CAMELOT
FACILITY & PROPERTY MANAGEMENT

2024–2025 Employee Benefits Guide

An overview of the wide array of benefits provided by Camelot Services, Inc. to help you enjoy increased well-being and financial security.

Prepared by George Knox for Camelot Services, Inc.

CAMELOT
FACILITY & PROPERTY MANAGEMENT

Introduction

Employee benefits can be difficult to decipher. We try to keep it simple. Camelot provides a full menu of options to help you protect your finances and your family. We offer four EPO medical plan options from United Healthcare (UHC), a well-known provider with a reputation for quick and easy claim payments. Our medical plans also include prescription drug coverage with UHC.

We also offer dental, vision, long & short-term disability, and basic & voluntary life coverage, as well as a 401k retirement plan.

Camelot invests a significant amount in employee benefits, but they still require a commitment on your part. Your role is to understand how the plan you select works and to take advantage of what it has to offer.

This Benefit & Cost Summary is your starting point and one-stop shop for what you need to know about benefits — whether you're enrolling for the first time, reconsidering your benefits during Annual Enrollment, or checking into specific features of a plan during the year. If you have a question about your benefits, start here, and we'll point you in the right direction to find the answers you need.

Your benefits are a valuable part of your total compensation package. Be sure to make the most of them — today and throughout the year. We understand that your situation is unique, and Camelot offers an overall benefits package with many possible choices - one that can be shaped and molded by you to fit your needs.

This enrollment booklet is a summary description of your Camelot benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This booklet and plan summaries do not constitute a contract of employment.

We hope this enrollment booklet, along with our additional communication and decision-making tools, will help you make the best healthcare choices for you and your family.

We created our memorable web portal, www.insuranceisboring.com, to gather all employee benefit information in one location. Using Login to Access Benefits, you will find benefit, eligibility, and enrollment information, as well as carrier links for each specific benefit plan.

Getting Started: Go to www.insuranceisboring.com, and from the "Home" page, you can log in by using a generic email of benefits@camelotservices.com and a generic password Camelot.

Eligibility

As a full-time employee regularly working 30 or more hours per week, you are eligible to participate in the Camelot benefits program on the first day of the month that follows 30 days of continuous employment. Employees are eligible for employer-paid group basic group life & AD&D insurance, short-term disability, & long-term disability insurance. You & your qualified dependents are also eligible for medical & dental insurance, with Camelot contributing a substantial portion of the employee premium. In addition, Camelot makes an HSA contribution for employees enrolled in the qualified HDHP medical plan. Vision and supplemental life & AD&D insurance are optional. It is your responsibility to enroll in and manage your benefits program.

Eligible Dependents
You can elect coverage under Camelot's medical, dental, and vision plans for your spouse and dependent children, as described below:

Spouses: You may enroll your spouse if they are a person to whom you are legally married. A domestic partner who meets the criteria for domestic partnership as outlined by the insurance carriers can be considered a dependent for benefit coverage.

Dependent and Adult Children: You may enroll your children if they are under the age of 26, regardless of student or marital status. Coverage will end on the last day of the month in which the child reaches age 26.

Changes and Qualifying Events

When Coverage Begins and Ends
Your benefits become effective on the first day of the month following 30 days of continuous employment. Additional waiting periods or exceptions are covered under each benefit description.

Your coverage under the benefits plans will end if you no longer meet the eligibility requirements, your contributions are discontinued, or the Group Insurance Policy is terminated.

Open Enrollment for group medical, dental, and vision insurance provides you the opportunity to enroll for coverage or make changes to your coverage. Keep in mind the decision you make at open Enrollment regarding your insurance coverage is effective for the entire plan year (March 1, 2024 – February 28, 2025). After March 1, 2024, you may change your plan and/or dependent status if you have a "qualifying event" as defined by the IRS, such as marriage, divorce, birth, adoption, or loss of medical coverage.

