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NAVIGATING YOUR BENEFITS

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General Benefit Questions

1 When am I eligible for benefits?

You are eligible for benefits on the 1st of the month following a full month of employment in the Full-time Year Round status.

2 Where do I go to enroll?

Enrolling is done at the same site where you complete on-boarding as well as access your time sheets and pay statements at timeclock.eastwest.com.

3 What is a "cafeteria-style" plan?

"Cafeteria-style" means that you are able to pick and choose from most of the offerings including the voluntary elections. The options can be selected a-la-carte, so you decide which plans you want as well as which dependents you want on each plan.

4 Can I change my benefit elections mid-year?

You can only make changes outside of the Open Enrollment period if you experience a Qualifying Life Even (QLE) such as, marriage, divorce, birth or adoption of a child, among other things. For a more detailed explanation on QLE including how to request one and what information you will need to complete the process, please see page 8.

5 Is a common-law marriage the same as a domestic partnership?

No. The state of Colorado recognizes common-law marriage the same as a ceremonial marriage, a domestic partnership does not meet the requirements for a partner to be considered a dependent. Please visit the Colorado department of revenue for more information tax.colorado.gov/common-law-marriage.

6 What can I access at mycigna.com or the MyCigna mobile app?

By registering in MyCigna you will have access to finding in-network care; track claims and out of pocket payments towards your deductible and max-out-of-pocket; view, print, or email Insurance Cards; access virtual health; many behavioral health options; and much more.

Medical

7 How does medical insurance work?

The key terms to know:

Deductible — This is the amount you pay out of pocket *before* the plan starts paying. This can happen with one high medical expense or as an accumulation of smaller expenses until the deductible is reached.

Coinsurance — After the deductible is reached, the remaining balance of a large expense and future expenses are subject to this cost-share where the plan will cover 80% of the cost to your 20%.

Copay — This is a flat fee you pay for specific health care services, such as doctor or specialist visits as well as prescription drugs.

Out-of-pocket maximum — This is the total amount you are responsible for all medical expenses in the plan year. It is the accumulation of the deductible + your portion of coinsurance. Additional medical expenses would be covered entirely by the plan.

The table below uses $5,000 in medical expenses with in-network providers. You would first pay the deductible; the remaining amount would be subject to you paying the 20% coinsurance. Deductible + coinsurance is your total out of pocket expense.

$5,000 in-network expense	PPO	HSA	HDHP
Individual Deductible	$1,000	$3,000	$5,000
Remaining amount subject to coinsurance	$4,000	$2,000	N/A
Your 20%	$800	$400	N/A
Total paid out-of-pocket	**$1,800**	**$3,400**	**$5,000**

8 How are the plans different?

Below is a simple comparison chart highlighting the main differences in the plans.

Coverage amounts are for In-network providers	PPO	HSA	HDHP
Per-check Cost	Highest	Middle	Lowest
Preventative Care	Covered 100%	Covered 100%	Covered 100%
Deductible* (individual/family)	$1,000/$3,000	$3,000/$6,000	$6,650/$13,300
Out-of-pocket maximum* (individual/family)	$4,000/$12,000	$6,650/$13,300	$6,650/$13,300
Coinsurance* (Plan%/Your%)	80%/20%	80%/20%	*100%/0%
Prescription Drugs	Copay	Deductible	Copay
Flexible Spending Account	Full Medical, Dental, and Vision	Limited Dental and Vision	Full Medical, Dental, and Vision
Office Visits	Copay	Deductible	Deductible

9 How does the PPO plan work?

This is a traditional low deductible medical plan. All preventative care is covered at 100%. All other treatment is subject to a copay or the deductible. This plan offers copays for regular office visits as well as specialists. The copay is what you pay for going to the office ($25 or $50) with any treatment beyond that being subject to the deductible. For example, if you hurt your back and go see your doctor you would pay the copay and any additional tests or treatments during the visit would be subject to the deductible. Once you have paid the deductible amount, the plan will cover 80% of medical costs until you've paid your max-out-of-pocket then the plan will pay 100% of all covered medical expenses.

This plan also has copays for prescription drugs. This means there is a set cost for prescriptions dependent on the tier.

This is a great plan for those who traditionally see specialists regularly or are planning on having any high medical expenses during the plan year; like having a baby or a surgical procedure.

This plan can be paired with a full Healthcare and FSA (medical, dental, vision, pharmacy expenses), and supplemental coverages like Critical Illness or Accident insurance.

