to a doctor fast.

Telemedicine

We provide a telemedicine benefit through Blue Cross Blue Shield of Texas to you and your dependents. Blue Cross Blue Shield of Texas offers on-demand access to board-certified doctors through online video, telephone or secure email. You and your family can be treated for general health issues at equal or lower costs as in-person visits. Telemedicine is useful for after-hours non-emergency care, when your primary care doctor is unavailable, if you need prescriptions or refills or if you're traveling. Please note that some states do not allow physicians to prescribe medications via telemedicine. For more information, visit www.MDLive.com.

Blue Cross Blue Shield of Texas doctors can treat many medical conditions, including:

- Allergies
- Asthma
- Cold & flu
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems

Behavioral health is also a covered component of the telemedicine benefit so you can utilize certified physicians at any time for anxiety, depression, or family and/or marriage issues.

Call MDLive at 888-680-8646 or download the MDLive mobile app on your phone.

To register, you will need to provide your first and last name, date of birth, and BCBSTX member ID number.

Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through Blue Cross Blue Shield. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at www.bcbstx.com or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred or Non-Preferred.

	PPO	$3,000 HDHP	$5,000 HDHP
	PREFERRED PHARMACY	PREFERRED PHARMACY	PREFERRED PHARMACY
RETAIL RX (30-DAY SUPPLY)			
GENERIC	$20	$10 copay*	$10 copay*
PREFERRED	$40	$25 copay*	$25 copay*
NON-PREFERRED	$60	$50 copay*	$50 copay*

*After Deductible

Generic Drugs

Looking to save money on medication costs? You've most likely heard that generic prescription drugs are a more affordable option, so here's the skinny: Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety and strength. Because they are the same medicine, generic drugs are just as effective as brand-name drugs and undergo the same rigid FDA standards. But on average, **a generic version costs 80% to 85% less than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Note: Apps such as GoodRx and RxSaver let you compare prices of prescription drugs and find possible discounts. If you use these tools, make sure to check the price against the cost through your insurance to get the best deal. Note that these discounts can't be combined with your benefit plan's coverage. As a result, if you choose to use a discount card from an app such as GoodRx or RxSaver, the amount you pay will not count toward your deductible or out-of-pocket maximum under the benefit plan.

Health Savings Account

Need funds to help cover out-of-pocket healthcare expenses? Consider a Health Savings Account (HSA). An HSA is a personal healthcare bank account used to pay for qualified medical expenses and funded by you. OrthoLoneStar will also make a contribution to covered employees' HSAs! HSA contributions and withdrawals for qualified healthcare expenses are tax-free. You must be enrolled in an HDHP to participate.

Your HSA can be used for qualified expenses for you, your spouse and/or tax dependent(s), even if they are not covered by your plan. If you are not currently enrolled in an HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

HSA Bank will issue you a debit card, giving you direct access to your account balance. Use your debit card to pay for qualified medical expenses, with no need to submit receipts for reimbursement. You must have a balance in your HSA account to use the card.

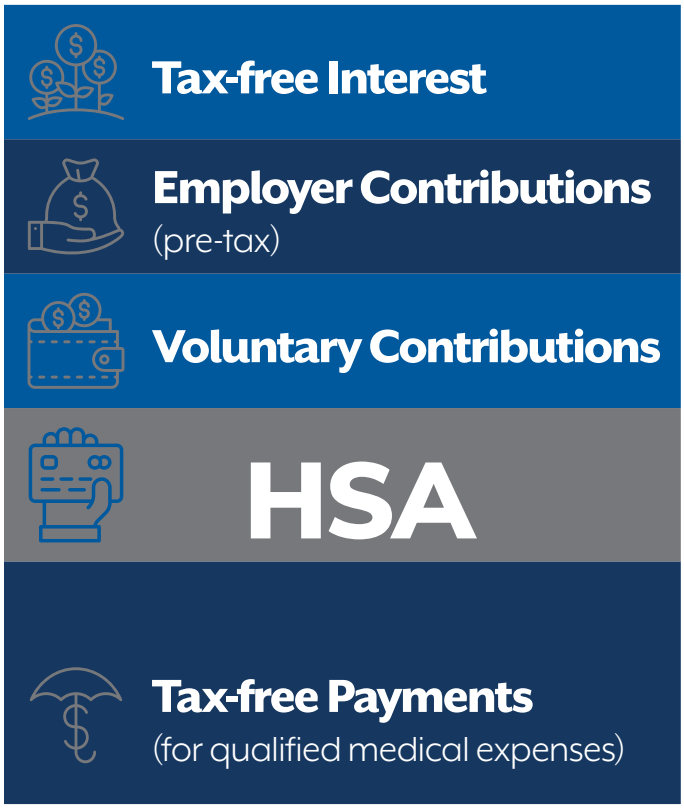
Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery and more. Check out IRS Publication 502 on www.irs.gov for a complete list of eligible expenses.