Qualifying Events

Eligible employees may enroll or make changes to their benefits elections during the annual open enrollment period. As with most benefits, once you elect an option, you are bound to that choice for the entire plan year unless you experience a "Qualifying Event". These may include, but are not limited to:

- Changes in employment status
- Changes in legal marital status
- Changes in the number of dependents
- Taking an unpaid leave of absence
- Dependent satisfies or ceases to satisfy the eligibility requirement
- Family Medical Leave Act (FMLA) leave.
- A COBRA-qualifying event
- Entitlement to Medicare or Medicaid
- A change in the place of residence of the employee, resulting in the current carrier not being available

Resources:

Benefit	Provider	Website	Phone	Group #
Medical	United Healthcare	www.myuhc.com	800-357-0978	TBD
HSA	Optum Bank	www.optumbank.com/health-accounts/hsa.htm	877-470-1771	
Dental	BCBSTX	mybam.bcbstx.com	800-521-2227	339975
Vision	BCBSTX	www.eyemedvisioncare.com/bcbstxvis	855-556-8796	VF027290
Basic Life/AD&D	UNUM	www.unum.com	800-868-6745	934599
Voluntary Life/AD&D	UNUM	www.unum.com	800-868-6745	934599
Short-Term Disability	UNUM	www.unum.com	800-868-6745	934599
Long-Term Disability	UNUM	www.unum.com	800-868-6745	934599
401k	OneAmerica	https://pages.oneamerica.com/camelot401k	800-338-4015	
Broker Contact	Jami Weinman George Knox	jami@insuranceisboring.com george@insuranceisboring.com	214-443-1400 866-629-7963 214-443-1423(fax)	
Camelot Benefits Portal		www.insuranceisboring.com USERNAME: benefits@camelotservices.com PASSWORD: Camelot		
Camelot Enrollment Portal		www.access.paylocity.com		

Medical plan info

Annual Deductible

The amount you pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

Out-of-Pocket Maximum

This is the total in-network amount you can pay out of pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible, copays, and coinsurance.

Copays and Coinsurance

These expenses are your share of the cost paid for covered healthcare services. Copays are a fixed dollar amount and are usually due when you receive in-network care. Coinsurance is your percentage of the allowed amount charged after the deductible.

Plan Types

- PPO - A network of doctors, hospitals, and other health care providers.
- EPO is a network of doctors, hospitals, and other healthcare providers that do not provide out-of-network benefits.
- HMO - A network that requires you to select a Primary Care Physician (PCP) who coordinates your health care.
- POS - Combines aspects of a PPO and HMO
- HDHP - A plan that has higher annual deductibles in exchange for lower premiums and allows for pre-tax contributions to a Health Savings Account.