10 How does the HSA plan work?

The HSA or Health Savings Account Medical Plan is the only plan we offer that qualifies under the IRS guidelines to be paired with an employer-sponsored health savings account. All preventative care is covered at 100%. All other treatment is subject to the deductible. This means that you will pay all of the costs from providers up to the deductible amount before this plan begins to pay. Once you reach your deductible, the plan will then pay 80% of all covered medical expense. You will pay the remaining 20% of covered out-of-pocket medical expenses up to your out-of-pocket maximum. Once you reach your out-of-pocket maximum, the plan will pay 100% of all covered medical expenses.

An important note about the HSA plan is coverage of prescription drugs; while prescriptions are covered, the cost is subject to the deductible unless the prescription is on Cigna's preventative drug list. There are no copays, you will pay out-of-pocket until you reach your deductible and then you will be responsible for 20%.

11 How does the High Deductible Health Plan (HDHP) plan work?

The HDHP or High Deductible Health Plan offers very basic coverage with a high deductible and low per-check cost. All preventative care is covered at 100%. All other treatment is subject to the deductible. This means that you will pay all of the costs from providers up to the deductible amount before this plan begins to pay. Once you reach your deductible, the plan will then pay 100% of all covered medical expenses.

This plan also offers copays for prescriptions.

This is a good plan option for individuals looking for basic coverage for preventative care and a cost-cap if you were to experience unexpected large medical expenses.

12 Why can't I have a Health Savings Account (HSA) with the HDHP plan?

While the HDHP plan is a High Deductible Health Plan, it does not meet all of the requirements put forth by the IRS to be able to pair a Health Savings Account with that plan. Due to the tax-advantaged nature of a Health Savings Account, IRS requirements are very strict regarding not receiving other cost assistance such as copays.

13 How do I know which plan to select?

It is important to use the tools available in MyCigna as well as the plan information to answer questions, like:

- Am I expecting any high cost medical expenses this year such as a planned surgery or having a baby?
- Where do I currently stand with my deductible and max-out-of-pocket? Am I using the benefits I am paying for?
- Could I benefit from investing outside of the premiums, like a Health Savings Account? In the event of an unexpected expense, you could pay more up front, but a moderate to low expense means you could still be putting extra money aside.

14 Can I continue to contribute to or use my Health Savings Account if I switch to the PPO or HDHP plan?

No, a Health Savings Account has very specific rules regarding eligibility. In order to contribute to a Health Savings Account you must be enrolled in an HSA qualified health plan and the HSA Medical Plan is the only plan we offer that is qualified to pair with a Health Savings Account.

While you can no longer contribute to an HSA on a non-qualified health plan, you can continue to use the funds for any qualified expenses.

15 How does a Flexible Spending Account (FSA) work with the medical plans?

An FSA is a great option for individuals anticipating certain medical, dental, or vision expenses. Once eligible, the FSA is pre-funded with the elected amount and those funds can then be used on any qualified expenses. It is also helpful in covering high initial costs if you are on a higher deductible plan like the HDHP.

Please note if you enroll in the HSA plan, your Flexible Spending Account expenses are limited to just dental and vision expenses.

16 I am planning to have surgery in the next year, which plan is the better option?

It depends. Both the PPO and HSA plan could be good options. The PPO offers more coverage at a higher per check cost, while the HSA plan allows you to save and use pre-tax dollars for qualified medical expenses. It is important to evaluate the deductible and out-of-pocket cost for each plan before making a final decision.

17 What is considered preventative care?

Preventative care is a specific group of services recommended when you don't have any symptoms and haven't been diagnosed with a related health issue. It includes your periodic wellness exam and specific tests, certain health screenings and most immunizations.

For a full listing, login to your mycigna.com account, under "Coverage" select "Medical" and scroll down to Preventative Care.

Dental

18 What is the difference between the Base and Buy-Up plan?

While the Base and Buy-Up plans both cover preventative care and two cleanings per calendar year, you will see the biggest differences in the calendar year max and orthodontia coverage.

The Buy-Up plan has a higher max benefit amount at $2,500. The Base plan has a max benefit of only $1,500. This means the Buy-Up plan offers more coverage for care beyond preventative care and normal cleanings. Additionally, the Buy-Up plan pays a higher percentage of basic and major restorative procedures as well as implants.

The other major difference is that the Buy-Up plan has orthodontia coverage, whereas the Base plan has no coverage.

