



Benefits Guide

2022–2023





Horner Electric Benefit Plan Annual Enrollment

New plan year begins 10/01/2022

Open enrollment is September 7 through September 16.

This is an ACTIVE enrollment. Active enrollment means everyone must complete the enrollment process.

EVEN IF—you want to keep the same benefits OR you don't want benefits at all—you still need to complete the enrollment.

Enrollment is quick and easy using the online enrollment system. The instructions to access the enrollment system are on the last page of this guide. If you do not have internet access or prefer not to use the online benefits system, you can reach out to the call center at 866-575-5089 to complete the enrollment process.

As always, if you have questions or need help, please reach out to the Benefit Innovations team:

Amber Blevins, Client Services Consultant	317.663.4044	amberb@benefiti.com
Cara Ramsey, Client Services Consultant	317.663.4046	carar@benefiti.com
Wanza Schweiger, Management Partner	317.663.4041	wanzas@benefiti.com

This year, all voluntary coverage lines are moving from the current carriers, MetLife and The Hartford, to Principal Financial. The same coverage options are available, but you may notice minor changes in benefits and rates.

Due to the change in carrier, **Critical Illness coverage will have an open enrollment.** This means **you may elect Critical Illness coverage with no medical questions asked.** If you are considering taking Critical Illness coverage, now is the time! If you fail to elect Critical Illness coverage during this enrollment and then decide to elect it later, you will be required to submit a medical questionnaire and could be denied coverage.

GPA and ELAP have merged and are now known as Imagine360. You still have the same medical plan administration; they're simply undergoing a name change. You may still see GPA or ELAP referenced in various places, as the rebranding is still underway. **GPA and ELAP phone numbers and email addresses still work and your medical benefits ID number and claims submission details remain the same.**

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Eligibility Criteria

As a full-time employee, or a part-time employee working at least 30 hours per week, you are eligible to enroll in the Horner Electric, Inc benefit plan the first of the month following or coinciding with 60 days of continuous employment. This eligibility requirement applies to:

- Medical
- Prescriptions-ScriptSourcing
- Regenexx
- Dental
- Vision
- Short Term Disability
- Long Term Disability
- Critical Illness
- Personal Accident
- Employee Basic Term Life
- Employee Voluntary Term Life
- Spouse and Child Term Life
- Employee Assistance Program
- HRA
- FSA

No exceptions can be made to the eligibility criteria. The Horner Electric, Inc benefit plan is a Section 125 plan, governed by the Internal Revenue Service. Some premiums are deducted on a pre-tax basis and as such, changes can only be made during annual enrollment or if you experience a Family Status Change.

Once you make your elections they are **binding and cannot be changed** unless there is a Significant Family Status Change. See below for a partial listing of qualifying status changes. You must enroll or make changes by notifying Human Resources within 30 days of a status change or you will be required to wait until the next annual enrollment and exclusions may apply. You may be required to submit proof of your family status change.

The Horner Electric, Inc benefit plan has a spousal carve-out provision. If your spouse is eligible for medical coverage from their employer, they cannot enroll in the Horner Electric, Inc medical plan. There is a Spousal Carve-out form that may require verification from your spouse's employer. See your Human Resources to obtain the Spousal Carve-out form.

Pre-existing conditions exclusions may apply to non-medical coverages.

Significant Family Status Change

Reasons You May Be Eligible to Change Your Benefits

- Involuntary loss of coverage
- A change in your marital status, such as marriage, divorce, or death of a spouse
- A change with your dependents, such as birth, adoption, or death of a dependent
- A change in employment status for you, your spouse, or your dependent
- Your dependent gaining or losing eligibility as a dependent on the plan
- A change in residence for you, your spouse, or your dependent that affects your healthcare options
- Losing or gaining eligibility for Medicare, Medicaid, or CHIP
- A court order, judgement, or decree, including QMCSO
- A several curtailment in coverage available under this plan or a dependent's plan
- A change your dependent's coverage under a plan sponsored by the dependent's employer
- A HIPPA special enrollment event
- Any other change permitted under IRS rules

Notice of Non-Grandfathered Plan

Our group health plan believes the Horner Electric, Inc Health Plan is a non-grandfathered health plan under the Patient Protection and Affordable Care Act (the Affordable Care Act). Being a non-grandfathered health plan means that your plan should include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing and the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. For ERISA plans, you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Pre-existing Condition Limitations

Pre-existing conditions do not apply for anyone covered under the Horner Electric, Inc Health Plan effective January 1, 2014.

No Annual Dollar Limits on Essential Health Benefits

Group health plans are prohibited from imposing lifetime or annual dollar limits on all Essential Health Benefits (EHB's). The general EHB definition includes health care services in the following ten benefit categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care (services for individuals under 19 years)

Dependent Coverage to Age 26

All plans beginning January 1, 2014 must allow dependent children to remain on the plan until the age of 26 regardless of grandfathered status.

Co-pays and Deductibles Must Track to Out of Pocket Maximums

Beginning January 1, 2014, all co-pays, including RX co-pays, must track toward the out of pocket maximum.

Medical Benefits

Administered by Imagine360

Your Medical Plan	
Individual Deductible	\$2,000
Family Deductible	\$4,000
Individual Max Out of Pocket	\$8,700
Family Max Out of Pocket	\$17,400
Coinsurance	Plan Pays: 80% You pay 20%
HRA Contribution	Employee Only: \$700 Employee + Spouse: \$1,200 Employee + Child(ren): \$1,100 Family: \$1,500

Your Expenses for Common Medical Events	
General/Specialist Office Visit	In network co-pay: \$40 Out-of-network co-pay: \$80
Preventative Care	No Charge
UCM Digital Health	No Charge
Urgent Care	In network co-pay: \$60 Out-of-network co-pay: \$120
Emergency Room	Co-Pay: \$125 (waived if admitted)
Facility Charges	Co-Pay: \$500 per visit
Outpatient Lab Services	At Quest or Compunet–No charge During an office visit–Co-Pay: \$40 / \$80 At a freestanding lab–Deductible + Co-insurance At a hospital facility–Co-Pay: \$500

Provider Networks	
Outpatient Office Visits	PHCS Network www.multiplan.com/mpipracanc
Outpatient Lab Services	Quest Diagnostics www.questselect.com or CompuNet Lab www.compunetlab.com
Facilities	Your plan does not utilize a network for facilities. You may visit any facility of your choice.

Need Help with Your Benefits or Booking an Appointment?

Call Imagine360 at 800-716-2852 or email myplan@gpatpa.com

Prescription Co-Pays		
	<i>At the Pharmacy (30-day supply)</i>	<i>Mail Order (90-day supply)</i>
Tier 1 – Generic	30% (minimum \$20)	\$30
Tier 2 – Brand Name	30% (minimum \$20)	\$100
Tier 3 – Non-formulary	20% (minimum \$40)	\$200
Specialty Drugs	See below	See below

***Specialty medications** are not covered by your plan. You will have access to a program where they may be sourced. Refer to the next page for more information about ScriptSourcing.

Your Rate per Paycheck		
	<i>Tobacco Free Rates</i>	<i>Tobacco User Rates</i>
Employee Only	\$30	\$40
Employee + Spouse	\$55	\$65
Employee + Child(ren)	\$45	\$55
Family	\$60	\$70

Pharmacy Savings

Sometimes it's cheaper to *skip* using your benefits card!

Did you know many major retailers and grocery stores have discount pharmacy programs? You may find your prescriptions at a deep discount—or even *free*—through one of these programs! Check out the pharmacy programs at these retailers.

