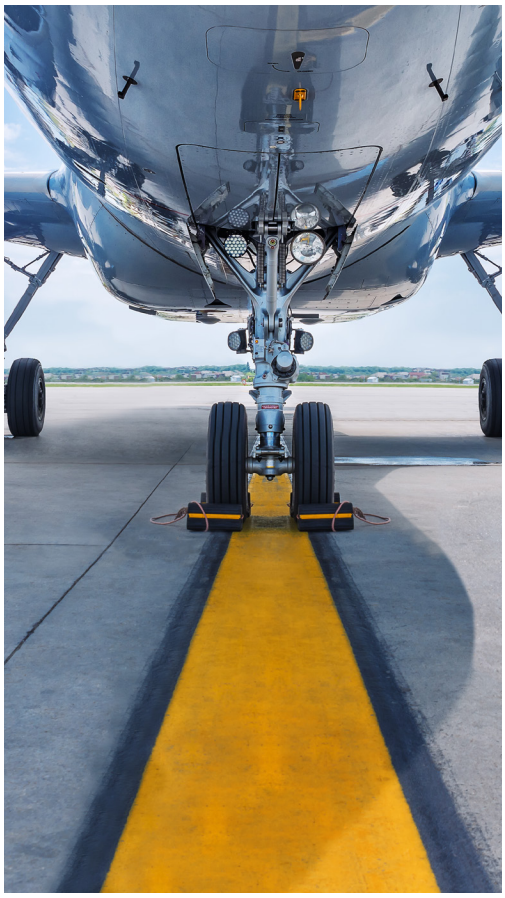
Paradigm Precision

2023



BENEFITS GUIDE

WELCOME

TO ANNUAL ENROLLMENT!

Paradigm Precision appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefit plans. We understand that you may have questions about annual enrollment, and we'll do our best to help you understand your options and guide you through the process.

This guide is not your only resource, of course. Anytime you have questions about benefits or the enrollment process, you can contact your human resources representative. Although this guide contains an overview of benefits, for complete information about the plans available to you, please see the summary plan description (SPD) at myparadigmbenefits.com

Here's where to find ...

What's NEW for 2023! 3

Medical 5

Telemedicine 6

Benefits Accounts 7

Dental 10

Vision 11

Life Insurance 13

Disability Insurance 14

Paradigm Perks 17

Employee Assistance Program 18

Enrollment & Eligibility 21

Glossary For Insurance Terms 23

You can find a complete summary plan desctiption at:

www.myparadigmbenefits.com

What's NEW for 2023!

At Paradigm Precision, we are committed to providing a world-class work environment for our people—our greatest asset. A key aspect of that commitment is our investment in a well-rounded benefits package.

Each year, Paradigm evaluates our benefits with a focus on providing a cost-effective, competitive package. We believe your health is important and we continue to invest in wellness resources for all employees. Our goal is to provide offerings that continue to evolve and meet the needs of you and your family.

Open enrollment begins on Monday, October 31st and ends on Friday, November 11th. This year we are having an **ACTIVE ENROLLMENT**, meaning that you must login to ADP at www.workforcenow.adp.com to confirm your benefits, even if you are not making changes for the 2023 plan year. Be sure to confirm your HSA elections again, even if you are not making any changes.

Members changing their medical plan will receive a new Cigna medical ID card in the mail priory to January 1st. Members remaining on the HSA+ Plan (formerly named the Core HSA plan) will not receive a new ID card. Members enrolled in the PPO Plan Plan OR changing medical plans will receive a new Cigna medical ID card in the mail prior to January 1st.

What is Changing for 2023

Coverage	Change
Medical	Addition of a new medical plan Plan design changes Employee contribution changes
Other	Addition of PerkSpot Removal of $40.00 per month vaccine surcharge

What is staying the same for 2023

Life of Coverage	Carrier
Medical	Cigna (plan and employee contribution changes)
Pharmacy	Welldyne (plan changes)
Dental	Anthem (employee contribution changes)
Vision	EyeMed
Life/Voluntary Life	Reliance Standard
Short Term and Long Term Disability	Reliance Standard
Critical Illness and Accident	Reliance Standard
Pet Insurance	Nationwide
Enrollment Platform	ADP

Qualifying life events

It is your responsibility to notify human resources within 30 days of the qualifying life event. Failure to do so may result in an inability to change your benefit election(s).

Here are some examples of qualifying life events:

- Birth, legal adoption or placement for adoption.
- Marriage, divorce or legal separation.
- Dependent child reaches age 26.
- Spouse or dependent loses or gains coverage elsewhere.
- Death of your spouse or dependent child.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or the state children's health insurance program.