	Cigna Base Plan		Cigna Buy-up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Individual/Family	$100/$300		$50/$150	
Annual Maximum Per Person	$1,500		$2,500	
Diagnostic and Preventive	100%, no deductible			
Basic Service	80% after deductible		90% after deductible	
Major Services	50% after deductible		60% after deductible	
Orthodontia	Not covered		50% — $2,000 lifetime max	

19 Is orthodontia covered?

The Base plan **does not** cover orthodontia. The Buy-Up plan will pay 50-50 on approved orthodontics, up to a lifetime max of $2,000 per covered individual. The lifetime max carries year to year and does not reset at the turn of the calendar year, once it has been reached there is no more coverage for orthodontia.

20 What is the difference between the deductible and the annual maximum on a dental plan?

The deductible is how much you pay out-of-pocket before the plan starts paying. The annual maximum is how much the plan will pay after the deductible is reached for the calendar year (January 1 through December 31). Note that some diagnostic and preventative care visits are covered 100% and do not count towards the deductible or the annual maximum.

21 What is the cost of preventive dental care?

Preventive care is covered at 100% under both Base and Buy-up plans.

22 What is preventive dental care?

Preventive helps maintain good oral health through a combination of dental check-ups along with developing good habits like brushing and flossing.

Preventive dentistry services may include:

- Regular oral exams, usually every 6 months
- Teeth cleaning
- Routine X-Rays
- Fluoride treatments. Only for children under the age of 19

23 What are the benefits of preventive dental care?

- Lower your risk for developing tooth decay, gum disease, and more serious dental problems.
- Early identification of dental problems may help minimize treatment and cost.
- Enables your dentist to do a full exam of your mouth, jaw, neck, etc. to identify any related problems, including some cancers.
- Can help reduce your risk of medical conditions such as heart disease and diabetes.

24 How do I access my dental card?

Cigna doesn't provide a separate dental card. Your dental care provider can pull your information by using your medical card. You can still access a dental card by logging in to mycigna.com or downloading the MyCigna mobile app.

Vision

25 What is the difference between the Base and Buy-Up plan?

While the Base and Buy-Up plan share the same exam coverage, you will see differences in coverage for the elective contact lens allowance as well as the frame allowance. The other main difference is the frequency period for frames is 12 months with the Buy-Up plan and 24 months with the Base plan, meaning the plan covers new frames every year with the Buy-Up plan and every other year with the Base plan.

	Cigna Base Plan		Cigna Buy-up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Exam Copay	$10	Up to $45	$10	Up to $45
Material Copay	$20	N/A	$10	N/A
Frequency Period Exam Lenses or contacts Frames	12 months 12 months 24 months		12 months 12 months 12 months	
Basic Service	Up to $130 after copay	Up to $71	Up to $250 after copay	Up to $71

26 Can I file a claim for out-of network eyeglasses?

Yes, you can fill out a claim form for out-of-network vision expenses at mycigna.com. The completed form must be submitted along with an itemized receipt to receive the reimbursement.

27 What does it mean by "frequency period"?

Both vision plans go by a frequency period that begins January 1 and goes through December 31. The frequency period resets at the next calendar year (January 1). As an example, purchasing contact lenses in June does not mean you have to wait until June of the next year to purchase again. The frequency period resets on January 1.

28 What is the cost of preventive vision care?

Your annual exam is covered 100% after your $10 copay under both plans when seeing an in-network provider.

29 What is vision preventive care?

Preventive vision care can give you and your eye care provider the opportunity to detect and treat potential disease early.

Preventative vision care may include:

- Vision testing
- Glaucoma testing
- Wellness examinations

30 What are the benefits of preventive vision care?

A yearly eye exam allows your eye care provider to monitor your vision and eye health over the long-term, can help detect signs of medical conditions such as:

- High blood pressure
- Heart disease
- Diabetes
- and may more

31 Can I use the plan at Eye Pieces?

Yes. Simply let an Eye Pieces associate know that you are an East West employee, and they will apply a 30% discount after they process your vision claim through your East West vision insurance. You can contact Eye Pieces at 970-476-1947.

32 How do I access my vision insurance card?

Cigna doesn't provide a separate vision card. Your vision care provider can pull your information by using your medical card. You can still access your vision coverage information by login in to MyCigna.com or downloading the MyCigna mobile app.

Flexible Spending Accounts

33 What is a Flexible Spending Account (FSA)?

A Flexible Spending Account is a special account you put money into that you use to pay for certain out-of-pocket health care cost. You don't pay taxes on this money. This means you'll save an amount equal to the taxes you would have paid on the money you set aside. One thing to note, these are use it or lose it accounts.