Camelot - MEDICAL BENEFITS AT A GLANCE

	BCZX 1500/80 EPO Plan	BCZZ 2500/80 EPO Plan	CZW2 5000/80 EPO Plan	DDZY 5000/100 EPO HSA Plan
	In-Network	In-Network	In-Network	In-Network
CALENDAR YEAR DEDUCTIBLE				
Individual Deductible	$1,500	$2,500	$5,000	$5,000
Family Deductible Maximum	$3,000	$5,000	$10,000	$10,000
MAXIMUM OUT-OF-POCKET PER CALENDAR YEAR PER PERSON (includes copays or deductibles)				
Individual	$5,000	$6,000	$7,150	$6,000
Family	$10,000	$12,000	$14,300	$12,000
WELLNESS & IMMUNIZATIONS				
Well Child Care, includes immunizations	100%	100%	100%	100%
Well Adult (exam, mammogram, PSA)	100%	100%	100%	100%
INPATIENT				
Hospitalization (inpatient)	80% after deductible	80% after deductible	80% after deductible	100% after deductible
Inpatient Mental Health/Chemical Dependency	80% after deductible	80% after deductible	80% after deductible	100% after deductible
OUTPATIENT				
Physician Office Visit (illness or injury, except surgery)	$25 copay PCP $0 copay <19 $25 copay Des SP $50 copay SP	$30 copay PCP $0 copay <19 $30 copay Des SP $60 copay SP	$10 copay PCP $0 copay <19 $40 copay Des SP $80 copay SP	100% after deductible
Outpatient Surgery (surgical facility or doctor's office)	80% after deductible	80% after deductible	80% after deductible	100% after deductible
MRI, CT Scan, PETSCAN, etc.	80% after deductible	80% after deductible	$500 copay	100% after deductible
Diagnostic Lab & X-ray	100%	100%	$40 copay	100% after deductible
Urgent Care Visit	$75 copay	$75 copay	$25 copay	100% after deductible
Emergency Room Services	$250 copay plus 20%	$250 copay plus 20%	$300 copay Deduct plus 20%	100% after deductible
OTHER EXPENSES				
Virtual Visits	$0 Copay	$0 Copay	$0 copay	$49 copay
PRESCRIPTIONS				**Plan Deductible Applies**
Tier 1 – Retail & Specialty	$15 copay	$15 copay	$15 copay	$10 copay
Tier 2 – Retail & Specialty	$45 copay	$45 copay	$45 copay	$35 copay
Tier 3 – Retail & Specialty	$85 copay	$85 copay	$85 copay	$60 copay
Tier 1 – Preferred Specialty	$15 copay	$15 copay	$15 copay	$10 copay
Tier 2 – Preferred Specialty	$100 copay	$100 copay	$100 copay	$100 copay
Tier 3 – Preferred Specialty	$300 copay	$300 copay	$300 copay	$300 copay

BlueCross BlueShield of Texas

BCZX - EPO Plan

Per Pay Period Pricing	
Employee	$ 73.50
Employee & Spouse	$378.53
Employee & Child(ren)	$286.49
Employee & Family	$584.22

BCZZ - EPO Plan

Per Pay Period Pricing	
Employee	$ 60.64
Employee & Spouse	$349.39
Employee & Child(ren)	$258.41
Employee & Family	$584.22

CZW2 - EPO Plan

Per Pay Period Pricing	
Employee	$ 22.47
Employee & Spouse	$260.66
Employee & Child(ren)	$177.45
Employee & Family	$412.34

DDZY - EPO HSA Plan

Per Pay Period Pricing	
Employee	$34.81
Employee & Spouse	$234.83
Employee & Child(ren)	$171.89
Employee & Family	$373.01

Camelot currently uses **Optum Bank** as its HSA depository custodian. Employees enrolling in the HSA plan for the first time need to open an HSA account with Optum Bank to receive the company's HSA contributions. You may request instructions on opening your Optum Bank HSA online from HR. You may have additional HSA custodian accounts, but all Camelot employer contributions will be made to Optum Bank.

For the March 2024-2025 plan year, Camelot's monthly HSA contributions are:

- **$100.00 for employee-only coverage**
- **$150.00 for employee & spouse coverage**
- **$150.00 for employee & child(ren) coverage**
- **$200.00 for employee & family coverage**

You may make additional payroll deduction HSA contributions to your account up to the IRS contribution limits. You are encouraged to take full advantage of the tax savings by contributing to your HSA through pre-tax payroll deductions.

Maximum HSA Contribution Levels	**2024**
Individual coverage	$4,150
Family coverage	$8,300
Catch-up contributions are allowed for those 55 and over	$1,000

Refer to your HSA documentation for more information.

Health Savings Account (HSA)

This is how an HSA works:

A health savings account (HSA) is a health care account, and savings account in one. The main purpose of this account is to offset the cost of a qualifying high deductible health plan (HDHP) and provide savings for your out-of-pocket eligible healthcare expenses - those you and your tax dependents may have now, in the future, and during your retirement.

After you set up your account, it's yours to keep, even if you change jobs or retire.

Once your HSA is established, money is contributed to your account by you and Camelot; and you can then use your HSA dollars tax-free to pay for eligible health care, dental, and vision expenses. You save money on expenses you're already paying for, like doctors' office visits, prescription drugs, and much more. Best of all, you decide how and when to use your HSA dollars.

Why is it a good idea to have an HSA?

