2025 Guide to Employee Benefits

Invited

Explore your benefit options.

INVITED EMPLOYEES:

Welcome to Invited – we're pleased to share that you are now benefits eligible!

Our top priority is to support you and your family in enhancing your overall health and wellbeing. We're committed to providing you with cost-effective benefit plan options, and we're excited to share the details of these plans with you.

Our plans offer a range of options to suit your needs. From our Aetna **SimplePay** plan that has *no deductibles*, which could be more cost-effective for you knowing ahead of time copays per service, to our United Healthcare (UHC) **High Deductible** health plan with lower paycheck contributions but higher out-of-pocket costs when visiting the doctor. We also offer our UHC **Choice Plus PPO** plan with higher weekly paycheck contributions, a lower annual deductible but you share in greater costs. *More information can be found in this guide.*

FOCUS FOR YOUR 2025 BENEFITS

1. *Investing in you and working together to manage costs.*
    - Healthcare costs are on the rise, with Invited experiencing a 12% increase in healthcare expenses for 2025. Instead of passing on a portion of these rising costs to Employees, we will keep your weekly paycheck deductions flat ONLY IF employees and their spouse complete a preventive diagnostic screening.
    - **You will have 90 days after your start date to submit the preventive diagnostic screening.**
    - Ready to save? Follow these easy steps (also outlined in detail on page 10).
      STEP 1: Register with Quest. Visit the Benefits portal (**InvitedBenefits.com/DiagnosticScreening**) and follow the steps to create an account with Quest.
      STEP 2: Select one of these options to submit your preventive diagnostic screening within 90 days of your benefits effective date.
        - *Submit a previous preventive diagnostic screening to Quest.*
        - *Book an appointment at an available Quest location.*
2. *Helping Employees better understand their options.*
    - Throughout this process, you will be educated on the various plan options, the advantages and differences between them, so you can make a more informed decision about your benefits.
    - We will help clarify key concepts related to benefits (e.g., deductibles, copays, premiums, surcharges, etc.).
    - We'll also share more throughout the year about how you can make better choices for your health and pocket book, including when to go to your doctor, urgent care or an emergency room.
3. *At your fingertips – tools and resources to help you decide.*
    - Utilize this guide, visit the Benefits portal (**InvitedBenefits.com**) and attend an education session to learn more about the incredible offerings available to you. Learn how actual Employees have made the most of their plan and/or available tools to easily get the help they needed.
    - Take advantage of our interactive, benefits decision-making tool on the Benefits portal (**InvitedBenefits.com**) to see which plan may be best for you and your family.
    - Through the HealthJoy App, Employees enrolled in one of our medical plans can get free telehealth medical care and mental health visits, 24/7 access to a healthcare concierge (answer medical questions, recommend a local physician or specialist, help resolve claims, etc.), track your plans and access cards, as well as help find low prices on your prescriptions.
    - Visit the 'Resources' tab on the Benefits portal (**InvitedBenefits.com**) to get contact information for all benefit vendors and offerings.
    - Reach out to an Invited Benefits specialist for assistance – 833-964-2967 or **Invitedbenefits@avantsb.com**.

TAKE ADVANTAGE OF MENTAL HEALTH CARE AND TREATMENT – AT NO COST TO YOU.

More than three-quarters of adults are negatively impacted by stress.[1] That's why we strive to remove barriers for you and/or your family members in seeking the care you need, especially for mental health support. Research indicates that mental health counseling can be highly effective in supporting those in need. While medication may alleviate certain symptoms, counseling addresses underlying issues and helps individuals work through and overcome them.[2] We offer several benefits to assist you in finding immediate access to high quality providers.

- **HealthJoy Telehealth:** If you are enrolled in one of our medical plans, the HealthJoy App gives you access to FREE virtual appointments with licensed physicians for general medical issues and mental health needs – appointments are available 24 hours a day, 7 days a week via video or phone.
- **SupportLinc Employee Assistance Program (EAP):** Offers expert guidance to help address and resolve everyday situations, with the first 6 sessions with a licensed counselor available at NO COST. Access support whenever, wherever is most convenient for you (e.g., phone, email, live chat or live session) – **www.supportlinc.com** (username: invitedclubs) or 888-881-5462.
- **New in 2025:** We are expanding our mental health care under the UHC Choice Plus PPO plan by offering all office visits - whether with an in-network or out-of-network mental health provider - at a $10 copay per visit. We will always encourage you to select Tier 1 providers that are in-network to save you money; however, we know that patients have long-standing relationships with mental health providers who are critical in driving their care.

NEXT STEPS

As a company, we remain committed to assessing the cost implications for you and taking shared responsibility for your health. We encourage you to also make choices to manage costs (e.g., participate in preventive diagnostic screening, consider SimplePay, use telehealth and the HealthJoy app, your primary care doctor or urgent care instead of the emergency room, etc). Be sure to review the details in this guide closely to take advantage of all our benefits have to offer.

Note: To ensure you have benefits coverage, you MUST complete your enrollment within **30 days** of your start date. If you do not make your benefit elections during your **30-day** enrollment period, you will not have benefits coverage for 2025.

Sincerely,

Sherry Vidal-Brown, Chief Human Resources Officer

[1] **American Psychological Association**, Stress in America, 2022
[2] **https://www.nimh.nih.gov/health/topics/psychotherapies**

Table of Contents

This guide highlights the main features of many of the benefit plans sponsored by Invited. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. Invited reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Enrollment

You and your family have unique needs, which is why Invited offers a variety of benefit plans from which you may choose. To ensure you have benefits coverage you **MUST** complete your enrollment within 30 days of employment or becoming benefits eligible. If you don't make benefit elections during your 30-day enrollment period, you will not have benefits for 2025.

ELIGIBILITY

You are eligible to participate if you are an active, full-time Employee working a minimum of 30 hours per week and have met the required waiting period. This includes eligibility to participate in Medical, Dental, Vision, Life and AD&D, and Flexible Spending Accounts, as well as any additional benefits.

ELIGIBLE DEPENDENTS

Dependents eligible for coverage in an Invited benefits plan include:

- Your legal spouse (or common-law spouse in states that recognize common-law marriages)
- Dependent children up to age 26 (includes biological, adopted, stepchildren, legal guardian, legal ward or children you are required to cover under terms of a Qualified Medical Child Support Order (QMCSO))
- Dependent children, regardless of age, who are incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26

WHEN DOES COVERAGE BEGIN?

New hires are eligible the first of the month following date of hire. Similarly, Employees moving from Part-Time to Full-Time are eligible the first of the month following their employment status change.

Due to IRS regulations, once you have made your choices, you won't be able to change your benefits until the next enrollment period, unless you experience a Qualifying Life Event – see page 9.

INVITED BENEFITS WEBSITE AND ENROLLMENT SUPPORT

Access all benefits information at www.invitedbenefits.com. Here you will find the self–enrollment guide, this benefit booklet, videos, plan summaries, an interactive decision tool and more.

Deciding on which benefits you may need can feel overwhelming, but we are here to help. We have benefits specialists who will walk you through the Group Benefit Plans made available to you so that you can confidently choose which benefits are best for you and your family.

- To speak with an Invited Benefits Specialist, call (833) 964-2964.
- Email an Invited Benefits Specialist at **Invitedbenefits@avantsb.com**.
- To schedule an appointment with a Benefits Specialist, click **here**.
- You can also use the decision tool to help you select the best plans for you. Scan the QR code or visit **www.invitedbenefits.com/voya/** to get started.

WHEN DOES COVERAGE END?

Your Medical, Dental and Vision benefits end the last day of the month in which your employment ends. All other benefits (e.g., Life and AD&D, Short-Term and Long-Term Disability, Voluntary) end on the date of termination.

BEFORE YOU ENROLL

- Carefully review the benefits listed in this guide and determine the Medical, Dental, Vision and other coverage that's best for you and your family
- Ensure family members meet the eligibility requirements
- Understand the cost of the plans you selected
- Log in to Oracle (if you have an account) or Register (new users) at **www.myclublifeonline.com**
- Select, review and submit your desired coverage
- Be sure to complete beneficiary information for Life and AD&D benefits
- If you have any questions, call an Invited Benefits Specialist at 833-964-2967 or email **Invitedbenefits@avantsb.com**.

We have a tool to help you select the best plans for you and your family. Scan the QR code to get started or visit the link below:
www.invitedbenefits.com/voya/

ELIGIBILITY

If you enroll your dependent(s) in Medical Plan coverage, proof of dependent status is required. **Dependent Verification documents must be received no later than 30 days after your benefits effective date**.

DEPENDENT VERIFICATION DOCUMENTS

- Upload to **www.myclublifeonline.com**
  - To load the documents to **www.myclublifeonline.com**, select the Benefits icon. On the Benefits screen, select the Dependent Verification Documents box and select the Add button in the right corner of the Document Records page.
- Acceptable Verification Documents:
  - Birth certificate
  - Marriage license
  - Proof of guardianship
  - Proof of adoption

UNVERIFIED DEPENDENT(S)

If the valid dependent verification documentation is not received within **30 days** of your benefits effective date, the dependent(s) coverage in the Invited Medical plan will not be active. Only your coverage of verified dependent(s) will be active in the Invited Medical plan.

Steps to Enroll

OPTION 1:

SELF ENROLL ONLINE VIA ORACLE at: www.myclublifeonline.com.

OPTION 2:

WANT TO SPEAK WITH A LICENSED BENEFITS SPECIALIST?

- **Call: 833-964-2967**
- **Email: Invitedbenefits@avantsb.com**
- **Schedule an appointment by clicking here.**

Get Ready to Enroll

Log in to Oracle HCM at **myclublifeonline.com**.

Have an **InvitedClubs.com** email? Click the “Company Single Sign On” button.

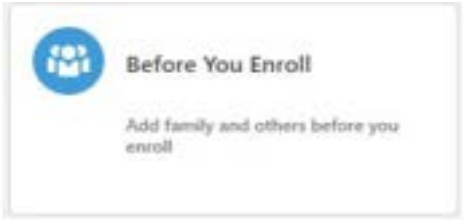
Don’t have an **InvitedClubs.com** email? **Enter your User ID and Password. Then click the “Sign In” button.**

User IDs are **firstname.lastname** but may include a number or middle initial if more than one match exists. Example firstname.m.lastname

Use the “Forgot Password” link to reset your password. Password reset emails are sent to the email address in your Oracle HCM profile. If you are unsure of what that is or don’t have access to that email, contact the Invited Help Desk at **(972) 888-7777**.

From the “Me” dashboard, click the “Benefits” app.

Click the “Before You Enroll” card.



Full-Time Hourly Employees: Access complete Oracle enrollment instructions, click here.

Full-Time Salaried Employees: Access complete Oracle enrollment instructions, click here.

Mid-Year Qualifying Events

When one of the following events occurs, you have **30 days** from the date of the event to notify Invited's Benefits Department and/or request changes to your coverage. Contact the Benefits Department at 833-964-2967.

BENEFITS ALLOWED TO CHANGE										
QUALIFYING LIFE EVENT	MEDICAL	DENTAL	VISION	EMPLOYEE LIFE	SPOUSE LIFE	CHILD LIFE	DEPENDENT CARE	HEALTH CARE FSA	BENEFICIARIES	DOCUMENTATION
Change in marital status: **Marriage** **Divorce or Annulment** **Legal Separation** **Domestic Partner Dissolution** **Death of Spouse**	√	√	√		√		√	√	√	Marriage Certificate Divorce Decree Final Court Document Notarized Statement of Disenrollment Death Certificate
Change in the number of dependents: **Birth** **Adoption** **Guardianship of a Child** **Death of a Dependent**	√	√	√			√	√	√	√	Birth Certificate Hospital Announcement Adoption Agreement Court Decree for Guardianship Death Certificate
Dependent Loses Other Coverage	√	√	√				√	√	√	Proof of Loss of Coverage, such as termination letter; Certificate of Credible Coverage
Dependent Gains Other Coverage	√	√	√				√	√	√	Proof of Coverage with start date of benefits and name(s) of covered dependents
A change in Employee's, spouse's or dependent's work hours (Including a switch between full and part-time status)	√	√	√				√	√	√	Proof of loss of Coverage due to employment status change, such as a Certificate of Credible Coverage or letter from the company
Change in Dependent Care Costs							√			Letter from your Day Care Provider
Court Ordered Dependent, add or drop from coverage	√	√	√			√	√	√	√	Contact your Benefits Team Directly

Preventive Diagnostic Screenings

As an Invited Employee, you have the opportunity to participate in a preventive diagnostic screening. Not only will you learn important information about your health, **but can also avoid paying up to $780 more ($1,560 with spouse) for your medical plan coverage in 2025**!

