WINDSONG EMPLOYEE HEALTH & WELFARE BENEFITS

2025

US Radiology Specialists
Imaging and Interventional Partners

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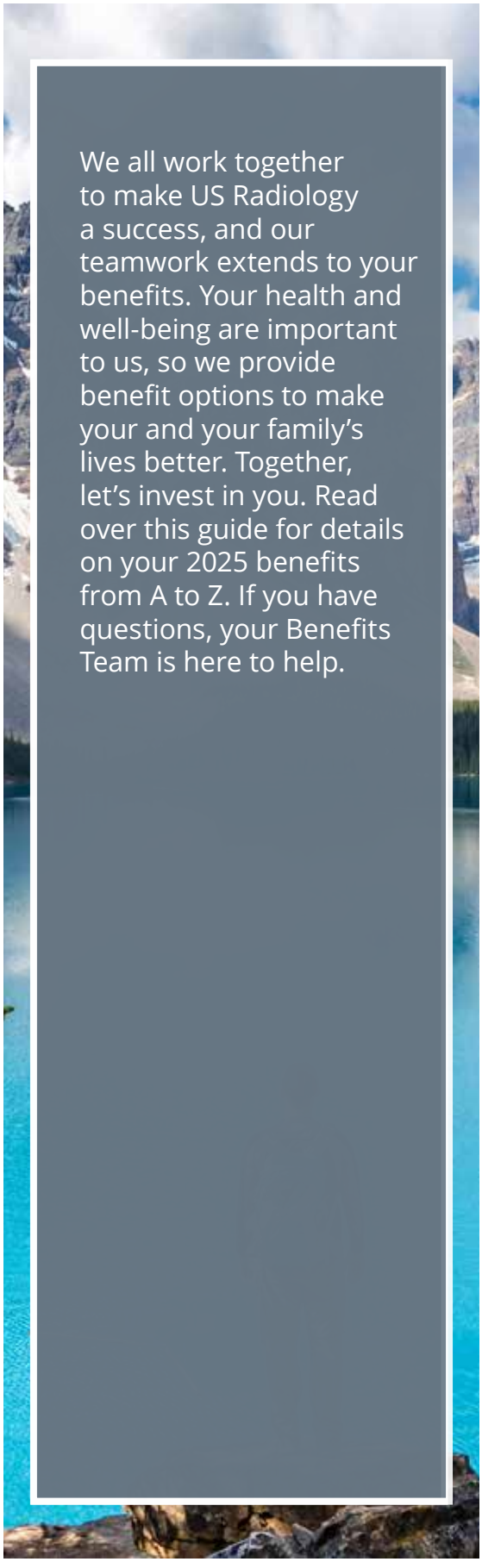


We all work together to make US Radiology a success, and our teamwork extends to your benefits. Your health and well-being are important to us, so we provide benefit options to make your and your family's lives better. Together, let's invest in you. Read over this guide for details on your 2025 benefits from A to Z. If you have questions, your Benefits Team is here to help.

See **page 36** for important information concerning Medicare Part D coverage.

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

ELIGIBILITY & ENROLLMENT

US Radiology offers a variety of benefits to support your and your family's needs. You can choose options that cover what's important to your unique lifestyle.

Eligibility

If you are regular full-time or part-time employee of US Radiology (Windsong) who is working the minimum number of hours set forth by your employer, you are eligible to participate in **medical, dental, vision, life, disability plans, and additional benefits**.

When Does Coverage Begin?

Coverage begins on the first of the month following your date of hire. If your start date is on the first of the month, your benefits are effective immediately. As a new hire, you have 30 days to enroll from your date of hire. You won't be able to change your benefits until the next enrollment period unless you experience a Qualifying Life Event. Any elections made during the Annual Open Enrollment will be effective January 1 of the following calendar year.

When Does Coverage End?

If you lose your eligibility (terminate employment, reduce hours below the minimum number of hours set forth by your employer):

- Your medical coverage ends at the end of the month in which you have your last day of eligibility.
- Your life/voluntary benefits end on your last day of eligibility.
- Your reimbursement account contributions end on your last day of eligibility.

Eligible Dependents

Dependents eligible for coverage in the US Radiology benefits plans include:

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

Can I change my benefit elections during the calendar year?

Yes, but only with a **Qualifying Life Event.**

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

When a Qualifying Life Event occurs, **you have 30 days to request changes to your coverage.** Keep in mind your change in coverage must be consistent with your change in status.

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

Common qualifying events include:

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

Some lesser-known qualifying events are:

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

PREPARING FOR ENROLLMENT

As a committed partner in your health, US Radiology contributes a significant amount to your benefit costs. Also, your contributions for medical, dental, vision and Spending Account benefits are deducted on a pre-tax basis, lessening your tax liability. Please note that employee deductions vary depending on level of coverage. Typically, the more coverage you have, the higher your portion.

You may select any combination of medical, dental and/or vision plan coverage. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of US Radiology, must elect coverage for yourself in order to elect coverage for any qualified dependent.

Enrollment To-Do

Update your personal information.

Have you moved, married or had a baby? Please update your personal information!

Double-check covered and restricted medications.

Check to ensure your medications are covered on your prescription coverage.

Review available plans' deductibles.

Take a look at your options — if you foresee a lot of medical needs this year, you might want a lower deductible. If not, you could switch to a higher deductible and enjoy lower premiums.

Update Life Insurance beneficiaries.

Who would you want to give any monetary life insurance benefits to if you passed away? Make sure that person(s) is listed as your beneficiary!

Consider your HSA or FSA.

An HSA or FSA can help cover healthcare costs including dental and vision services and prescriptions. Enrollments in an HSA or FSA do not carry over from year to year, so if you want to make contributions to these accounts, you must elect during the Open Enrollment period.

Check to see if your pharmacy is in-network.