MEDICAL

	2023 Plan Designs		
Plan Name	**Basic HSA**	**HSA+**	**PPO**
	Embedded In Network Benefits		
Deductible (Individual/Family)	$6,500/$13,000	$3,000/$6,000	$1,000/$2,000
HSA Contribution* *can earn up to $500/$1000	$100 / $200	$100 / $200	N/A
Out-of-Pocket Maximum (Individual/Family)	$7,500/$15,000	$6,000/$12,000	$2,000/$4,000
Coinsurance	75%	80%	90%
PCP / Specialist Visit	Deductible then 75%	Deductible then 80%	$15 copay / $20 copay
ER Visit	Deductible then 75%	Deductible then 80%	$100 copay
Urgent care	Deductible then 75%	Deductible then 80%	$50 copay
Inpatient	Deductible then 75%	Deductible then 80%	Deductible then 90%
Outpatient	Deductible then 75%	Deductible then 80%	Deductible then 90%
Lab / X-Ray	Deductible then 75%	Deductible then 80%	Deductible then 90%
CT/PET/MRI	Deductible then 75%	Deductible then 80%	Deductible then 90%
Pharmacy Deductible	**Combined with Med**	**Combined with Med**	**Combined with Med**
Tier 1 (Generic)	Deductible then $15	Deductible then $10	$5 copay no deductible
Tier 2 (Preferred Brand)	Deductible then $30	Deductible then $40	$10 copay no deductible
Tier 3 (Non-Preferred Brand)	Deductible then $45	Deductible then $60	$20 copay no deductible
Tier 4 (Specialty)	Deductible then 25% up to $125	Deductible then 20% up to $125	10% Coinsurance up to $125
90-day Retail / Mail Order	2X retail	2X retail	2X retail
Out-of-Network Benefits			
Deductible (Individual/Family)	$8,000/$16,000	$8,000/$16,000	$3,000/$6,000
Out-of-Pocket Maximum (Individual/Family)	$10,000/$20,000	$10,000/$20,000	$4,000/$8,000
Coinsurance	50%	50%	70%
Rx	Not covered	Not covered	Not covered

VIRTUAL CARE

MDLIVE®

What is Virtual Care?

Between your responsibilities at work and in your day-to-day life, you stay busy. And, while you may plan to maintain or even improve your health, it's not always easy to make time for routine and preventive care. After all, doctors' appointments traditionally involve time and travel — and that usually means taking time off of work. Virtual primary care is through MDLIVE®.This convenient new option makes it easy to connect to a board-certified primary care physician (PCP) for routine care, plus preventive care with a virtual wellness screening — all on a schedule that works for you. Best of all, virtual primary care is available to you and your eligible dependents[1] as part of your health benefits.

Routine and preventive care that works for you — and with you.

- Connect to care from just about anywhere via video or phone
- Get virtual primary care 7 days a week, 365 days a year, including flexible hours
- Access board-certified physicians for routine care, as well as preventive care with a wellness screening
- Choose your provider and build a relationship with the same PCP for follow-ups
- Receive prescriptions, if appropriate, that can be sent to a local or home delivery pharmacy
- Schedule an appointment through myCigna.com in just minutes
- Undergo labs, blood work and biometrics at local facilities[2]
- Receive referrals to specialists, when appropriate

3 Easy Steps to Connect to Care

Virtual primary care visits are quick, easy and affordable. To schedule an appointment:

Access MDLIVE by logging into myCigna.com and click on "Talk to a doctor." You can also call MDLIVE at 888.726.3171.

Select virtual medical care

Make an appointment whenever it's convenient

Appointments are available via video or phone, whenever it's most convenient for you. Wellness screenings are also available at no additional cost to you or your eligible dependents ages 18+, as part of preventive care.[3]

Visit myCigna.com to make an appointment for virtual primary care.

1. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna medical members aged 18 and older.

2. Limited to LabCorp and Quest labs contracted with MDLIVE for virtual primary care.

3. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.

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BENEFITS ACCOUNTS

Paradigm's HSA is administered by Cigna Choice Fund TakeCharge. Health Savings Accounts, or HSA's, are like personal savings accounts, but the money in them can only be used for IRS qualified medical expenses including medical, dental and vision expenses. You - Not your employer or insurance company - own and control the money in this account. Note to self: the money you deposit is not taxed.

Your employer contributes up to $500 for employee-only coverage & $1,000 for Employee + Dependent(s). A portion of these funds is earned by completing wellness incentives.

Who can set up a Health Savings Account?

To be eligible for and contribute to an HSA, you must:

- ✓ Be enrolled in a qualified High-Deductible Health Plan (HDHP)
- ✓ Not be claimed as another person's tax dependent
- ✓ Those enrolled in the Medicare CANNOT contribute to an HSA. (if you are collecting Social Security, you are likely enrolled in Medicare. If you are unsure, contact the Centers for Medicare Services at 1-800-MEDICARE or access www.medicare.gov and then check "Your Enrollment Toll")
- ✓ Not be enrolled in a general-purpose Flexible Spending Account (FSA), but a limited purpose FSA may be available to you.

Who can set up a Health Savings Account?

HSA's Are Triple Tax Free!

All contributions are tax free to you, regardless of sources. That means withdrawals for qualified expenses are tax free and interest accumulates in your account tax free.

You Own Your HSA!

Unused funds rollver from year to year and belong to you. Use the funds to pay for the qualified expenses or let the money grow. Your account is portable to you and you are in control of the expenditures.

TIP!

For 2023, the IRS limits are $3,850 for individuals and $7,750 for family coverage. You are responsible for knowing the rules and keeping accurate records (save your receipts!). You will receive annual form 1099SA and 5498SA from the bank in order to report your contributions, earnings, and distributions on your individual tax return.