- Kroger
- Sam's Club
- Target
- Needler's Fresh Market
- Costco
- Walmart
- Meijer
- Indy Scripts

Before you visit one of these pharmacies, be sure to give them a call and tell them the name of your medication and the dosage. This allows the pharmacist to confirm your medication is on the discount list and/or that you qualify for their program.

If you qualify for a pharmacy discount, **DO NOT** present your health benefits ID card at the pharmacy. Discounts will not apply if you present or use your benefits ID card.

GoodRx

With the GoodRx Comparison Tool, you can compare drug prices at over 70,000 pharmacies and discover free coupons and savings. Simply visit www.goodrx.com or download the GoodRx app on your mobile device, enter the drug name, and instantly look up current drug prices at pharmacies near you. It's easy!



Using a pharmacy discount program or GoodRx not only saves you money, it also saves the Horner Electric medical plan money, which helps keep your renewal costs down!

This is an outline of benefits only and is not a complete list of all plan parameters. The plan certificate contains complete details and is the governing document for benefits parameters.



\$0 COPAYS

for over **800** maintenance, name-brand, and specialty **medications**.

WHY SCRIPTSOURCING?



Employees and their dependents pay a **\$0 copay** for their medication(s).



ScriptSourcing saves the health plan money, and **lowers premiums**.



Prescriptions are **shipped directly to the member** with no shipping and handling fees or out-of-pocket expenses.



Enrollment is easy. Simply call **410-902-8811**, and ask for a member advocate, or schedule a call online.

ENROLLMENT IS EASY!



CALL 410-902-8811

or search for your med and schedule a call online at

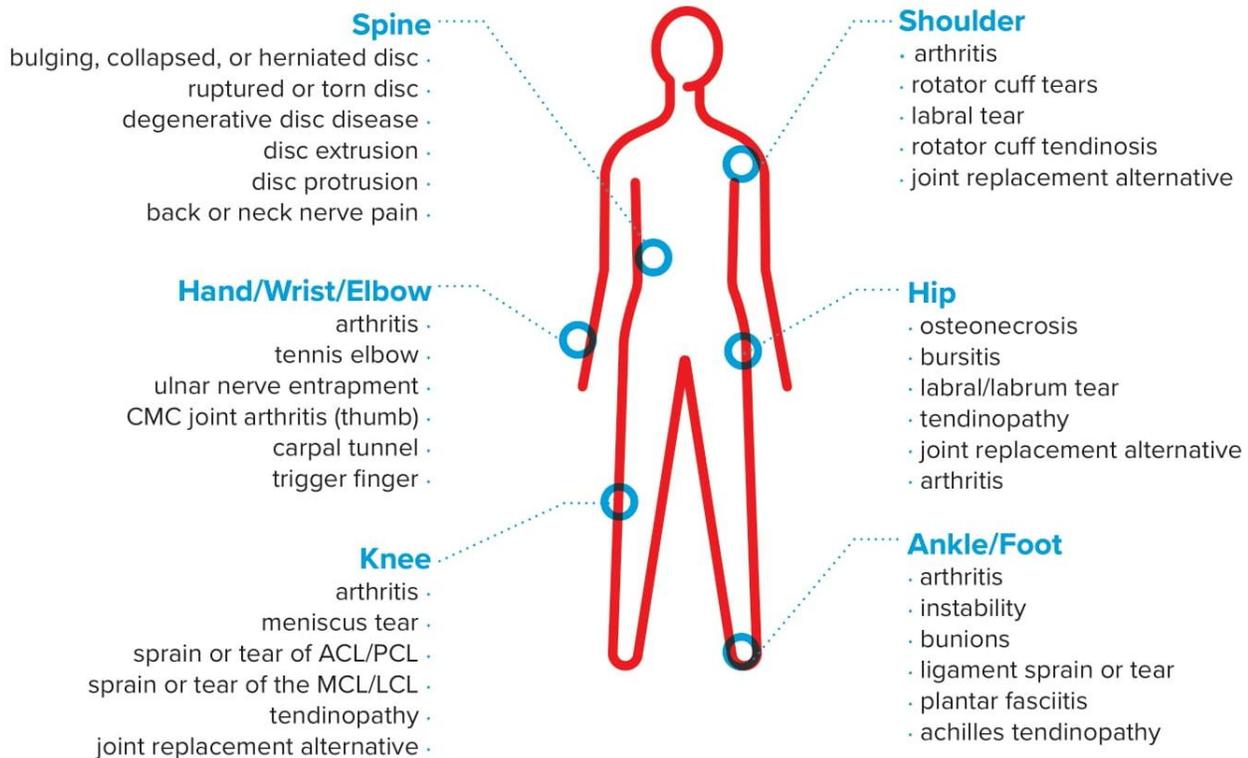
www.script sourcing.com/med-finder.

Horner Electric covers Regenexx under your health plan

Regenexx uses your body's natural healing agents to replace the need for up to 70% of elective orthopedic surgeries. Your stem cells and blood platelets are concentrated in our on-site orthobiologics lab and injected under image guidance into the precise area of your injury. With Regenexx, you can get back to doing what you love without invasive surgery and lengthy recovery.



Conditions Treated



Learn more about Regenexx and your benefits

For an in-depth overview, **Regenexx** hosts weekly informational sessions where you can learn about **Regenexx** and how our procedures may be able to help treat your orthopedic pain. You'll also have the opportunity to ask questions about your benefits. Follow the QR code or visit the address below to register for a webinar. Scheduled dates and times are updated regularly.



regenexxbenefits.com/webinar?card

Contact us at **866-780-5911** or visit regenexxbenefits.com/hornerelectric.

Horner Electric covers
Regenexx under
your health plan

What is Regenexx?

Regenexx uses your body's natural healing agents to replace the need for up to 70% of elective orthopedic surgeries by using your stem cells and blood platelets to treat your damaged bone, cartilage, muscle, tendon, and ligament tissues.

Am I a candidate for a **Regenexx** procedure?

Are you a candidate?

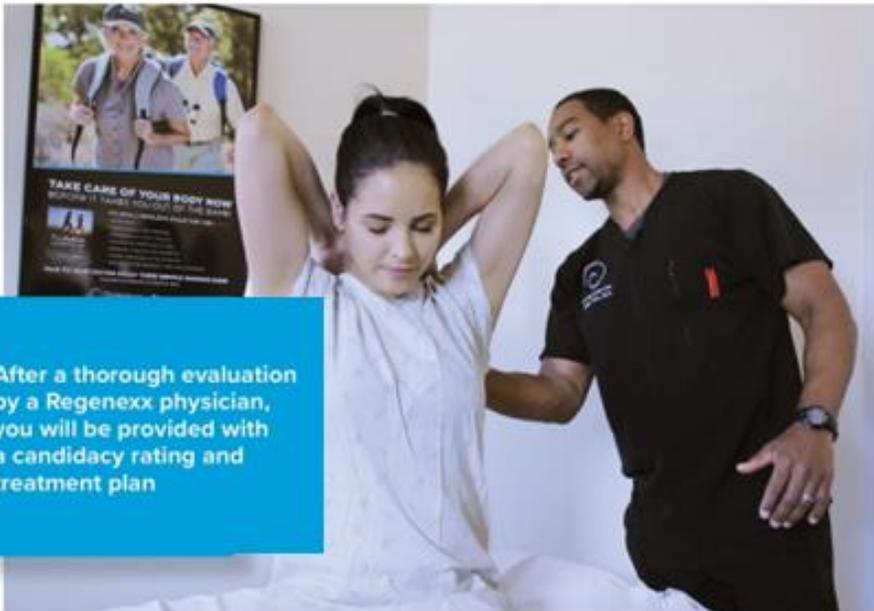
Regenexx procedures treat a broad range of chronic and acute orthopedic injuries. Whether you suffer from the lingering aches and pains often associated with aging or a tear or sprain due to activity, Regenexx may be able to help return you to full function without invasive surgery. Speak with your Horner Electric Regenexx patient liaison to learn more.

