



Benefits Guide

January 1 – December 31, 2026

Utah

TAKE A LOOK INSIDE



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BENEFIT ELIGIBILITY

Who Is Eligible?

The following individuals are eligible to participate in the Company's benefits program:

- Active, full-time employees
- Your legally married spouse or domestic partner
- Your dependent children up to age 26
- Your unmarried children aged 26 or older who are mentally or physically disabled and who rely on you for support and care

Dependent Information for Enrollment

To enroll your eligible dependents in benefits, you must provide their full legal names, Social Security numbers and dates of birth, so keep this information handy when making your benefit elections online.

For Domestic Partner details, please review the [Domestic Partner Disclaimer here](#).



BENEFIT ENROLLMENT

Enrollment Periods

Annual Open Enrollment

Each calendar year, the Company conducts an Open Enrollment. This is the time for you to re-evaluate your needs and elect benefit options for the new plan year.

New Hire and Newly Eligible Employee Enrollment

Newly hired or newly eligible employees must complete their online enrollment within 30 days of their date of hire or within 30 days of the date they become eligible.

Between Enrollment Periods

Generally, once you enroll, you cannot make changes to your enrollment selections until the next Open Enrollment period. You may make changes to your benefit elections outside of the annual Open Enrollment **ONLY** if you experience a Qualifying Life Event (QLE), as defined by the IRS. Benefit changes must also be consistent and made within 60 days of the QLE.

Qualifying life events (QLEs) that may allow you to make benefit changes:

- Change in legal marital status
 - Marriage
 - Divorce, legal separation, annulment
 - Death of your spouse
- Change in your eligibility
 - Taking or returning from a leave of absence
 - Change in work schedule or status that causes a gain or loss of eligibility
 - Change in family member's eligibility
- Change in the number of eligible children
 - Birth, adoption or death of a child
 - Child gains or loses eligibility for coverage under the plan
- They gain a benefit option or lose coverage
 - New coverage choices made during their employer's annual enrollment
 - You or your family member's COBRA coverage from another employer expires
 - You or your family member becomes eligible for or loses Medicare or Medicaid
 - You or your family member loses coverage under a government's or educational institution's plan



[Click here](#) to watch a video about QLEs.

BENEFIT ENROLLMENT

When Coverage Begins

New Hires: You must complete the enrollment process within 30 days of your date of hire. If you enroll on time, your coverage will begin on the first day of the month following your hire date. If your hire date is on the first day of the month, coverage begins on that day.

- If your hire date is March 1, your coverage begins March 1.
- If your hire date is March 2, your coverage begins April 1.

If you fail to enroll on time, you will not have benefits coverage (except for company-paid benefits) until you enroll during our next annual Open Enrollment period.

When Coverage Ends

Medical, dental and vision coverage for you and your family will end on the last day of the month in which your employment with the Company ends or you lose full-time eligibility status. The HSA and all other benefits will end on your last day.

When Coverage Ends for Your Children

Your children are eligible for medical, dental and vision coverage until the end of the month in which they turn 26. Life insurance will end when your child reaches age 26 unless the child is disabled and meets certain requirements.

COBRA

If your health care coverage ends, you and your family may have coverage continuation rights under the federal law known as COBRA. If your coverage terminates, you will be notified of your COBRA rights.



BENEFIT ENROLLMENT

Enroll Online

Enrolling in benefits is easy. ADP is available 24 hours a day, seven days a week, so you can visit the site anytime and anywhere you have computer access.

Step 1:

Visit www.workforcenow.adp.com.

Step 2:

Review and/or add your beneficiary and/or dependents in the Beneficiary section.

Step 3:

To enroll or waive benefits, start by navigating to the enrollment section.

Follow the instruction prompts on each page to enroll or decline your benefit elections.

After You Enroll

Save Your Summary

Save or print a copy of your Enrollment Summary after making your coverage selections. Review it thoroughly to ensure that your benefit elections have been recorded correctly.

If there are any errors, contact the HR Department immediately at Benefits@scorpion.co so the necessary corrections can be made. Errors that are not reported by the communicated deadline cannot be corrected. Your next opportunity to correct any errors will be during the next annual Open Enrollment or within 30 days of experiencing a Qualifying Life Event.

Benefits Website

Our benefits website https://scorpion-intranet--simpplr.vf.force.com/apex/simpplr_app?u=/site/a143t00000RhdlZAAZ/dashboard can be accessed anytime you want additional information on our benefit programs.