NOTE: HSA Bank will charge a $2.00 monthly service fee for balances below $3,000. This charge will be deducted monthly from your HSA bank account balance.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse's non-HDHP.
- Your spouse does not have a healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)



Your Money. Your Account.

Your HSA is a personal bank account that you own and administer. It's up to you how much you contribute, when to use the money for medical services, and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year-over-year to use in retirement. HSA funds are also portable if you change plans. There are no vesting requirements or forfeiture provisions.

How to Enroll

To enroll in the company-sponsored HSA, you must elect one of the company's HDHP medical options. Complete all HSA enrollment materials and designate the amount to contribute on a pre-tax basis.

Plan. Spend. Save.

Contributions to an HSA can be made through payroll deduction on a pre-tax basis when you open an account with HSA Bank. **The money in this account (including interest and investment earnings) grows tax-free.** When the funds are used for qualified medical expenses, they are spent tax-free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2023, contributions are limited to the following:

HSA FUNDING LIMITS

	2023
EMPLOYEE	$3,850
FAMILY	$7,750
CATCH -UP CONTRIBUTION (AGES 55+)	$1,000

OrthoLoneStar provides an HSA employer contribution that will be deposited on a per pay period basis.

ANNUAL EMPLOYER HSA CONTRIBUTIONS

	$3,000 HDHP	$5,000 HDHP
EMPLOYEE	$300	$600
FAMILY	$300	$600

HSA contributions in excess of the IRS annual contribution limits are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed from your HSA.
- Leave the excess contributions in your HSA and pay 6% excise tax on excess contributions. Next year consider contributing less than the annual limit to your HSA to make up for the excess contribution during the previous year.

The OrthoLoneStar HSA is established with HSA Bank. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources Department or visit www.hsabank.com.

Thoughts & Tips: **It's up to you how much to contribute to your HSA. Buying a new house or sending a kid to college? You can contribute less this year. Paid off your student loans or got a new job? Stash the annual max in your account.**

Flexible Spending Accounts

Flex your spending power! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to $3,050 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, over-the-counter medications, etc.) with pre-tax dollars, reducing your taxable income and increasing your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them without waiting for reimbursement.

Your full election amount will be immediately available to you on day one of your plan and you do not need to wait to accrue the funds. For example, if you elect $500, you could spend all $500 on the first day the plan is effective.

The IRS' use it or lose it rule states that FSA funds must be spent within the FSA's plan year which ends 12/31/2023. For employees who continue to participate in the Health Care FSA the next year, the IRS allows up to $610 (amount is adjusted annually) of Health Care FSA funds to carry over from one plan year to the next.

Thoughts & Tips: **Your healthcare FSA money can cover the cost of going to a chiropractor or acupuncturist, if your insurance doesn't already cover it.**

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — whether or not you elect any other benefits. You can set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time.

- **Carrell Clinic contributes $1,250 per child towards your Dependent Care FSA up to $2,500.**
- With the Dependent Care FSA, you can set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the principal place of residence as the employee for more than half the year may be a qualifying individual.
- Expenses are reimbursable if the provider is not your dependent.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. Examples of eligible dependent care expenses include:

- In-home babysitting services (not provided by a tax dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

How to Use the Account

OrthoLoneStar partners with WEX Inc. to administer your FSA and WEX will issue a debit card when you elect to contribute to a FSA account. You can use your FSA debit card at doctor and dentist offices, pharmacies and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you attempt to use the card at an ineligible location.

Once you incur an eligible expense, submit a claim form along with the required documentation. Contact WEX Inc. with reimbursement questions. If you need to submit a receipt, you will be notified by WEX Inc.. Always retain a receipt for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Without proof that an expense was valid, your card could be turned off and your expense deemed taxable.

General Rules and Restrictions

The IRS has the following rules and restrictions for Healthcare and Dependent Care FSAs:

- Expenses must be incurred during the 2023 plan year.
- Dollars cannot be transferred between FSAs.
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must "use it or lose it" — any unused funds will be forfeited.
- Up to $610 may be rolled over to the next plan year for Healthcare FSAs.
- You cannot change your FSA election in the middle of the plan year unless you experience a qualifying life event.
- Terminated employees have ninety (90) days following the date of termination to submit their FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $125,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more information.

FSA vs HSA

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are both ways to save pre-tax money to pay for your eligible healthcare costs. Which one is right for you?