The procedure experience

Regenexx procedures are injection-based, outpatient procedures. On procedure days, blood and/or stem-cells are collected in the morning, processed in our on-site lab, and reinjected under image-guidance in the afternoon. Most patients describe only moderate discomfort, and patients are encouraged to re-engage in activity within a week following the procedure.

Scheduling an evaluation

Our dedicated patient liaisons understand Horner Electric's benefits and will guide you through the process of finding the clinic nearest to you and scheduling your evaluation. No physician referral is needed to schedule a Regenexx evaluation and phone evaluations are available for patients who have recent imaging and do not live close to a clinic location.



After a thorough evaluation by a Regenexx physician, you will be provided with a candidacy rating and treatment plan



Call us today to speak with your dedicated Regenexx patient liaison for Horner Electric at **866-780-5911** or visit regenexxbenefits.com/hornerelectric to learn more about how Regenexx can help you.

Stay Connected with Your Health Benefits



Your health plan provides an easy-to-navigate online portal and mobile app that gives you access to all of your key benefits information. You can:

- Review your account summary and plan benefits
- Check claim status
- Find and compare providers using metrics like quality and cost
- View a temporary ID card
- Ask questions about your plan

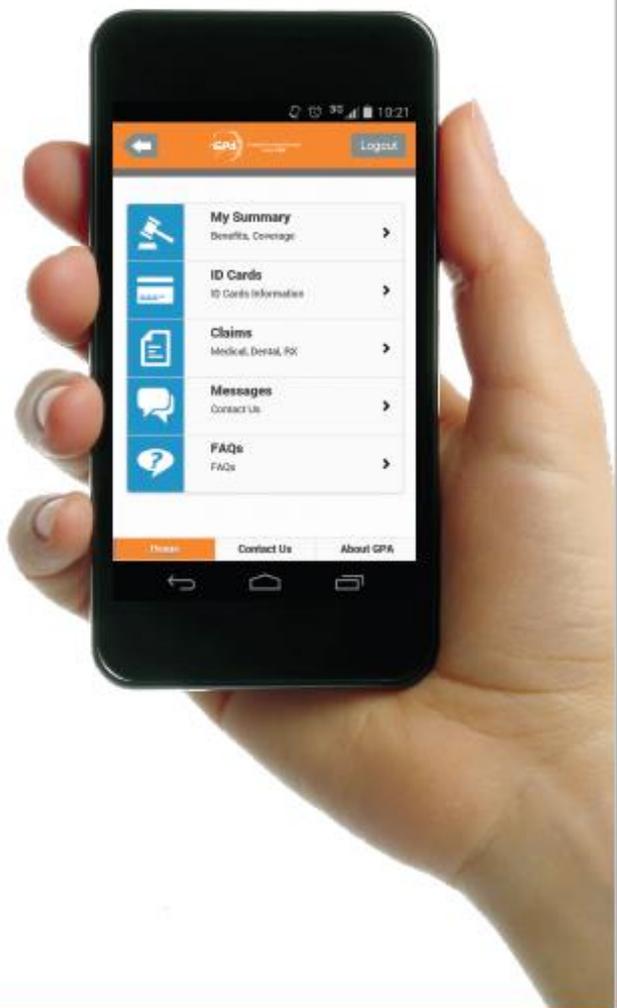
Get Started Today - Visit gpatpa.com!

Click on "Members" in the upper right hand corner of the homepage. You can then sign in or create an account to access all of your benefits information.

Download the GPA Mobile App today through the Google Play Store or the Apple App Store.



Search for "Group Pension Mobile", download the app for free, register and set up a user ID and password. It's that simple!



We're here for you with expert service and support.

Use the contact information on your Benefits ID card to get in touch with a member experience representative.



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Advocating on Your Behalf

Balance Bill Support

We are here anytime you need us, especially if you have billing questions. When you work with our team, you'll never stand alone in the face of resolving a bill for healthcare services that is more than your responsibility.



How will you know if you're being charged too much?

After receiving medical care, you will get an Explanation of Benefits (EOB) specifying what you owe for services. If you receive a bill for more than this amount, contact us immediately.



How will we help you?

Once you receive your bill, you and your family are assigned a personal advocacy expert who will provide you with support every step of the way. After you give us written permission to advocate on your behalf, our team begins working to resolve the claim with your healthcare provider.



Who can you call with questions?

Your dedicated advocacy expert is your main line of support, continually monitoring the progress of your account while proactively keeping you up to date.

Have a question? Call or email us at any time.



Keep an Eye on your Mail

If it sounds easy, it's because it is. If you receive any billing correspondence in the mail, send it to us right away.

Our team will take it from there, keeping you in the loop throughout the process.

We're here for you with expert service and support.

Call the number on your Benefits ID card.

Hours: Mon-Thurs: 7am-9pm CST Friday: 7am-7pm CST



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Understanding Your Explanation of Benefits

An Explanation of Benefits (EOB) is a statement from your health plan to let you know how a claim was processed. It shows information about services received, the provider and date of service. It is not a bill.

Pay special attention to the following important areas of your EOB:

IMAGINE360
1550 LIBERTY RIDGE DRIVE
WAYNE, PA 19087
PLAN PART (972) 238-7900 (800) 827-7223
PROVIDERS (972) 744-2486 (866) 206-3224
7:00AM-9:00PM CST MON-THURS
7:00AM-7:00PM CST FRIDAY

 Temp-Return Service Requested

000720-001081-000001-001081 2020660 3472C302_1
JOE SMITH
1234 W ANY STREET
ANY TOWN, US 12345-6789

ABC Company
EXPLANATION OF BENEFITS

THIS IS NOT A BILL

Group#: H8707123456789 **1**
Date: 05/13/2021
Employee: JOE SMITH
Patient: MARY SMITH
Document #: 16123456789
Patient ID: NAHA1234
EOB#: 2012345-939

Provider/ Nature of Service	Dates of Service From To	Charges Submitted	Ineligible	Code **	Discount	Copay	Deductible	% Plan Pays	Benefit Payable
COMMUNITY HOSPITAL OP SURGERY HOSP	02/16/21 02/17/21	52759.01	40305.75	1				80% 100%	3344.92 8272.11
TOTAL AMOUNTS		52759.01	40305.75						11617.03

The percentage(s) payable or any patient deductible(s) or co-pay(s) has been applied in accordance with the schedule of benefits in the Summary Plan Description.
EXPLANATION OF CODE

3 882-882 THESE CHARGES EXCEED THE PLAN'S ALLOWABLE CLAIM LIMITS; THEREFORE, THE CHARGES HAVE BEEN DENIED AS STATED IN THE EXCLUSIVE AND LIMITATIONS IN YOUR SUMMARY PLAN DESCRIPTION. APPEAL RIGHTS UNDER THIS PLAN ALSO APPLY TO PROVIDERS OF SERVICE.