QUESTIONS?

For questions about any of your benefits please email Benefits@scorpion.co or you can contact Amy Pugliese our People Operations & Benefits Specialist at (661) 568-7645



HEALTH



MEDICAL COVERAGE

Options PPO 1500 & Options PPO 750

The Preferred Provider Organization (PPO) plan, provided through UnitedHealthcare, gives you the freedom to seek care from any provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the network.

A PPO plan relies on a network of health care clinics, hospitals and professionals who have agreed to provide their services at discounted rates. These preferred providers are considered “in-network.” In general, you will pay less for in-network services than you would were you to seek care outside the network.

How You Pay for Services

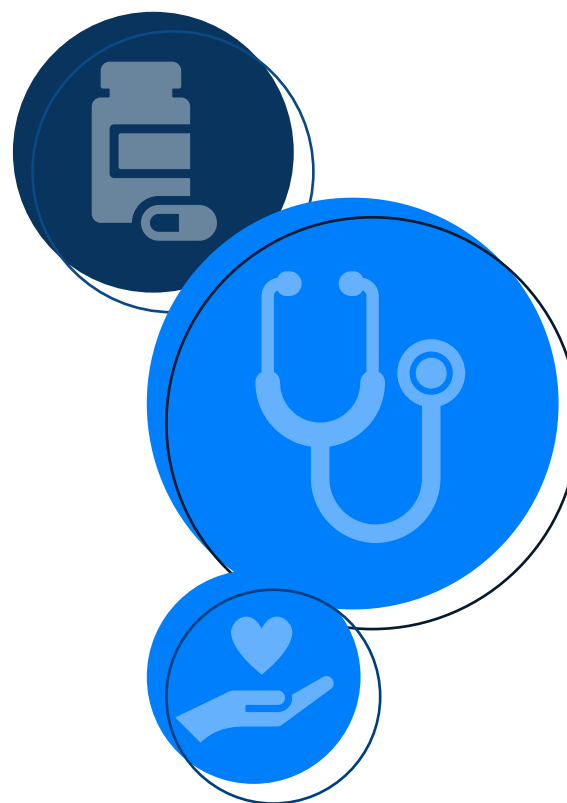
- You pay a flat dollar amount—or copay—for covered health care treatments and services, such as doctor’s office visits and prescription drugs.
- Once you satisfy your annual deductible, you will pay a percentage—or coinsurance—of the cost of the visit, and the plan will cover the rest.
- Once you hit your annual out-of-pocket maximum, the plan will cover 100% of the cost of covered services for the rest of the year.

To find an in-network provider, search:

<https://www.whyuhc.com/optionsppo>



[Click here](#) to watch a video about
comparing medical plan types.



MEDICAL COVERAGE

Options HDHP + HSA

The HDHP + HSA (High-Deductible Health Plan + Health Savings Account), provided through UnitedHealthcare, is an insurance plan that typically offers lower premiums and higher deductibles. The highlight of this plan is that it allows you to open an HSA, which is a tax-advantaged personal savings account that lets you save pre-tax dollars to pay for any qualified health-related expenses (state taxation rules may apply). This includes most medical care and services, prescriptions, dental, vision and expenses related to meeting the plan's deductible. For a complete list of qualified health-related expenses, visit [Publication 502](#).

For more information on the HSA, see page 20 in this benefit guide.

Individuals with HDHPs normally pay a lower amount each month but pay more on their yearly medical expenses before their insurance policy begins paying. You can visit any doctor, hospital or other health care provider you want, with greater cost savings in-network.

How You Pay for Services

- You pay the full cost of non-preventive health care services and prescription drugs until you meet the annual deductible. The deductible is waived for in-network routine preventive care services and medications on the preventive drug list.
- The HDHP includes copays for prescription drugs only. You must meet the annual deductible before prescription copays apply.
- Once you meet the annual deductible, you pay a percentage of your health care expenses (coinsurance), and the plan pays the rest.
- Once your deductible and coinsurance add up to the out-of-pocket maximum, this plan pays the full cost of all qualified health care services for the rest of the year.

To find an in-network provider, search: <https://www.whyuhc.com/optionsppo>



MEDICAL COVERAGE

Surest (PPO)

Surest, provided through UnitedHealthcare, gives you the freedom to seek care from any provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a Surest provider.