	FSA	HSA
OWNERSHIP	Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	You own your HSA. It is a savings account in your name and you always have access to the funds, even if you change jobs.
ELIGIBILITY & ENROLLMENT	You're eligible for an FSA if it's offered by your employer. You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	1. You must be enrolled in a qualified High Deductible Health Plan to be eligible to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or eligible for a spouse's FSA or enrolled in Medicare or TRICARE. 2. You can change your contribution at any time during the Plan Year.
TAXATION	Contributions are tax free via payroll deduction. However, the funds spent are not tax free.	For Federal tax purposes, the money in the account is "triple tax free," meaning: 1. Contributions are tax free. 2. The account grows tax free. 3. Funds are spent tax free (if used for qualified expenses).
CONTRIBUTIONS	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for 2023 is $3,050.	Both you and your employer can contribute to the account according to IRS limits. The contribution limit for 2023 is $3,850 for individual and $7,750 for families. This amount includes the employer contribution. If you are 55 or older, you may make a "catch-up" contribution of $1,000 per year.
PAYMENT	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit your receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal or checkbook to pay for qualified expenses directly. You can also use online bill payment services from the HSA financial bank. You decide when to use the money in your HSA to pay for qualified expenses, or if you want to use another account to pay for services and save the money in your HSA for future expenses or retirement.
ROLL OVER	You must use the money in the account by end of Plan Year; however, a Healthcare FSA may allow up to $610 to roll over to the next year. Any unclaimed funds at the end of the run out are lost and returned to your employer.	The money in the account rolls over from year to year. Funds are always yours and may be used for future qualified expenses — even in retirement years.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, over-the-counter medications, dental care and vision care. A full listing of eligible expenses is available at www.irs.gov.	Physician services, hospital services, prescriptions, menstrual products, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums and long-term care premiums. A full listing of eligible expenses is available at www.irs.gov.
OTHER TYPES	Other types of FSAs include: • Dependent Care FSA - Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as day care and before- and after-school care. Dependent Care FSAs do not allow for any rollover, so all funds must be used before the end of the plan year or they are forfeited.	There is only one type of HSA.

Please refer to your Summary Plan Description or plan certificate for your plan's specific FSA or HSA benefits.

Supplemental Health Benefits

OrthoLoneStar offers several ways for you to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and is offered at discounted group rates.

Accident Coverage

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident coverage, available through Allstate, provides benefits for you and your covered family members if you have expenses related to an accident that occurs outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help you pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits under this plan are payable to you, to use as you wish.

	ACCIDENT COVERAGE
PER PAY PERIOD COSTS	
EMPLOYEE ONLY	$5.69
EMPLOYEE + SPOUSE	$9.84
EMPLOYEE + CHILD(REN)	$16.21
EMPLOYEE + FAMILY	$20.64

BRIEF SUMMARY OF BENEFITS*	
INITIAL HOSPITAL CONFINEMENT	$1,500 + $300 per day ($600 per day for Intensive Care)
DISLOCATIONS/FRACTURES	Up to $8,000
AMBULANCE	Ground: $400 / Air: $1,200
ACCIDENT PHYSICIANS TREATMENT, URGENT CARE OR EMERGENCY ROOM SERVICES	$200
X-RAY	$400
ACCIDENT FOLLOW-UP TREATMENT	$100
BURNS	Up to $1,000
BRAIN INJURY DIAGNOSIS	$600
COMPUTED TOMOGRAPHY (CT) SCAN AND MAGNETIC RESONANCE IMAGING (MRI) BENEFIT	$100
COMA WITH RESPIRATORY ASSISTANCE	$20,000
OPEN ABDOMINAL OR THORACIC SURGERY	$2,000
TENDON, LIGAMENT, ROTATOR CUFF OR KNEE CARTILAGE SURGERY BENEFIT WITH REPAIR	$1,000
RUPTURED DISC SURGERY	$1,000
BLOOD AND PLASMA	$600
PHYSICAL, OCCUPATIONAL, OR SPEECH THERAPY	$60
APPLIANCE	$250

*This list is a summary. Refer to plan documents for a comprehensive list of covered benefits.

Critical Illness Coverage

Critical Illness coverage through Allstate pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like; for example: to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home health care costs or any of your regular household expenses.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
- Children are covered at NO COST when you elect employee coverage
- Benefits are payable based on the date of the covered event occurring or the date of diagnosis.; Illnesses or occurrences prior to the effective date of coverage will not be payable events
- $50 annual Wellness Benefit is payable for each covered member for completing certain wellness screenings such as a pap test, cholesterol test, mammogram, colonoscopy or stress test (once per year per covered person)