SEE BACK FOR APPEAL PROCESS

SUMMARY OF SUBMITTED CHARGES		PATIENT RESPONSIBILITY 4	
TOTAL SUBMITTED CHARGES	52759.01	INELIGIBLE CHARGES	40305.75
TOTAL BENEFITS PAID	11617.03	PATIENT'S DEDUCTIBLE	
TOTAL DISCOUNT		PATIENT'S CO-PAY	
OTHER INSURANCE CARRIER PAYMENT		PATIENT'S COINSURANCE	836.23
		TOTAL DUE TO PROVIDER	836.23

YEAR TO DATE ACCUMULATORS

THE PATIENT'S 2021 MEDICAL DEDUCTIBLE SATISFIED IS \$1,000.00 THE 2021 FAMILY MEDICAL DEDUCTIBLE SATISFIED IS \$1,000.00

PAYEE NAME:	AMOUNT:
COMMUNITY HOSPITAL	\$11617.03

- 1.** Basic information about the claim, including the patient ID and the EOB number.
- 2.** This section provides an overview of the services rendered, dates of services, the charges submitted, and how the plan benefits were applied.
- 3.** Explanation of the codes used when applying benefits. This box may also include comments regarding your claim. Please read this section to see if you need to take any action.
- 4.** This section lists the ineligible charges, any amounts applied to the deductible, as well as the copay and coinsurance amounts. The total due to provider is the amount you owe.

Compare this amount to any bill you get from your provider. If they do not match, call the number on your Benefits ID card.

If you are ever billed for more than your out-of-pocket responsibility that is listed on your EOB, or have a question about a bill, call us right away at the number on your Benefits ID card.

We're here for you with expert service and support.

Call the number on your Benefits ID card.
Hours: Mon-Thurs: 7am-9pm CST Friday: 7am-7pm CST



Frequently Asked Questions

Q. What if I need help finding a provider?

A. Finding the right provider for your needs is so important. We are here to help you get the most out of your health plan – just call at the number on your benefits ID card.

We will help you compare providers based on their location, quality ratings and estimated cost so you can make an informed choice. We will also check to see if the provider works well with your plan.

Q. My provider is stating that they don't recognize my ID card. What do I do?

A. Explain that you have health benefits and request they call the number on your benefits ID card to verify eligibility. You can call us at that same number if you have any difficulties.

Q. What if the provider asks me to pay for my procedure upfront?

A. The only out-of-pocket expense you should pay at the time of service is a copay or deductible (if applicable). Please call us at the number on your benefits ID card to confirm amounts or if the facility will not perform treatment without additional funds.

Q. What should I do in a medical emergency?

A. If you have a medical emergency and a facility is making it difficult to seek immediate treatment, please call at the number on your benefits ID card and we will contact a representative at the facility.

Q. What does it mean that my health plan includes price protection?

A. Overinflated hospital bills cause health plans to raise rates and members to pay more. We help to lower your out-of-pocket costs by reviewing medical claims to make sure you only pay what is fair and reasonable.

If you are ever billed for more than the out-of-pocket responsibility that is listed on your Explanation of Benefits, or have a question about a bill, notify us right away at the number on your benefits ID card.

Q. What types of medical bills are reviewed?

A. We review expenses from facilities including:

- hospitals
- outpatient surgery centers
- skilled nursing facilities

Q. I received a provider bill that doesn't match my Explanation of Benefits. What should I do?

A. Sometimes when you see a provider, they may bill you for charges that exceed your plan's allowable limits. This is called a "balance bill". If you receive one, call us at the number on your benefits ID card and we'll start the process of working to resolve it on your behalf.

Q. How do you help with balance bills?

A. If you receive a balance bill, call us at the number on your benefits ID card. We will work on your behalf to resolve billing issues directly with healthcare facilities, including with legal representation if needed. It is very important that you send us any bills or notices as you receive them so we can get to work on your behalf right away. We'll keep you updated throughout the process.

Q. What if I have a question about a chronic condition or newly diagnosed medical issue?

A. Our team specializes in assisting clients with specific care needs to receive support. We have programs and services to support oncology patients, diabetic patients, and other medically complex patients specializing in their area of need.

We're here for you with expert service and support.

Use the contact information on your Benefits ID card to get in touch with a member experience representative.



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24 / 7 / 365
Emergency Medicine Expertise
at the touch of a button.

No Deductibles. No Co-Pays. No Waiting Rooms.

Don't waste your time and money at unnecessary ER or Urgent Care visits.

Our partnership with UCM Digital Health provides you affordable, quality healthcare services 24/7/365. If you were not already aware, these services can save you and your family valuable time and money by avoiding unnecessary trips to the doctor's office, urgent care and ER.

At no cost to you, you and your eligible dependents will have unlimited access to UCM's Medical Team via phone, picture and secure video for treatment and triage of any acute medical problem you have. They can diagnose, prescribe medications when appropriate, order labs/diagnostic imaging and make recommendations to the best specialist in the area if needed.

UCM does not replace 911 for true life-threatening emergencies or any specialist for a chronic illness/disease management; however, for all other illness, injury, or medical questions, call UCM Digital Health first for treatment and triage.

To receive a consult all you must do is call 844-4-VIP-DOC (844-484-7362) and one of the care coordinators will set up a consult with a provider. You do not have to sign up or log into anything.

Download the SAM by UCM mobile app!

Using the mobile app or web portal is the best way to contact UCM Digital Health for a consultation whenever you need it. You can download the app and find out more on the website, www.ucmdigitalhealth.com. Don't hesitate to contact UCM Digital Health anytime of the day or night.

Questions about using this service?

Call 844-4-VIP (844-484-7362) or email info@ucmdigitalhealth.com.

For more information on the Samaritan Fund Program

Visit www.samaritanfundprogram.com

Call 866-764-9290 Email service@samaritanfundprogram.com

THE PEACE OF MIND TO HEAL

A serious medical diagnosis brings worry and anxiety. Unfortunately, much of that anxiety stems from the high cost of quality medical care. The Samaritan Fund Program exists to lift the financial burden of medical costs while you navigate a difficult journey. If you qualify, you will receive a plan from a top carrier, funds for premiums and out of pocket expenses, and *the peace of mind to heal.*



How it Works:



Complete a HIPAA Authorization Form. This ensures that your private information is kept confidential.



A representative from the Samaritan Fund Program will reach out to discuss the program and help you select an individual medical insurance plan that meets your needs.



Once an acceptable plan is found, a formal application is submitted to participate in the Samaritan Fund Program.



After you are accepted, we help you obtain your new insurance plan and set up the Samaritan Fund Program to take care of the expenses associated with your medical care.



The plan will be reassessed annually for eligibility.



Be at peace and heal.

Health Reimbursement Arrangement (HRA)

Administered by Imagine360

The Horner Benefit Plan features a health reimbursement arrangement (HRA). An HRA is an account that Horner Electric sets up for you and credits a particular dollar amount each year to help pay for certain covered health care expenses.

The HRA is only available to those who elect medical coverage. It is not a bank account with actual money in it and the amounts allocated to your HRA do not earn interest. HRA funds are not taxable income.

You will receive a debit-style card from Imagine360 to facilitate using your HRA funds.

Horner Electric's HRA Contribution	
<i>Contribution is based on the Medical coverage tier you elect</i>	
Employee Only	\$700
Employee + Spouse	\$1,200
Employee + Child(ren)	\$1,100
Family	\$1,500

Important Information About Your HRA

The HRA will only cover expenses that are approved by the medical/prescription plan. This includes charges such as prescription co-pays, office visit co-pays, and amounts applied toward your deductible.