HSAs benefit everyone who is eligible to have this account, including single individuals, families, and soon-to-be retirees. You save money on taxes in three ways:

- Tax-free deposits - The money you contribute to your HSA isn't taxed (up to the IRS annual limit).
- Tax-free earnings - Your interest and any investment earnings grow tax-free.
- Tax-free withdrawals - The money used toward eligible health care expenses isn't taxed - now or in the future.

Setting aside pre-tax dollars into your HSA means you pay fewer taxes and increase your take-home pay with your tax savings. You save money on eligible expenses that you are paying for out of your pocket. The amount you save depends on your tax bracket. For example, if you are in the 30% tax bracket, you can save $30 on every $100 spent on eligible healthcare expenses.

HSA funds roll over from year to year and accumulate in your account. There is no "use-it-or-lose-it" rule with HSAs, and you decide how and when to use your HSA funds, which can be used for eligible expenses you have now, in the future, or during retirement. And when you have a certain balance in your HSA, investment opportunities are available.

Preventative Care

Wellness and Health Management

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms, and immunizations. Through the plans offered by North Texas Preferred Health Providers, all covered individuals and family members are **eligible to receive routine wellness services like these at no cost; all copays, coinsurance, and deductibles are waived.**

Which preventative care services are covered?

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e. Health Care Reform) compliant insurance plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plans offered this year:

- Routine physical exam
- Well baby and child care
- Well women visit
- Immunizations
- Routine bone density test
- Routine breast exam
- Routine gynecological exam
- Screening for Gestational
- diabetes Obesity screening and
- counseling Routine digital
- rectal exam Routine colonoscopy
- Routine colorectal cancer screening
- Routine prostate test
- Routine lab
- procedures Routine
- mammograms
- Routine pap smear
  Smoking cessation
- Health education/counseling services
- Health counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and counseling for domestic violence

Dental plan info

Summary of Coverage

Dental coverage is similar to other insurance—you pay a premium, and then your insurance will cover part or all of the cost for many dental services.

Preventative care

Professional dental care can diagnose or help prevent common dental problems, including toothaches, inflamed gums, tooth decay, bad breath, and dry mouth. If conditions like these remain untreated, they can worsen into painful and expensive problems, such as gum disease or even tooth loss.

Diagnostic care

Additionally, dental health professionals can spot more serious health issues, including some types of cancer. That makes it even more important to see a dentist regularly.

Great for families

This coverage is also great for families. Since dental work can be very expensive, proactive dental care, such as routine cleanings, can help save children from costly issues as they age.

Specialized treatments

With dental insurance, you're investing in your smile and overall health. Beyond cleanings and routine care, dental coverage may also help pay for more specialized treatments, such as root canals or fillings.

Routine care

Dental coverage allows you to visit a dentist when you need to receive preventive and diagnostic care.

See everything your plan covers by reviewing the benefits statement and overview. Reach out to HR with any questions.

BlueCross BlueShield of Texas

BlueCare Dental℠

Plan ID: DTNHR31

This information only provides a summary of the benefits for this Dental Plan. Please refer to your Dental Benefit Booklet for additional benefit information. The Deductibles, Coinsurance and Benefit Period Maximum shown below are subject to change as permitted by applicable law.

Summary of Dental Benefits

Program Basics	Contracting Dentist	Non-Contracting Dentist
Benefit Period Maximum	$3,000	
Deductible	$25 Individual/$75 Family	$25 Individual/$75 Family
Covered Services	No Annual Maximum	No Annual Maximum
Diagnostic Evaluations Periodic oral evaluations Problem focused oral evaluations Comprehensive oral evaluations	100% (Deductible does not apply)	100% (Deductible does not apply)
Preventive Services Prophylaxis (cleanings) Topical fluoride applications	100% (Deductible does not apply)	100% (Deductible does not apply)
Diagnostic Radiographs Full-mouth and panoramic films Bitewing films Periapical films	100% (Deductible does not apply)	100% (Deductible does not apply)
Miscellaneous Preventive Services Sealants Space maintainers	100% (Deductible does not apply)	100% (Deductible does not apply)
Basic Restorative Services Amalgams Resin-based composite restorations	80%	80%
Non-Surgical Extractions Removal of retained coronal remnants Removal of erupted tooth or exposed root	80%	80%
Non-Surgical Periodontal Services Periodontal scaling and root planing Full-mouth debridement Periodontal maintenance procedures	80%	80%
Adjunctive Services Palliative treatment (emergency) Deep sedation / general anesthesia	80%	80%
Endodontic Services Therapeutic pulpotomy and pulpal debridement Root canal therapy Apexification/recalcification	80%	80%