There are 3 types of FSAs:

- **Healthcare FSA** — can be used for all eligible medical, dental and vision expenses.
- **Limited Purpose FSA** — can only be used with dental and vision expenses. This account is available when enrolled in the HSA medical plan.
- **Dependent Care FSA** — can be used to pay for childcare expenses, such as daycare.

34 How much can I contribute to an FSA?

The IRS sets annual contribution maximums to these accounts, due to their tax-advantaged benefit.

- **FSA** (both Limited and Healthcare) — $3,050
- **DCFSA** — $5,000

It is important to note that these are use it or lose it accounts and unused funds could be forfeit.

35 When am I eligible for an FSA?

Because the FSA is a pre-funded account, new employees are eligible to enroll the first of the quarter following 6 months of being a full-time year-round employee. Please see chart below to find your eligibility date.

FTYR Date	FSA Eligibility Date
April 2nd – July 1st	January 1st (Following Year)
July 2nd – October 1st	April 1st (Following Year)
October 2nd – January 1st	July 1st
January 2nd – April 1st	October 1st

The Dependent Care FSA is eligible the same date as you are eligible for benefits. The contributions are not available to be used until they are posted into your account.

36 If I am currently enrolled in the HSA medical plan, can I have an FSA?

If enrolled in the HSA Medical Plan you can also elect a Limited Purpose FSA to help cover dental and vision expenses. There is no reimbursement for medical or prescription drug expenses with a limited purpose FSA.

37 Can I change my FSA or Dependent Care FSA (DCFSA) amount mid-year?

You can make changes to the elected amounts if you experience a qualifying life event. Please contact the Benefits department at benefits@eastwest.com or 970-790-3102 if you feel that you have experienced a QLE and would like to change your election.

38 How do I access my account?

Simply login to 401k.com to manage your accounts, file claims, and/or request new cards.

39 What happens if I don't use all of my funds by the end of the year?

These are use-it-or-lose-it accounts, meaning any unused funds after the plan year would be forfeit. There is a run-out period that goes until mid-March of the next year to allow you to file for reimbursements, this helps for expenses for care or dependent care in the month of December.

The IRS does allow for $610 of Healthcare and Limited Purpose FSA to roll over to the next plan year, but the Dependent Care FSA does not have any rollover amount.

Health Savings Accounts

40 What is a Health Savings Account (HSA)

A Health Savings Accounts (HSA) is a type of savings account that lets you set aside money on a pre-tax basis that can be used to pay for qualified medical, dental or vision expenses. It is a triple tax advantage account that is yours and rolls over whether you use the funds during the year or not.

41 How does a HSA work?

A Health Savings Account works like an FSA in functional use but has a few key differences.

- Health Savings Accounts are not pre-funded
- Contributions are available as the funds are deducted from your paycheck.
- Contribution amounts can be changed at any time throughout the year.
- Available funds rollover year-to-year and can be taken with you if you leave the company or change to a non-qualified medical plan.

42 What happens to the money if I am no longer working for East West Family of Companies?

The account stays with you. Much like a 401(k), the funds you contribute into your account are yours whether still employed with us or not.

43 How much can I contribute?

While there is no minimum you can contribute, the IRS sets annual maximums of $4,150 under an individual medical plan and $8,300 under an individual plus family member(s) plan. If you are aged 55 or older during the tax year, you may also be eligible to make an additional $1,000 catch-up contribution annually.

44 How do I access my account?

You can visit 401k.com or call Fidelity at 833-811-7432. They will be able to assist in ordering a new card, investing your savings, and managing your payments.

Supplemental Coverage: Voluntary Accident and Critical Illness

45 What is Supplemental coverage?

Supplemental coverage provides a payment directly to you. This means in the event of an incident covered by a supplemental policy, you would file a claim and decide how best to spend the money.

46 How does Voluntary Accident coverage work?

There are fixed cash payments dependent on the treatment and injuries in the case of an accident. ER visit, fractures/dislocations, follow-up visits, physical therapy and more. Treatment you receive as a result of an accident still goes through your medical plan (if applicable), you would file a separate claim to receive a payment where you decide how to spend it. This can help with out-of-pocket expenses like your deductible, personal expenses if you have to miss work, you can even hang on to it for extra expenses down the road. The check is sent to you, and you decide how it will best help you.

This benefit is included with enrollment in the HSA Medical plan as well as the HDHP Medical plan.

47 How does Critical Illness coverage work?

You elect the amount of coverage you want; $5k, $10k, or $20k; and in the event of being diagnosed with a critical illness that amount would be paid as a lump sum to you. As a supplemental coverage, the payment is for you to decide how best to use it whether it be medical expenses, personal expenses if time away from work is needed, or held onto for extra financial security while recovering.