HEALTH AWARD INCENTIVE PROGRAM

Basic HSA and HSA+ Plans

Max Employer Contributions:
$500 for Employee Only
$1,000 for Employee + Dependent(s)

Paradigm Precision will contribute 20% up front ($100 for employee only and $200 for employee + dependents) and the remaining 80% must be earned by completing **one activity from each category:**

Preventative Care

- COVID-19 Vaccine (both doses)
- Annual Physical
- Annual OBGYN Exam
- Mammogram
- Colon Cancer Screening
- Cervical Cancer Screening
- Prostate Screening

Additional Wellness Activities

- Receive a COVID-19 booster shot
- Receiving the flu shot
- Annual cleaning with the dentist
- Complete Cigna's Health Risk Assessment
- Participate in Cigna's Health Advisor Coaching/Your Health First Coaching Programs for Diabetes

To receive funding for your COVID vaccine, you must receive the full vaccination in 2023 and report it on the Incentives page on the MyCigna website/app under Extra Goals. Award is subject to audit by HR.
The earned portion of the HSA contribution will be funded to employee accounts on a quarterly basis. All activities must be completed by October 31st to receive funding.

HEALTH AWARD INCENTIVE PROGRAM

PPO Plan

Employees participating in the PPO Plan are eligible for the Health Award Incentive Program as well. To qualify, employees must complete **one activity from each category:**

Preventative Care

- COVID-19 Vaccine (both doses)
- Annual Physical
- Annual OBGYN Exam
- Mammogram
- Colon Cancer Screening
- Cervical Cancer Screening
- Prostate Screening

Additional Wellness Activities

- Receive a COVID-19 booster shot
- Receiving the flu shot
- Annual cleaning with the dentist
- Complete Cigna's Health Risk Assessment
- Participate in Cigna's Health Advisor Coaching/Your Health First Coaching Programs for Diabetes

To receive funding for your COVID vaccine, you must receive the full vaccination in 2023 and report it on the Incentives page on the MyCigna website/app under Extra Goals. Award is subject to audit by HR. **If both activities are completed by October 31st, employees will be eligible for a $250 Health Award Incentive (taxable bonus).**

DENTAL

Anthem.

Aside from protecting your smile, dental care ensures good oral and overall health. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body--including your heart. Understanding and choosing dental coverage will help protect you and your family from high costs and dental disease and surgery.

Dental Benefits	CORE Dental Plan	BUY-UP Dental Plan
Network Name	**Anthem Dental Complete**	**Anthem Dental Complete**
Calendar Year Maximum	$1,000 (applies to Level 1, 2, 3)	$1,500 (applies to Level 1, 2, 3)
Calendar Year Deductible	$50 Ind. / $150 Family (applies to Level 2 & 3)	$25 Ind. / $75 Family (applies to Level 2 & 3)
Level 1 Coverage: Preventive Care	Deductible Waived Covered at 100%	Deductible Waived Covered at 100%
Level 2 Coverage: Basic Care	Deductible, then you pay 20%; Carrier pays 80%	Deductible, then you pay 20%; Carrier pays 80%
Level 3 Coverage: Major Care	Not Covered	Deductible, then you pay 50%; Carrier pays 50%
Level 4 Coverage: Orthodontia (Children only, to age 26)	Not Covered	50% (Lifetime Max - $1,500)
Out of Network:Coverage Limits	90th Percentile	90th Percentile

When you schedule regular preventive checkups, your dentist can detect problems early. This can help avoid more costly and complex procedures, like crowns and root canals, down the road. In fact, for each dollar spent on preventive services, it is estimated that $50 or more is saved on more expensive procedures.

Reminder: your annual dental check up counts towards your HSA wellness incentives!

Effective Jan. 1, 2023

	Buy-Up Plan	Core Plan
Dental biweekly employee payroll contributions		
Employee	$9.89	$2.31
Employee + spouse	$21.06	$4.80
Employee + child(ren)	$23.13	$5.83
Family	$36.76	$8.99
Dental weekly employee payroll contributions		
Employee	$4.95	$1.16
Employee + spouse	$10.53	$2.40
Employee + child(ren)	$11.57	$2.92
Family	$18.38	$4.49

Employees can elect the medical and prescription drug plan without enrolling in the dental or vision plan.

VISION

Routine eye exams will help you maintain your vision as well as detect various eye problems and concerns about your overall health. Obtaining vision insurance is a way to make sure you can continue enjoying good health as well as the sight around you.

Vision Benefits	In-Network	Out-Of-Network
Routine Eye Exam (every 12 months)	$10 Copay	Reimbursed up to $45
Single Vision Lenses (every 12 months)	$25 Copay	Reimbursed up to $30
Bifocal Lenses (every 12 months)	$25 Copay	Reimbursed up to $50
Contacts Instead of glass lenses (every 12 months)	80% of balance over $130 Allowance	Up to $105 Allowance
Contact Lens Fitting & Follow-Up (every 12 months)	$60 Copay, then 15% Discount	Up to $105 Copay
Frames (every 24 months)	20% of balance over $130 Allowance	Reimbursed up to $70

Effective Jan. 1, 2023

	Vision Plan
Vision biweekly employee payroll contributions	
Employee	$0.66
Employee + spouse	$1.08
Employee + child(ren)	$1.08
Family	$1.74
Vision weekly employee payroll contributions	
Employee	$0.33
Employee + spouse	$0.54
Employee + child(ren)	$0.54
Family	$0.87

Employees can elect the medical and prescription drug plan without enrolling in the dental or vision plan.