Covered Services (continued)

	Contracting Dentist	Non-Contracting Dentist
Oral Surgery Services Surgical tooth extractions Alveoloplasty and vestibuloplasty Excision of benign odontogenic tumor/cyst Excision of bone tissue Incision and drainage of an intraoral abscess	80%	80%
Surgical Periodontal Services Gingivectomy or gingivoplasty and gingival flap procedures Clinical crown lengthening Osseous surgery Osseous grafts Soft tissue grafts/allografts Distal or proximal wedge procedure	80%	80%
Major Restorative Services Single crown restorations Inlay/onlay restorations Labial veneer restorations Crowns placed over implants	50%	50%
Prosthodontic Services Complete and removable partial dentures Denture reline/rebase procedures Fixed bridgework Prosthetics placed over implants	50%	50%
Implants	50%	50%
Miscellaneous Restorative and Prosthodontic Services Prefabricated crowns Recementations Post and core, pin retention and crown/bridge repairs Adjustments	50%	50%

Orthodontic Services

Orthodontic Services Orthodontic Diagnostic Procedures and Treatment Lifetime Maximum per Participant Adult coverage and dependent children to age 19	50% $2,000 (Deductible does not apply)

The above is a listing of common services available through your network of Contracting Dentists. The Member's share of the cost is determined by whether care is received from a Contracting or Non- Contracting Dentist.

Per Pay Period Pricing	
Employee	$ 5.84
Employee & Spouse	$23.22
Employee & Child(ren)	$29.94
Employee & Family	$52.60

Vision plan info

Summary of Coverage

Similar to other forms of insurance, with vision care, you pay a premium, and the insurance company will cover part or all of your vision costs.

Preventative care

Vision coverage is important because an eye doctor can catch eye issues before they worsen. A visit with your eye doctor can determine whether you need corrective lenses and, if so, the correct prescription. Other eye concerns that will be addressed in an eye exam include checking for conditions or diseases— such as glaucoma and cataracts—which can lead to vision loss.

Plans

Vision plans typically cover eyeglass frames, lenses, contacts, and annual eye exams. In most cases, plans have a set dollar amount the insurance will pay for certain items. For instance, a plan may pay up to $150 for frames, and you cover anything over that amount. To maximize the benefits and discounts, you must utilize the vision network. Your plan specifics may vary.

Coverage

Vision coverage does not usually cover surgeries or experimental vision services. However, vision insurance may help lower the costs of some procedures, such as laser eye surgery, even if it's not 100% covered. This will depend on the plan.

Diagnostic care

Eye doctors can even help detect some types of cancer, making regular visits even more important.

Review your benefits statement to see everything your vision plan covers. Reach out to HR with any questions.

Vision

BlueCross BlueShield of Texas

PLAN 10: 12/12/12/$150	
Frequency	
Examination	Once every 12 months
Lenses or contact lenses	Once every 12 months
Frame	Once every 12 months
Contact lens eval/fitting	N/A