INVEST IN YOUR HEALTH

Our priority is to support you and your family in improving your overall state of health and wellbeing. An important step in that journey is investing in your own health by taking advantage of our benefits, such as a preventive diagnostic screening.

3 in 5 US adults have avoided or delayed in-person healthcare during the pandemic

67% of Americans have a chronic health condition, and nearly 1 in 3 say their condition has worsened since the pandemic began

2 in 5 Americans are concerned that they may have an undiagnosed health condition

So what IS a preventive diagnostic screening?

Preventive diagnostic screenings are tests/exams that can help detect health risk factors in their earliest stages — when you have the best chance to avoid developing chronic medical conditions (e.g., obesity, diabetes, high blood pressure), diseases (e.g., cancer, heart or liver disease), or having a catastrophic health event (e.g., heart attack, stroke). There are a variety of screenings ranging from blood tests to mammograms, to colonoscopies, etc.

If you enroll in an Invited medical plan option, we encourage you and your covered spouse to complete a blood test for your preventive diagnostic screening.

TAKE ACTION WITHIN 90 DAYS OF YOUR BENEFITS EFFECTIVE DATE

Employees and spouses will have the option of returning a Physician Results Form indicating a preventive diagnostic screening (blood work) was completed or going to a lab service center (Quest Patient Service Center).

STEP 1: Register Yourself and Your Covered Spouse

- **Visit my.questforhealth.com** to create your account.
- **Registration Key:** InvitedClubs
- **Use your Employee ID:** Your employee ID is what you use to clock in. It can also be found on the top left of your pay check. If you are unable to find your employee ID, email **employeesupport@invitedclubs.com**.
- **Enter your Spouse ID:** Use your employee ID *with an S on the end*.
- Complete the steps to register and verify your information.
- **Click here** for step-by-step instructions on how to complete your registration on Quest's website.
- If you are unable to register online, please email a Benefits Specialist at **Invitedbenefits@avantsb.com**.

STEP 2: Select an Option to Complete/Submit Your Screening

Option 1: Submit a Physician Results Form

- Select this option if you want your physician to perform your screening or if you already visited your physician for your annual bloodwork within the last year.
- Download the form from **my.questforhealth.com**.
- Provide it to your physician to fill out the form (preventive diagnostic screening).
- Upload the completed form with your screening results to **my.questforhealth.com** or your physician can fax in the completed form to 844-560-5221 **within 90 days of your benefits effective date**.
- **Click here** for step-by-step instructions on how to order a physician results form.

Preventive Diagnostic Screenings

Option 2: Visit a Quest Patient Service Center

Select this option to book an appointment at a Quest Diagnostics® Patient Service Center at a lab closest to you. Log in to the Quest site to search for a location, **but don't delay in making an appointment as results must be received within 90 days of your benefits effective date**.

Step 3: Attend Your Scheduled Screening

- Remember to fast nine or more hours before your scheduled appointment, drink plenty of water, and take any prescribed medications during the fasting period.
- Arrive on time for your scheduled screening.

Step 4: Review Your Results

- Five to seven days after your screening is complete, you can review your results at **my.questforhealth.com**.
- All individual results are confidential and not shared with Invited.
- Review your results with a board-certified provider via Quest's Virtual Care app, available to you through the end of the year.
- You can ask a clinical care team questions about your results and receive personalized guidance to take next steps.

Step 5: Avoid a Medical Plan Surcharge in 2025

- If you do not complete a preventive diagnostic screening within 90 days of your benefits effective date, you will pay up to a $30 bi-weekly* surcharge on your medical plan which appears as a deduction on your paycheck.
- If you choose to cover your spouse on an Invited medical plan option in 2025 and your spouse does not complete a preventive diagnostic screening within 90 days of your benefits effective date, up to a $30 bi-weekly* surcharge will appear as a deduction on your paycheck.

**If you are an employee that is paid weekly, you and/or your covered spouse will pay up to a $15 weekly surcharge.*

INVITED MEDICAL PLAN OPTIONS			
	2025	2025	2025
NO PREVENTIVE DIAGNOSTIC SCREENING	**WEEKLY SURCHARGE**	**BI-WEEKLY SURCHARGE**	**ANNUAL SURCHARGE**
Employee Only	Up to $15.00	Up to $30.00	Up to $780.00
Employee OR Spouse	Up to $15.00	Up to $30.00	Up to $780.00
Employee AND Spouse	Up to $30.00	Up to $60.00	Up to $1560.00

Your screening results are confidential and individual screening results will not be shared with Invited. The results of your preventive diagnostic screening, including your bloodwork, do not affect your medical plan coverage.

Notice of Reasonable Alternatives

All Invited benefits-eligible employees can participate in a preventive diagnostic screening to avoid paying a surcharge on 2025 medical plan premiums. If you think you might be unable to complete the preventive diagnostic screening, you might qualify for an opportunity to avoid the surcharge by different means. Contact an Invited Benefits Specialist within 90 days of your benefits effective date at (833) 964-2967 and we will work with you (and if you wish, with your physician) to find an alternative to avoid the surcharge.

Medical Plan Options Overview

Invited offers several medical plan options to meet your specific needs. Please take the time to review the detailed materials to understand each option.

	AETNA SIMPLEPAY HEALTH PLAN		UHC HIGH DEDUCTIBLE HEALTH PLAN		UHC CHOICE PLUS PPO PLAN		UHC MINIMUM ESSENTIAL COVERAGE	
NETWORK COVERAGE	IN-NETWORK	OUT-OF-NETWORK*	IN-NETWORK	OUT-OF-NETWORK*	IN-NETWORK	OUT-OF-NETWORK*	IN-NETWORK	OUT-OF-NETWORK
PER PAYCHECK DEDUCTIONS	$$$		$$		$$$$		$	
INSURANCE COMPANY	AETNA/CVS HEALTH		UHC/OPTUMRX		UHC/OPTUMRX		UHC/OPTUMRX	
Preventive Care Services by November 30th	Free	Not Covered	Free	Not Covered	Free	Not Covered	Free	Not Covered
Medical Telehealth Visit (HealthJoy)		Not Applicable		Not Applicable		Not Applicable		Not Applicable
Mental Telehealth Visit (HealthJoy)		Not Applicable		Not Applicable		Not Applicable		Not Applicable
Primary Care Physician Visit	Tier 1 $30 Tier 2 $40 Tier 3 $70	Tier 1 $85 Tier 2 $85 Tier 3 $85	Tier 1 Deductible then 20% Tier 2 Deductible then 40%	Deductible then 60%	Tier 1 $10 Tier 2 $40	Deductible then 60%	$25	Not Covered
Yearly Deductible	**None; Copays per Service**	**None; Copays per Service**	Individual $4,000 Family $8,000	Individual $10,000 Family $20,000	Individual $2,500 Family $6,250	Individual $4,000 Family $10,000	Not Applicable	Not Covered
Coinsurance	None; Copays per Service	None; Copays per Service	Tier 1 20% Tier 2 40%	Deductible then 60%	Tier 1 20% Tier 2 40%	Deductible then 60%	Not Applicable	Not Covered
Out-of-Pocket Max	Individual $6,500 Family $13,000	Individual Unlimited Family Unlimited	Individual $8,000 Family $16,000	Individual $75,000 Family $150,000	Individual $7,900 Family $15,800	Individual $75,000 Family $150,000	Individual $9,100 Family $18,200	Not Covered
Pretax Savings Account	Health Flexible Spending Account Up to $3,200		Health Savings Account Up to $4,300 Individual or Up to $8,550 Family		Health Flexible Spending Account Up to $3,200		Health Flexible Spending Account Up to $3,200	

*__Out-of-Network__: In addition to the out-of-pocket responsibility noted above, you are responsible for any costs charged by the provider that exceed the reasonable charge as determined by the health plan.

Medical Plan Options – Bi-Weekly Paycheck Deductions

AETNA SIMPLEPAY HEALTH PLAN				
	With Screening		No Screening	
	BI-WEEKLY RATE		BI-WEEKLY RATE	BI-WEEKLY SURCHARGE
Employee Only	**$79.38**	**Employee Only**	**$109.38**	$30.00
Employee + Spouse	**$238.15**	**Employee + Spouse** EE OR SP Without Screening	**$268.15**	$30.00
		Employee + Spouse EE AND SP Without Screening	**$298.15**	$60.00
Employee + Child(ren)	**$196.03**	**Employee + Child(ren)**	**$226.03**	$30.00
Employee + Family	**$299.72**	**Employee + Family** EE OR SP Without Screening	**$329.72**	$30.00
		Employee + Family EE AND SP Without Screening	**$359.72**	$60.00

UHC HIGH DEDUCTIBLE HEALTH PLAN				
	With Screening		No Screening	
	BI-WEEKLY RATE		BI-WEEKLY RATE	BI-WEEKLY SURCHARGE
Employee Only	**$43.92**	**Employee Only**	**$73.92**	$30.00
Employee + Spouse	**$197.64**	**Employee + Spouse** EE OR SP Without Screening	**$227.64**	$30.00
		Employee + Spouse EE AND SP Without Screening	**$257.64**	$60.00
Employee + Child(ren)	**$158.11**	**Employee + Child(ren)**	**$188.11**	$30.00
Employee + Family	**$254.74**	**Employee + Family** EE OR SP Without Screening	**$284.74**	$30.00
		Employee + Family EE AND SP Without Screening	**$314.74**	$60.00

UHC CHOICE PLUS PLAN				
	With Screening		No Screening	
	BI-WEEKLY RATE		BI-WEEKLY RATE	BI-WEEKLY SURCHARGE
Employee Only	**$104.37**	**Employee Only**	**$134.37**	$30.00
Employee + Spouse	**$313.11**	**Employee + Spouse** EE OR SP Without Screening	**$343.11**	$30.00
		Employee + Spouse EE AND SP Without Screening	**$373.11**	$60.00
Employee + Child(ren)	**$257.73**	**Employee + Child(ren)**	**$287.73**	$30.00
Employee + Family	**$394.05**	**Employee + Family** EE OR SP Without Screening	**$424.05**	$30.00
		Employee + Family EE AND SP Without Screening	**$454.05**	$60.00

UHC HEALTHLY START MEC PLAN				
	With Screening		No Screening	
	BI-WEEKLY RATE		BI-WEEKLY RATE	BI-WEEKLY SURCHARGE
Employee Only	**$29.00**	**Employee Only**	**$42.00**	$13.00
Employee + Spouse	**$52.08**	**Employee + Spouse** EE OR SP Without Screening	**$65.08**	$13.00
		Employee + Spouse EE AND SP Without Screening	**$78.08**	$26.00
Employee + Child(ren)	**$52.08**	**Employee + Child(ren)**	**$65.08**	$13.00
Employee + Family	**$52.08**	**Employee + Family** EE OR SP Without Screening	**$65.08**	$13.00
		Employee + Family EE AND SP Without Screening	**$78.08**	$26.00