2023 PAYROLL DEDUCTIONS

	Weekly Employee Contribution	Bi-weekly Employee Contribution
Medical Basic HSA Plan		
Employee	$0.00	$0.00
Employee + spouse	$33.32	$66.64
Employee + child(ren)	$30.15	$60.29
Family	$47.60	$95.20
Medical HSA+ Plan		
Employee	$31.02	$62.05
Employee + spouse	$65.15	$130.30
Employee + child(ren)	$58.94	$117.89
Family	$93.07	$186.15
Medical PPO Plan		
Employee	$105.78	$211.56
Employee + spouse	$211.03	$422.06
Employee + child(ren)	$190.93	$381.86
Family	$301.47	$602.94
Dental Core Plan		
Employee	$1.16	$2.31
Employee + spouse	$2.40	$4.80
Employee + child(ren)	$2.92	$5.83
Family	$4.49	$8.99
Dental Buy Up Plan		
Employee	$4.95	$9.89
Employee + spouse	$10.53	$21.06
Employee + child(ren)	$11.57	$23.13
Family	$18.38	$36.76
Vision Plan		
Employee	$0.33	$0.66
Employee + spouse	$0.54	$1.08
Employee + child(ren)	$0.54	$1.08
Family	$0.87	$1.74

Working Spouse Adjustments

	Weekly Employee Contribution	Bi-weekly Employee Contribution
Basic HSA Plan		
EE + spouse with Adjustment	$56.40	$112.80
Employee + family with adjustment	$70.68	$141.35
HSA+ Plan		
EE + spouse with Adjustment	$88.23	$176.46
Employee + family with adjustment	$116.15	$232.30
PPO Plan		
EE + spouse with Adjustment	$234.11	$468.21
Employee + family with adjustment	$324.55	$649.09

LIFE INSURANCE

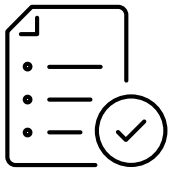
RELIANCE STANDARD
LIFE INSURANCE COMPANY

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

The premium for this benefit is paid 100% by your employer.

TIP!

Review and/or update your beneficiaries annually at open enrollment. A beneficiary is someone that would get your life insurance/AD&D payment in the event of you losing your life. You can have as many primary and contingent beneficiaries as you need or want. You can change your beneficiaries at any time.



Basic Life & AD&D	Benefit
Life Benefit	1X Base Annual Salary to maximum of $300,000
AD&D Benefit	Equal to Life Amount
Age Reduction Schedule	Reduces by 50% at age 70

Voluntary Life and Accidental Death & Dismemberment (AD&D)

This is an optional benefit that is paid entirely by you, the employee. This protection can be important not only for you, but for eligible dependents.

- Evidence of Insurability will be required for all employees, excluding new hires who enroll within 31 days of becoming eligible.
- Evidence of Insurability will be needed to enroll in any amount over the guarantee issue (unless you are newly eligible)!
- Any amount you are currently enrolled in will carry forward.
- You must purchase coverage for yourself in order to purchase coverage for your spouse and dependents

Voluntary Life & AD&D	Employee	Spouse	Child
Purchase Increments	$10,000	$5,000	$2,000
Max issue Amount	$500,000	$500,000 (not to exceed Employee Amount)	$10,000
Guaranteed Issue Amount	$150,000	$30,000	$10,000

DISABILITY INSURANCE

RELIANCE STANDARD
LIFE INSURANCE COMPANY

Short-Term Disability

Short-Term Disability (STD) coverage is designed to help you meet your financial needs if you are unable to work due to a non-occupational injury or illness. For working individuals, a disability is a medical condition that reduces your ability to perform your job duties, usually an injury or illness.

Short-Term Disability	Benefit
Plan Type	Employer Paid
Benefit	60%
Accident Benefits Begin	1st Day
Sickness Benefits Begin	8th Day
Duration of Benefits	12 Weeks

Long-Term Disability

Long-Term Disability (LTD) insurance protects workers in the event they become disabled for a prolonged period prior to retirement.

Long-Term Disability	Benefit
Plan Type	Employer Paid
Benefit	60%
Maximum Weekly Benefit	$7,500
Elimination Period	90 Days
Duration of Benefits	12 Weeks

TIP!

Currently, there are state-mandated disability insurance requirements in California, Hawaii, New Jersey, New York and Rhode Island. Speak with HR or reference your state's goverment web page for updates and changes.

FAMILY AND MEDICAL DISABILITY LEAVE

How to file a new Short-Term Disability claim

File a new Short-Term Disability claim any time (24/7) using one of the following methods:

- Online at matrixabsence.com.
- Using the Matrix eServices mobile app on your Android or iOS phone or tablet. Use the same login credentials used for matrixabsence.com.
- Call the Matrix toll-free phone number: 1-877-202-0055.