Going in-network often saves you money. Make sure your favorite pharmacy is still covered in-network.

MEDICAL BENEFITS

How to Pick a Plan

Consider any medical needs you might need for the upcoming plan year, your overall health, and any medications you currently take.

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

You'll pay the full cost of non-preventive medical services until you reach your deductible. This includes prescription medications.

Use your Health Savings Account for medical costs.

If you expect to mostly use preventive care (which is 100% covered), this plan could be best for you.

How does a PPO (Preferred Provider Organization) work?

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

The PPO plan includes pharmacy copays that are not subject to the deductible.

You may use your Medical FSA to pay for medical costs while getting a tax advantage at the same time.

Windsong Medical benefits are provided through Blue Cross Blue Shield of North Carolina (BCBSNC).

Your Medical Deduction

Medical premiums are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your per paycheck deduction.

	HDHP WITH HSA	PPO - 1750	PPO - 5000
SEMIMONTHLY DEDUCTION			
EMPLOYEE ONLY	$52.63	$66.24	$18.55
EMPLOYEE + SPOUSE	$146.93	$237.75	$81.35
EMPLOYEE + CHILD(REN)	$118.41	$189.15	$72.51
EMPLOYEE + FAMILY	$195.50	$348.39	$190.03

	HDHP WITH HSA	PPO - 1750	PPO - 5000
BIWEEKLY DEDUCTION			
EMPLOYEE ONLY	$48.58	$61.14	$17.12
EMPLOYEE + SPOUSE	$135.62	$219.46	$75.09
EMPLOYEE + CHILD(REN)	$109.30	$174.60	$66.93
EMPLOYEE + FAMILY	$180.46	$321.59	$175.41

Blue Cross Blue Shield of North Carolina Customer Service

Your Blue Cross Blue Shield of North Carolina customer service plan advisor is ready to guide you to the answers you seek. Call 877-275-9787 to speak to your plan advisor, Monday through Friday from 8 a.m. to 7 p.m. Eastern Time.

A few of the services they can assist you with:

- Find the right provider
- Schedule appointments
- Navigate healthcare
- Review your medical benefits with you
- Review a recent medical claim

How to Find a Provider

Visit bcbsnc.com or call 877-275-9787 for a current list of network providers in the National Blue Options network.

Working Spouse Surcharge

If your spouse has access to medical coverage through their employer, and you add them to your USRS medical coverage, you will pay a monthly $150 spouse surcharge. If your spouse does not work, works part-time, is self-employed, is not eligible for coverage, has lost coverage as an active employee but has been offered COBRA or is covered by Medicare, the spousal surcharge does not apply.

Note: The company reserves the right to verify if your spouse is provided coverage elsewhere.

Tobacco / Vaping Surcharge

If you smoke or vape and enroll in the USRS medical plan, you will pay a monthly $100 tobacco surcharge.

Get support at no cost with QuitlineNC at 844-862-7848.

Windsong Medical Plan Comparison

This chart summarizes the 2025 medical coverage provided by BCBSNC. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to an out-of-network fee schedule, which may pay a lesser benefit than the negotiated carrier discounted rates.

	HDHP WITH HSA		PPO - 1750		PPO - 5000	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLE						
INDIVIDUAL	$3,300	$6,600	$1,750	$3,500	$5,000	$10,000
FAMILY	$6,600	$13,200	$3,500	$7,000	$10,000	$20,000
COINSURANCE (PLAN PAYS)	80%*	50%*	70%	50%*	100%	30%*
OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$6,600	$13,200	$4,750	$9,500	$9,200	$18,400
FAMILY	$12,000	$26,400	$9,500	$19,000	$18,400	$36,800
COPAYS/COINSURANCE (WHAT YOU PAY)						
PREVENTIVE CARE (routine physical examinations and screenings, preventive vision exam, well-baby and well-child care, well woman care, immunizations, mammogram, PSA test, colonoscopy	$0.00 (Covered at 100%)	30%*	$0.00 (Covered at 100%)	30%*	$0.00 (Covered at 100%)	30%*
PRIMARY CARE OFFICE VISIT	20%*	50%*	$35	50%*	$25	30%*
SPECIALIST OFFICE VISIT	20%*	50%*	$70	50%*	$50	30%*
DIAGNOSTIC SERVICES (lab tests, X-ray, MRI, CT Scan, EEG, ECG)	20%*	50%*	30%	50%*	0%*	30%*
OUTPATIENT SERVICES (physician services, hospital and hospital-based and outpatient clinic services, therapy services including rehabilitative and habilitative)	20%*	50%*	30%	50%*	0%*	30%*
INPATIENT HOSPITAL & SKILLED NURSING FACILITIES	20%*	50%*	30%	50%*	0%*	30%*
INPATIENT SERVICES (includes physician services, hospital and hospital based services and maternity delivery)	20%*	50%*	30%	50%*	0%	30%*
HOME HEALTH CARE	20%*	50%*	30%	50%*	0%*	30%*
OUTPATIENT MENTAL HEALTH / SUBSTANCE ABUSE	20%*	50%*	Office visit copay: $10 Other outpatient services: 30%*	50%*	0%*	30%*
INPATIENT MENTAL HEALTH / SUBSTANCE ABUSE	20%*	50%*	30%	50%*	0%*	30%*
DURABLE MEDICAL EQUIPMENT	20%*	50%*	30%	50%*	0%*	30%*
URGENT CARE	20%*	50%*	$70	$140	$50 copay	$100 copay
EMERGENCY ROOM	Emergency Room Visit with or without observation - 20% after deductible Emergency Roon Visit with Inpatient observation - 20% after deductible		Emergency Room Visit with or without observation - $300 Emergency Room Visit with Inpatient observation - 30% after deductible		Emergency Room Visit with or without observation - $300 Emergency Room Visit with Inpatient observation - 50% after deductible	
INFERTILITY	20% coinsurance, after deductible, Lifetime Infertility Benefit Maximum Three ovulation induction cycles, with or without insemination.	50% coinsurance, after deductible, Lifetime Infertility Benefit Maximum Three ovulation induction cycles, with or without insemination.	30% coinsurance, after deductible, Lifetime Infertility Benefit Maximum Three ovulation induction cycles, with or without insemination.	50% coinsurance, after deductible, Lifetime Infertility Benefit Maximum Three ovulation induction cycles, with or without insemination.	0% coinsurance, after deductible, Lifetime Infertility Benefit Maximum Three ovulation induction cycles, with or without insemination.	50% coinsurance, after deductible, Lifetime Infertility Benefit Maximum Three ovulation induction cycles, with or without insemination.