Medical Plan Options – Weekly Paycheck Deductions

AETNA SIMPLEPAY HEALTH PLAN				
	With Screening		No Screening	
	WEEKLY RATE		WEEKLY RATE	WEEKLY SURCHARGE
Employee Only	**$39.79**	**Employee Only**	**$54.79**	$15.00
Employee + Spouse	**$119.08**	**Employee + Spouse** Employee OR Spouse Without Screening	**$134.08**	$15.00
		Employee + Spouse Employee AND Spouse Without Screening	**$149.08**	$30.00
Employee + Child(ren)	**$98.02**	**Employee + Child(ren)**	**$113.02**	$15.00
Employee + Family	**$149.86**	**Employee + Family** Employee OR Spouse Without Screening	**$164.86**	$15.00
		Employee + Family Employee AND Spouse Without Screening	**$179.86**	$30.00

UHC HIGH DEDUCTIBLE HEALTH PLAN				
	With Screening		No Screening	
	WEEKLY RATE		WEEKLY RATE	WEEKLY SURCHARGE
Employee Only	**$21.96**	**Employee Only**	**$36.96**	$15.00
Employee + Spouse	**$98.82**	**Employee + Spouse** Employee OR Spouse Without Screening	**$113.82**	$15.00
		Employee + Spouse Employee AND Spouse Without Screening	**$128.82**	$30.00
Employee + Child(ren)	**$79.06**	**Employee + Child(ren)**	**$94.06**	$15.00
Employee + Family	**$127.37**	**Employee + Family** Employee OR Spouse Without Screening	**$142.37**	$15.00
		Employee + Family Employee AND Spouse Without Screening	**$157.37**	$30.00

UHC CHOICE PLUS PLAN				
	With Screening		No Screening	
	WEEKLY RATE		WEEKLY RATE	WEEKLY SURCHARGE
Employee Only	**$52.19**	**Employee Only**	**$67.19**	$15.00
Employee + Spouse	**$156.56**	**Employee + Spouse** Employee OR Spouse Without Screening	**$171.56**	$15.00
		Employee + Spouse Employee AND Spouse Without Screening	**$186.56**	$30.00
Employee + Child(ren)	**$128.87**	**Employee + Child(ren)**	**$143.87**	$15.00
Employee + Family	**$197.03**	**Employee + Family** Employee OR Spouse Without Screening	**$212.03**	$15.00
		Employee + Family Employee AND Spouse Without Screening	**$227.03**	$30.00

UHC HEALTHLY START MEC PLAN				
	With Screening		No Screening	
	WEEKLY RATE		WEEKLY RATE	WEEKLY SURCHARGE
Employee Only	**$14.50**	**Employee Only**	**$21.00**	$6.50
Employee + Spouse	**$26.04**	**Employee + Spouse** Employee OR Spouse Without Screening	**$32.54**	$6.50
		Employee + Spouse Employee AND Spouse Without Screening	**$39.04**	$13.00
Employee + Child(ren)	**$26.04**	**Employee + Child(ren)**	**$32.54**	$6.50
Employee + Family	**$26.04**	**Employee + Family** Employee OR Spouse Without Screening	**$32.54**	$6.50
		Employee + Family Employee AND Spouse Without Screening	**$39.04**	$13.00

Aetna SimplePay Health Plan

With SimplePay, you no longer have to worry about deductibles, coinsurance or bills from your provider. You simply get one monthly statement from SimplePay. The SimplePay App identifies top quality providers and shows you a price for every medical service, giving you control over your health care decisions.

Use the QR code to see if your current provider is in SimplePay's network.

SimplePay is designed to help you find high-quality, low-cost providers so you don't have to sacrifice getting great care to save money. With SimplePay, providers are categorized into three copay rankings based on the following criteria:

Quality Providers that have best in class training and certifications, aligned with good care outcomes.	**Relationship** Providers that are associated with top quality service lines at their facility.
Experience Providers that deliver positive patient experiences and outcomes.	**Efficiency** Providers that deliver the best care outcome by providing the appropriate amount of care.

Provider Ranking Legend

Tier 1 Provider	Tier 2 Provider	Tier 3 Provider
Meets all standards above	Meets most standards above	Meets minimum standards above

HOW IS SIMPLEPAY DIFFERENT FROM THE UNITEDHEALTHCARE (UHC) MEDICAL PLAN OPTIONS?

- **No Deductibles:** SimplePay has no annual deductible — you pay a flat dollar amount (called a copay) for all medical services and prescriptions from day one.
- **Out-of-Pocket Cost Certainty:** Know the price of every medical service ahead of time. No upfront out-of-pocket costs, add-ons or surprise bills.
- **Great Care and Value:** Easily locate high-quality providers at a predetermined cost for all services on the SimplePay App — from checkups to advanced procedures.
- **Payments are Made to SimplePay:**
  - When you visit a doctor or a facility for medical services, your provider will not collect your payment.
  - When you fill prescriptions through a network pharmacy, the pharmacy will not collect your payment.
  - Instead, SimplePay will track all your out-of-pocket costs (copays) and then send you a monthly statement.
  - SimplePay offers 0% financing for medical services and prescriptions.
- **Get One Monthly Statement:** You have the option to pay your medical bills out over time with 0% financing, with a credit card, link to your bank account or through payroll deductions. Additionally, when you pay your bill in full, you will receive 1.5% cash back to use towards your next bill! SimplePay is designed to save you time and money so you can spend time on the things you love.
- **Health Valet Service:** Your Health Valet can assist with a variety of different needs, such as finding quality providers, coordinating appointments with providers and answering questions on billing or coverage information.

Aetna SimplePay Health Plan

PLAN HIGHLIGHTS	SIMPLEPAY HEALTH PLAN
NETWORK	AETNA CHOICE POS2
	YOU PAY
CALENDAR YEAR DEDUCTIBLE	
Individual Deductible	None
Family Deductible	None
Coinsurance	None
CALENDAR YEAR OUT-OF-POCKET MAX	
Individual Out-Of-Pocket	$6,500
Family Out-of-Pocket	$13,000
OFFICE VISIT	
PCP Office Visit	**Tier 1:** $30 / **Tier 2:** $40 / **Tier 3:** $70
Specialist Office Visit	**Tier 1:** $65 / **Tier 2**: $85 / **Tier 3:** $140
General Medical Telemedicine (HealthJoy)	$0
Mental Health Telemedicine (HealthJoy)	$0
Urgent Care	$65
HOSPITAL SERVICES	
Inpatient Hospital	Varies by Treatment **Tier 1:** $3,130 / **Tier 2:** $4,175 / **Tier 3:** $6,500
Outpatient Hospital	Varies by Surgery **Tier 1:** $1,020 / **Tier 2:** $1,355 / **Tier 3:** $2,260
DIAGNOSTIC SERVICES	
Routine Labs	**Tier 1:** $20 / **Tier 2:** $30 / **Tier 3:** $45
Diagnostic Radiology/Labs	**Tier 1:** $90 / **Tier 2:** $120 / **Tier 3:** $195
Advanced Imaging	**Tier 1:** $315 / **Tier 2:** $415 / **Tier 3:** $695
EMERGENCY MEDICAL CARE	
Emergency Room	$580

RETAIL PHARMACY (30-DAY SUPPLY)

	CVS PHARMACY	IN-NETWORK PHARMACIES EXCLUDING CVS/WALGREENS	WALGREENS PHARMACY
Affordable Care Act Generic Drug	No Charge	No Charge	No Charge
Preventive Generic Drug	N/A	N/A	N/A
Generic Drug	$20	$25	$40
Preferred Brand Drug	$50	$60	$100
Non-Preferred Brand Drug	$75	$90	$150
Specialty Drugs	$200	$200	$200

THE SIMPLEPAY PAYMENT PLAN IS EASY

- Single monthly statement
- No payment at the time of service
- 0% financing
- Pay manually or autopay
- 1.5% cash back when you pay your bill in full

BILL PAYMENT IS DIFFERENT	
KNEE SURGERY AT AN OUTPATIENT FACILITY	
TODAY	**SIMPLEPAY**
Member receives bills & explanation of benefits for each provider.	**Member receives one monthly statement from SimplePay.**
All bills apply towards your deductible: UHC Choice Plus PPO $2,500 NEW UHC HDHP $4,000	No annual deductible: All bills are consolidated into a single copay.
Anesthesia Bill: You owe $$$	All Providers: You owe $1,020 (Tier 1)
Radiology Facility: You owe $$$	
Radiologist: You owe $$$	
Pathologist: You owe $$$	
Surgeon: You owe $$$$	
Surgery Center: You owe $$$$	
You pay each provider directly - typically, payment is required upfront.	You pay SimplePay directly - no payment is required upfront.

FINANCIAL ONBOARDING FORM

One of the benefit features included with your Aetna SimplePay plan is a financial line of credit, available to you up to your out-of-pocket maximum.

- Can be used to pay your out-of-pocket cost over an extended period of time at a 0% interest rate
- Automatically included with your plan election
- Does not require a credit check and will not impact your credit report

ACTION REQUIRED WITHIN 30 DAYS OF BENEFITS EFFECTIVE DATE

In order to offer 0% financing with no background check, you are required to sign a financial onboarding form and provide a payment method (e.g., bank account, credit card, paycheck, etc.) to receive your financial benefits. If you do not complete the financial onboarding form within 30 days of your benefits effective date, then you will automatically be enrolled in the UHC High Deductible Health Plan retro to your benefits effective date.

When completing this Financial Onboarding Form, you are agreeing to the following:

- Agree to pay your monthly statement balance either in full or to pay the minimum amount by the due date.
- Authorize the auto-payment of any balance due and not paid by the due date from either your personal account on file or as a payroll deduction.
- If you decide not to pay your statement balance in full, your line of credit will adjust based on your total balance. That amount may be higher or lower than the amount listed in your Financial Authorization agreement of $6,500, which serves only as an example in your document.

Please refer to the Financial Onboarding Form for additional details and terms associated with a line of credit.

UnitedHealthcare

UnitedHealthcare High Deductible Health Plan

Invited offers a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA). If you elect the HDHP, you can make pretax contributions to a savings account to help pay for out-of-pocket health care costs and/or save for retirement. *Use the QR code to see if your current provider is in UHC's network.*

- To have the advantage of contributing to an HSA, HDHPs are required to meet certain deductible requirements per the IRS. With the exception of preventive care services (e.g., annual physicals, health screenings and immunizations), you pay the contracted rate that has been negotiated between UHC and your provider (e.g., physician, pharmacy, etc.).
- Once your total out-of-pocket costs reach the deductible, you begin paying 20% of any remaining out-of-pocket costs until you reach your out-of-pocket maximum.

PLAN HIGHLIGHTS	HDHP PLAN
NETWORK	NEXUS
	YOU PAY
CALENDAR YEAR DEDUCTIBLE	
Individual / Family	$4,000 / $8,000
Coinsurance	Tier 1: 20% / Tier 2: 40%
CALENDAR YEAR OUT-OF-POCKET MAX	
Individual / Family	$8,000 / $16,000
OFFICE VISIT	
Primary Care Physician (PCP)	Tier 1: 20% after Deductible / Tier 2: 40% after Deductible
Specialist	Tier 1: 20% after Deductible / Tier 2: 40% after Deductible
Preventive Care Services	No Charge
General Medical Telemedicine (HealthJoy)	No Charge
Mental Health Telemedicine (HealthJoy)	No Charge
Urgent Care	Tier 1: 20% after Deductible / Tier 2: 40% after Deductible
HOSPITAL SERVICES	
Inpatient Hospital, Outpatient Surgery	Tier 1: 20% after Deductible / Tier 2: 40% after Deductible
DIAGNOSTIC SERVICES	
Cat Scans/MRIs, Nuclear Medicine	20% after deductible
EMERGENCY MEDICAL CARE	
Emergency Room	$250 Copay, Deductible, then coinsurance
RETAIL PHARMACY (30-DAY SUPPLY)	
Affordable Care Act Generic Drug	No Charge, in-network only
Preventive Generic Drug	No Charge, in-network only
Generic Drug	20% coinsurance after deductible
Preferred Brand Drug	20% coinsurance after deductible
Non-Preferred Brand Drug	30% coinsurance after deductible
Specialty	50% coinsurance after deductible
MAIL ORDER (90-DAY SUPPLY)	
Preventive Generic	No Charge
Other Generic	20% coinsurance after deductible
Preferred Brand Drug	20% coinsurance after deductible
Non-Preferred Brand Drug	30% coinsurance after deductible
Specialty	50% coinsurance after deductible
Out-of-Network	
CALENDAR YEAR DEDUCTIBLE	
Individual / Family	$10,000 / $20,000
Coinsurance	60%
CALENDAR YEAR OUT-OF-POCKET MAX	
Individual / Family	$75,000 / $150,000

The above information is a summary only. Please refer to your Summary Plan Description for complete details of Plan benefits, limitations and exclusions.