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement*
Exam with dilation as necessary	$10 copay	Up to $30
Contact lens fit and follow-up	Up to $40 for standard; 10% off retail price for premium	N/A
Frames		
Any available frame at provider location	$0 copay, $150 allowance, 20% off balance over $150	Up to $75
Standard Lenses		
Single vision	$25 copay	Up to $25
Bifocal	$25 copay	Up to $40
Trifocal	$25 copay	Up to $55
Lenticular	$25 copay	Up to $55
Standard progressive lens	$90 copay	Up to $40
Premium progressive lens	Refer to the full benefit summary	Up to $40
Lens Options		
Tint	$15	N/A
Scratch resistant coating	$0	Up to $5
Polycarbonate lenses	$0 kids; $40 adults	Up to $5 kids
Ultraviolet coating	$15	N/A
Anti-reflective coating	Refer to the full benefit summary	N/A
High index lenses	20% off retail	N/A
Polarized lenses	20% off retail	N/A
Photochromic/transitions plastic	$75	N/A
Contact Lenses (in lieu of spectacle lenses)		
Conventional	$0 copay, $150 allowance, 15% off balance over $150	Up to $120
Disposable	$0 copay, $150 allowance, plus balance over $150	Up to $120
Medically necessary	$0 copay, paid-in-full	Up to $210

Per Pay Period Pricing	
Employee	$ 4.37
Employee & Spouse	$ 8.30
Employee & Child(ren)	$ 8.74
Employee & Family	$12.84

Group Life Insurance

Summary of Coverage

Plan Features	Basic Life - Group
Employee benefit amount	$50,000
Maximum benefit amount	$50,000
AD&D benefit	Same as Basic Life amount
The following shows how much benefits are reduced at certain ages.	
Age band	**Benefit reduction**
Age 65 Age 70	35% of the original amount 50% of the original amount

Group life is 100% covered by the employer with the option of employees adding voluntary life.

Life insurance isn't a fun thing to think about. Still, if you have people who depend on you for financial support, then life insurance is really about protecting them in case something happens to you. Your designated beneficiary would collect a financial benefit upon your death. You can name a beneficiary during the enrollment process and change it anytime.

Group life insurance coverage is an employer-sponsored safety net in case the worst happens, with no out- of-pocket costs to you. You may also enroll in voluntary life insurance if you need additional coverage.

Voluntary Life Insurance

Summary of Coverage

Plan Features	Basic Life - Voluntary
Employee benefit amount	Up to 5 times annual earnings in increments of $10,000. Not to exceed $500,000.
Minimum benefit amount	$10,000
Maximum benefit amount	$500,000 Guarantee Issue – Employee - $70,000
AD&D benefit	Same as the voluntary life amount
Spouse benefit	Up to 100% of the employee amount in increments of $5,000. Not to exceed $500,000. $25,000 Guarantee Issue - not to exceed 100% of the employee benefit amount
Dependent benefit	Up to 100% of the employee coverage amount in increments of $2,000. Not to exceed $10,000
The following shows how much benefits are reduced at certain ages.	
Age band	**Benefit reduction**
Age 65 Age 70	35% of the original amount 50% of the original amount

Employees must fill out an EOI form if they exceed the guaranteed issue amount.

Voluntary life insurance is similar to group life insurance, except you pay for it. It can provide additional financial security to your family in case the worst happens. You may also insure your spouse and children.

With voluntary life insurance, you pay a monthly premium through payroll deductions. You can name a beneficiary during the enrollment process and change it anytime. Plans are typically flexible and allow you to set your payment amounts.

Disability Insurance Long-term

Summary of Coverage

Plan Features	Long Term Disability
Employee benefit amount	60%
Maximum benefit amount	$15,000
Elimination period	90 days
Benefit duration	To Age 65 - SSNRA

Disability insurance provides income protection if you cannot work due to an injury or illness. With disability coverage, you are compensated for 60% of your lost income up to $15,000 per month after a 90-day elimination period.

For example, if you're covered under short-term disability (STD) insurance, the LTD insurance would start once the STD policy is exhausted, after 90 days.

The length of the LTD maximum benefit period for employees that become disabled before age 60 is up to their Social Security Normal Retirement Age (SSNRA). For those employees who become disabled at age 60 or over, the benefit period varies and is limited to a period between 10 years and 12 months.