- The Surest plan gives you more control of cost and coverage. When you receive care, you pay a copay—set dollar amount— and can see that price before making an appointment.
- Having the ability to see costs up front means you'll be able to plan ahead. You'll also have access to one of the largest networks of doctors, clinics, and hospitals.
- The Surest health plan includes preventive care at no cost, primary and specialty visits, urgent and emergency care, hospital stays, chronic conditions, maternity care, 24/7 virtual care, and prescription drug coverage.
- The out-of-pocket maximum limits your overall costs.

How You Pay for Services

- You pay a flat dollar amount—or copay—for covered health care treatments and services, such as doctor's office visits and prescription drugs.
- Once you hit your annual out-of-pocket maximum, the plan will cover 100% of the cost of covered services for the rest of the year.

To find an in-network provider, search or scan the QR code:

<https://www.surest.com/plan?accesscode=FICA25266AltI&slide=1>



This plan utilizes the Select Plus UHC Network*.

*Does not include University of Utah.



MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductibles and out-of-pocket maximums are per calendar year.

Key Benefits	UHC Options PPO 750 Plan ^{2,3}		UHC Options PPO 1500 Plan ^{2,3}		UHC Options HSA ^{2,3}	
	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹	In-Network	Out-of-Network ¹
Deductible (Individual/Family)	\$750 / \$1,500	\$1,500 / \$3,000	\$1,500 / \$3,000	\$3,000 / \$6,000	\$3,400 / \$6,800	\$6,000 / \$12,000
Out-of-Pocket Max (Individual/Family)	\$3,000 / \$6,000	\$6,000 / \$12,000	\$4,000 / \$8,000	\$8,000 / \$16,000	\$5,000 / \$10,000	\$10,000 / \$20,000
Office Visits (physician/specialist)	\$25 / \$50 copay	40%*	\$25/\$50 copay	40%*	10%*	30%*
Routine Preventive Care	No charge	Not covered	No charge	Not covered	No charge	30%*
Diagnostics (lab/X-ray)	10%	40%*	10%	40%*	10%*	30%*
Complex Imaging	10%*	40%*	10%*	40%*	10%*	30%*
Chiropractic	\$25 copay	Not covered	\$25 copay	Not covered	10%*	Not covered
Ambulance	10%	10%*	10%	10%*	10%*	10%*
Emergency Room	\$250 copay		\$250 copay		10%*	10%*
Urgent Care Facility	\$75 copay	40%*	\$75 copay	40%*	10%*	30%*
Inpatient Hospital Stay	10%*	40%*	10%*	40%*	10%*	30%*
Outpatient Surgery	10%*	40%*	10%*	40%*	10%*	30%*

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.

*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. The deductible is embedded. This means that once a family member meets their individual deductible, the plan will begin to pay coinsurance for that family member.
3. The out-of-pocket maximum is embedded. This means that, once an individual family member meets their out-of-pocket maximum, that individual's expenses are covered at 100%.



MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The out-of-pocket maximums are per calendar year.

General Plan Details - Surest	
Deductible (Individual/Family)	\$0
Out-of-Pocket Limit (Individual/Family)	\$4,000 / \$8,000

Your Copays	
Preventive Visit	\$0
Virtual Visit	\$0
Office Visit	\$10 to \$65
Virtual mental health visit	\$25
Mental health office visit	\$10
Urgent care visit	\$35
Emergency room visit	\$375
Basic diagnostic lab tests, x-rays and ultrasounds	\$0
Physical therapy (60 visits)	\$5 to \$45
Maternity labor and delivery	\$625 to \$1,600



- No deductible
- Look up actual prices (not estimates)
- Access the large, national UnitedHealthcare network
 - Please note, University of Utah is NOT in-network



Access Code: FICA25266AltI

I. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.



PRESCRIPTION COVERAGE

Retail Pharmacy

When you fill a prescription at a participating retail pharmacy, you may purchase up to a 30-day supply. At the participating pharmacy, you will need to present your ID card and an applicable payment. Most major pharmacies are in our plan's pharmacy network.

Tier 1 will typically be your lowest cost and include mostly generic drugs.

Tier 2 are your mid-range cost.

Tier 3 are your highest cost.

Specialty is a separate tier.