*After deductible

How an Embedded Deductible Works

If you have dependents covered on your medical plan, there is an embedded deductible. An embedded deductible means that once a dependent meets the individual deductible, they move to the copay arrangement. In other words, no one dependent would be responsible for more than the individual amount.

How to Find a Provider

The medical plan is administered by BCBSNC and utilizes the Blue Cross Blue Shield of North Carolina Network. Use a Blue Cross Blue Shield of North Carolina in-network doctor or hospital to ensure you receive the highest level of benefits. Visit www.bcbsnc.com or call 877-275-9787 for a current list of network providers in the national Blue Options network.

Precertification or Prior Authorization

- Call BCBSNC for precertification or prior authorization, if necessary. Refer to the phone number on the back of your member ID card.

After You Receive Care, You Should:

- Not have to complete any claim forms.
- Not have to pay upfront for medical services, except for the out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay.
- Receive an explanation of benefits from Blue Cross Blue Shield of North Carolina (BCBSNC).

Healthcare Cost Transparency

There are so many different providers and varying costs for healthcare services. How do you choose? Online services called healthcare cost transparency tools can help. Available through most health insurance carriers, these tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit bcbsnc.com or call 877-275-9787 for a current list of network providers in the national Blue Options network.

OUT-OF-POCKET COSTS

Deductible

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

UP TO DEDUCTIBLE

YOU PAY **100%**

Copay

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

Know before you go: Paying for services

Coinsurance

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

% YOU PAY

% PLAN PAYS

AFTER DEDUCTIBLE IS REACHED

UP TO THE OUT-OF-POCKET MAXIMUM

Out-of-Pocket Maximum

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

AFTER OUT-OF-POCKET MAXIMUM IS REACHED

PLAN PAYS **100%** THROUGH END OF PLAN YEAR

PREVENTIVE CARE

The US Radiology plans provide in-network preventive services — **at no cost to you!**

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

- Wellness visits, physicals, and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes
- Pediatric screenings for hearing, vision, obesity, and developmental disorders

- Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women
- Iron supplements (for children ages 6 to 12 months at risk for anemia)

Preventive care is important to your health. Contact a BCBSNC Customer Service Representative at 877-275-9787 if you have questions whether a service will be paid as preventive.

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

WHERE TO GO FOR CARE

PRIMARY CARE CENTER

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

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

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

TELEMEDICINE

What are the costs and time considerations?
- Flat fee for service, depending upon your medical plan choice.
- Access to care is usually immediate.
- Some states may not allow for prescriptions through telemedicine or virtual visits.

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

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

DO YOUR HOMEWORK

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

URGENT CARE CENTER

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

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

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

EMERGENCY ROOM

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

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

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

*This is a sample list of services and may not be all-inclusive.

TELEMEDICINE

When you're sick, the last thing you want to do is leave your home. Telemedicine is a convenient and easy way to talk to a doctor fast. All employees enrolled in the medical plan (HDHP or PPO) are eligible to receive telemedicine services.

Telemedicine

Telemedicine benefits are provided by Teladoc via Blue Cross Blue Shield of North Carolina (BCBSNC) for you and your covered dependents. State licensed, board-certified doctors are available any time of day to address acute care concerns, get a diagnosis and have a prescription sent straight to your pharmacy of choice, if necessary. Behavioral health services are available by appointment seven days a week. Please note that some states do not allow physicians to prescribe medications via telemedicine.

General / Acute Care

We all experience times where we don't feel well – it's not a case for the emergency room or even urgent care, but we also don't want to wait a week to see the doctor. That's where telemedicine can step in. When you activate their account, you are ready to connect to state licensed, board-certified doctors. Medical professionals are available by telephone or video, 24 hours a day, seven days a week and in all 50 states.

Common Conditions

- Allergies
- Asthma
- Bronchitis
- Cold & Flu
- Fever
- Joint Pain
- Nausea & Vomiting
- Pink Eye
- Sinus Infection
- Sore Throat

Mental Health

Approximately 1 in 5 adults in the U.S. deals with a mental, behavioral or emotional health issue in a given year. Addressing behavioral health concerns is an important part of your overall well-being. Using online tools, you can search for state licensed mental health professionals to securely connect with via telephone or video call.

Common Conditions

- Anxiety
- Depression
- Not feeling like yourself
- Marital issues
- Stress
- And more

Dermatology

Upload images of a skin issue online or on the Teladoc app and get a custom treatment plan within 24 hours for conditions including:

- Acne
- Eczema
- Skin infection
- Psoriasis
- Rosacea
- And more

Access Telemedicine

Call 800-835-2362 or visit teladoc.com to request a virtual visit. Once you register and request a consult, you will pay your portion of the service costs according to your medical plan, and then enter a virtual waiting room. During your visit you can talk to a doctor about your health concerns, symptoms and treatment options.

Your Cost for Telemedicine

If you elected the PPO 5000 or PPO 1750, all Teladoc visits are covered at 100% with no cost to you. This includes general / acute care, mental health, and dermatology visits.