Be ready to provide your personal, job, illness/injury and provider information. Within 24 hours, you will receive an Absence Packet from Matrix noting what documentation is needed.

How to file a Connecticut Paid Family and Medical Leave (CT PFML) claim

To apply for paid leave online, you will first need to create an account with CT.gov. Once you have an account you will have easy access to:

- Submit a claim
- View the status of your claim
- Check payments for your claim
- Add time to an existing claim
- Upload documents to your claim
- Message your case manager
- View correspondence

Ready to submit and view your claims?
Visit https://ctpaidleave.org/s/employee-landing-page?language=en_US to get started.

Visit https://myparadigmbenefits.com/family-medical-and-disability-leave/ for more information and resources about Family Medical and Disability Leave

How to file a Massachusetts Paid Family and Medical Leave (MA PFML) claim

File a new MA PFML claim any time (24/7) using one of the following methods:

- Online at matrixabsence.com.
- Using the Matrix eServices mobile app on your Android or iOS phone or tablet. Use the same login credentials used for matrixabsence.com.
- Call the Matrix toll-free phone number: 1-877-202-0055.

In addition to filing your claim with Matrix, you must provide at least 30 days' advance notice of your intent to take leave to Paradigm, or provide notice as soon as practicable if the need for leave is not foreseeable.

How to file a new FMLA claim

File a new FMLA claim any time (24/7) using one of the following methods:

- Online at matrixabsence.com.
- Using the Matrix eServices mobile app on your Android or iOS phone or tablet. Use the same login credentials used for matrixabsence.com.
- Call the Matrix toll-free phone number: 1-877-202-0055.

Be ready to provide your personal, job, illness/injury and provider information. Within 24 hours, you will receive an Absence Packet from Matrix noting what documentation is needed.

Additional Voluntary Benefits

Critical Illness Insurance & Accident Insurance

These coverages are voluntary and paid for by you, the employee.

Critical Illness:

Wellness Benefit-Members are provided a $50 per year benefit for completing certain routine wellness screenings or procedures.

Employees	Option of $5,000 to $50,000 in increments of $5,000, Guarantee Issue: $25,000
Spouse	Option of $5,000 to $50,000 in increments of $5,000, Guarantee Issue: $25,000. Has to be under age 70 and coverage terms at age 75.
Dependent Children	Coverage limited to 25% of employee approved Amount of Insurance to a Guarantee Issue and maximum of $12,500.

Group Accident:

Insurance is designed to help covered employees meet the out of pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic. Lump sum benefits are paid directly to you based on the schedule of benefits. No health questions are required to elect coverage. Refer to the chart for a few examples.

Emergency Room visit	$150 benefit is payable to you
X-rays	$25 benefit is payable to you
Initial Hospital Admission	$500 benefit is payable to you
Concussion	$100 benefit is payable to you
Physical Therapy	$25 per session benefit is payable to you, 6 sessions max

Pet Insurance

Paradigm Precision offers you the opportunity to purchase Pet Insurance with Nationwide.

There are three simple ways to sign up:

1. Go directly to the dedicated URL for your company: http://www.petinsurance.com/paradigmprecision This link is also available in ADP.
2. Visit PetsNationwide.com and enter your company name
3. Call 877-738-7874 and mention that you are an employee of Paradigm Precision to receive preferred pricing

Paradigm Perks

PerkSpot

What is the Paradigm Discount Program? Your PerkSpot Discount Program is a one-stop-shop for thousands of exclusive discounts in more than 25 different categories. That means there's something for everyone!

How to navigate your discount program

Local Offers
Located in the Quick Links section, Local Offers allow you to use your location to see all of the discounts near you, wherever you are! Discounts can be filtered by category and distance.

Interests
Let us know what what you're interested in so we can ensure you're seeing the perks you'll most enjoy, front and center on your Discount Program Home Page.

Brands
Looking for something specific? The Brands tab, found in the Quick Links section, is an easy and quick way to search for all the discounts available to you.

Suggest a Business
Don't see what you're looking for? Head to the Suggest a Business page, found in the upper right-hand corner of your Home Page, to suggest your favorite brands and local spots be added to your Discount Program.

Need Some Help? Reach Out To Us!
PerkSpot's customer service team works tirelessly to help you access your Discount Program and redeem deals easily. Below are some important details regarding customer service availability.

Hours
Monday-Friday
9am-6pm

Phone Number
866-606-6057

Email
cs@perkspot.com

Support*
support.perkspot.com

**If you've still got some questions, visit support.perkspot.com to submit a request. Our bilingual Customer Service team will reach out and can answer any questions in both English and Spanish.*

Ready to register? Head to http://locktonnortheast.perkspot.com to create an account!

Employee Assistance Program

Legal and Financial Services

Employees and family members are eligible to receive legal and financial consultation for an unlimited number of issues at no cost. 24/7 access is also available to a secured site for information, resources and personal documents.