PDL Name: Advantage 3 Tier

Specialty Program

With a rare or complex medical condition (e.g., cancer, hepatitis, hemophilia, rheumatoid arthritis or HIV), the appropriate use of specialty medications can be critical to maintaining or improving a patient's health and quality of life. We use the Optum program to make these medications accessible and cost effective for plan members. It provides focused, specialized support to individuals with complex medical conditions that often require multiple specialty medication therapies.

Save Money on Medications

Ask for Generic Drugs

You can save money by asking for generic drugs. The FDA requires that generic drugs have the same high quality, strength, purity and stability as brand-name drugs. The next time you need a prescription, ask your doctor to prescribe a generic drug if it is available and appropriate.

Use Mail Order

If you require regular medication for a long-term or chronic condition, such as arthritis or diabetes, you can save money by using your plan's mail-order service.

Key Benefits	UHC Options PPO 750 Plan		UHC Options PPO 1500 Plan		UHC Options HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Retail Pharmacy (30-day supply)						
Tier 1	\$10	\$10	\$10	\$10	\$10*	\$10*
Tier 2	\$30	\$30	\$30	\$30	\$30*	\$30*
Tier 3	\$50	\$50	\$50	\$50	\$50*	\$50*
Specialty	Copay based on tier level		Copay based on tier level		Copay based on tier level*	
Mail Order Pharmacy Retail Pharmacy (90-day supply)						
Tier 1	\$20	Not covered	\$20	Not covered	\$20*	Not covered
Tier 2	\$60	Not covered	\$60	Not covered	\$60*	Not covered
Tier 3	\$100	Not covered	\$100	Not covered	\$100*	Not covered

*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.



[Click here](#) to watch a video about prescription drug coverage.



PRESCRIPTION COVERAGE

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Key Benefits	UHC Surest Plan	
	In-Network	Out-of-Network
Retail Pharmacy (30-day supply)		
Tier 1	\$10	Not covered
Tier 2	\$35	Not covered
Tier 3	\$70	Not covered
Specialty	Copay based on tier level	
Mail Order Pharmacy Retail Pharmacy (90-day supply)		
Tier 1	\$25	Not covered
Tier 2	\$87.50	Not covered
Tier 3	\$175	Not covered



[Click here](#) to watch a video about prescription drug coverage.

VIRTUAL VISITS

Carrier: UnitedHealthcare

Our telehealth program is a convenient and cost-effective way to get quick medical advice by phone, online or on your mobile device about many non-emergency conditions. It's just one more way our organization invests in you and your family.

Why Use Telehealth?

It's Affordable

A trip to the ER, urgent care center or doctor's office can easily set you back hundreds of dollars in out-of-pocket costs. For PPO enrollees, a call to our telehealth program will cost you a flat \$0 copay/fee, regardless of your condition. For those on the HSA, the cost will be \$54 or less.

It's Convenient

Long wait times at the ER, urgent care center or doctor's office are an unfortunate reality for many. Whether you are at home or work or on the road, a medical professional is available 24/7/365 so you can get the care you need when and where it's convenient for you. Even better: There is no time limit to the consult, giving you plenty of time to ask questions and resolve your issue.

It's Easy to Use

A telehealth medical professional is never more than a phone call, click or tap away!

Option PPO & HSA: Sign in to myuhc.com/virtualvisits or access via the UHC App

Surest: Sign in to surest.com or access via the Surest App



[Click here](#) to watch a video about how telehealth works.

Get Care in Minutes

It takes just a few minutes to set up your medical history online. Once you submit a request, it often takes less than 10 minutes for a doctor to call you back.

Common Reasons to Call

- Allergies
- Anxiety issues
- Back problems
- Bronchitis
- Cold and flu symptoms
- Ear infections
- Diarrhea or constipation
- Headaches and migraines
- Rash and skin problems
- Sore throat and stuffy nose
- Sprains and strains
- Urinary tract infections



DENTAL COVERAGE

DHMO

With the dental Health Maintenance Organization (HMO) plan, provided through UnitedHealthcare, you choose a primary dental provider to manage your care. There are no charges for most preventive services, no claim forms and no deductibles. Reduced, pre-set charges apply to other services. You will select Exclusive Network Dental Plan when searching for a provider.

Please note, the DHMO is only available in certain states. Availability will be reflected in ADP.

To find an in-network provider, search:

<https://www.whyuhc.com/endlp>

Select: Exclusive Network Dental Plan

DPPO

The dental Preferred Provider Organization (PPO) plan, provided through UnitedHealthcare, offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a dentist who participates in the National Options PPO 20 network.