If you elect the HDHP, you pay for telehealth services until your deductible is met, then there is no cost to you.

Teladoc visit costs are as follows:

2025 TELEHEALTH SERVICE FEES		
PRIMARY CARE	New patient, well or sick visit	$165
	Existing patient, well or sick visit	$99
ACUTE CARE	New or existing patient visit	$55
MENTAL HEALTH TELETHERAPY	Initial psychiatrist visit	$212
	Ongoing psychiatrist visit	$102
	All therapy visits	$92
NUTRITION	Initial or reoccurring visit	$59
DERMATOLOGY	New or existing patient visit	$85

PHARMACY BENEFITS

Prescription Drug Coverage for Medical Plans

The prescription drug program is with Prime Therapeutics. **Your Rx information is on your Medical ID card.** You may find information on your benefits coverage and search for network pharmacies by logging on to www.myprime.com or by calling the Customer Service number on your ID card. Medications are assigned as Generic, Preferred Brands, Non-Preferred Brands, or Specialty. Your cost is determined by the tier assigned to the prescription drug product.

	HDHP WITH HSA		PPO - 1750		PPO - 5000	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
TIER 1	20%*	NA	$10	$10	$10	$10
TIER 2	20%*	NA	$25	$25	$35	$35
TIER 3	20%*	NA	$40	$40	$60	$60
TIER 4	20%*	NA	$80	$80	25%	25%
TIER 5	20%*	NA	25%	25%	25%	25%

*After Deductible

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

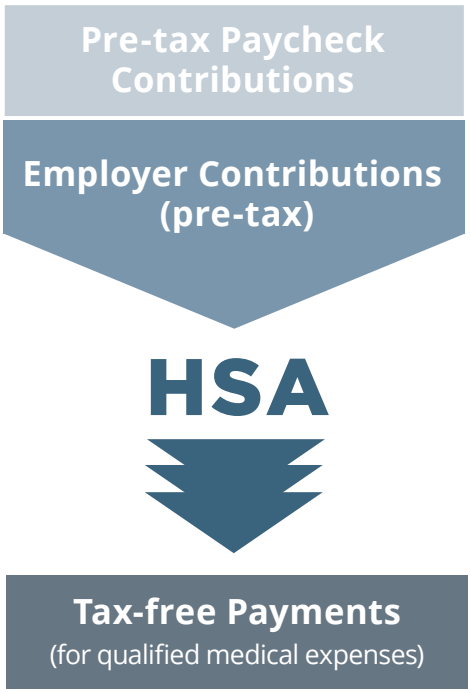
HEALTH SAVINGS ACCOUNT

Need funds to help cover out-of-pocket healthcare expenses? An HSA is a personal healthcare bank account used to pay for qualified medical expenses and funded by you and, in some cases, your employer too. HSA contributions and withdrawals for qualified healthcare expenses are tax-free. You must be enrolled in a HDHP to participate. **If you enrolled in a PPO plan, you are not eligible for an HSA.**

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan.

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

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on irs.gov for a complete list.



Eligibility

You are eligible to contribute to an HSA if:

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

You Own Your HSA

Your HSA is a personal bank account that you own and manage. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements (you own all contributed HSA funds immediately) or forfeiture provisions (you keep all HSA funds whether you leave the company or retire).

How to Enroll

To enroll in US Radiology's HSA, you must elect the HDHP with US Radiology. Submit all HSA enrollment materials and choose the amount to contribute on a pre-tax basis. US Radiology will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

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

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax. This is why it's important to know what medical expenses qualify for HSA use and to keep track of where you spend your HSA funds.

HSA Funding Limits

The IRS sets an annual limit on the maximum amount that can be contributed to HSAs. For 2025, contributions (which include employer contribution) are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$4,300
FAMILY	$8,550
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

US Radiology provides an HSA employer contribution that will be deposited on a quarterly basis.

EMPLOYER HSA CONTRIBUTION	
EMPLOYEE	Up to $1000
FAMILY	Up to $1000

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

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

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed but won't have to pay a penalty tax.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The US Radiology HSA is established with HealthEquity. You may be able to roll over funds from another HSA. For more enrollment information, contact HealthEquity.

Note: USRS contributes $500 to your HSA in January. It's prorated to $250 if your HSA eligibility starts July through September. You can earn an additional $500 by completing the health survey by 9/30.

*State income taxes are also waived on HSA contributions in almost all states.

FLEXIBLE SPENDING ACCOUNTS

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

Healthcare Flexible Spending Account

You can contribute up to $3,300 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Thoughts & Tips: **The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.**

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent daycare expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

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

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

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact HealthEquity with reimbursement questions. If you need to submit a receipt, HealthEquity will notify you. Always save receipts for your records.

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

General Rules

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

- Expenses must occur during the 2025 plan year.
- Funds cannot be transferred between FSAs.
- You are not permitted to claim the same expenses on both your federal income taxes and Dependent Care FSA.
- You must "use it or lose it" — any unused funds at plan's end will be forfeited. There is no grace period.
- You cannot change your FSA election in the middle of the plan year without a Qualifying Life Event.
- Terminated employees have thirty (30) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $155,000 or more last year) may have different FSA contribution limits. Visit irs.gov for more info.

FSA VS HSA

Flexible Spending Accounts		Health Savings Accounts
Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	OWNERSHIP	You own your HSA. It is a savings account in your name, and you always have access to the funds, even if you change jobs.
You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	ELIGIBILITY & ENROLLMENT	You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
FSA contributions are tax-free via payroll deduction. Funds are spent tax-free when used for qualified expenses.	TAXATION	HSA contributions are tax-free; the account grows tax-free; and funds are spent tax-free on qualified expenses.
You can contribute up to $3,300 in 2025 to an FSA.	CONTRIBUTIONS	Both you and your employer can contribute up to $4,300 in 2025 (up to $8,550 for families). Ages 55+ can make an annual $1,000 "catch-up" HSA contribution.
Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	PAYMENT	Many HSAs include a debit card to pay for qualified expenses directly. Alternatively, you can save funds for future expenses or retirement.
Any unclaimed funds at the end of the year are forfeited.	ROLLOVER OR GRACE PERIOD	HSA funds roll over from year to year. The account is portable and may be used for future qualified expenses — even in retirement years.
Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at irs.gov.	QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at irs.gov.