Your HRA funds may be used for health insurance deductibles and co-payments, as well as uninsured medical expenses, dental and vision care, hearing care, and other supplies. Visit www.fsastore.com to view other HRA-eligible items.

You may use your HRA card to pay for eligible expenses or you may pay out-of-pocket and submit a claim for reimbursement.

If you do not use the full amount of HRA funds available to you during the plan year, the remaining funds do not carry over to the next year.

HRA funds are available to you only for expenses incurred while you are actively covered by the medical plan.

If you lose coverage under the Plan for any reason, you may continue to use your HRA credits to pay for expenses you or your covered dependents incurred while you were still covered under the Plan. Any expenses you incur after your coverage ends will not be paid by your HRA. For certain losses of coverage, you or your covered dependents have a right to continue coverage under COBRA for the Plan (including the HRA credit amount that Horner Electric, Inc allocates depending on the coverage level you elect under COBRA).

Horner Electric is under no obligation to fund the HRA in future years.

Flexible Spending Account (FSA)

Administered by Imagine360

The Horner Electric Flexible Spending Account provides each eligible employee with the opportunity to set aside part of their pay on a *pre-tax* basis to provide for payment of unreimbursed medical and dependent care expenses. There are two separate Flexible Spending Accounts available, as noted below.

Your annual election is for expenses incurred in the plan year covering your effective date through the last day of the plan year.

Flexible Spending Account Options

Medical FSA

For Medical Expenses

In determining an amount of your salary to defer into a medical spending account, you should consider your health insurance deductibles and co-payments, as well as uninsured medical and dental expense, vision care and hearing care. Generally, the expenses covered must be “medically necessary” as determined by a doctor.

Visit www.fsastore.com to view other FSA-eligible items.

The minimum annual election to participate in is \$2.00 per week with a maximum annual election of \$2,850.

You may choose to participate in the Horner Electric Flexible Spending Benefits Plan even if you do not participate in the medical plan.

DCFSA

For Dependent Care Expenses

If you pay a person (provider cannot be your spouse or person you list as your dependent on income taxes) to care for your dependent child (under age 13), or a disabled dependent, while you work, you may allocate money to the dependent care account. These eligible expenses will be reimbursed to you with pre-tax dollars.

The minimum annual election to participate is \$52 with a maximum annual election of \$5,000 (\$2,500 if married and filing separate taxes returns).

You cannot claim dependent care expenses which you submitted to your dependent care account for reimbursement on your tax return. It is encouraged that employees contact a professional tax consultant to determine if it would be more advantageous to claim the tax credits on your tax return.

Important Update to Eligible FSA Expenses

The CARES Act, signed into law on 03/27/2020, allows participants to use FSA funds for over-the-counter medications (medicines which do not have a prescription from the doctor,) as well as menstrual care items. These items may now be purchased or reimbursed using pre-tax FSA dollars.

Dental

Principal Financial Group

Option 1 or 2: You can visit any dentist, but you pay less out-of-pocket when you choose a network dentist. Non-network benefits are based on a percentile of the fee data for the dentist's area.

Your Dental Plan	Option 1: High Plan		Option 2: Low Plan	
Your Network is	Principal Dental Network		Principal Dental Network	
Calendar year deductible	<i>In-Network</i>	<i>Out-of-Network</i>	<i>In-Network</i>	<i>Out-of-Network</i>
Individual	\$50	\$50	\$50	\$50
Family limit	3 deductibles per family		3 deductibles per family	
Waived for	Preventive	Preventive	Preventive	Preventive
Annual Maximum Benefit	\$2,000	\$2,000	\$1,000	\$1,000
Maximum Accumulation/Rollover	Lesser of 50% of the max benefit or \$1000			N/A

Charges covered for you	In-Network	Non-Network	In-Network	Non-Network
<i>Preventive Care</i>	100%	100%	100%	100%
Routine Exams		2 exams per calendar year		
Emergency Exams		Subject to exam frequency		
Cleanings		2 per calendar year		
X-Rays		Frequency depends on type of x-ray		
Fluorides (to age 16)		2 times per calendar year		
Sealants (to age 16)	1 per every 36-months (on first and second permanent molars)			
<i>Basic Care</i>	80%	80%	60%	50%
Fillings				
Stainless Steel Crowns				
Simple/Complex Oral Surgery		Not more than once per tooth		
Simple/Complex Root Canals		1 per quadrant per 24-months		
Periodontics (non-surgical)		1 per quadrant per 36-months		
Periodontal Surgery				
<i>Major Care</i>	50%	50%	Not Covered	Not Covered
General Anesthesia/IV Sedation				
Crowns	1 per tooth per 120 months (if tooth cannot be restored by a filling)			
Complete/Partial Dentures	Initial placement; replacement after 60-months			
Inlays, Onlays, Post/Core		1 per tooth per 120-months		
Implant Services		1 per tooth per 120 months		
<i>Orthodontia</i>	Not Covered		Not Covered	

Your Rate per Paycheck		
	High Plan	Low Plan
Employee Only	\$7.69	\$4.12
Employee + Spouse	\$17.74	\$9.42
Employee + Child(ren)	\$17.51	\$10.31
Family	\$27.57	\$15.80

Find Principal Dental Network providers at: www.principal.com/find-dentist

This is an outline of benefits only and is not a complete list of all plan parameters. The plan certificate contains complete details and is the governing document for benefits parameters.

Vision

Principal Financial Group

Visit any doctor with your plan but save money by visiting any of the 50,000+ locations in the nation's largest vision network, VSP.

Your Vision Plan	
Your Network is	VSP Choice Network
In-Network Copay	
Exams	\$10
Materials	\$10

Sample of Covered Services	Amount you pay (after applicable co-pay):	
	In-Network	Out-of-Network
Eye Exams	\$0	Amount over \$45
Single Vision Lenses	\$0	Amount over \$30
Lined Bifocal Lenses	\$0	Amount over \$50
Lined Trifocal Lenses	\$0	Amount over \$65
Lenticular Lenses	\$0	Amount over \$100
Frames	Amount over \$130 + 20% discount	Amount over \$70
Contacts Eval & Fitting (medically necessary)	\$0	Amount over \$210
Contact Lenses (medically necessary) <i>In lieu of lens and frame benefit</i>	\$0	Amount over \$210
Contacts Eval & Fitting (elective)	Up to \$60	N/A
Contact Lenses (elective) <i>In lieu of lens and frame benefit</i>	Amount over \$130	Amount over \$105

Service Frequencies	
Vision Exams	1 per 12 months
Lenses (for glasses)	1 pair per 12 months
Frames	1 set per 24 months
Contacts Eval & Fitting (elective)	1 per 12 months
Contacts Eval & Fitting (medically necessary)	1 per 12 months

Your Rate per Paycheck	
Employee Only	\$1.57
Employee + Spouse	\$3.15
Employee + Child(ren)	\$2.66
Family	\$4.39

Find VSP Network providers at: www.vsp.com/eye-doctor

This is an outline of benefits only and is not a complete list of all plan parameters. The plan certificate contains complete details and is the governing document for benefits parameters.

Employee Basic Life

Principal Financial Group

Life and Accidental Death and Dismemberment (AD&D) Insurance is provided at no cost to you. Life insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed.

AD&D Insurance is equal to your Life Insurance benefit amount and is payable to your beneficiary in the event of your death resulting from an accident and may also pay benefits for certain injuries.