Disability Insurance Short-term

Summary of Coverage

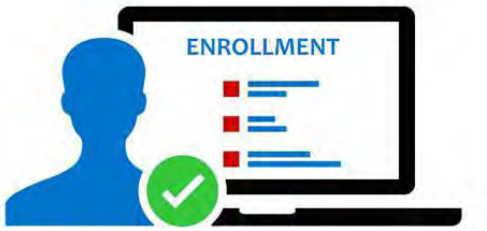
Plan Features	Short Term Disability
Employee benefit amount	50% of basic weekly earnings
Maximum benefit amount	$1,500
Elimination period (Accident)	7 days
Elimination period (Sickness)	7 days
Benefit duration	12 weeks

Short-term disability insurance provides income protection should you be unable to work due to an injury or illness. With disability coverage, you are compensated for a portion of your lost income.

Short-term disability (STD) coverage begins 8 days after the event causing your disability. The coverage allows you to continue to receive benefits at 50% of your pre-disability income up to the maximum weekly benefit amount of $1,500. When STD coverage ends, long-term disability (LTD) coverage is available.

STD benefits last for up to 12 weeks. The exception is maternity-related claims, which are covered the same as other illnesses with a time limitation. With a routine delivery without complications, the mother's recovery period is deemed to be 6 weeks from the delivery date. With a C-section delivery, the mother's recovery period is 8 weeks from the delivery date. Maternity complications that affect the mother's health are covered the same as any other illness. Contact HR for information regarding additional maternity leave benefits.

How to Enroll in Benefits



Enrollment Reminders

REMEMBER that your elections will be done online at Paylocity.
To make elections online: Go to: www.access.paylocity.com

- All newly hired employees are required to complete the online enrollment process. If you do not wish to participate in the benefit, please select "waive" to confirm your intent.
- Print and keep a copy for your records.
- To ensure timely processing of benefit elections and receipt of ID cards, please enroll as soon as you can.
- To make an eligible change due to a qualifying life event, notify HR at 214-270-0656.

Questions?

If you have any questions or need help updating information, please email Candice.beasley@camelotservices.com or call 214-270-0656. HR Support is available Monday – Friday, 9 a.m. – 5 p.m. (CT).

401k Benefits

Camelot offers a 401(k) plan, a tax-qualified retirement savings program. Because the plan is tax-qualified, you are allowed to make pre-tax contributions to the plan, which are excluded from your gross income. Investment earnings on your contributions accumulate tax-deferred until you withdraw them, usually at retirement.

You can elect to contribute a percentage of your salary or a flat amount to the plan each pay period in your OneAmerica portal. The payments are then deducted automatically from your paycheck. You have the option to make tax-deferred or Roth, taxable contributions.

Your plan offers a variety of investment alternatives for your contributions. You may change the amount of your contributions or stop contributions in accordance with plan provisions. You may review the investment options in your OneAmerica portal, and you may change your investment options online in accordance with plan provisions. Provided you are not an Excluded Employee, you may become a "Participant" in the Plan once you have satisfied the eligibility requirements and reach your "Entry Date" (You are eligible for the Plan on the first of the month following 1 month of employment and your Entry Date will be the first of the month coinciding with or next following the date you satisfy the eligibility requirements).

To access your account online or enroll, please visit **https://link.edgepilot.com/s/68529bcf/YJBRlHSLCkG1PMu2yeipAA?u=https://pages.oneamerica.com/camelot401k**.

Employee inquiries can contact OneAmerica Participant Services Call Center at 800-249-6269. Registered representatives are available to assist employees Monday through Friday from 6:00 a.m. to 8:00p.m., Mountain Time and Saturday from 7:00 a.m. to 3:30 p.m., Mountain Time.

***If you need to consult with Camelot's Broker, Marc Rossouw, he can be reached at 469-573-8604 or Marc.Rossouw@edwardjones.com

Please refer to the enrollment booklet or the Summary Plan Description for more details.

Important Laws and Notices

Newborn & Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your physician, nurse midwife or physician's assistant) after consultation with the mother, discharges the mother or newborn earlier.

Plans and issuers may not select the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification.