CRITICAL ILLNESS COVERAGE

AGE	PLAN 1		PLAN 2	
	EMPLOYEE ONLY AND EMPLOYEE + CHILDREN	EMPLOYEE + SPOUSE AND EMPLOYEE + FAMILY	EMPLOYEE ONLY AND EMPLOYEE + CHILDREN	EMPLOYEE + SPOUSE AND EMPLOYEE + FAMILY
PER PAY PERIOD COSTS				
18-24	$2.33	$4.66	$4.00	$7.99
25-29	$2.87	$5.73	$5.05	$10.11
30-34	$3.83	$7.65	$6.94	$13.89
35-39	$5.69	$11.37	$10.60	$21.21
40-44	$7.66	$15.31	$14.47	$28.94
45-49	$10.58	$21.14	$20.21	$40.42
50-54	$14.55	$29.10	$28.03	$56.06
55-59	$19.22	$38.42	$37.21	$74.42
60-64	$27.21	$54.43	$52.98	$105.98
65-69	$37.99	$75.98	$74.23	$148.47
70-74	$51.74	$103.50	$101.39	$202.77
75-79	$68.28	$136.56	$134.27	$268.53
80+	$101.22	$202.43	$200.04	$400.08

Premiums are based on the Employee's age on the effective date of coverage. Even if the Spouse is in a different age band, the rates are driven off of the employee's age. Children are covered at no additional cost, when you elect Employee coverage.

Coverage Amounts:

- **Employee:** $15,000 or $30,000
- **Spouse:** $15,000 or $30,000
- **Children:** $7,500 and $15,000

Covered Conditions and Benefit Amounts*

A covered employee and a covered spouse each have the full benefit amount illustrated below. Any covered child(ren) are covered at 50% of the benefit amount illustrated below.

	PLAN 1	PLAN 2
ADVANCED ALZHEIMER'S DISEASE	$15,000	$30,000
ADVANCED PARKINSON'S DISEASE	$15,000	$30,000
BENIGN BRAIN TUMOR	$15,000	$30,000
COMA	$15,000	$30,000
COMPLETE LOSS OF HEARING	$15,000	$30,000
COMPLETE LOSS OF SIGHT	$15,000	$30,000
COMPLETE LOSS OF SPEECH	$15,000	$30,000
CORONARY ARTERY BYPASS SURGERY	$3,750	$7,500
END STAGE RENAL FAILURE	$15,000	$30,000
HEART ATTACK	$15,000	$30,000
MAJOR ORGAN TRANSPLANT	$15,000	$30,000
PARALYSIS	$15,000	$30,000
PULMONARY EMBOLISM	$3,750	$7,500
PULMONARY FIBROSIS	$3,750	$7,500
STROKE	$15,000	$30,000
SUDDEN CARDIAC ARREST	$3,750	$7,500
CANCER BENEFITS		
INVASIVE CANCER	$15,000	$30,000
CARCINOMA IN SITU	$3,750	$7,500
SKIN CANCER	$250	$250
SPECIFIED CHRONIC ILLNESSES **		
ADRENAL HYPOFUNCTION (ADDISON'S DISEASE)	$7,500	$15,000
ARTHRITIS	$7,500	$15,000
HUNTINGTON'S CHOREA	$7,500	$15,000
LOU GEHRIG'S DISEASE (ALS)	$7,500	$15,000
MULTIPLE SCLEROSIS	$7,500	$15,000
MUSCULAR DYSTROPHY	$7,500	$15,000
OSTEOMYELITIS	$7,500	$15,000
OSTEOPOROSIS	$7,500	$15,000

*This is a summary. Refer to plan document for details including definitions, plan exclusions and limitations.
**Pays after 90-days of loss of ADL's due to listed condition

Hospital Indemnity Coverage

Hospital Indemnity Coverage through Allstate pays cash benefits directly to you if you have a covered stay in a hospital or intensive care unit. You can use the benefits from this policy to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging, or everyday expenses such as groceries and utilities.

- Benefits are payable for pregnancy on the first day you have the policy
- Coverage is guaranteed issue; no medical questions

SUMMARY OF BENEFITS*	
FIRST DAY HOSPITAL CONFINEMENT BENEFIT	$1,000 (max one time per month)
DAILY HOSPITAL CONFINEMENT BENEFIT	$200 per day (max 30 days per confinement)
DAILY HOSPITAL INTENSIVE CARE UNIT BENEFIT	$200 per day (max 30 days per confinement)

*This is a summary. Refer to plan documents for details.

PER PAY PERIOD COSTS	
EMPLOYEE ONLY	$13.38
EMPLOYEE + SPOUSE	$23.58
EMPLOYEE + CHILD(REN)	$18.12
EMPLOYEE + FAMILY	$26.40

Dental Benefits

Brushing your teeth and flossing are great, but don't forget to visit the dentist, OrthoLoneStar offers affordable plan options for routine care and beyond, and we are happy to share for the first time the company will make a contribution to help offset some of the costs for coverage is available from Blue Cross Blue Shield.

Network Dentists

If you use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Blue Cross Blue Shield at www.bcbstx.com.

Dental Premiums

Premium contributions for dental are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your per pay period premium.

Dental Plan Summary

This chart summarizes the 2023 dental coverage provided by Blue Cross Blue Shield.