**IMPORTANT: This is a fixed indemnity policy,
NOT health insurance**

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

SUPPLEMENTAL BENEFITS

US Radiology offers supplemental coverage through The Hartford insurance company. This additional insurance can help cover unexpected hospital stay expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and is offered at discounted group rates. You do not have to be enrolled in a US Radiology medical plan to purchase this insurance.

Hospital Indemnity Coverage

Hospital Indemnity Coverage through The Hartford pays cash benefits directly to you if you have a covered stay in a hospital or critical care unit. The benefit amount is determined based on the type of facility and the number of days you stay. You can use the benefits from this policy to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging or everyday expenses such as groceries and utilities. US Radiology offers two voluntary plan options:

BENEFIT AMOUNT BASE PLAN	
HOSPITAL ADMISSION	$1,000 PER CALENDAR YEAR
DAILY BENEFIT FOR HOSPITAL STAY	$100, 30-DAY MAX PER CALENDAR YEAR
DAILY BENEFIT FOR CRITICAL STAY	$200, IN LIEU OF HOSPITAL STAY, 10-DAY MAX PER CALENDAR YEAR

BENEFIT AMOUNT PREMIUM PLAN	
HOSPITAL ADMISSION	$2,000 PER CALENDAR YEAR
DAILY BENEFIT FOR HOSPITAL STAY	$150, 30-DAY MAX PER CALENDAR YEAR
DAILY BENEFIT FOR CRITICAL STAY	$250, IN LIEU OF HOSPITAL STAY, 10-DAY MAX PER CALENDAR YEAR

Plan Highlights

- Guaranteed Issue Coverage (no medical questions).
- Pre-existing Conditions: This plan does NOT have a pre-existing condition exclusion. Benefits are payable for hospitalizations that occur on or after the effective date of your policy.

SEMIMONTHLY DEDUCTION	BASE PLAN	PREMIUM PLAN
EMPLOYEE ONLY	$7.77	$14.44
EMPLOYEE + SPOUSE	$16.21	$30.16
EMPLOYEE + CHILD(REN)	$14.85	$27.47
EMPLOYEE + FAMILY	$24.32	$45.08

BIWEEKLY DEDUCTION	BASE PLAN	PREMIUM PLAN
EMPLOYEE ONLY	$7.17	$13.33
EMPLOYEE + SPOUSE	$14.96	$27.84
EMPLOYEE + CHILD(REN)	$13.70	$25.36
EMPLOYEE + FAMILY	$22.44	$41.61

DENTAL BENEFITS

US Radiology offers affordable plan options for routine care and beyond. Coverage is available from Delta Dental of North Carolina.

Network Dentists

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

Dental Premiums

Premiums for dental are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your per paycheck deduction.

Dental Plan Summary

The chart on the next page summarizes the 2025 dental coverage provided by Delta Dental of North Carolina.

	DELTA DENTAL PPO PLUS PREMIER BASE BASIC PLAN		DELTA DENTAL PPO PLUS PREMIER BUY-UP PLAN		DELTA DENTAL PPO PLUS PREMIER ENHANCEMENT PLAN	
SEMIMONTHLY DEDUCTION						
EMPLOYEE ONLY	$12.84		$18.70		$22.70	
EMPLOYEE + SPOUSE	$26.31		$33.17		$40.28	
EMPLOYEE + CHILD(REN)	$28.99		$44.94		$52.31	
EMPLOYEE + FAMILY	$44.47		$66.81		$78.80	
BIWEEKLY DEDUCTION						
EMPLOYEE ONLY	$11.85		$17.26		$20.95	
EMPLOYEE + SPOUSE	$24.28		$30.61		$37.18	
EMPLOYEE + CHILD(REN)	$26.76		$41.48		$48.29	
EMPLOYEE + FAMILY	$41.05		$61.67		$72.73	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE						
INDIVIDUAL	$50	$50	$50	$50	$50	$50
FAMILY	$150	$150	$150	$150	$150	$150
ANNUAL MAXIMUM						
PER PERSON	$1,000	$1,000	$1,500	$1,500	$1,500	$1,500
COVERED SERVICES (WHAT YOU PAY)						
Preventive Services Exams, Routine Cleanings (covered twice per calendar year), Fluoride, Space Maintainers, Sealants, Brush Biopsies, X-rays	$0 (Covered at 100%)	Covered at 100% of Reasonable and Customary Charges exceeding Reasonable and Customary are the member's responsibility	$0 (Covered at 100%)	Covered at 100% of Reasonable and Customary Charges exceeding Reasonable and Customary are the member's responsibility	$0 (Covered at 100%) Preventive Services do not apply to annual maximum	$0 (Covered at 100%) Charges exceeding Reasonable and Customary are the member's responsibility Preventive Services do not apply to annual maximum
Basic Services Fillings, Endodontics (Root Canals), Periodontics (Treat Gum Disease), Repairs to Crowns/Bridges/ Implants/Dentures	20%*	20%*	20%*	20%*	$0 (Covered at 100%)	Covered at 100% of Reasonable and Customary Charges exceeding Reasonable and Customary are the member's responsibility
Major Services Oral Surgery (Extractions and Dental Surgery), Crowns, Bridges/Impants/Dentures	Not covered	Not covered	50%*	50%*	40%*	40%*
Orthodontics Child and Adult Coverage (no age limit)	Not covered		50%*		50%*	
Orthodontic Lifetime Maximum	Not covered		$1,500		$1,500	

*After deductible

VISION BENEFITS

US Radiology provides you and your family access to quality vision care with a comprehensive vision benefit through EyeMed.