TaxSaver Plan

UnitedHealthcare High Deductible Health Plan – Health Savings Account (HSA)

An HSA is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pretax dollars — now or in the future. Once you're enrolled in the HSA, you'll receive a debit card to help manage your HSA reimbursements. Your HSA can also be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP medical plan.

ADVANTAGES OF AN HSA

- An HSA allows you to pre-fund your healthcare expenses with tax-free dollars.
- You contribute funds on a pretax basis, saving you tax dollars.
- Like a bank account, your funds grow with interest.
- You don't pay taxes on any interest or growth in your funds.
- As long as you use your funds for qualified medical, dental and vision expenses, you don't have to pay taxes when you use the funds.
- Unlike a Flexible Spending Account, you are not required to use your funds – they roll over year after year with no limit – so you can save them for retirement.
- The funds are all yours – you take them with you if you leave the company.

HOW A HEALTH SAVINGS ACCOUNT WORKS

ELIGIBILITY

You must be enrolled in the UHC High Deductible Health Plan.

CONTRIBUTIONS

You contribute on a pretax basis and can change how much you contribute from each paycheck up to the annual IRS maximum of $4,300 if you enroll only yourself or $8,550 if you enroll in family coverage. You can make an additional $1,000 catch-up contribution if you are age 55 or older.

ELIGIBLE EXPENSES

You may use your HSA funds to cover Medical, Dental, Vision and prescription drug expenses incurred by you and/or your eligible family members.

USING YOUR ACCOUNT

Use the debit card linked to your HSA to cover eligible expenses, or pay for expenses out of your own pocket and save your HSA money for future health care expenses.

YOUR HSA IS ALWAYS YOURS — NO MATTER WHAT

One of the best features of an HSA is that any money left in your account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the Company or retire, your HSA goes with you so you can continue to pay for or save for future eligible health care expenses.

UnitedHealthcare

UnitedHealthcare High Deductible Health Plan – Provider Selection Requirement

Employees electing the High Deductible Health Plan (HDHP) are required to choose a Primary Care Physician (PCP) from the Nexus network to receive discounted Tier 1 pricing. The steps to complete the process are outlined below. If you do not choose a PCP within 60 days of your effective date, you will automatically be assigned one.

FOLLOW THESE STEPS TO CHOOSE YOUR PCP

Log into your **myuhc.com** account.	Select Find Care & Costs from the tabs across the top of the page and choose Primary care providers.	"Which type of primary care provider (PCP)?" will appear and a selection can be made from the options listed.	Once you find a provider you wish to select as your primary care provider, click on "SELECT PCP."	If the provider has multiple locations, the next screen will ask for selection of a specific location.	Confirm PCP selection by clicking on "Assign as PCP."

UnitedHealthcare

UnitedHealthcare Choice Plus PPO Plan

Choice Plus is a Preferred Provider Organization (PPO) which means you can choose any provider in the Choice Plus Network, as well as non-network providers.

- You receive the highest benefit by using Choice Plus Network providers, and can also take advantage of copays for office visits and some prescription drugs.
- You can lower your out-of-pocket cost by using Tier 1 Providers.

Locate Tier 1 Providers at **www.myuhc.com** or by scanning the QR code — *look for the blue dot to identify if your doctor is a Tier 1 Provider in the online provider finder.*

PLAN HIGHLIGHTS	CHOICE PLUS PPO PLAN
NETWORK	CHOICE PLUS
	YOU PAY
CALENDAR YEAR DEDUCTIBLE	
Individual / Family	$2,500 / $6,250
Coinsurance (you pay)	Tier 1: 20% / Tier 2: 40%
CALENDAR YEAR OUT-OF-POCKET MAX	
Individual / Family	$7,900 / $15,800
OFFICE VISIT	
Primary Care Physician (PCP)	Tier 1: $10 Copay / Tier 2: $40 Copay
Specialist	Tier 1: $30 Copay / Tier 2: $90 Copay
Preventive Care Services	No Charge
General Medical Telemedicine (HealthJoy)	No Charge
Mental Health Telemedicine (HealthJoy)	No Charge
Urgent Care	$100 Copay
HOSPITAL SERVICES	
Inpatient Hospital	Tier 1: Deductible then 30% / Tier 2: $500 copay, Deductible then 50%
Outpatient Surgery	Tier 1: $400 copay / Tier 2: $650 copay
DIAGNOSTIC SERVICES	
Cat Scans/MRIs	Freestanding Facility: $300 Copay Hospital: $400 Copay
EMERGENCY MEDICAL CARE	
Emergency Room	$250 Copay, Deductible then 30% coinsurance
RETAIL PHARMACY (30-DAY SUPPLY)	
Affordable Care Act Generic Drug	No Charge
Preventive Generic Drug	N/A
Generic Drug	$15 Copay
Preferred Brand Drug	$40 Copay
Non-Preferred Brand Drug	Deductible then 30% ($180 copay or cost of drug, whichever is less)
Specialty	30% Coinsurance (no Deductible: $250/$500 max)
MAIL ORDER (90-DAY SUPPLY)	
Preferred Generic	No Charge
Non-Preferred Generic	$30 Copay
Preferred Brand	$80 Copay
Non-Preferred Brand	Deductible then 30% ($360 copay or cost of drug, whichever is less)
Specialty	30% Coinsurance (no Deductible: $150/$300 max)
Out-of-Network	
CALENDAR YEAR DEDUCTIBLE	
Individual / Family	$4,000 / $10,000
Coinsurance	60%
CALENDAR YEAR OUT-OF-POCKET MAX	
Individual / Family	$75,000 / $150,000

The above information is a summary only. Please refer to your Summary Plan Description for complete details of Plan benefits, limitations and exclusions.

UnitedHealthcare

UnitedHealthcare Healthy Start MEC Plan

The Healthy Start Minimum Essential Coverage (MEC) plan does not meet the Affordable Care Act (ACA) requirements for health coverage. It is intended for individuals that are looking for some level of "basic" coverage, but do not anticipate a significant need.

The coverage includes options for wellness, preventive services, prescription discounts and telehealth services. It **DOES NOT** provide hospital, emergency room or pharmacy services **AND** requires you to use an in-network provider. Outlined below are the covered benefits, you must use a network provider for all services.

Scan the QR code or go to **myuhc.com** and click Register Now.

PLAN HIGHLIGHTS	UHC HEALTHY START MEC PLAN
NETWORK	CHOICE PLUS
	YOU PAY
CALENDAR YEAR DEDUCTIBLE	
Individual / Family	None
Coinsurance (you pay)	None
CALENDAR YEAR OUT-OF-POCKET MAX	
Individual / Family	Individual: $9,100 / Family: $18,200
OFFICE VISIT	
Primary Care Physician (PCP)	$25 Copay, 4 combined visits with Specialist
Specialist	$50 Copay, 4 combined visits with PCP
Preventive Care Services	No Charge
General Medical Telemedicine (HealthJoy)	No Charge
Mental Health Telemedicine (HealthJoy)	No Charge
Urgent Care	$150 Copay, 2 visits per year
HOSPITAL SERVICES	
Inpatient Hospital	Not Covered
Outpatient Surgery	
DIAGNOSTIC SERVICES	
Cat Scans/MRIs, Nuclear Medicine	1 allowed per year at Freestanding Facility: $50 Hospital: $150
EMERGENCY MEDICAL CARE	
True Emergency	Not Covered
RETAIL PHARMACY (30-DAY SUPPLY)	
Affordable Care Act Generic Drug	Prescriptions Not Covered Pharmacy Discount Card Available
Preventive Generic Drug	
Generic Drug	
Preferred Brand Drug	
Non-Preferred Brand Drug	
Specialty	Not Covered
Out-of-Network	Not Covered

The above information is a summary only. Please refer to your Summary Plan Description for complete details of Plan benefits, limitations and exclusions.

HealthJoy Healthcare Advocacy App

HealthJoy is a mobile app that offers you health care guidance and support at your fingertips. Once you download the app and create your profile, you will see all your benefits displayed in HealthJoy's benefits wallet. Employees enrolled in an Invited medical plan, and their family members, will have access to this app at **NO COST**!

Through the app, you have 24/7 access to a dedicated health care concierge team and care navigation tools. They will help you locate in-network providers, find extra savings on prescriptions and answer any care questions you might have.

- **FREE 24/7 General Health Telemedicine**
- **FREE 24/7 Mental Heath Telemedicine**
- **Benefits Wallet**
- **Healthcare Concierge**
- **Provider Recommendations**
- **Medical Bill Review**
- **Appointment Booking**
- **HSA / FSA Support**
- **Rx Savings Review**

The HealthJoy App will help you save time and money. To get started, download and activate the HealthJoy App from Google Play or the App Store.

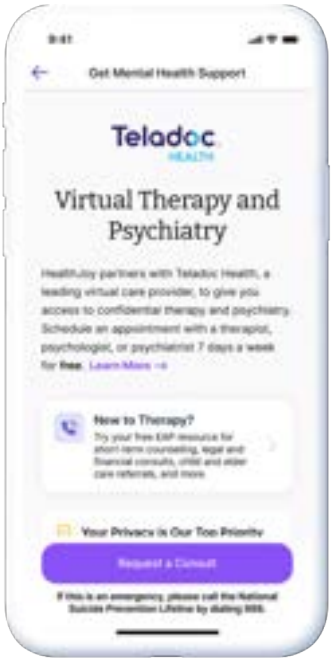
Download on the App Store

GET IT ON Google Play

Free HealthJoy Telehealth Visits

THE RIGHT CARE WHEN YOU NEED IT MOST

Virtual General Medical and Mental Health services, powered by Teladoc Health, are accessible through HealthJoy to provide you and your families with access to board-certified doctors, nutritionists and dermatologists, as well as licensed mental health professionals and psychiatrists for non-emergency health issues.



FOCUSED ON YOUR PHYSICAL AND MENTAL WELLBEING

General Medical provides critical care 24/7 for non-emergency conditions like cold, flu, sinus infections and allergies. It also provides care for specialty needs such as dermatology and nutrition consultations.

Mental Health virtual visits provide high-quality virtual therapy and psychiatric services for a wide range of conditions with support from board-certified psychiatrists and licensed therapists. You, your covered spouse, **and covered children age 13 and up** can utilize the mental health virtual visits.

Teladoc providers can prescribe medication including, but not limited to, antibiotics, antihistamines, antiviral medications and others. Teladoc doctors will not prescribe any controlled substances.

*Available for all employees enrolled in an Invited Medical Plan option.

HOW TO ADD DEPENDENTS TO HEALTHJOY

Immediate family including spouses and dependent children can use the same great HealthJoy services you enjoy! To use HealthJoy, your family must be added to your profile. To add a family member to your profile:

1. Open the HealthJoy app
2. Tap “Chat” in the bottom menu
3. Use the chat to tell our concierge team you would like add a family member
4. You will be asked for their name, date of birth, and if they are covered by your health plan
5. Spouses or dependents over age 18 can create their own HealthJoy profile. Just tell the concierge you would like to send them an invitation

1 Download & activate the HealthJoy App

2 Complete your registration with Teladoc in the HealthJoy App

3 Start a consult whenever you need care or call HealthJoy at 877-500-3212

Start a virtual visit by logging into the HealthJoy App. Download and activate the HealthJoy App from Google Play or the App Store.