	BASE				BUY-UP			
	MONTHLY			PER PAY PERIOD	MONTHLY			PER PAY PERIOD
	TOTAL PREMIUM	EMPLOYER COST	EMPLOYEE COST	EMPLOYEE COST	TOTAL PREMIUM	EMPLOYER COST	EMPLOYEE COST	EMPLOYEE COST
EMPLOYEE ONLY	$37.51	$7.00	$30.51	$14.08	$46.52	$7.00	$39.52	$18.24
EMPLOYEE + SPOUSE	$72.41	$7.00	$65.41	$30.19	$90.04	$7.00	$83.04	$38.33
EMPLOYEE + CHILD(REN)	$69.78	$7.00	$62.78	$28.98	$86.29	$7.00	$79.29	$36.60
EMPLOYEE + FAMILY	$107.67	$7.00	$100.67	$46.46	$133.56	$7.00	$126.56	$58.41
CALENDAR YEAR DEDUCTIBLE								
INDIVIDUAL	$50				$50			
FAMILY	$150				$150			
CALENDAR YEAR MAXIMUM								
PER PERSON	$1,000				$1,500			
COVERED SERVICES								
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers, Panoramic X-rays	100%				100%*			
BASIC SERVICES Full Mouth X-rays, Fillings, Oral Surgery, Simple Extractions	80%*				90%*			
MAJOR SERVICES Oral Surgery, Complex Extractions, Denture Adjustments and Repairs, Root Canal Therapy, Periodontics, Crowns, Dentures, Bridges	50% *				60%*			
ORTHODONTICS Age limitation for dependent child(ren) is 26	50%				50%			
ORTHODONTIC LIFETIME MAXIMUM	$1,000				$1,500			

*After Deductible

Thoughts & Tips: Oral health is linked to your overall health — keeping your mouth healthy can protect you from cardiovascular disease, pregnancy complications, and pneumonia.

Vision Benefits

Don't wear glasses? Even you shouldn't skip an annual eye exam! OrthoLoneStar provides you and your family access to quality vision care with a comprehensive vision benefit through Blue Cross Blue Shield.

Vision Premiums

Premium contributions for vision are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your per pay period premium.

Vision Plan Summary

This chart summarizes the 2023 vision coverage provided by Blue Cross Blue Shield.

	VISION (EYEMED NETWORK)		
PER PAY PERIOD COSTS			
EMPLOYEE ONLY	$3.15		
EMPLOYEE + SPOUSE	$5.99		
EMPLOYEE + CHILD(REN)	$6.30		
EMPLOYEE + FAMILY	$9.27		
	IN-NETWORK	**OUT-OF-NETWORK**	**FREQUENCY**
EXAMS			
COPAY	$10 Copay	Up to $30 reimbursement	Once per calendar year
LENSES			
SINGLE VISION	$25 Copay	Up to $25 reimbursement	Once per calendar year
BIFOCAL	$25 Copay	Up to $40 reimbursement	
TRIFOCAL	$25 Copay	Up to $55 reimbursement	
LENTICULAR	$25 Copay	Up to $55 reimbursement	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING AND EVALUATION	Up to $40	N/A	Once per calendar year
ELECTIVE	$150 allowance then 15% off above the allowance	Up to $120	
MEDICALLY NECESSARY	Paid in full	Up to $210	
FRAMES			
ALLOWANCE	$150 Retail Allowance, then 20% off above the allowance	Up to $75 reimbursement	Once every 2 years
OTHER SERVICES			
EXTRAS	Discount on Laser Vision Surgery	N/A	N/A

Thoughts & Tips: More than 150 million Americans use corrective eye wear to compensate for refractive errors.

Survivor Benefits

It's difficult to think about what would happen if something ever happened to you, but it's important to have a plan in place to make sure your family is provided for. Survivor benefits provide financial protection and security in the event of an absence or unexpected event. Securing Life insurance now ensures your family will be protected for the future.

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

OrthoLoneStar provides employees with Basic Life and AD&D insurance as part of your basic coverage through Blue Cross Blue Shield, which guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an employee's benefits after death.

Your Basic Life and AD&D insurance benefit is $50,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you elect to waive other coverage.

What's a beneficiary?

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by OrthoLoneStar. You receive the benefit payment for a dependent's death under the Blue Cross Blue Shield insurance.

Name a primary and contingent beneficiary to make your intentions clear. Make sure to indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches majority age at 18. If you need assistance, contact Human Resources Department or your own legal counsel.