Vision Plan Summary

This chart summarizes the 2025 vision coverage provided by EyeMed.

Vision Premiums

Deduction are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your per paycheck deduction.

VISION PLAN

	SEMIMONTHLY DEDUCTION	BIWEEKLY DEDUCTION
EMPLOYEE ONLY	$3.14	$2.89
EMPLOYEE + SPOUSE	$5.95	$5.49
EMPLOYEE + CHILD(REN)	$6.27	$5.78
EMPLOYEE + FAMILY	$8.95	$8.26

	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT	FREQUENCY
EXAMS (WHAT YOU PAY)			
COPAY	$10	Up to $40	Once every 12 months
LENSES (WHAT YOU PAY)			
SINGLE VISION	$25	Up to $30	Once every 12 months
BIFOCAL	$25	Up to $50	
TRIFOCAL	$25	Up to $70	
STANDARD PROGRESSIVE LENS	$75	Up to $50	
CONTACTS (IN LIEU OF LENSES AND FRAMES) (WHAT YOU PAY)			
FITTING AND EVALUATION*	$40 fee	Not covered	Once every 12 months
ELECTIVE	$0 copay, $130 allowance	Up to $130	
MEDICALLY NECESSARY	$0 copay, covered in full	Up to $210	
FRAMES (WHAT YOU PAY)			
ANY AVAILABLE FRAME AT PROVIDER LOCATION	$0 copay; $140 allowance, 20% off balance over $140	Up to $98	Once every 12 months
OTHER SERVICES (WHAT YOU PAY)			
RETINAL IMAGING	$39 fee	Not covered	Once every 12 months

*Fitting and Evaluation fee applied to contact lens allowance.

SURVIVOR BENEFITS

Survivor benefits provide financial protection and security in the event of death or serious accident. Securing Life insurance now ensures your family will be protected for the future.

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

US Radiology provides employees with Basic Life and AD&D insurance as part of your coverage through The Hartford. This coverage guarantees that loved ones, such as a spouse or other designated beneficiaries, receive monetary benefits after your death.

Your Basic Life and AD&D insurance benefit is $50,000. If you are a regular full-time or part-time employee working the minimum number of hours set forth by your employer, you automatically receive Life and AD&D insurance even if you elect to waive other coverage.

If death is the result of an accident, your beneficiary will receive an additional amount equal to your basic life insurance coverage. If you are dismembered (such as loss of sight in an eye, loss of a hand, foot, limb, hearing, speech, etc.), benefits will be paid to you as a percentage of the basic life amount.

What's a beneficiary? Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by US Radiology. You receive the benefit payment for a dependent's death under the The Hartford insurance.

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

Voluntary Life and AD&D Insurance

Extra coverage is available to protect you and your family. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions. In order to elect Voluntary Life Insurance for a dependent, you (the employee) have to first elect it for yourself.

BASIC EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	$50,000
WHO PAYS	US Radiology
BENEFITS PAYABLE	In the event of your death, while covered under the plan
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY EMPLOYEE LIFE	
COVERAGE AMOUNT	$10,000 increments; age reductions to 65% at age 65, 50% at age 70
WHO PAYS	Employee
BENEFITS PAYABLE	If you die while covered under the plan. This benefit is in addition to your Basic Life benefit.
MAXIMUM BENEFIT	Lesser of 5x annual earnings or $500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	First eligible employees amounts over $300,000 All other increases in coverage require EOI*
VOLUNTARY EMPLOYEE AD&D	
COVERAGE AMOUNT	Same as Voluntary Life election amounts
WHO PAYS	Employee
MAXIMUM BENEFIT	Same as Voluntary Life election amounts
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Same as Voluntary Life election amounts
VOLUNTARY SPOUSE LIFE	
COVERAGE AMOUNT	$5,000 increments; age reductions to 65% at age 65, 50% at age 70
WHO PAYS	Employee
BENEFITS PAYABLE	If your spouse dies while covered under the plan.
MAXIMUM BENEFIT	Lesser of 50% of employee's coverage amount or $250,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	For amounts over $50,000 and for increases after first eligibility
VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	$10,000 for 6 months old to age 26, $500 for 15 days to 6 months old
WHO PAYS	Employee
BENEFITS PAYABLE	If your dependent dies while covered under the plan.
MAXIMUM BENEFIT	$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No

*When you are first eligible, you are allowed a one time opportunity to elect Voluntary Life coverage up to the guarantee issue amount (if you choose to do so) without having to complete evidence of insurability (EOI). Going forward, you would have to complete an EOI if you choose to increase your Voluntary Life up to the guarantee issue at each Open Enrollment.

VOLUNTARY LIFE INSURANCE

RATES/$1,000		
AGE AS OF JANUARY 1, 2025	**EMPLOYEE/SPOUSE SEMIMONTHLY DEDUCTION**	**EMPLOYEE/SPOUSE BIWEEKLY DEDUCTION**
<25	$0.017	$0.015
25-29	$0.014	$0.013
30-34	$0.016	$0.015
35-39	$0.024	$0.022
40-44	$0.036	$0.033
45-49	$0.059	$0.054
50-54	$0.095	$0.087
55-59	$0.138	$0.127
60-64	$0.177	$0.163
65-69*	$0.256	$0.236
70-74*	$0.452	$0.417
75+*	$1.030	$0.951
Child Life Rate/Per Unit	$0.30	$0.277

*Benefits Subject to Age Reduction Schedule

VOLUNTARY AD&D INSURANCE

	SEMIMONTHLY DEDUCTION	**BIWEEKLY DEDUCTION**
Employee (Per $1,000)	$0.006	$0.006
Spouse (Per $1,000)	$0.006	$0.006
Child (Per Child Unit)	$0.12	$0.111