Plan Provisions	
Life Insurance Benefit	Employees with less than 10 years of service: \$10,000 Employees with 10 or more years of service: \$15,000
AD&D Benefit	Equal to the life benefit
Benefit Reduction Schedule	At age 65, benefits reduce by 35% At 70, benefits reduce by 50%
Termination	Benefits cease when the employee retires or when employment is terminated

Coverage Portability

Employees who terminate employment may be able to convert to individual policies. Upon coverage termination, employers are required to inform employees of their right to convert to an individual policy without proof of good health. The purchase amount varies depending on the termination situation.

This is an outline of benefits only and is not a complete list of all plan parameters. The plan certificate contains complete details and is the governing document for benefits parameters.

Voluntary Life

Principal Financial Group

You will have the opportunity to elect Voluntary Life Insurance. This will provide an additional Life Insurance benefit for yourself, your spouse, and/or your dependent child(ren.)

Electing or Increasing Coverage

As a new employee, you may elect up to the Guarantee Issue amount (as noted below) without answering any medical questions. If you elect more than the Guarantee Issue amount, you will be required to complete a health questionnaire and could be denied the additional coverage amount you requested.

If you have existing coverage, you may increase your coverage amount by one or two increments (as noted below) without answering any medical questions. If you elect an amount that exceeds two increments, you will be required to complete a health questionnaire and could be denied the additional coverage amount you requested.

If you did not elect Voluntary Life when it was initially offered to you and you choose to take the coverage now, you may elect one or two increment (as noted below) without answering any medical questions. If you elect an amount that exceeds two increments, you will be required to complete a health questionnaire and could be denied the additional coverage amount you requested.

Provisions	Employee	Spouse	Child
Increment Election	\$10,000	\$5,000	\$5,000, \$10,000
Maximum Election	\$500,000	100% of employee election up to \$250,000	\$10,000
Guarantee Issue Amount	\$150,000 to age 70 \$10,000 age 70 or over	\$30,000 to age 70 \$10,000 age 70 or over	N/A

Monthly Rates – Voluntary Employee and Spouse Life (per \$1,000 of coverage)

Age*	0-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Rate	\$0.052	\$0.078	\$0.091	\$0.134	\$0.221	\$0.351	\$0.602	\$0.997	\$1.625	\$3.241

*Spouse rates are based on Employee's age

Monthly Rates for Child Life (per family)

Benefit Amount	\$5,000	\$10,000
Rate	\$0.85	\$1.70

Coverage Portability

Employees may continue coverage for themselves and any covered dependents until age 70 if the employee ceases to qualify as a member. The employee or spouse must enroll within 60 days from the date they cease to qualify as a member. Maximum age requirements apply. Portability is not available if: coverage is continued during disability / the employee has received accelerated benefits / individual purchase rights have been exercised / the employee dies / a dependent no longer meets the eligibility requirements.

This is an outline of benefits only and is not a complete list of all plan parameters. The plan certificate contains complete details and is the governing document for benefits parameters.

Short Term Disability

Principal Financial Group

Horner Electric offers a short-term disability policy can provide income replacement benefits if you become disabled. Your policy may provide coverage if your absence from work is due to a sickness, off-the-job injury, or pregnancy.

Electing Coverage

If you did not elect this benefit when it was offered previously and wish to apply during this enrollment, you are required to submit a medical questionnaire and could be denied coverage. You will not have coverage unless you are approved by medical underwriting.

Plan Provisions

	Benefit Maximum	50% of weekly earnings to a \$1,000/week maximum
Elimination Period – Benefits Begin On		1 st day of accident / 8 th day of sickness
	Maximum Benefit Duration	13 weeks
	Pre-Existing Exclusion	3 months prior / 12 months insured
	Rate	\$0.49 per \$10 of weekly benefit

Calculate your benefit and premium

This example is based on an employee with a \$35,000 annual salary.

If your annual income is \$35,000 ÷ 52 = \$673.07 weekly income

\$673.07 × 50% = \$336.54 Weekly STD Benefit

\$336.54 ÷ 10 × \$0.49 = \$16.49 × 12 ÷ 52 = \$3.81 weekly premium

\$ _____	÷ 52 =	\$ _____	× .50	\$ _____
Your Salary		Weekly Income		STD Benefit

_____	÷ 10 × 0.49 =	\$ _____	× 12 ÷ 52 =	\$ _____
STD Benefit		Per Month		Per Week

This is an outline of benefits only and is not a complete list of all plan parameters. The plan certificate contains complete details and is the governing document for benefits parameters.

Long Term Disability

Principal Financial Group

Long Term Disability Income Insurance helps protect your income when, due to a covered illness or injury, you are totally or partially disabled. Your long-term disability plan has been designed to cover a disability sustained on or off the job.

Electing Coverage

If you did not elect this benefit when it was offered previously and wish to apply during this enrollment, you are required to submit a medical questionnaire and could be denied coverage. You will not have coverage unless you are approved by medical underwriting.

Plan Provisions

Benefit Maximum	60% of pre-disability earnings
Maximum Monthly Benefit	\$10,000
Definition of Disability	2 years – Own occupation
Elimination Period / Waiting	90 days
Pre-Existing Exclusion	6 months prior / 12 months insured
Benefits Duration	To age 65 (reducing benefit duration) If age 62 or older when disabled, see below for maximum benefits duration.
Rate	\$0.66 per \$100 of covered monthly income

Maximum Duration of Benefits (if age 62 or older when disabled)

Age When Disabled	Benefits Payable for	Age When Disabled	Benefits Payable for
Age 62	42 months	Age 66	21 months
Age 63	36 months	Age 67	18 months
Age 64	30 months	Age 68	15 months
Age 65	24 months	≥ Age 69	12 months

Calculate your benefit and premium
This example is based on an employee with a \$35,000 annual salary.

$\$35,000 \div 12 = \$2,916.67$ monthly income
 $\$2,916.67 \div 100 = 29.16 \times \$0.66 = \$19.25$ monthly premium
 $\$19.25 \times 12 \div 52 = \4.44 weekly premium

_____	÷ 12 =	_____		
Annual Salary		Monthly		
_____	÷ 100 =	_____	×	\$0.66 = _____
Monthly Income				Monthly Premium
_____	× 12 =	_____	÷ 52	_____
Monthly Premium				Weekly LTD Premium

This is an outline of benefits only and is not a complete list of all plan parameters. The plan certificate contains complete details and is the governing document for benefits parameters.

Critical Illness

Principal Financial Group

Critical Illness coverage provides you with a lump sum benefit to help cover your expenses if you from certain critical illnesses. Payment is made directly to you. Conditions and exclusions apply.

Electing or Increasing Coverage

If you did not elect this benefit when it was initially offered to you or if you wish to increase your existing benefit amount, **you may do so during this enrollment period without answering any medical questions.** If you do not elect/increase your coverage now and choose to do so later, you will be required to complete a medical questionnaire and could be denied coverage.