Voluntary Life and AD&D Insurance

Life and AD&D benefits are an important part of your family's financial security. The basic benefits provided to you by OrthoLoneStar may not be enough to cover expenses in a time of need. Therefore, extra coverage is available to protect you and your family. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

BASIC EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	$50,000
WHO PAYS	OrthoLoneStar
BENEFITS PAYABLE	If you die or become applicably disabled while covered under the plan
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	Increments of $10,000
WHO PAYS	Employee
BENEFITS PAYABLE	If you die or become applicably disabled while covered under the plan
MAXIMUM BENEFIT	$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	If enrolling after your initial enrollment opportunity or when electing over $200,000
VOLUNTARY SPOUSE LIFE/AD&D	
COVERAGE AMOUNT	Increments of $5,000
WHO PAYS	Employee
BENEFITS PAYABLE	If your dependent dies or becomes applicably disabled while covered under the plan
MAXIMUM BENEFIT	$250,000 not to exceed 50% of employee benefit
EVIDENCE OF INSURABILITY (EOI) REQUIRED	If enrolling after your initial enrollment opportunity or when electing over $50,000
VOLUNTARY CHILD LIFE/AD&D	
COVERAGE AMOUNT	Live birth to 6 months: $1,000 6 months to 26 years: $10,000
WHO PAYS	Employee
BENEFITS PAYABLE	If your dependent dies or becomes applicably disabled while covered under the plan
MAXIMUM BENEFIT	$10,000 not to exceed 50% of employee Amount
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No

Survivor Benefits

VOLUNTARY LIFE INSURANCE	
RATES/$1,000 (MONTHLY)	
AGE (AS OF JANUARY 1, 2023)	EMPLOYEE/SPOUSE*
< 25	$0.054
25 - 29	$0.064
30 - 34	$0.086
35 - 39	$0.097
40 - 44	$0.107
45 - 49	$0.161
50 - 54	$0.247
55 - 59	$0.461
60 - 64	$0.708
65 - 69	$1.363
70 and over	$2.211

You must elect coverage for yourself in order to cover your dependents
*Spouse premium rates based on employee's age

VOLUNTARY AD&D INSURANCE	
PREMIUM RATES – $1,000 (MONTHLY)	
Employee	$0.021
Spouse	$0.029

VOLUNTARY CHILD LIFE/AD&D INSURANCE	
PREMIUM RATES – $1,000 (MONTHLY)	
Life	$0.197
AD&D	$0.051

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

$	÷ 1,000 =	$	x Age Based Rate =	$
Benefit Elected				Monthly Premium

Income Protection

Maintaining your quality of life counts on your income. OrthoLoneStar offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury. A portion of your income is protected until you can return to work or until you reach retirement age.

Voluntary Short Term Disability (STD) Insurance (100% Employee Paid)

Short Term Disability (STD) benefits are available for purchase on a voluntary basis. STD insurance replaces 60% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or HR Department for details.

WEEKLY BENEFIT	60% of weekly earning to a maximum of $1,500, but no less than $25
ELIMINATION PERIOD	7 days
BENEFITS ARE PAYABLE	Up to 12 weeks following the elimination period or until LTD begins

VOLUNTARY STD INSURANCE	
RATES - PER $10 OF COVERED BENEFIT (WEEKLY)	
AGE (AS OF JANUARY 1, 2023)	RATE
< 20	$0.917
20 - 24	$0.919
25 - 29	$0.973
30 - 34	$0.855
35 - 39	$0.769
40 - 44	$0.688
45 - 49	$0.699
50 - 54	$0.825
55 - 59	$1.050
60 - 64	$1.280
65 - 69	$1.308
70 and over	$1.479

Basic Long Term Disability (LTD) Insurance (100% Employer Paid)

Long Term Disability (LTD) benefits are available at no cost. LTD insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or HR Department for details.

MONTHLY BENEFIT	60% of monthly earnings to a maximum of $10,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

Thoughts & Tips:

Short-term disability benefits can be used when a condition puts you out of work temporarily such as pregnancy, surgery rehabilitation or severe illness.

Additional Benefits

OrthoLoneStar cares about you and wants you to succeed in all aspects of life, so we offer a variety of additional benefits to help make your day-to-day easier.

Employee Assistance Program

We know life is complicated, and sometimes we all just need a little help. Our Employee Assistance Program (EAP) helps manage your and your family's total health, including mental, emotional and physical. And it comes at no cost to you — whether you're enrolled in a company-sponsored medical plan or not.

Through this program, you have access to mental health assistance and legal and financial help from a number of professionals. You have 24-hour access to helpful resources by phone, and the EAP benefit includes three face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with Carrell Clinic. You may access information, benefits, educational materials and more either by phone at 866-899-1363 or visit www.guidanceresources.com (Company Code: DISRES).