Some covered critical illnesses are cancer, heart attack, stroke, organ transplant and more.

48 How do I file a claim?

There are several ways to file your claim:

- Online at mycigna.com
- Paper copy from Cigna
  - Fax to 866-304-3001
  - Email to SuppHealthClaims@cigna.com
  - Mail to Cigna Supplemental Health Solutions, PO Box 188028, Chattanooga, TN 37422
- You can also call 800-754-3207 to file your claim

Voluntary Elections

49 Do I need Voluntary Life coverage if I get basic coverage?

Life Insurance is an important part of your financial security, especially if others depend on you for support. Life insurance offers your family financial resources and support at the time of your death.

Basic Life includes up to 1.5X your annual basic earnings (some exclusions apply), up to a max benefit of $200,000. This coverage is 100% tied to your employment. If you leave your position at East West, your coverage will end.

Additional Voluntary Life Insurance can increase your financial security in addition to any basic life coverage. Coverage can be elected in increments of $10,000 for the employee up to the lesser of 5X your salary or $500,000. Voluntary Life and AD&D is a 100% portable plan, if you leave employment with East West you can take this plan with you.

50 Is Accidental Death & Dismemberment (AD&D) different from Life Insurance?

Accidental Death and Dismemberment insurance is designed to provide additional benefits in the event of accidental death or loss of a limb or vision (dismemberment) but does not cover death from a natural cause. Life Insurance covers for death both accidental and natural.

51 How does Pet Insurance work?

As part of East West Family of Companies you can receive preferred pricing through Nationwide Pet Insurance. This is administered by Nationwide and can be added or canceled at anytime throughout the year and payments are made directly to Nationwide. Go to benefits.petinsurance.com/ewpartners or call 877-738-7874 to speak with a specialist.

52 What is the difference between Legal Insurance and the ID Theft coverage?

Legal Insurance through MetLife gives participants access to a nationwide network of law firms for things such as selling, purchasing, or refinancing a home; wills, living trusts, name changes, premarital agreements; civil litigation defense; debt collection; and more.

ID Theft protects you and your dependents' identity and finances on the internet and mobile devices.

401(k)

53 When will I be eligible for 401(k)?

Employees are eligible for the 401k the first of the month following 60 days from the hire date.

54 How do I change my 401(k) election?

You can change your election or opt-out by logging into 401k.com or by calling Fidelity at 800-835-5095.

Qualifying Life Event (QLE)

55 What is a QLE?

A qualifying life event (QLE) makes you eligible for a special enrollment period. It's an event that may trigger a need for health insurance or to make changes to your health plan.

Events such as having a child, losing coverage elsewhere, or getting married/divorced allows you to make changes to your elections **within 30 days of the event**.

56 How do I request a QLE?

Contact the Benefits Department as soon as you know or think you might have a QLE and we will help guide you through the process. Remember, you only have 30 days from the event to make changes. Benefits@eastwest.com or 970-790-3102.

57 What do I need to complete a QLE?

QLEs require proof of the event. The chart below gives some examples of what kinds of documents would be needed for different QLEs.

QLE	Examples	Effective Date	Proof of Eligibility
Birth or adoption	Gaining a new dependent due to a new birth or adoption of a child	Date of birth or adoption	Copy of a birth certificate or adoption papers with effective date
Death of dependent	Passing of a spouse or eligible child	Date of passing	Copy of a certificate of death
Dependent gains benefits elsewhere	Spouse or eligible child starts receiving benefits through an employer or Medicare	Date new insurance becomes active	Letter from new employer or insurance provider stating the date the new coverage begins and the name of your dependent receiving the benefit
Dependent loses coverage elsewhere	Spouse or eligible child separates from an employer and loses coverage	First day dependent does not have coverage. This date can be different from the separation date.	Letter from employer or insurance provider stating the dependent's name and date that coverage ends. COBRA notice with eligibility date will also work
Divorce	Divorce	Date divorce is finalized	Copy of court decree with date of divorce
Marriage	Marriage or common-law marriage	Effective date of marriage	Copy of marriage certificate
Employee Loses coverage elsewhere	Aging out of being a dependent on another plan. Spouse loses coverage on which you are covered as a dependent.	First day that you do not have coverage. This date can be different from the date of aging out or spouse's separation date.	Letter from employer or insurance provider stating the date your coverage ends. COBRA notice with the eligibility date will also work

You have 30 days from the event to provide documentation to the Benefits Department.