- **Legal Services**
- **Financial Services**
- **Document Preparation**

Bereavement Support Services

Bereavement Support Services provide confidential and professional support services to all covered employees and family members to cope with the loss of a loved one—at no extra cost.

long with your coverage from Reliance Standard Life Insurance Company, you are offered access to unlimited and confidential telephonic grief counseling, legal and financial consultation through ACI Specialty Benefits just when you need it most.

- **Grief Counseling**
- **Legal and Financial Services**
- **Program Access**

Assistant Program

Reach out to your Assistance Program for short-term counseling, financial coaching, care giving referrals and a wide range of well-being benefits to reduce stress, improve mental health and make life easier.

The following services are free to use, confidential, and available to you and your family members:

- **Mental Health Sessions**
- **Life Coaching**
- **Financial Consultation**
- **Legal Consultation**
- **Life Management**
- **Personal Assistant**
- **Medical Advocacy**
- **Member and Portal App**

Member and Portal App

Your Assistance Program offers a wide range of benefits to help improve mental health, reduce stress and make life easier—all easily accessible through your member portal and app.

- **Video, Chat and Telephonic Access**
- **Thousands of Self-Care Articles and Resources**
- **Events Calendar and Free Webinars**
- **Exclusive Discounts**

What Can Cigna Do For You?

Pre and Post Enrollment Line Support

Cigna makes it easy to be healthier.
Cigna offers so much more than your employer's medical coverage. From helping you answer health questions 24 hours a day to a virtual team of health and wellness coaches, we're here for you.

- **24/7/365 service**
  Whenever you need us, just call the toll-free number printed on the back of your Cigna ID card 24 hours a day, seven days a week, 365 days a year.
- **Health Information Line**
  Have a health question? You can talk with a clinician 24 hours a day, seven days a week.
- **Network of quality doctors**
  You can save money when you use a doctor, hospital or facility that's part of your plan's Cigna network. It's easy to find quality, cost-effective care right where you need it. You can find a doctor right on mycigna.com or on the myCigna® website or app once enrolled.
- **Cigna Veteran Support Line**
  This free hotline is available 24/7/365 to all veterans, their families and caregivers. No need to be a Cigna customer.

Cigna One Guide

Call a Cigna One Guide representative during preenrollment to get personalized, useful guidance. Your personal guide will help you:

- Easily understand the basics of health coverage
- Identify the types of health plans available to you
- Check if your doctors are in-network to help you avoid unnecessary costs
- Get answers to any other questions you may have about the plans or provider networks available to you

The best part is, during the enrollment period, your personal guide is just a call away. Don't wait until the last minute to enroll. Call **888.806.5042** to speak with a Cigna One Guide representative today.

Questions about your health plan? One Guide is here with answers.

Understand Your Plan	Get Care	Save and Learn
		

Employee Assistance Program

At No Cost To You

Cigna's Omada Diabetes Prevention Program

Omada is a digital lifestyle change program designed to help you lose weight, gain energy, and reduce the risks of type 2 diabetes and heart disease. The program surrounds you with the tools and support you need to make lasting, meaningful changes to the way you eat, move, sleep, and manage stress—one small step at a time.

You'll receive the program at no additional cost if you or your covered adult dependents are enrolled in the company medical plan offered through Cigna, are at risk for type 2 diabetes or heart disease, and are accepted into the program. To learn more, visit omadahealth.com/paradigmprecision.

Cigna's Your Health First® Chronic Condition Coaching Program

If you have a chronic health condition you'll develop a one-on-one relationship with a dedicated health coach, to help you:

- Manage a chronic health condition, ranging from asthma and low back pain to depression and coronary artery disease, among many others
- Make more educated decisions about your health and treatment options
- Obtain information and resources about your condition
- Save money on your medically related expenses
- Create a plan to help improve your health, based on your personal goals
- Understand medications and doctor's orders
- Identify the triggers that affect your condition
- Know what to expect if you need to stay in the hospital

Reminder: Participation counts towards the incentive programs

Enrollment & Eligibility

All coverage effective **January 1, 2023.**

Coverage	Eligibility	Coverage Starts	Coverage Ends
Medical	All full-time employees who work more than 30 hours per week.	You are eligible for coverage on the first day of the month following date of hire.	For employees, on the last day of the month that you or your dependents are no longer eligible; for children, on the last day of the month in which they turn 26.
Dental	All full-time employees who work more than 30 hours per week.	You are eligible for coverage on the first day of the month following date of hire.	For employees, on the last day of the month that you or your dependents are no longer eligible; for children, on the last day of the month in which they turn 26.
Vision	All full-time employees who work more than 30 hours per week.	You are eligible for coverage on the first day of the month following date of hire.	For employees, on the last day of the month that you or your dependents are no longer eligible; for children, on the last day of the month in which they turn 26.
Life & Disability Insurance	All full-time employees who work more than 30 hours per week.	You are eligible for coverage on the first day of the month following date of hire.	For Life and AD&D, on the last day of the month after termination; for disability, on the date that you are no longer eligible. Dependent children are covered to age 19 or 23 if they are a full time student.
Critical Illness & Accident Insurance	All full-time employees who work more than 30 hours per week.	You are eligible for coverage on the first day of the month following date of hire.	For employees, on the last day of active employment; for children, on the day in which they turn 26. This policy is portable on date of term.
Pet Insurance	All full-time employees who work more than 30 hours per week.	You are eligible for coverage on the first day of the month following date of hire.	For employees, on the last day of active employment. This policy is portable on date of term. You can enroll or term this coverage at any time.