The Program provides referrals to help with:

- Emotional Health and Well-Being
- Alcohol or Drug Dependency
- Marriage or Family Relationship Problems
- Job Pressures
- Stress, Anxiety, Depression
- Grief and Loss
- Financial or Legal Advice

Will Preparation

Will Prep Services offers a range of services to help you communicate how you want to provide for your loved ones. To access these services, you may call 800-769-9187 or go to www.BeneficiaryResource.com (User Name: beneficiary). Services include:

- Free Will Prep: Members have access to an interactive web-based program to develop their own will, free of charge, or for a modest charge can opt for the attorney assisted will preparation.
- Estate Planning Documents Library including Power of Attorney, Living Wills, Advances Health Care Directives and more
- Telephonic consultations with an Estate Planner

Travel Assistance

Travel Aid provides members with travel assistant when an emergency strikes and you are far from home. Services include World Wide Physician & Hospital Referrals, Emergency RX replacement, Evacuation and Repatriation, Medical Transport, Lost Document Replacement, Return of minor children, and much more. For assistance, call 877-715-2593.

Pet Insurance

A plan that's right for you and your pet

Save up to 20% on ASPCA Pet Health Insurance! Complete Coverage℠ can help you give your pet the best care possible with less worry about the cost. It offers robust coverage that you can customize for a fit that suits your pet's needs and feels right for your budget.

Coverage includes accidents, illnesses, cancer, hereditary conditions, alternative therapies, behavioral issues and more. You can also add preventive care at a low additional cost to cover things that help keep your pet healthy.

- Use any vet, specialist or emergency clinic
- Submit claims easily online, by fax or by mail
- Get your payouts fast by direct deposit or check
- Sign up in minutes anytime on any device or by phone
- www.aspcapetinsurance.com/OrthoLonestar

Prepaid Legal Coverage

LegalShield offers you and your family value, convenience and peace of mind by giving you low-cost access to attorneys for a wide variety of personal legal services. Payments are made conveniently and easily through payroll deductions. It's like having your own attorney on retainer, but for a lot less.

LegalShield

- Legal Consultation and Advise
- Court Representation
- Dedicated Law Firm
- Legal Document Prep and Review
- Uncontested Divorce (buy-up)
- Speeding Ticket Assistance
- Will Prep
- 24/7 Emergency legal Access
- Mobile App

	BASE	BASE + DIVORCE
BI-WEEKLY CONTRIBUTIONS		
EMPLOYEE + FAMILY (ONE RATE COVERS ALL)	$7.04	$8.19

Identity Theft Protection

InfoArmor, a leader in the benefits space for 12+ years, delivers the next generation of identity protection with PrivacyArmor®, a proactive monitoring service that alerts you at the first sign of fraud.

Our tools find what others can't. Get alerts for credit inquiries, financial transactions, new accounts and more. If fraud occurs, our Privacy Advocates® fully manage and restore your identity, and our $1 million insurance policy covers any out-of-pocket costs associated with restoring your identity.

With PrivacyArmor:

- Dark web monitoring
- Rapid alerts
- High-risk transaction monitoring
- Financial transaction monitoring
- Monthly updated credit score and annual credit report from TransUnion
- Accounts secured with two-factor authentication
- Human-sourced intelligence
- Social media reputation monitoring
- Digital wallet storage and monitoring
- Deceased family member coverage

	PRIVACY ARMOR	PRIVACY ARMOR PLUS
BI-WEEKLY CONTRIBUTIONS		
EMPLOYEE ONLY	$3.67	$4.59
EMPLOYEE + FAMILY*	$6.44	$8.28

*Covering one or more family members

Glossary

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount, as determined by your insurance plan, you pay for healthcare services received.

Deductible – The amount you owe for healthcare services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

- **Healthcare FSA** – A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA** – A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in an HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, so if you change jobs your account goes with you.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, there are no copays and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

Network – A group of physicians, hospitals and other healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network** – Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network** – Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating** – Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage, make changes or decline coverage.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