Benefit Options

Employee: \$5,000 or \$20,000

Spouse: \$2,500 or \$10,000
(50% of Employee benefit)

Child: \$1,250 or \$5,000
(25% of Employee benefit)

Illnesses	1 st Occurrence	Add'l Occurrences
Alzheimer's disease	100%	0%
Amyotrophic lateral	100%	0%
Benign brain tumor	100%	0%
Carcinoma in situ	25%	25%
Coma	100%	0%
Coronary artery	25%	25%
Heart attack	100%	100%
Invasive cancer	100%	100%
Loss of hearing	100%	0%

Infectious Diseases	1 st Occurrence	Add'l Occurrences
COVID-19	25%	25%
Diphtheria	25%	25%
Encephalitis	25%	25%
Legionnaire's	25%	25%
Lyme disease	25%	25%
Malaria	25%	25%
Meningitis	25%	25%
MRSA	25%	25%

Childhood Conditions	1 st Occurrence	Add'l Occurrences
Cerebral palsy	100%	N/A
Cleft lip / palate	100%	N/A
Cystic fibrosis	100%	N/A
Down syndrome	100%	N/A
Muscular dystrophy	100%	N/A
Spina bifida	100%	N/A

Illnesses	1 st Occurrence	Add'l Occurrences
Loss of sight	100%	0%
Loss of speech	100%	0%
Major organ failure	100%	100%
Multiple sclerosis	100%	0%
Occ infectious disease	100%	0%
Paralysis	100%	0%
Parkinson's disease	100%	0%
Skin cancer	\$250	\$0
Stroke	100%	100%

Infectious Diseases	1 st Occurrence	Add'l Occurrences
Necrotizing faciitis	25%	25%
Osteomyelitis	25%	25%
Poliomyelitis	25%	25%
Rabies	25%	25%
Sepsis	25%	25%
Tetanus	25%	25%
Tuberculosis	25%	25%

Coverage Portability

If employees cease to meet the definition of an employee, they may be eligible to continue insurance, for themselves and their covered dependents, without submitting proof of good health.

To continue insurance, the employee must have been insured for 12 consecutive months, be less than age 70, and not incurred a critical illness.

This is an outline of benefits only and is not a complete list of all plan parameters. The plan certificate contains complete details and is the governing document for benefits parameters.

Critical Illness

Principal Financial Group

Employee – \$5,000 Benefit – Rate per Paycheck		
Age	Non-Tobacco	Tobacco User
≤ 24	\$0.50	\$0.51
25 - 29	\$0.64	\$0.67
30 - 34	\$0.77	\$0.88
35 - 39	\$0.91	\$1.14
40 - 44	\$1.22	\$1.72
45 - 49	\$1.68	\$2.66
50 - 54	\$2.49	\$4.31
55 - 59	\$3.47	\$6.43
60 - 64	\$5.00	\$9.90
65 - 69	\$7.04	\$14.75
≥ 70	\$10.26	\$20.00

Employee – \$20,000 Benefit – Rate per Paycheck		
Age	Non-Tobacco	Tobacco User
≤ 24	\$2.00	\$2.03
25 - 29	\$2.56	\$2.68
30 - 34	\$3.08	\$3.52
35 - 39	\$3.63	\$4.56
40 - 44	\$4.87	\$6.87
45 - 49	\$6.73	\$10.63
50 - 54	\$9.98	\$17.25
55 - 59	\$13.87	\$25.72
60 - 64	\$20.01	\$39.60
65 - 69	\$28.16	\$59.02
≥ 70	\$41.05	\$80.02

Spouse – \$2,500 Benefit – Rate per Paycheck		
Age	Non-Tobacco	Tobacco User
≤ 24	\$0.25	\$0.25
25 - 29	\$0.32	\$0.34
30 - 34	\$0.39	\$0.44
35 - 39	\$0.45	\$0.57
40 - 44	\$0.61	\$0.86
45 - 49	\$0.84	\$1.33
50 - 54	\$1.25	\$2.16
55 - 59	\$1.73	\$3.21
60 - 64	\$2.50	\$4.95
65 - 69	\$3.52	\$7.38
≥ 70	\$5.13	\$10.00

Spouse – \$10,000 Benefit – Rate per Paycheck		
Age	Non-Tobacco	Tobacco User
≤ 24	\$1.00	\$1.02
25 - 29	\$1.28	\$1.34
30 - 34	\$1.54	\$1.76
35 - 39	\$1.81	\$2.28
40 - 44	\$2.44	\$3.43
45 - 49	\$3.37	\$5.32
50 - 54	\$4.99	\$8.62
55 - 59	\$6.94	\$12.86
60 - 64	\$10.01	\$19.80
65 - 69	\$14.08	\$29.51
≥ 70	\$20.52	\$40.01

*Children are covered at no cost when the Employee elects coverage. Child benefit is 25% of Employee's benefit.

*Spouse rates are based on Employee's age

Additional Plan Provisions	
Pre-existing Exclusion	6 months prior/12 months insured
Multiple Payouts	Benefits for a first occurrence of a different critical illness will be payable if incurred more than 12 months after the preceding critical illness. Benefits for additional occurrences of the same critical illness will be payable if incurred more than 12 months after the preceding critical illness and 12 months treatment free.
Infectious Diseases	For diseases covered under the infectious disease benefit, the insured must be confined to a hospital for at least 3 days.
Other Exclusions	Refer to the official plan certificate for a complete list of exclusions and other plan limitations.
Wellness Benefit	Per year benefit for completing certain routine wellness screenings. Employee \$50; Spouse \$50; Child \$50

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Accident

Principal Financial Group

Accident coverage provides you with a lump sum benefit to help cover your expenses if you suffer an off-the-job injury and receive certain treatments. Payment is made directly to you. Conditions and exclusions apply.

Injury		Available Benefit	
	Burn	Scheduled; \$500 - \$5,000	
	Coma	\$15,000	
	Concussion	\$500	
	Dental injury	\$500	
	Dislocation	Open (surgical)	Closed (non-surgical)
	Hip	\$7,500	\$3,750
	Knee	\$5,000	\$2,500
	Ankle, collarbone, elbow, foot (excl. toes), hand (excl. fingers,) lower jaw, shoulder, wrist	\$3,000	\$1,500
	Eye injury with surgical repair	\$500	
	Fracture	Open (surgical)	Closed (non-surgical)
	Hip, skull (depressed), thigh (femur)	\$10,000	\$5,000
	Lower leg (fibula/tibia,) pelvis, skull (non-depressed,) vertebrae	\$5,000	\$2,500
	Ankle, arm, collarbone, elbow, facial bones, foot (excl. toes), hand (excl. fingers,) jaw, kneecap, shoulder blade, wrist	\$3,000	\$1,500
	Sternum, vertebral processes	\$2,000	\$1,000
	Rib, tailbone (coccyx)	\$1,000	\$500
	Injuries not specifically listed	\$100	
	Internal injury	\$1,500	
	Knee cartilage injury with surgical repair	\$1,500	
	Ruptured disc with surgical repair	\$1,500	
	Tendon / ligament / rotator cuff injury with surgical repair	\$1,500	
	Wellness Benefit	Per year benefit for completing certain routine wellness screenings. Employee \$50; Spouse \$50; Child \$50	

Coverage Portability

If employees cease to meet the definition of an employee, they may be eligible to continue insurance for themselves and their covered dependents. To continue insurance, the employee must have been insured 12 consecutive months and be less than age 70. Ported insurance will terminate on May 1 following the employee's 70th birthday.

Your Rate per Paycheck

Employee Only	\$2.78
Employee + Spouse	\$4.23
Employee + Child(ren)	\$5.02
Family	\$7.62

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Help handling life's ups and downs

Life can be unpredictable. And it's not always easy. So it's a big deal to know there's help available when you need it. That's what the employee assistance program (EAP), provided by Magellan Healthcare, is all about.

With an EAP, you and your family have access to **free, confidential** resources to help handle life's everyday—and not so everyday—challenges.

You might use your EAP to help: manage stress, handle relationship issues, balance work and life, work through grief, cope with anxiety, and more. Plus, your EAP gives you access to discounts on major brands and everyday needs.

Services for you and your family

Your EAP offers these services to help you and your family deal with the big and little things.