Download on the App Store

GET IT ON Google Play

Free SupportLinc Employee Assistance Program (EAP) Available to ALL Employees

The licensed counselors at SupportLinc EAP offer expert guidance to help you address and resolve everyday issues. Access support whenever and wherever is most convenient for you (e.g., phone, email, live chat or live session). The first 6 visits with a licensed counselor are FREE – this benefit is available to you and your family members, **even if you are not enrolled in an Invited Medical Plan option**.

Note: All EAP conversations are voluntary and confidential.

COUNSELOR BENEFITS

- Support for grief counseling
- Financial planning
- Legal consultation
- Personal stress
- Marital and relationship issues
- And much more!

Work-Life Voluntary Benefits

WHAT SERVICES ARE INCLUDED?

FINANCIAL CONSULTATION

- Guidance and consultation from financial planners and budget specialists

CONVENIENCE AND CONCIERGE RESOURCES

Expert referrals for everyday needs

- Home improvement
- Entertainment services
- Pet care
- Auto repair
- Wellness
- Travel
- Plumbers and other contractors
- Volunteer opportunities

DEPENDENT CARE RESOURCES

Childcare referrals

- Daycare centers
- Home childcare
- Nannies
- Recreational programs

Elder care referrals

- Adult day care
- Assisted living
- Home health care
- Meals on Wheels support
- Retirement communities

Phone: 888-881-LINC (5462)

Web: www.supportlinc.com

Username: invitedclubs

Dental Benefits – Delta Dental

Invited offers two dental plan options through Delta Dental: a Dental Provider Organization Plan and a Dental Health Maintenance Plan. DPO stands for Dental Provider Organization.

For the DPO plan, Delta Dental contracts with a network of dentists who have agreed to charge certain fees for approved services. The DPO plan offers dental provider choice as you have the freedom to visit network and out-of-network dentists. When you visit in-network dentists, the fees for covered services will generally be lower than out-of-network dentists. DHMO insurance plans typically cover dental services at a low cost and minimal or no copayments with a pre-selected primary care dentist or a dentist facility with multiple dentists.

DENTAL PROVIDER ORGANIZATION (DPO) OPTION

Preventive services at in-network providers generally are covered at no cost to you and include routine exams and cleanings. You pay a small deductible and coinsurance for basic and major services. For information on finding a dental provider using the Delta Dental PPO network, visits **www.deltadental.com** and click Find A Dentist.

Scan the QR code or visit **www.deltadental.com** for more information on Delta Dental networks and plans.

DENTAL HEALTH MAINTENANCE ORGANIZATION (DHMO) OPTION

If you decide to enroll in the DHMO Option for the first time or add new dependents under this option, you need to select a primary care dentist. You can only change your dentist once per year and you can choose a different DHMO dentist for yourself and each covered dependent. You should consult the participating provider directory prior to enrolling.

The DHMO plan is offered in AL, AR, AZ, CA, CO, DC, FL, GA, KS, KY, LA, MD, MI, MS, NV, NY, OH, PA, SC, TN, TX, WA, WI and WV.

PLAN HIGHLIGHTS	DPO PLAN	DHMO PLAN
NETWORK	DELTA DENTAL PPO NETWORK	DELTA DENTAL DHMO NETWORK
Calendar Year Maximum Benefit	$1,500	None
	YOU PAY	
CALENDAR YEAR DEDUCTIBLE		
Individual / Family	$50 / $150	None / None
PREVENTIVE		
Exams, Cleanings, Fluoride, X-Rays, Sealants, and Space Maintainers	0%	**DHMO Benefits Schedule**
BASIC SERVICES		
Filings and Simple Extractions	20%	**DHMO Benefits Schedule**
MAJOR SERVICES		
Crowns, Inlays, Onlays, Endodontics, Periodontics, Bridges, Dentures, and Oral Surgery	50%	**DHMO Benefits Schedule**
ORTHODONTIA SERVICES		
Coverage / Lifetime Maximum per Individual	50% / $1,500 for Adults & Children	For Adults: $2,100 / For Children (up to 19): $1,150

The above information is a summary only. Please refer to your Benefit Summary for complete details of Plan benefits, limitations and exclusions.

DENTAL PLAN COST	DPO PLAN		DHMO PLAN	
	BI-WEEKLY	WEEKLY	BI-WEEKLY	WEEKLY
Employee Only	$15.74	$7.87	$7.23	$3.62
Employee and Spouse	$33.34	$16.67	$12.42	$6.21
Employee and Child(ren)	$32.70	$16.35	$12.50	$6.25
Employee and Family	$53.01	$26.51	$18.01	$9.01

SuperiorVision By MetLife

Vision Benefits – MetLife Superior

Healthy eyes and clear vision are an important part of your overall health and quality of life. You can enroll yourself and your eligible dependents in our vision benefits plan. Also, you do not have to enroll in medical coverage to elect the vision plan.

To find a network provider, visit **www.metlife.com**, click "Find a Vision Provider," then click "MetLife Vision Superior."

*View a full list of covered vision services by clicking **here**.*

PLAN HIGHLIGHTS		
NETWORK	METLIFE NETWORK	OUT-OF-NETWORK
	YOU PAY	REIMBURSEMENT
VISION EXAM – EVERY 12 MONTHS		
Exam	$15 Copay	Ophthalmologist: Up to $42, Optometrist: Up to $37
LENSES – EVERY 12 MONTHS		
Single Lenses	$15 Copay	Up to $26
Bifocal Lenses	$15 Copay	Up to $34
Trifocal Lenses	$15 Copay	Up to $50
FRAMES – EVERY 24 MONTHS		
Frames	$15 Copay, $125 Allowance	Up to $50
CONTACTS – EVERY 12 MONTHS (IN LIEU OF LENSES & FRAMES)		
Medically Necessary Contacts	$0	Up to $210
Elective Contacts	$120 Allowance	Up to $100

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

VISION PLAN COST	BI-WEEKLY	WEEKLY
Employee Only	$2.93	$1.47
Employee and Spouse	$4.36	$2.18
Employee and Child(ren)	$4.66	$2.33
Employee and Family	$7.45	$3.73

Flexible Spending Account (FSA) – TaxSaver

TaxSaver administers the Flexible Spending Accounts. FSAs allow you to pay for eligible health care and dependent care using tax-free dollars. There are two types of FSAs – the Health Care FSA and the Dependent Care FSA.

HEALTH CARE FSA

The Health Care FSA allows Employees to pay for certain IRS-approved medical care expenses not covered by their insurance plan with pretax dollars.

The 2025 annual maximum amount you may contribute to the Health Care FSA is $3,300, pretax.

You will receive a debit card to pay for eligible medical expenses (funds must be available in your account). Examples of qualified medical expenses include copays, prescription expenses, lab exams and tests, contact lenses and eyeglasses. A list of eligible expenses can be found at: **www.irs.gov/pub/irs-pdf/p502.pdf**.

At the end of the calendar year, participants can roll over eligible, unused health care funds.

DEPENDENT CARE FSA

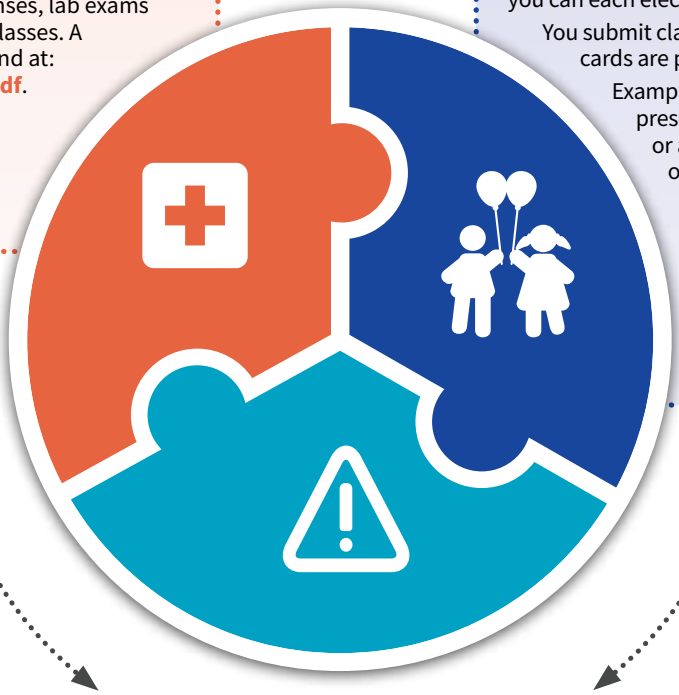
The Dependent Care FSA allows you to set aside pretax dollars to pay for dependent care for children up to age 13, a disabled dependent of any age or a disabled spouse. To be eligible, you and your spouse (if applicable) must work, be looking for work or be full-time students.

The 2025 annual IRS limit for this type of account is $5,000. If you are married and file separate returns, you can each elect $2,500 for the calendar year.

You submit claims for reimbursement; no debit cards are provided.

Examples of eligible expenses include preschool, summer day camp, before or after school programs, and child or elder daycare. A list of eligible expenses can be found at: **www.irs.gov/pub/irs-pdf/p503.pdf**.

You cannot use your Health Care FSA to pay for Dependent Care expenses, and you cannot use your Dependent Care FSA to pay for health care expenses.



USE IT OR LOSE IT

Submit claims by **March 31, 2026**, for expenses from January 1 to December 31, 2025.

IRS "use it or lose it" rules apply. If you don't spend all the funds in your current-year FSAs by March 15 of next year (and submit your claims by March 31), you may lose them.

The Health Care FSA allows you to roll over up to $660 unused funds to the next plan year and they can be used anytime in 2025.

Commuter Spending Account – TaxSaver

Contribute $325 per month, pretax, to pay for your parking or public transportation expenses while commuting to work, including monthly passes, tokens or fare cards. This program, administered by TaxSaver Plan, is voluntary and you may participate on a month-to-month basis. Both payroll contributions and reimbursements cannot exceed the monthly statutory limits. Unused funds in any month are rolled over to the next month's contribution. To learn more about this program, click **here**.

Basic Life and AD&D – Lincoln Financial

Invited provides Employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance through Lincoln Financial. This benefit is provided at no cost to you.

In the event of a death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is caused by an accident or you suffer dismemberment, your AD&D coverage may be applicable.

PLAN HIGHLIGHTS	
Life and AD&D Benefit Amount	Hourly Employees: $10,000 Salaried Employees: $25,000
Accelerated Death Benefit	Included
Age Reduction	Benefits reduced by 35% at age 65 and 55% at age 70.
Portability	Included

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

View the 2025 Lincoln Life & AD&D benefit summary by clicking **here** for Hourly employees or clicking **here** for Salaried employees.

BENEFICIARY DESIGNATION

You **MUST** designate a beneficiary for your Life and AD&D insurance when you become eligible for coverage. Your beneficiary is the person (or people, estate, trust, etc.) who will receive your life insurance benefits if you pass away. If you do not name a beneficiary or if there are no surviving beneficiaries, in the event of your death, benefits will be paid to your estate.

You must elect a primary beneficiary (the first to receive benefits) and you may also elect a secondary beneficiary (if no surviving primary beneficiaries). Note: Texas is a community property state and if you designate someone other than your spouse as a beneficiary, your spouse must consent to such designation.

When naming minor children as beneficiaries, unless you have a clear will and/or estate plan in place that directs the court where and how your estate is treated in the event of your death, a minor cannot receive such payments and, in most cases, that benefit could be assigned to probate court for a judge to decide.

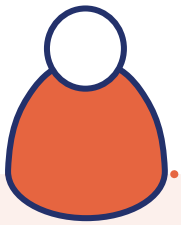
Situations often change, resulting in the need to update your beneficiary information. You should review and update this information every year, or prior to retirement.

Voluntary Life – Lincoln Financial

Voluntary Life insurance allows you to tailor coverage for your individual needs and provide financial protection for your beneficiaries in the event of your death.