Women's Health & Cancer Rights Act

On October 21, 1988, the Women's Health and Cancer Rights Act became effective. This law requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. As the Act requires, we have included this notification to inform you about the law's provisions. The law mandates that a plan participant receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and co-insurance provisions that apply for the mastectomy.

Health Insurance Portability & Accountability Act of 1996 (HIPAA)

HIPAA requires that you be informed of your Special Enrollment rights when you and/or your eligible dependents decline health care coverage during the initial enrollment period.
If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself and/or your dependents in an PH medical plan provided that you request cover- age within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption or a court order, you may be able to enroll yourself and/or your dependents, provided that you request Enrollment within 31 days after the marriage, birth, adoption or placement for adoption or the court order.

If you are declining health coverage for yourself or your dependents (including your spouse) and you are not currently covered under a medical plan, you will be considered a late applicant.

HIPAA allows a late applicant to enter a medical plan only during an open enrollment period.

The Plan will use Protected Health Information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended. The plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The Plan Sponsor hereby certifies that in accordance with HIPAA, access to PHI information may be given only to the Plan Sponsor and staff of the Plan Sponsor who receive protected health information related to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business in carrying out Plan administration functions that the Plan Sponsor performs for the Plan. If the Plan Sponsor and said staff do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. With an authorization, the Plan will disclose PHI for the purposes granted, and to the parties specified in the authorization.

Mental Health Parity of 2010

Taking an active, involved approach to caring for your mental and emotional health can help you lead a healthier, more balanced life. Effective January 1, 2010, the Paul Wellstone and Pete Domenici Health Parity and Addiction Equity Act removed any visit limits for the following:

- Mental Health Outpatient
- Mental Health Inpatient
- Alcohol and Substance Abuse Outpatient
- Alcohol and Substance Abuse Inpatient stays for detoxification and rehabilitation

Premium Assistance Under Medicaid & the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1 877 KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1 866 444 EBSA (3272).

You can find a list of the eligible states on the Camelot benefits portal compliance page at www.insuranceisboring.com. You may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility

Continuation of Coverage - COBRA

Eligibility

Employees enrolled in the medical, pharmacy, dental, vision and/or FSA plans are eligible for COBRA continuation coverage. If you experience an event that normally results in loss of the previously mentioned coverage, you may be eligible to continue receiving benefits for up to 18 months if you meet one of the following conditions:

- The death of the employee who was the primary account holder
- Termination of employment (other than by reason of the employee's gross misconduct) or reduction in hours
- The divorce or legal separation of the employee
- A dependent child ceases to be a dependent under the terms of the plan
- Newborn and newly adopted children of a COBRA beneficiary become eligible for continuation coverage at the time of their birth or adoption

If you meet the eligibility requirements, you will be sent a notice for COBRA options within 60 days of your loss of coverage.

Continuation Coverage Cost

If you choose to continue coverage under COBRA, you are responsible to pay the full cost of coverage and an administrative fee. You must make your first payment for coverage no later than forty-five (45) days after the date of your election. If you do not make your first payment for continuation coverage in full, no later than forty-five (45) days after the date of your election, you will lose all continuation coverage rights under the plan. After you make your first payment, monthly payments are due each month that continuation coverage is available and requested.

Change of Status under active COBRA Coverage

If you are already receiving benefits from COBRA and you experience a life-status change, you must notify the employer in writing within sixty (60) days of the event. Coverage will be affected and determined by your new status, with deductions adjusted accordingly.

Qualifying Life-Event Changes Include:

- Death of employee
- Divorce of employee
- Legal separation of employee
- Child's loss of "dependent" status

Covered Dependents

Covered dependents may also be eligible for this coverage if the employee loses eligibility status under the group plan, the employee becomes deceased, or if the dependent is no longer an eligible dependent.

It is the employee's responsibility to notify Camelot's Benefits Department when there is a change in dependent eligibility for any Camelot benefit plan.

Camelot Services, Inc.

2024 - 2025 Employee Benefits Guide

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