In-person or virtual counseling

One valuable way to work through personal or work issues is by talking with a professional. You and your family can meet with a licensed, EAP professional in person, via text message, or by live chat, video, or phone sessions. Three counseling sessions per year are included.

Legal, financial, and identity theft services

You and your family have access to these services:

- **Legal services.** Receive a free 60-minute consultation to help deal with issues such as car accidents or family law.

- **Financial wellness.** Receive three free 30-minute consultations. This may include help with budget planning, debt consolidation, or retirement planning.
- **Identity theft resources.** Receive a free 60-minute consultation to help restore your identity if stolen.

Work-life web services

You and your family can access webinars, live talks, and articles on topics such as child and elder care, education, parenting, and more.

Help when and where you need it—day or night

Life's challenges don't always happen during regular business hours. That's why you and your family have 24/7 access to your EAP.



800-450-1327

International: 800-662-4504
TTY: 711



Member.MagellanHealthcare.com

When you create an account, enter **Principal Core** as the program name.

Insurance products issued by Principal Life Insurance Company®, a member of the Principal Financial Group®, Des Moines, IA 50392.

Principal® has arranged with Magellan Healthcare to make its employee assistance program (EAP) available to employees with select group coverage insured by Principal Life Insurance Company. Not all services are available to group policies issued in New York. EAP isn't part of the insurance contract or policy and may be changed or canceled at any time. Magellan is responsible for all EAP services provided through this program. EAP services in California are provided through Magellan Health Services of California, Inc.—Employer Services. Magellan isn't a member of the Principal Financial Group®.

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Notice of Portal Posting

www.benefiti.com

The legal notices that we are required by law to distribute each year at enrollment are no longer included in this booklet. Instead, you can quickly and conveniently access these notices and other helpful documents through the online employee portal. These notices include:

- Notice of Non-Grandfathered Plan
- Medicare Part D – Notice of *Creditable Coverage*
- HIPAA Privacy Notice
- Marketplace Notice
- COBRA Notice
- CHIP and Women’s Health Notice
- NMHPA Notice
- Appeal Rights

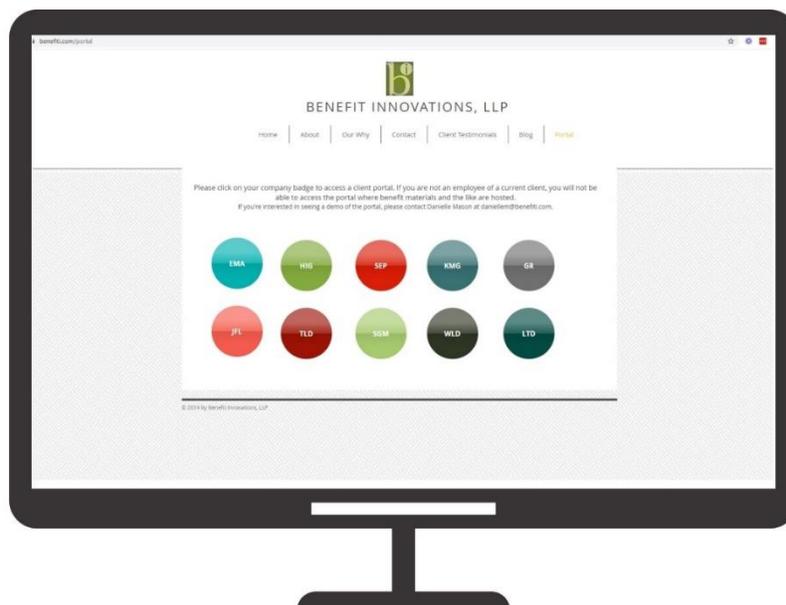
You will also find helpful plan information, including:

- Medical Summary Plan Document (SPD)
- Medical Summary of Benefits and Coverage (SBC)
- Dental, Vision, STD, LTD, Critical Illness, Accident, Basic Life, and Voluntary Life plan documents and benefit summaries

The portal is easy to access and use. It’s available to all employees of Horner Electric, Inc.

Follow these steps to login to the portal:

1. Open an internet browser and go to www.benefiti.com
2. Click on the “Portal” in the main menu.
3. Click the badge labeled “HIG.”
4. Enter the password *hornerben***



Contacts

<u>Company Name</u>	<u>Benefit</u>	<u>Phone</u>	<u>Website/E-mail Address</u>
Imagine360 Group # H870970	Medical Benefits, HRA, and FSA	800-716-2852	myplan@gpatpa.com
ELAP	Balance Bills	800-977-7381 Fax: 888-560-2447	balancebills@elapservices.com
Provider Network – PHCS	Practitioners Only	877-952-7427	www.multiplan.com (select practitioner only)
Regenexx	Orthopedic Treatment	866-780-5911	www.regenexxbenefits.com/hornerelectric
US-Rx Care <i>Prescriptions at the Pharmacy</i>	Members/Pharmacists	877-200-5533	www.usrxcare.com/member
Prescription Mart <i>Mail Order Prescriptions</i>	Members/Pharmacists	800-630-3206	www.presmartinc.com
ScriptSourcing	Specialty Medications	410-902-8811	www.scriptsourcing.com
UCM Digital Health	Telemedicine	844-484-7362	www.ucmdigitalhealth.com
Principal Financial <i>via VSP Choice</i>	Vision	800-877-7195	www.vsp.com/eye-doctor
Principal Financial <i>with Principal Dental Network</i>	Dental	800-247-4695	www.principal.com/find-dentist
Principal Financial	Life, Disability, Accident, and Critical Illness	800-245-1522	www.principal.com/individuals
Magellan EAP	Employee Assistance Program	800-450-1327	www.member.magellanhealthcare.com <i>Program name: Principal Core</i>
Enrollment Call Center	4MyBenefits	866-575-5089	https://benefits.plansource.com
Benefit Innovations, LLP			
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Managing Partner	Wanza Schweiger	317-663-4041	wanzas@benefiti.com

Online Benefits Enrollment



2022–2023 OPEN ENROLLMENT

Annual Open Enrollment for benefits will be held from
September 7 – September 16

If you need assistance enrolling in your benefits, you can contact the Call Center at:
866-575-5089

Monday – Friday 8:30am – 5pm EST

Please Note: All changes made during this enrollment period will remain in force until the next open enrollment period. Only changes due to a Qualifying Event (i.e. Marriage, Birth, Loss of Coverage, etc.) will be allowed after open enrollment so be sure to review all your elections.

Enrolling in Benefits

1. Open a web browser
2. Navigate to <https://benefits.plansource.com/>
3. Enter your User Name & Password, see information to the right for logging in your first time.
4. You will then be taken to the Welcome Screen to begin your enrollment, make changes to your benefits, see your benefit summaries & review benefit plan information, among other resources.



5. Click **Get Started** to begin enrolling.
6. Once you are enrolled you will be given a Confirmation Statement to download, email or print for your own records.

Congratulations! You have successfully enrolled!

How To Login

User Name:

- HORNER +
- First initial of your First Name +
- Your Last Name +
- Your Year of Birth (YYYY)

Example: John Smith, 1/1/1970 = **HornerJSmith1970**

Temporary Password:

- Your Birthdate – YYYYMMDD
- You will then select a new one.

Example: January 1,1970 = **19700101**

Required Dependent Information

In order to enroll your dependents in benefits, be sure to have the following information available:

- Full Name
- Date of birth
- Social Security Number (*for children over 90 days of age*)
- Address (*if different than yours*)



Benefit Innovations

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Clear, powerful, and positive results.

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