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

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

INCOME PROTECTION

Disability insurance protects a portion of your income if you are unable to work as a result of illness or injury. Disability benefits will be provided as long as you meet the definition of disability or until the maximum benefit duration is met. **US Radiology provides Short-Term Disability coverage for all employees, at no cost for employees. Long-Term Disability is voluntary.**

THE HARTFORD SHORT-TERM DISABILITY	
ELIMINATION PERIOD	14 days for injury or sickness, benefits begin on 15th day
WEEKLY BENEFIT	60% weekly earnings
WHO PAYS	US Radiology
MAXIMUM WEEKLY BENEFIT	$2,000
MAXIMUM BENEFIT DURATION	24 weeks
BENEFITS	Any benefits received are taxable

THE HARTFORD VOLUNTARY LONG-TERM DISABILITY	
ELIMINATION PERIOD	180 days
MAXIMUM MONTHLY BENEFIT *Earnings <$200,000/year*	60% of monthly income to $10,000/month
MAXIMUM MONTHLY BENEFIT *Earnings = $200,000+/year*	2 options: 60% of monthly income to $10,000/month or 70% of monthly income to $15,000/month
WHO PAYS	Employee
MAXIMUM BENEFIT DURATION	Social Security Normal Retirement Age, see LTD policy booklet for benefit durations for disabilities beginning at age 62 or later
PRE-EXISTING CONDITIONS EXCLUSION	Treatment/consultation/medication for condition 3 months prior / 12 months after the employee's effective date of coverage
DEDUCTIONS AND BENEFITS	Deductions are taken post-tax, and any benefits received are not taxable

VOLUNTARY LONG-TERM DISABILITY RATES

SEMIMONTHLY DEDUCTION/PER $100 COVERED PAYROLL		
YOUR AGE (AS OF 1/1/2025)	60% BENEFIT	70% BENEFIT OPTION FOR $200K+ SALARY ONLY
<25	$0.06	$0.09
25-29	$0.10	$0.14
30-34	$0.14	$0.20
35-39	$0.20	$0.29
40-44	$0.26	$0.37
45-49	$0.33	$0.48
50-54	$0.45	$0.65
55-59	$0.62	$0.91
60+	$0.66	$0.96

BIWEEKLY DEDUCTION/PER $100 COVERED PAYROLL		
YOUR AGE (AS OF 1/1/2025)	60% BENEFIT	70% COLUMN OPTION FOR $200K+ SALARY ONLY
<25	$0.06	$0.08
25-29	$0.09	$0.13
30-34	$0.12	$0.18
35-39	$0.18	$0.26
40-44	$0.24	$0.34
45-49	$0.30	$0.44
50-54	$0.41	$0.60
55-59	$0.57	$0.84
60+	$0.61	$0.89

Thoughts & Tips: **Nearly 6% of working Americans will experience a short term disability due to illness, injury, or pregnancy on average every year.**

ADDITIONAL BENEFITS

US Radiology offers a variety of additional benefits to help make your day-to-day life easier.

Employee Assistance Program

We know life can get complicated, and sometimes we all just need a little help. Our Employee Assistance Program (EAP), through McLaughlin Young helps manage your and your family's total health, including mental, emotional, and physical. And it comes at no cost to you.

Through this program, you have access to mental health assistance and legal and financial help from a number of professionals. You and members of your immediate family have 24 hour access to helpful resources by phone and by going online. The EAP benefit also includes three free face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with US Radiology. You may access information, benefits, educational materials, and more either by phone at 800-633-3353 or online at mygroup.com.

The Program provides referrals to help with:

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

Website Access Instructions

1. Visit mygroup.com
2. Select the "Work-Life" Portal
3. Enter Credentials
   User ID: USRadiology1
   Password: guest

Retirement Planning

US Radiology offers an employer-sponsored retirement account to help you save money tax-free from your pay check. Due to the value of compounding interest, the sooner you participate in a 401(k), the better.

Eligible employees can invest for retirement while receiving certain tax advantages. Administrative and record-keeping services for this plan are provided by One America.

If you have any questions related to your retirement plan account or need assistance with reviewing your balance, requesting rollovers, loans, or hardship distributions, you can contact OneAmerica directly at 800-858-3829, Monday - Friday from 7:00 a.m. – 11:00 p.m. EST, and Saturday 8:00 a.m. – 2:00 p.m. EST or by visiting oaretirement.com.

Legal and Identity Theft Protection

LegalShield and ID Shield provide the Legal and Identity Theft protection you and your family need. This benefit is voluntary and employee paid.

LegalShield

- Legal Consultation and Advice
- Court Representation
- Dedicated Law Firm
- Legal Document Prep and Review
- Uncontested Divorce
- Speeding Ticket Assistance
- Will Preparation
- 24/7 Emergency Legal Access
- Mobile App

LEGALSHIELD		
	Semimonthly Deduction	Bi-Monthly Deduction
Employee + Family (one rate covers all)	$9.13	$8.42

IDShield

- Identity Consultation and Advice
- Dedicated Licensed Private Investigators
- Identity and Credit Monitoring
- Social Media Monitoring
- Child Monitoring
- Comprehensive Identity Restoration
- Identity and Credit Theft Alerts
- 24/7 Emergency Access
- Mobile App

IDSHIELD		
	Semimonthly Deduction	Bi-Monthly Deduction
Employee Only	$4.48	$4.13
Employee + Family	$8.48	$7.82

LEGALSHIELD + IDSHIELD (BUNDLED PLAN)		
	Semimonthly Deduction	Bi-Monthly Deduction
Employee Only	$12.95	$11.95
Employee + Family	$16.35	$15.09

All of the following benefits are offered free of charge to employees who are covered under The Hartford's Group Life/AD&D insurance policy.