Eligible Employees may purchase Voluntary Life insurance for themselves and their dependents. Premiums are paid through post-tax payroll deductions.

Employees and dependents who elect coverage when first eligible can elect up to the Guaranteed Issue amount without being required to submit an Evidence of Insurability (EOI) form. If you elect more than the Guaranteed Issue amount or choose to waive coverage now and elect at a later date, you will be required to submit an EOI form.



For You

Increments of $10,000

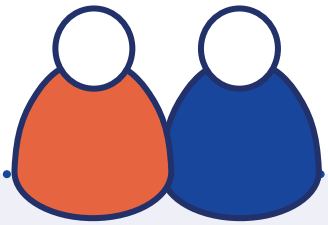
Maximum: Lesser of $500,000 or 7 times annual salary

EOI not required if:

- Coverage amount is $380,000 or less

EOI required if:

- Coverage amount exceeds $380,000



For Your Spouse

Increments of $5,000

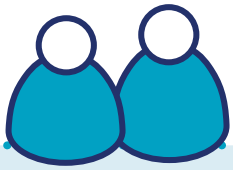
Maximum: Lesser of $100,000 or 50% of Employee amount.

EOI not required if:

- Coverage amount is $30,000 or less

EOI required if:

- Coverage amount exceeds $30,000



For Your Child

Increments of $5,000

Maximum: $25,000

EOI not required

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

View the 2025 Lincoln Voluntary Life & AD&D benefit summary by clicking here.

Voluntary Short-Term Disability – Lincoln Financial

Disability insurance replaces a portion of your income when you are unable to work due to a qualified illness or non-work-related injury, such as the birth of a new child. Invited provides you with the opportunity to elect Short-Term Disability (STD) through Lincoln Financial.

Eligible Hourly Employees working in clubs may participate in the Voluntary STD Plan (except for Employees working in clubs located in HI, NJ, NY or RI due to state-mandated disability plans already available to you).

SHORT-TERM DISABILITY BENEFITS AT A GLANCE	
Definition of Disability	Prevented from performing the material and substantial duties of your own occupation
Elimination Period	14 Days
Weekly Benefit	60% of your average weekly salary
Maximum Weekly Benefit	$1,000
Benefit Duration	11 Weeks
Pre-Existing Condition Limitation	No pre-existing condition limitations apply

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

View the 2025 Lincoln Short-Term Disability benefit summary by clicking **here**.

SHORT-TERM DISABILITY COST	
EMPLOYEE AGE AS OF JANUARY 1, 2025	MONTHLY RATE PER $10
Under age 25	$0.620
25-29	$0.552
30-34	$0.587
35-39	$0.516
40-44	$0.446
45-49	$0.526
50-54	$0.562
55-59	$0.706
60-64	$0.846
65-69	$0.942
70-74	$0.975
75-79	$0.842
80-84	$0.988
85-89	$1.313
90+	$1.417

Calculate Your Short-Term Disability Rate

Example:

A 30-year-old Employee earns $500 per week, resulting in a benefit of $300 per week ($500 x 60% = $300)

$300 / $10 = $30.00

$30 x $0.587 = $17.61

$17.61 x 12 ÷ 26 = $8.13 per paycheck

COMPANY-SPONSORED SHORT-TERM DISABILITY

Home Office & Salaried Employees in clubs receive company-paid STD benefits at 66.67% of salary for up to 11 weeks with a cap of $1,500 per week, following a 14-day elimination period.

View the 2025 Lincoln Short-Term Disability benefit summary by clicking **here**.

Voluntary Long-Term Disability – Lincoln Financial

Long-Term Disability insurance replaces a portion of your income when you are unable to work due to a qualified illness or injury. Invited provides you with the opportunity to elect Long-Term Disability (LTD) through Lincoln Financial.

You must be in one of the following positions to be eligible to participate in the LTD plan:

- Home Office and Salaried Employees
- General Managers, Club Managers, or
- Salaried Department Heads who are primarily responsible for managing a department, such as (but not limited to): Athletic Director, Executive Chef, F&B Director, Golf Course Superintendent, Head Golf and Tennis Pro, Membership Director, Private Events Director or Service Director.

LONG-TERM DISABILITY BENEFITS AT A GLANCE	
Monthly Benefit Maximum	$10,000
Monthly Benefit	60% of monthly earnings
Elimination Period	90 Days
Benefit Duration	Normal Retirement Age
Pre-Existing Condition Limitation	3/12

The above information is a summary only. Please refer to your Certificate of Coverage for complete details of Plan benefits, limitations and exclusions.

LONG-TERM DISABILITY COST
MONTHLY RATE PER $100 MONTHLY EARNINGS
$0.413

Calculate Your Long-Term Disability Rate

Example:

35-year-old Employee with $40,000 annual salary

$40,000 Salary ÷ 12 Months = $3,333.33

$3,333.33 / $100 Monthly Earnings = $33.33

$33.33 x $0.413 = $13.77 per month

$13.77 x 12 ÷ 26 = $6.36 per paycheck

PRE-EXISTING CONDITIONS

A pre-existing condition is an injury or illness for which you have received advice or treatment from a doctor within 3 months prior to the effective date of your insurance plan.

View the 2025 Lincoln Long-Term Disability benefits summary by clicking **here**.

Lincoln Financial Group®

Voluntary Accident – Lincoln Financial

Accident insurance pays out a lump sum if you incur an injury as a result of an accident. These benefits may supplement both health and disability insurance, and can be used to pay for expenses that your health insurance doesn't cover or provide additional financial support if a covered event causes you to lose income due to being out of work.

ACCIDENT	BI-WEEKLY	WEEKLY
Employee Only	$3.86	$1.93
Employee and Spouse	$7.72	$3.86
Employee and Child(ren)	$9.36	$4.68
Employee and Family	$11.04	$5.52

BENEFITS	AMOUNT
FRACTURES	**IF MORE THAN ONE BONE IS FRACTURED; MAX BENEFIT IS NO MORE THAN 2X HIGHEST FRACTURE BENEFIT**
Face or Nose	$2,000
Jaw	Lower Mandible $1,000, Upper Maxilla $2,000
Arm	Upper (shoulder to elbow) $2,000, Lower (elbow to wrist) $1,000
Vertebrae	Vertebral Body $2,000, Vertebral Process $750
Pelvis	$2,000
Hip	$4,000
Leg	Upper (hip to knee) $4,000, Lower (knee to ankle) $2,000
Chip Fracture	25%
DISLOCATIONS	**IF MORE THAN ONE JOINT IS DISLOCATED, THE AMOUNT WE WILL PAY FOR ALL DISLOCATIONS COMBINED WILL BE NO MORE THAN 2 TIMES THE HIGHEST DISLOCATION BENEFIT**
Lower Jaw	$1,000
Collarbone	$1,000
Shoulder	$1,000
Knee (except knee cap)	$2,000
Elbow	$1,000
Wrist	$1,000
Hip	$4,000
Partial Dislocation	25% of dislocation benefit
BURN BENEFIT	**1 TIME PER ACCIDENT; UNLIMITED TIME(S) PER CALENDAR YEAR**
2nd degree burns: =<9% within 72 hours of the accident	$100
2nd degree burns: 10%-18% within 72 hours of the accident	$200
2nd degree burns: 19%-36% within 72 hours of the accident	$750
2nd degree burns: =>37% within 72 hours of the accident	$1,500
3rd degree burns: =<9% within 72 hours of the accident	$1,500
3rd degree burns: 10%-18% within 72 hours of the accident	$2,000
3rd degree burns: 19%-36% within 72 hours of the accident	$7,000
3rd degree burns: => 37% within 72 hours of the accident	$12,000
MEDICAL TREATMENT AND SERVICES	
Ambulance Transportation	$400
Air Ambulance Transportation	$1,200
Emergency Care Treatment	$200
Physician Office or Urgent Care Visit	$100
Hospital Admission	$1,000
Occupational, Physical and Chiropractic Therapy	$50 per visit up to 10 visits
Health Screening Benefit	**$100 1 time per calendar year for all enrolled; pays IF you have your annual wellness visit.**

View the 2025 Accident insurance benefit summary by clicking **here**.

Voluntary Critical Illness – Lincoln Financial

Critical Illness insurance is coverage that can help safeguard your finances by providing you with a lump-sum payment when you or your family may need it most. This lump-sum payment allows you to pay for whatever you need, such as expenses that may not be covered by your main medical plan (e.g., copays, deductibles, childcare, mortgage, groceries and experimental treatments).

COVERED CONDITIONS	INITIAL BENEFIT	RECURRENCE BENEFIT
Invasive Cancer	100% of Benefit Amount	100%, after the separation and pre-treatment periods are met
Heart Attack	100% of Benefit Amount	100%, after the separation and pre-treatment periods are met
Benign Brain Tumor	100% of Benefit Amount	None
Childhood Diseases – Cerebral Palsy, Cystic Fibrosis, Cleft Lip or Cleft Palate, Down Syndrome, T1 Diabetes	100% of Benefit Amount	None
End Stage Renal (Kidney) Failure	100% of Benefit Amount	100%, after the separation and pre-treatment periods are met
Stroke	100% of Benefit Amount	100%, after the separation and pre-treatment periods are met
Major Organ Failure	100% of Benefit Amount	100%, after the separation and pre-treatment periods are met
Loss of Speech, Hearing	100% of Benefit Amount	None
Health Screening Benefit	**$100, one time per calendar year for all enrolled; pays IF you have your annual wellness visit.**	None

$15,000 EMPLOYEE BENEFIT AMOUNT BI-WEEKLY RATES

ATTAINED AGE	EMPLOYEE ONLY	EMPLOYEE AND SPOUSE	EMPLOYEE AND CHILD(REN)	EMPLOYEE AND FAMILY
<25	$1.53	$3.06	$4.67	$6.20
25-29	$1.94	$3.88	$5.08	$7.02
30-34	$2.51	$5.02	$5.65	$8.16
35-39	$3.45	$6.90	$6.59	$10.04
40-44	$4.95	$9.90	$8.09	$13.04
45-49	$6.95	$13.90	$10.09	$17.04
50-54	$9.72	$19.44	$12.86	$22.58
55-59	$12.86	$25.72	$16.00	$28.86
60-64	$18.17	$36.34	$21.31	$39.48
65-69	$25.61	$51.22	$28.75	$54.36
70+	$43.61	$87.22	$46.75	$90.36

$30,000 EMPLOYEE BENEFIT AMOUNT BI-WEEKLY RATES

ATTAINED AGE	EMPLOYEE ONLY	EMPLOYEE AND SPOUSE	EMPLOYEE AND CHILD(REN)	EMPLOYEE AND FAMILY
<25	$3.06	$6.12	$8.29	$11.35
25-29	$3.87	$7.74	$9.10	$12.97
30-34	$5.01	$10.02	$10.24	$15.25
35-39	$6.90	$13.80	$12.13	$19.03
40-44	$9.90	$19.80	$15.13	$25.03
45-49	$13.89	$27.78	$19.12	$33.01
50-54	$19.44	$38.88	$24.67	$44.11
55-59	$25.71	$51.42	$30.94	$56.65
60-64	$36.33	$72.66	$41.56	$77.89
65-69	$51.21	$102.42	$56.44	$107.65
70+	$87.21	$174.42	$92.44	$179.65

View the 2025 Critical Illness insurance benefit summary by clicking **here**.

Lincoln Financial Group®

Voluntary Hospital Indemnity – Lincoln Financial

Hospital Indemnity insurance pays you benefits when you are confined to a hospital, whether for planned or unplanned reasons, including having a baby. This benefit may supplement both health insurance and disability insurance, if a covered incident causes you to have expenses that your health insurance doesn't cover.