Account Type	Details
Health Savings Account (HSA)	Only for employees enrolled in the HSA+ Medical Plan. Your employer contributes $500 for Employee-only coverage & $1,000 for Employee + Dependent(s) coverage.

Enrollment & Eligibility

Where can I enroll?

Log onto your ADP Workforce Now account to elect your benefits for 2023 during the annual open enrollment period.

Who can I add to my plan?

- Legally married spouse
- Natural or adopted children up to age 26
- Children under legal guardianship
- Stepchildren
- Domestic Partners - medical only
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

When can I make changes?

Generally, you may enroll in benefits, or make changes to your benefits, when you are first eligible or during open enrollment. However, you can make changes/enroll during the plan year if you experience a **qualifying event** (marriage, have a baby, divorce, lose other coverage, gain other coverage, etc.).

If you have a qualifying event, you must submit your changes **within 30 days of the event**, or you must wait until yearly open enrollment to make any benefits changes.

Visit www.myparadigmbenefits.com to view all required notices under the "Compliance" tab

Glossary of Insurance Terms

Open enrollment is the time of year reserved for making changes to your benefits elections. While it is extremely important to understand each plan before making a decision, it can also be challenging to navigate, and unfamiliar terms can make this process even more stressful. According to a recent workforce study1, two-thirds of employees feel that making sense of benefits is too complicated, and nearly three in four employees report there is some part of their coverage they don't understand.

Below is a quick and easy guide of frequently used employee benefits terms to help you navigate your benefits options and feel confident in your plan selection.

ALLOWED AMOUNT
Maximum amount on which payment is based for covered health care services. This may be called "maximum allowable coverage," "eligible expense," "payment allowance," or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference.

APPEAL
A request for your health insurer or plan to review a decision or a grievance again.

BALANCE BILLING
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

BENEFICIARY
A beneficiary is someone that would receive money or other benefits from the person insured. In life insurance, this is the person who would get your payments in the event you lose your life.

CLAIM
A health insurance claim is a bill for health care services that your health care provider turns in to the insurance company for payment.

COBRA
A federal law that can allow for temporary health coverage after employment ends, the loss of coverage as a dependent of a covered employee or another qualifying event. The individual will pay 100% of the premiums, including the share the employer used to pay, plus a small administrative fee.

COINSURANCE
Your share of the costs of a covered health care service, calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe.

CONSUMER DRIVEN HEALTH CARE (CDHC)
Health insurance plans that are intended to give you more control over your health care expenses. Under CDHC plans, you can use health care services more effectively and have more control over your health care dollars. CDHC plans are designed to be more affordable because they offer reduced premium costs in exchange for higher deductibles.

COPAYMENT
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

COVERED EXPENSES
Health care expenses that are covered under your health plan.

DEDUCTIBLE
The amount you owe for health care services that your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

DEPENDENT
An individual enrolled in the health plan as a qualified dependent of the subscriber and who meet eligibility requirements.

1. Aflac. Aflac 2017 Workforces Report Employee Overview. Accessed August 16, 2019.

EMBEDDED DEDUCTIBLE VS. NONEMBEDDED DEDUCTIBLE

Embedded: A policy with a deductible for each person covered. Benefits kick in for a family member when they meet their individual deductible and for the whole family when at least two members do so. Embedded policies tend to have higher premiums to accommodate lower deductible options.
Nonembedded: A policy with a single, combined deductible for all covered individuals. No benefits begin for any covered individual until this deductible is met either by one member or a combination of several members. The nonembedded policy's higher deductible level carries a lower policy premium than embedded policies.

EVIDENCE OF INSURABILITY

Proof of good health, otherwise known as evidence of insurability (EOI), is an application process in which you provide information on the condition of your health or your dependent's health to get certain types of insurance coverages.

EXCLUSION

A provision within a policy that eliminates coverage for specific medical services or items.
Before 2014, individual health insurance policies frequently contained exclusions for pre-existing medical conditions. As a result of the Affordable Care Act, all new individual major medical policies have been guaranteed issue and pre-existing condition exclusions are no longer allowed.

EXPLANATION OF BENEFITS (EOB)

A statement from your health insurance plan describing the costs it covers for medical care or products received. The EOB is generated when your provider submits a claim for the services you received and provides clarification around the cost of the care received, money saved by visiting in-network providers and out-of-pocket medical expenses you are accountable for.

FLEXIBLE SPENDING ACCOUNT (FSA)

An account that allows you to save tax-free dollars for qualified medical and/or dependent care expenses that are not reimbursed. You determine how much you want to contribute to the FSA at the beginning of the plan year.

GRIEVANCE

A complaint that you communicate to your health insurer or plan.

HEALTH MAINTENANCE ORGANIZATION (HMO)

A type of health insurance plan that usually limits coverage to care from doctors who work for/contract within a specified network. Premiums are paid monthly, and a small copay is due for each office visit and hospital stay. HMOs require that you select a primary care physician who is responsible for managing and coordinating all of your health care.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

An employer-owned medical savings account in which the company deposits pre-tax dollars for each of its covered employees. Employees can then use this account as reimbursement for qualified health care expenses.