Travel Assist

When the unexpected happens, when traveling away from home, it's important to know whom to call for assistance.

You and your family have access to Travel Assistance Services provided by Europ Assistance USA. With a local presence in 200 countries and territories around the world and numerous 24/7 assistance centers, they are available to help you anytime, anywhere. Call 800-243-6108 or 202-828-5885 if you need assistance. Your travel identification number is GLD-09012.

Health Champion

If you are experiencing a healthcare issue, HealthChampion specialists can help ensure that you're fully supported with employee assistance programs and/or work-life services. You can access guidance consultants 24/7 via a toll-free line: 800-964-3577.

Estate Guidance

Whether your assets are few or many, it's important to have a will. It's the only way to ensure that your intentions will be honored in the event of your death. A will states your wishes about who will inherit your property, who will be the guardian of your children, and who will manage your estate. Without a will, those decisions may be left to others. Visit estateguidance.com/wills and use the code WILLHLF to create a will.

Beneficiary Assist

If you experience the loss of a loved one, in addition to grief, you may have financial and legal worries. Beneficiary Assist counseling services provided by ComPsych can assist you with these concerns. Find out more about Beneficiary Assist counseling services by calling 800-411-7239.

Funeral Planning – Life Conversations

The death of a loved one is one of life's most stressful situations. That's why we offer a funeral planning and concierge service — provided by Everest. Find out more by calling 866-854-5429 or visiting everestfuneral.com/hartford and using the code HFEVLC.

When Does Coverage Change?

WHEN I HAVE A STATUS CHANGE	
AND I GAIN BENEFITS ELIGIBILITY (I.E., MOVE FROM PRN TO FULL TIME)	
WHEN DOES MY COVERAGE START?	
MEDICAL	The first of the month following status change
DENTAL	The first of the month following status change
VISION	The first of the month following status change
HARTFORD PLANS	The first of the month following status change

AND I LOSE BENEFITS ELIGIBILITY (I.E., MOVE FROM FULL TIME TO PRN)	
WHEN DOES MY COVERAGE END?	
MEDICAL	The end of the month following status change
DENTAL	The end of the month following status change
VISION	The end of the month following status change
HARTFORD PLANS	The day of the status change

WHEN I HAVE A QUALIFYING LIFE EVENT	
IF I AM BENEFITS ELIGIBLE WHEN I HAVE A QUALIFYING LIFE EVENT	
WHEN DOES MY COVERAGE CHANGE?	
MEDICAL	The date of Qualifying Life Event
DENTAL	The date of Qualifying Life Event
VISION	The date of Qualifying Life Event
HARTFORD PLANS	The date of Qualifying Life Event

WHEN MY EMPLOYMENT ENDS AT USRS	
WHEN DOES MY COVERAGE END?	
MEDICAL	The end of the month of my last day of employment
DENTAL	The end of the month of my last day of employment
VISION	The end of the month of my last day of employment
HARTFORD PLANS	The last day of employment

GLOSSARY

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

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

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

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

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

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," meaning that funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or a rollover into the next plan year.

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

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

Health Reimbursement Account (HRA) – A personal healthcare account funded by your employer that you could use to pay for qualified medical expenses.

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

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

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

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

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

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

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

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

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

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

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

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

Required Notices

Important Notice From US Radiology About Your Prescription Drug Coverage and Medicare Under the BCBSNC - PPO $1750, PPO $3300, and PPO $5000 Plan(s)

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

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

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

2. US Radiology has determined that the prescription drug coverage offered by the BCBSNC - PPO $1750, PPO $3300, and PPO $5000 plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

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

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

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

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

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

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2025
Name of Entity/Sender:	US Radiology
Contact—Position/ Office:	Human Resources
Address:	4200 Six Forks Road, Suite 1000 Raleigh, NC 27609
Phone Number:	919-763-1100

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 919-763-1100.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 919-763-1100.

HIPAA Special Enrollment Rights

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

Loss of eligibility includes but is not limited to:

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

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 919-763-1100.

IMPORTANT CONTACTS

MEDICAL
Blue Cross Blue Shield of North Carolina
877-275-9787
bcbsnc.com
Group #: 14181728

PHARMACY
Prime Therapeutics
877-258-3334
www.myprime.com
BIN: 015905
Group: 14181728

DENTAL
Delta Dental of North Carolina
800-662-8856
deltadentalnc.com
Policy #: 10010

VISION
EyeMed
866-800-5457
eyemed.com
Policy #: 1025048

HEALTH SAVINGS ACCOUNT
HealthEquity
877-713-7682
healthequity.com
Employer ID: 80114

FLEXIBLE SPENDING ACCOUNTS
HealthEquity
877-713-7682
healthequity.com
Employer ID: 80114

LIFE AND AD&D
The Hartford
888-563-1124
thehartford.com
Policy #: 676612

DISABILITY
The Hartford
800-549-6514
thehartford.com
STD Policy #: 073390
LTD Policy #: 676612

EMPLOYEE ASSISTANCE PROGRAM
MYgroup (McLaughlin Young)
800-633-3353
mygroup.com
Username: usradiology1
Password: guest

HOSPITAL INDEMNITY
The Hartford
866-547-4205
thehartford.com
Policy #: 681757

PREPAID LEGAL AND IDENTITY THEFT
LegalShield / IDShield
800-654-7757
legalshield.com
Policy #: 204227

401(k) RETIREMENT PLAN
OneAmerica
800-858-3829
usradiologyretirement.com
Plan #: 964120

COBRA ADMINISTRATOR
P&A Group
716-852-2611
Padmin.com
Live chat available

THE BENEFITS TEAM
Benefits Assistance Center
833-981-1399
usrsbenefits@lockton.com

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US Radiology Specialists
Imaging and Interventional Partners