BENEFITS	AMOUNT
Hospital Admission Benefit	$1,000 4X per calendar year
ICU Admission Benefit	$1,000 Paid in addition to Hospital Admission Benefit
Hospital Confinement	$200 15 days per calendar year
Newborn Nursery Care	$50 2 days per confinement
Inpatient Rehabilitation (For Injury or Sickness)	$100 15 days per calendar year
Health Screening Benefit	$100 **1 time per calendar year for all enrolled; pays IF you have your annual wellness visit.**

	BI-WEEKLY RATE	WEEKLY RATES
Employee Only	$6.44	$3.22
Employee and Spouse	$13.73	$6.86
Employee and Child(ren)	$10.05	$5.03
Employee and Family	$18.09	$9.05

View the 2025 Hospital Indemnity insurance benefit summary by clicking **here**.

Voluntary Legal Plan – MetLife

The Legal Plan is designed to give you access to quality legal services while protecting you from the high cost of legal fees. Every year 70% of people have a legal issue and need assistance. Legal Plan includes benefits that help you with wills and trusts, bankruptcy, consumer law, as well as estate planning and more.

You, your spouse and dependents can get legal assistance for **$4.27 per bi-weekly pay period** — there are no waiting periods, no deductibles and no claim forms when using a network attorney for a covered matter.

CATEGORY	SERVICES OFFERED		
Money Matters	• Debt collection defense • Identity theft defense	• Negotiations with creditors • Promissory notes	• Tax collection defense
Home & Real Estate	• Boundary or title tisputes • Deeds • Eviction defense	• Foreclosure • Mortgages • Property tax assessments	• Security deposit assistance • Tenant negotiations
Estate Planning	• Codicils • Complex wills • Healthcare proxies • Living wills	• Powers of attorney (healthcare, financial, childcare, immigration)	• Simple wills
Family & Personal	• Affidavits • Conservatorship • Demand letters • Divorce (20 hours) • Garnishment defense	• Guardianship • Immigration assistance • Name change • Personal property protection	• Protection from domestic violence • Review of ANY personal legal document • School hearings
Civil Lawsuits	• Administrative hearings • Disputes over consumer goods & services	• Incompetency defense	• Small claims assistance
Elder-Care Issues	Consultation & document review for your parents: • Deeds • Leases	• Medicaid • Medicare • Notes • Nursing home agreements	• Powers of attorney • Prescription plans • Wills
Traffic & Other Matters	• Defense of traffic tickets • Driving privileges restoration	• License suspension due to DUI	• Repossession

To learn more about your coverages, view our attorney network or grant your dependents access, create an account.

Your account will also give you access to our self-help document library to complete simple legal forms. The forms are available to you, regardless of enrollment.

Create an account at members.legalplans.com or scan the QR code.

Questions? Call the **MetLife Legal Plans Client Service Center** at **800-821-6400** Monday – Friday, 8:00 a.m. to 8:00 p.m., ET.

Voluntary Identity Theft & Fraud Protection – MetLife

MetLife and Aura Identity Theft & Fraud Protection helps safeguard the things that matter to you most: your identity, money and assets, family, reputation and privacy.

Get coverage for yourself for **$3.90 per bi-weekly pay period** or cover your family for **$6.44 per bi-weekly pay period.**

POWERFUL SECURITY THAT FITS SEAMLESSLY INTO YOUR LIFE

Keep your accounts and identity safe

Protect your finances and credit

Protect your Wi-Fi network and devices

Effortless privacy whenever you go online

A choice of plans to fit your needs and budget

FINANCIAL FRAUD PROTECTION	PROTECTION PLUS
Credit Monitoring & Alerts	3 Bureau
Annual Credit Report	3 Bureau
Monthly Credit Score Tracker	✓
In-Platform Credit Dispute	✓
Credit, Bank & Utility Account Freeze Assistance	✓
Home & Vehicle Title Monitoring	✓
Financial Accounts and Transactions Monitoring	✓
Investment & Loan Account Monitoring	✓
IDENTITY THEFT PROTECTION	**PROTECTION PLUS**
Privacy Assistant & Spam Reduction	✓
Dark Web Monitoring	✓
Digital Vault	✓
SSN & Identity Authentication Alerts	✓

FAMILY SAFETY (WITH FAMILY COVERAGE ONLY)	PROTECTION PLUS
Parental Controls	✓
Child Cyberbullying Protection	✓
3-Bureau Child Credit Freeze Wizard	✓
Child SSN Monitoring & Alerts	✓
SERVICES AND SUPPORT	**PROTECTION PLUS**
$5M Insurance Policy per Enrolled Adult	✓
Lost Wallet Protection with $500 Emergency Cash	✓
24/7/365 100% US-based Customer Care	✓
PRIVACY & DEVICE PROTECTION	**PROTECTION PLUS**
Password Manager	✓
Email Alias	✓
Safe Web Browsing	✓
IP Address Monitoring	✓

For a full list of services, click **here**.

ADDITIONAL BENEFITS THAT WORK FOR YOU:

- Choice of plans and options to fit your needs and budget.
- 100% U.S.-based Customer Support available 24 hours a day, 7 days a week throughout the year to answer account technical or billing questions.
- Fraud resolution services to assist victims of fraud through every step of the restoration process.

Voluntary Pet Insurance Plan – MetLife

Let's not forget about our furry friends! A MetLife Pet Insurance plan is available to all Employees, and helps cover the costs when unexpected accidents or illnesses occur, so nothing gets in the way of caring for your pet when they need it most. This benefit is not payroll deducted. MetLife will bill you directly for your Pet Insurance plan.

With MetLife Pet Insurance, you can get:

- Flexible insurance plans that can cover the entire pet family with no breed exclusions.
- Freedom to visit any U.S. veterinarian and reimbursement up to 90% of the cost of services.
- Family plans covering multiple cats and dogs on one policy – a benefit exclusive to MetLife Pet.
- 24/7 access to Telehealth Concierge Services for immediate assistance.
- Discounts up to 30% and additional offers on pet care, where available.
- Optional Preventive Care coverage.
- Coverage of previously covered pre-existing conditions when switching provider.

Monthly premiums vary depending on the number of pets you cover and the type of coverage you select.

Choose the coverage that's right for you.	Visit any U.S. licensed veterinarian or emergency clinic.	Pay the bill within 90 days and send it with your claim documents via our mobile app, online portal, email, fax or mail.	Get a percentage of your money reimbursed by check or direct deposit if the claim expenses is covered under the policy.

With MetLife Pet Insurance, pet parents have the power of choice to customize their pet insurance to meet their needs.

Essential Needs

- Accidents and illness
- Diabetes
- Ear infections
- Pancreatitis
- Cancer
- Hip dysplasia
- Cruciate ligament
- And more…

Sophisticated Care

- Laser therapy
- Holistic care
- Acupuncture
- Hydrotherapy
- IVDD
- And more…

Policy Features where available

- Telehealth
- Mortality benefits
- Discounts and rewards
- Deductible savings
- And more…

Optional Preventive Care Coverage

- Flea and tick
- Spay and neuter
- Heartworm
- Behavioral training
- Teeth cleaning
- And more…

Enroll at metlife.com/getpetquote or scan the QR code.

Questions?
Call 1-800-GET-MET8 (1-800-438-6388)

BenefitsMe Purchasing Platform

BUY NOW, PAY LATER.

Invited Employees can now make purchases interest-free through payroll deductions.

Check your eligibility at shop.benefitsme.com.

Invited Employees have access to a unique voluntary benefit platform that will make purchasing quality, brand-name items simple and manageable.

The BenefitsMe platform allows you to utilize payroll deductions to shop now and make payments over time without interest, required credit checks or down payments (in most cases).

WHAT DO I NEED TO PARTICIPATE?

- A minimum of 90 days of full-time employment with Invited
- An active Employee ID
- Your date of birth
- Basic contact information

HOW DOES MY SPENDING LIMIT WORK?

When you make purchases at **shop.benefitsme.com** you can choose the payroll deduction schedule that is right for you. As you make deduction payments towards your purchases over time, your available balance will reflect those payments, allowing you to make additional purchases within your available spending limit at any time.

HOW DO I GET A SPENDING LIMIT?

Access your spending limit by creating a BenefitsMe account. It's that simple. Go to My Account at any time to view your spending limit, available balance, and order details.

CAN I BUY MORE THAN ONE ITEM AT A TIME?

Absolutely, you have the flexibility to purchase any number of products or services, as long as the total cost does not exceed your available spending limit.

Need Assistance?

Call Us:
(800) 960-4509

Email Us:
Support@BenefitsMe.com

Empathy Life Beneficiary Services

Empathy features an app and provides support with the emotional and practical aspects of losing a loved one. This information will be provided to beneficiaries directly at the time of claim and is available up to 18 months after a loss.

Valuable services include:

- Care Team: On-demand dedicated bereavement concierge.
- Probate and Estate Administration: Including estate administration experts on demand, property clearance assistance, and probate guidance and resources.
- Emotional Support: Including confidential grief support sessions, funeral assistance services, comforting grief audio guides, mindfulness and motivation activities, sleep support with guided audio, and self-care tools.
- Family Collaboration: Beneficiaries can invite non-beneficiary family members to use empathy services (limit to 5 invites per claim, not per beneficiary).
- Planning and Resources: Beneficiaries can be provided a personalized step-by-step care plan and access a smart checklist and task tracker, and comprehensive content library.

FUNERAL PLANNING & DISCOUNTS

Through Lincoln Financial, you and your family will have access to compassionate counselors, as well as discounts on funeral services through the largest network of funeral homes and cemetery providers in North America.

Expert assistance - available 24 hours, 7 days a week, 365 days a year — to help guide you and your family in making confident decisions.

Planning Services - online, over the phone or by paper — to help make final wishes easier to manage.

Bereavement travel services to assist with time-sensitive travel arrangements to be with loved ones.

Don't wait. Prepare your family for life's unexpected outcomes.
Visit **lincolnfuneralprep.com** or call 866-408-7300.

HOW TO ACCESS LINCOLN FUNERAL PREP

You can access Lincoln FuneralPrep in two ways:

1. Visit the self-service online portal

The online portal at **lincolnfuneralprep.com** includes a wealth of online funeral planning resources and services, including the ability to:

- **Search for funeral homes**
  Access an interactive list of funeral homes and cemeteries around the country. You can filter by location, service, and budget.
- **Access market information**
  Review price ranges and service options in your selected geographic location.
- **View guides and checklists**
  Organize your priorities, consider your options, and make informed decisions based on your preferences with our easy-to-use online guides and checklists.

2. Connect with a funeral planning consultant

Work with a funeral planning expert who can guide you through the preplanning process and:

- **Help compare options**
  Get assistance comparing preplanning options, even if you haven't chosen a specific funeral home.
- **Provide personalized service**
  Work with our specialists to ensure that your plans reflect your wishes and goals.
- **Offer objective advice**
  Get guidance on planning options and various funding strategies.

Auto & Home Insurance – Farmers

This voluntary benefit program, offered through MetLife's partnership with Farmers GroupSelect, provides you with access to special savings on auto and home insurance. Plus, you can choose the convenience of paying your premiums through automatic payroll deductions. You may start or stop your coverage at any time throughout the year, and your coverage stays with you even if you leave the Company.

All Employees are eligible to contact Farmers GroupSelect to request quotes for Home and Auto Insurance discounts.

Switch today to see how much you could save - get a quote.

AUTO INSURANCE

Choose your coverage while enjoying savings and benefits, like:

- Special group discounts
- Automated payment options
- Claim-free driving rewards
- Enhanced rental car damage coverage
- No deductible repairs for certain windshield damage
- Roadside assistance
- Guaranteed auto repairs for covered losses
- ID protection services

As an Employee, you have access to special savings on auto insurance. Others have saved an average of $579 by making the switch.

HOME INSURANCE

Choose home insurance coverage along with savings and benefits, like:

- Special group discounts
- Replacement cost coverage
- Referral networks
- Automated payment options
- ID protection services

GET QUOTES

Call today, 800-438-6381 and mention your discount code A58 or visit **www.farmers.com/groupselect**.