HEALTH SAVINGS ACCOUNT (HSA)

An employee-owned medical savings account used to pay for eligible medical expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified time period. HSAs must be coupled with qualified high-deductible health plans (HDHP).

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

A qualified health plan that combines very low monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

IN-NETWORK COINSURANCE

The percent you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

INPATIENT VS. OUTPATIENT

Inpatient: A person who stays in a hospital or other healthcare facility while receiving medical care or treatment. For the purposes of healthcare coverage, health insurance plans require formal admittance into a hospital for a service to be considered inpatient.
Outpatient: A patient who receives medical treatment without being admitted to a hospital. Many surgical services, rehabilitation treatments, as well as mental health services, are available as outpatient services.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

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

MEDICARE

An insurance program administered by the federal government to provide health coverage to individuals aged 65 and older, or who have certain disabilities or illnesses.

MEMBER

You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

NETWORK

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

In-Network Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

Out-Of-Network Health care you receive without a physician referral or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Preferred Provider A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great and you may have to pay more.

Non-Preferred Provider A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health plan has a "tiered" network and you must pay extra to see some providers.

OUT-OF-POCKET EXPENSE

Amount that you must pay toward the cost of health care services. This includes deductibles, copayments and coinsurance.

OUT-OF-POCKET MAXIMUM (OOPM)

Also commonly referred to as out-of-pocket limit. The most you pay during a policy period before your health insurance begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or care that your health insurance doesn't cover.

PHARMACY COVERAGE

Prescription Drugs A pharmaceutical drug, also known as prescription medication or prescription medicine, that legally requires a medical prescription to be dispensed. In contrast, over-the-counter drugs can be obtained without a prescription.

Generic Drugs Generic drugs are copies of brand-name drugs that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety and strength as the original drug. In other words, their pharmacological effects are exactly the same as those of their brand-name counterparts. The FDA (U.S. Food and Drug Administration) requires that generic drugs be as safe and effective as brand-name drugs.

Drug Formulary A list of prescription drugs, both generic and brand name, that are preferred by your health plan and that they have deemed as offering the greatest value. A committee of independent, actively practicing physicians and pharmacists maintain the formulary.

Drugs on a formulary are typically grouped into tiers. The tier that your medication is in determines your portion of the drug cost. A typical drug benefit includes three or four tiers.

Tier 1 Preferred generic drugs, lowest cost-sharing Tier 2 Non-preferred generic drugs
Tier 3 Preferred brand-name drugs
Tier 4 Non-preferred brand-name drugs
Tier 5 Specialty drugs, highest cost-sharing

BRAND NAME DRUGS ON THE FORMULARY These formulary drug lists have brand name prescriptions that have been tested and researched to be safe and effective, as well as less costly to both the insurance carrier and the member.

BRAND NAME DRUGS OFF THE FORMULARY These are brand name prescriptions not on the formulary. These are often most costly to purchase.

SPECIALTY MEDICATIONS Although the definition of specialty drugs continues to evolve, they can usually be defined by several common attributes. They are prescribed for a person with a complex/chronic medical condition, defined as a physical, behavioral, or developmental condition that may have no known cure, is progressive, and/or is debilitating or fatal if left untreated or under-treated. Usually, they treat rare or orphan disease indications and require additional patient education, adherence, and support beyond traditional dispensing activities. They can be difficult to administer, often given by injection or infusion and may require special handling, including temperature control. Typically, specialty drugs have a high monthly cost and potentially unique storage or shipment requirements and are not stocked at the majority of retail pharmacies.

POINT-OF-SERVICE PLAN (POS)

A managed care plan that is a hybrid of a HMO and PPO plan. Like an HMO, participants designate an in-network physician to be their primary care provider. But like a PPO, patients may go outside of the provider network for health care services.

PREFERRED PROVIDER ORGANIZATION (PPO)

A managed care organization of medical doctors, hospitals and other health care providers who have agreed with

an insurer or a third-party administrator to provide health care at reduced rates to the top insurer's or administrator's clients.

PREMIUM

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

PRIMARY CARE PHYSICIAN (PCP)

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

QUALIFYING EVENT

A change in your situation — like getting married or having a baby — that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the yearly Open Enrollment Period.

SPECIALIST

A health care professional whose practices focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. Often, due to additional, advanced training this professional is certified by a specialty board.

SUBSCRIBER

Refers to the person or organization that pays for health insurance premiums, sometimes referring to the person whose employment makes them eligible for group health insurance benefits.

USUAL, CUSTOMARY AND REASONABLE (UCR) ALLOWANCE

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

90TH PERCENTILE

This means that 90% of the health care providers' fees will be covered in full. The carrier may cover a portion of the bill and the member may be balance billed the difference. Out-of-network (non-participating) providers are not limited in the amount they may balance bill.

This glossary includes many commonly used terms but is not a full list. These glossary terms and definitions are intended to be educational.

Paradigm Precision

All changes must be made by Friday, November 11th!

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.