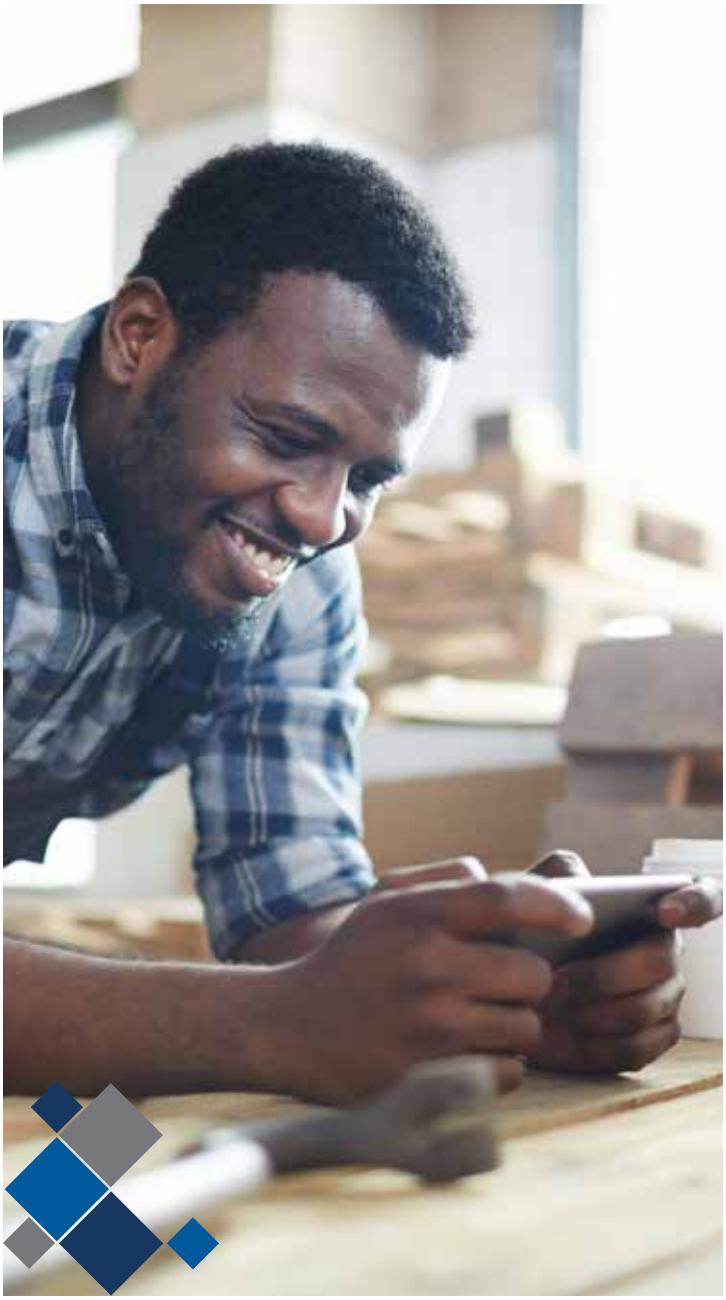
Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – Also known as the UCR (Usual, Customary, and Reasonable) amount. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, your insurance carrier provides you with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) - The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.



Required Notices

Important Notice from OrthoLoneStar, LLC About Your Prescription Drug Coverage and Medicare under the BlueCross BlueShield - PPO, - $3,000 HDHP, and - $5,000 HDHP Plan(s)

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. OrthoLoneStar, LLC has determined that the prescription drug coverage offered by the BlueCross BlueShield - PPO, - $3,000 HDHP, and -$5,000 HDHP plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current OrthoLoneStar, LLC coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information about This Notice or Your Current Prescription Drug Coverage…

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

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2023
Name of Entity/Sender:	OrthoLoneStar, LLC
Contact—Position/ Office:	Human Resources
Address:	8210 Walnut Hill Ln Suite 130 Dallas, TX 75231
Phone Number:	214-750-1207

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 214-750-1207.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 214-750-1207.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 214-750-1207.

Important Contacts

MEDICAL
Blue Cross Blue Shield
800-521-2227
www.bcbstx.com
Policy #: PPO 296416
HDHP 296417

TELEMEDICINE
Blue Cross Blue Shield of Texas
888-680-8646
www.MDLive.com

DENTAL
Blue Cross Blue Shield
800-541-7846
www.bcbstx.com
Policy #: 296418

VISION
Blue Cross Blue Shield
866-723-0514 or member services at 855-556-8796
https://member.eyemedvisioncare.com/member/en
Policy #: F025695

HEALTH SAVINGS ACCOUNT
HSA Bank
800-357-6246
www.hsabank.com

FLEXIBLE SPENDING ACCOUNT
WEX Inc.
866-451-3399
www.wexinc.com

SUPPLEMENTAL INSURANCE (ACCIDENT, CRITICAL ILLNESS, HOSPITAL INDEMNITY)
Allstate
800-521-3535
www.allstatebenefits.com/mybenefits

ID THEFT PROTECTION
InfoArmor
800-789-2720
www.myprivacyarmor.com

PET DISCOUNT/INSURANCE
ASPCA
www.aspcapetinsurance.com/OrthoLonestar

PRE-PAID LEGAL ASSISTANCE
LegalShield
800-654-7757
Benefits.legalshield.com/ortholonestar

LIFE/AD&D AND DISABILITY
Blue Cross Blue Shield
800-525-4542
www.bcbstx.com
Policy #: F025695

EMPLOYEE ASSISTANCE PROGRAM
866-899-1363
www.guidanceresources.com
Company Code: DISRES

CARRELL CLINIC HUMAN RESOURCES DEPARTMENT
9301 N. Central Expressway, Tower I,
Suite 400
Dallas, TX 75231
214-378-3318

Benefits in Hand
Directly access benefits information with the Lockton BenefitLink Mobile App. You'll find benefits contact information, Lockton's digital Lifestyle Benefits newsletter and more!

Download on the App Store
GET IT ON Google Play

Username: ortholonestar
Password: benefits

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