OTHER POLICY OPTIONS

By purchasing auto, home and other policies from Farmers GroupSelect, you could save even more! Others saved $751 on average!

RV	RENTER'S	MOTORCYCLE	BOAT	CONDO

E.C.F
EMPLOYEE CARE FUND

Employee Care Fund (E.C.F.)

Here to support you - the Employee Care Fund was established in 2007 to support Employees during times of crisis. Although not a benefit, the Fund is a resource for Employees and can help during times of hardship such as home loss, death, illness, as well as domestic situations and catastrophic events.

HOW TO REQUEST ASSISTANCE

We are excited to continue the legacy of the Fund by partnering with the Emergency Assistance Foundation to assist us in managing the Fund. If you are seeking assistance or would like to donate, visit: **www.InvitedEmployeeCareFund.com**. You can also reach out to the E.C.F. Support Team at **Invited@emergencyassistancefdn.org** or call (833) 703-4575. Available 24/7 and bilingual support is offered.

GUIDELINES FOR DETERMINING ASSISTANCE

The guidelines for determining assistance, additional information on types of assistance, and a list of FAQs can be found **here**.

Important Benefit Plan Contact Information

COVERAGE	DESCRIPTION	CONTACT	PHONE	WEBSITE
Invited Benefits	General benefits helpline & enrollment assistance	Invited Benefits	833-964-2967	www.invitedbenefits.com
Dependent Verification	Proof of dependent eligibility	Invited Benefits	N/A	www.myclublifeonline.com
HealthJoy	Mental & general medical telehealth & benefits navigation (available to medical plan enrollees)	HealthJoy	877-500-3212	support@healthjoy.com
SupportLinc Employee Assistance Program (EAP)	Mental health counseling & work-life support (available to all employees)	SupportLinc	888-881-5462	www.supportlinc.com Username: invitedclubs
SimplePay Health Plan Group #20422 Rx Bin: 004336 Rx PCN: ADV	Medical/pharmacy insurance plan	Aetna CVS Health	800-606-3564	healthvalet@simplepayhealth.com
HDHP Medical Plan Group #: 925871	Medical insurance plan	UnitedHealthcare	Member Services: 888-331-3408	www.whyuhc.com/nexus2
Health Savings Account (HSA)	Health Savings Account for UHC HDHP	TaxSaver	800-328-4337	www.taxsaverplan.com
Choice Plus Medical Plan Group #: 925871	Medical insurance plan	UnitedHealthcare	Member Services: 800-865-9386	www.myuhc.com
Healthy Start MEC Plan Group #: 7800-000101	Medical insurance plan	UnitedHealthcare	Member Services: 855-892-2401 Option 2	www.myallsaversconnect.com
UHC Pharmacy Plan Group #: INVITED Rx Bin: 610011 Rx PCN: IRX	Prescription insurance plan for hdhp or choice plus	OptumRx	Member Services: 855-524-0381 Specialty Pharmacy Support: 877-656-9604	www.specialty.optumrx.com
Tobacco Cessation Program	Quit tobacco program	American Institute for Preventive Medicine	800-345-2476 extension 1	www.healthylife.com
Dental Plan Group #: 05813	Dental insurance plan	Delta Dental	PPO: 800-521-2651 DHMO: 800-422-4234	www.deltadental.com
Vision Plan Group #: 34013	Vision insurance plan	Superior Vision by MetLife	833-393-5433	www.metlife.com
Flexible Spending Accounts (FSA)	Health care & dependent care savings account	TaxSaver	800-328-4337	www.taxsaverplan.com
Commuter Savings Account	Transit & parking savings account	TaxSaver	800-328-4337	www.taxsaverplan.com
Life & AD&D Policy #: 09-LF1568	Life insurance plans	Lincoln Financial	888-408-7300	www.lincolnfinancialgroup.com
Short-Term Disability and Long-Term Disability Policy #: 09-LF1568	Disability insurance plans	Lincoln Financial	888-408-7300	www.lincolnfinancialgroup.com
Accident **Critical Illness** **Hospital Indemnity** Policy #: 09-LF1568	Supplemental health insurance plans	Lincoln Financial	888-408-7300	www.lincolnfinancialgroup.com
Legal Insurance	Access to legal & attorney services	MetLife	800-821-6400	legalplans.com
MetLife/Aura Identity Theft & Fraud Protection	Identity & fraud protection	MetLife	800-638-5433	www.metlife.com/identity-and-fraud-protection/
Pet Insurance	Veterinary insurance	MetLife	855-270-7387	www.metlifepetinsurance.com
Home & Auto Plans	Personal home & auto insurance	MetLife & Farmers Insurance	800-438-6381	www.farmers.com/groupselect
BenefitsMe	Interest free purchases	BenefitsME	800-960-4509	http://shop.benefitsme.com/

Invited Club's Required Notices

FOR YOUR FILES

This booklet contains legal notices for participants in group health plan(s) sponsored by Invited Clubs. The notices included in this booklet are:

- **Health Insurance Marketplace Coverage Options and Your Health Coverage** that describes the Health Insurance Marketplace and eligibility and tax credit information
- **Notice of Privacy Practices** that explains how the health care plan(s) protect your personal medical information.
- **Medicare Part D Notice** that provides information about how your current prescription drug coverage under the health care plan(s) is affected—and your options for coverage—when you become eligible for Medicare.
- **COBRA Rights Notice** that explains when you and your family may be able to temporarily continue coverage under the health care plan(s) if coverage would otherwise end for you.
- **Newborn & Mothers Health Protection Notice** that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.
- **Women's Health and Cancer Rights Act** that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.
- **Patient Protection Disclosure** that explains who you and your family can designate as a primary care provider under the health care plans and rules around access to obstetrical/gynecological care.
- **Wellness Program and Reasonable Alternatives Notice** that informs Employees of what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential , as well as options for those who have a medical condition that makes wellness program participation difficult.
- **Expanded Coverage for Women's Preventive Care** that explains how the health care plan(s) cover(s) women's preventive care, including contraceptives, under the Affordable Care Act
- **Notice of Special Enrollment Rights** that explains when you can enroll in the health care plan(s) due to special circumstances.
- **60-Day Special Enrollment Period** that describes a special 60 -day timeframe to elect or discontinue coverage.

IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see pages 48-49 for more details.

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

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 or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your 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 summary plan description or contact Benefits at 800-800-4615 or **benefits@invitedclubs.com**.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

3. Employer name Invited	3. Employer Identification Number (EIN) 75-2114856	
4. Employer address 5221 N. O'Connor Blvd, Suite 300	5. Employer phone number 972-243-6191	
6. City Irving	7. State TX	8. ZIP code 75039
9. Who can we contact about employee health coverage at this job? Benefits Department		
10. Phone number (if different from above)	11. E-mail address **benefits@invitedclubs.com**	

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

- As your employer, we offer a health plan to some Employees.

Eligible Employees are:

- Active, full-time Employees working a minimum of 30 hours per week and have met the required waiting period.
- With respect to dependents, we do offer coverage.

Eligible dependents are:

- Your legal spouse
- Dependent children up to age 26
- Dependent children, regardless of age, who are incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your Medical Plan to continue coverage past age 26

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, **www.healthcare.gov** will guide you through the process.

INVITED MEDICAL PLANS NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

OUR COMPANY'S PLEDGE TO YOU

This notice is intended to inform you of the privacy practices followed by the Invited Medical Plans (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 1/1/2025.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Invited requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

PROTECTED HEALTH INFORMATION

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

HOW WE MAY USE YOUR PROTECTED HEALTH INFORMATION

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Invited for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

YOUR RIGHTS

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

OUR LEGAL RESPONSIBILITIES

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Sherry Vidal-Brown Invited

5221 N. O'Connor Blvd, Suite 300

Irving, TX 75039

800-800-4615 & **benefits@invitedclubs.com**

COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit **www.hhs.gov/ocr** for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

IMPORTANT NOTICE FROM INVITED ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Invited 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. Invited has determined that the prescription drug coverage offered by the Invited Choice Plus and SimplePay Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Invited coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Invited 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 Invited and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Invited 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 "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date: 1/1/2025

Name of Entity/Sender: Invited Contact/Office: Benefits Team

Address: 5221 N. O'Connor Blvd, Suite 300, Irving, TX 75039 Phone Number: 800-800-4615

IMPORTANT NOTICE FROM INVITED ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Invited 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are three 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. Invited has determined that the prescription drug coverage offered by the Invited Healthy Start Plan and High Deductible Health Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Invited Medical Plans. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from Invited Medical Plans. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully — it explains your options.

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.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

Since the coverage under Invited Medical Plans is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 Invited coverage may be affected.

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

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Invited 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).

Date: 1/1/2025

Name of Entity/Sender: Invited Contact/Office: Benefits Team

Address: 5221 N. O'Connor Blvd, Suite 300, Irving, TX 75039 Phone Number: 800-800-4615

COBRA RIGHTS NOTICE

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days from when the qualifying event occurs. You must provide this notice to the Benefits Department.

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning the earlier of:

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit **https://www.medicare.gov/medicare-and-you**.

[1] **https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods**.

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Date: 1/1/2025

Name of Entity/Sender: Invited Contact/Office: Benefits Team

Address: 5221 N. O'Connor Blvd, Suite 300, Irving, TX 75039 Phone Number: 800-800-4615

Other Notices

WELLNESS PROGRAM AND REASONABLE ALTERNATIVES NOTICE

The tobacco cessation program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the tobacco cessation program you will be asked to complete the program and provide your diploma of completion to the Benefits Department no later than 90 days from the effective date of your coverage.

However, employees who choose not to participate in the tobacco cessation wellness program will receive a surcharge of $162.50 per month. Although you are not required to complete the tobacco cessation program only employees who do so will avoid the surcharge.

If you are unable to participate or achieve a smokeless status required to avoid the surcharge, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the benefits department at **benefits@invitedclubs.com**.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Invited may use aggregate information it collects to design a program based on identified health risks in the workplace, the tobacco cessation program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the American Institute for Preventive Medicine in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

REASONABLE ALTERNATIVES

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under the tobacco cessation wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Benefits Department at **benefits@invitedclubs.com** and we will work with you (and if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the benefits department at **benefits@invitedclubs.com**.

EXPANDED COVERAGE FOR WOMEN'S PREVENTIVE CARE

Under the Affordable Care Act, Invited provides female plan participants with expanded access to recommended in-network preventive services, including contraceptives, without cost sharing.

Additional women's preventive services that will be covered without cost sharing requirements include:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- STI counseling, and HIV screening and counseling
- Contraception and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening

For a description of what these items include, visit **https://www.healthcare.gov/preventive-care-women/**.

PATIENT PROTECTION DISCLOSURE

Invited generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Benefits at 800-800-4615 or **benefits@invitedclubs.com**.

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

You do not need prior authorization from Invited or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Benefits at 800-800-4615 or **benefits@invitedclubs.com**.

60-Day Special Enrollment Period

In addition to the qualifying events listed in this document, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in Invited medical coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no more than 30 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in Invited medical coverage as long as you request enrollment by contacting the benefits manager no more than 30 days after the marriage, birth, adoption or placement for adoption. For more information, contact Invited, Benefits at 800-800-4615 or **benefits@invitedclubs.com**.

NEWBORN & MOTHERS HEALTH PROTECTION NOTICE

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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 consultations with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact the benefits department or your medical plan administrator.

This Benefit Guide is not a legal document and does not replace or supersede the Certificate of Coverage or Summary Plan Description. Please refer to the Certificate of Coverage or Summary Plan Description for a complete description of the coverage, eligibility criteria, controlling terms, exclusions, limitations, and conditions of coverage.

Invited reserves the right to terminate, suspend, withdraw, reduce, or modify the benefits described in the Certificate of Coverage or Summary Plan Description in whole or in part, at any time. No statement in this or any other document and no oral representation should be construed as a waiver of this right. This Benefit Guide is the confidential property of Invited.