To find an in-network provider, visit:

<https://www.whyuhc.com/dentalppo>

Select: Search the Dental PPO 20 Network





DENTAL COVERAGE

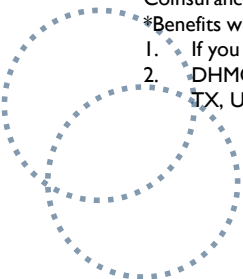
Following is a high-level overview of your dental plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductibles and annual benefit maximums are per calendar year.

Key Benefits	DHMO ²	DPPO	
	In-Network Only	In-Network	Out-of-Network ¹
Deductible (Individual/Family)	None	\$50 / \$150	\$50 / \$150
Annual Benefit Maximum (per person)	None	\$1,500	\$1,500
Preventive Services	No charge	No charge	20%
Basic Services	See copay schedule in ADP	20%*	40%*
Major Services	See copay schedule in ADP	50%*	60%*
Orthodontic Services (Child & Adult)	\$2,185 Copay	\$1,250 Max Benefit	

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.

*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. DHMO is available in the following states: AZ, CA, CO, DC, DE, FL, GA, IL, IN, MD, MO, NJ, NV, NY, OH, OR, PA, TN, TX, UT, VA



VISION COVERAGE

Vision Plan

Your eyesight is an integral part of your overall health and a key component of safety. This plan, provided through UnitedHealthcare, gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the UHC Vision Network. If you decide to use an out-of-network provider, you will pay the provider in full at the time of your appointment and submit a claim form for reimbursement up to the amount allowed by the plan.

Receiving benefits from a network provider is as easy as making an appointment with the provider of your choice from the list of providers. The provider will coordinate all necessary authorizations you supply in your membership information.

Special discounts are offered on non-covered services, such as an additional pair of glasses, special lens options and LASIK.

To find an in-network provider, search: <https://www.whyuhc.com/vision>

Following is a high-level overview of your vision plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	UHC Vision Network	
	In-Network	Out-of-Network Reimbursement
Exam (once every 12 months)	\$10	Up to \$40
Materials Copay	\$10	N/A
Frames (once every 12 months)	Covered up to \$180	Up to \$45
Lenses (once every 12 months)		
Single Vision	\$10	Up to \$40
Bifocal	\$10	Up to \$60
Trifocal	\$10	Up to \$80
Contact Lenses (in lieu of glasses; once every 12 months)	Covered up to \$150	Up to \$125

PLAN CONTRIBUTIONS

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members.

Medical

Coverage	Per Paycheck Contributions			
	UHC Options PPO 750 Plan	UHC Options PPO 1500 Plan	UHC HSA Plan	UHC Surest Plan
Employee Only	\$39.09	\$28.81	\$0.00	\$14.48
Employee + Spouse	\$273.44	\$251.86	\$186.56	\$221.78
Employee + Child(ren)	\$200.50	\$181.99	\$139.76	\$156.21
Employee + Family	\$431.85	\$401.01	\$266.51	\$358.03

Dental

Coverage	Per Paycheck Contributions	
	DHMO	DPPO
Employee Only	\$0.00	\$0.00
Employee + Spouse	\$7.06	\$13.78
Employee + Child(ren)	\$6.68	\$10.33
Employee + Family	\$14.54	\$24.60

Vision

Coverage	Per Paycheck Contributions
	Vision
Employee Only	\$0.00
Employee + Spouse	\$2.53
Employee + Child(ren)	\$2.33
Employee + Family	\$4.89





WEALTH



HEALTH SAVINGS ACCOUNT (HSA)

The Select Plus HSA features an HSA provided through Optum. The HSA lets you set aside pre-tax dollars to help offset your annual deductible and pay for qualified health care expenses.

How the HSA Works

- You contribute pre-tax dollars through automatic payroll deductions or make after-tax contributions that are deductible when you file your taxes.
- The Company contributes the following amounts annually to your HSA account to help it grow. These contributions are completed on a quarterly basis:
 - Employee only coverage: \$1,250
 - Employee + dependent(s) coverage: \$2,500
- You may change your contributions at any time throughout the year.
- You can withdraw HSA funds tax free to pay for current qualified health care expenses, or save them for the future, also tax free. Unused funds roll over from year to year and are yours to keep, even if you change medical plans or leave your employer.

Contribution Limits

Coverage Tier	2026
Individual	\$4,400
Family	\$8,750
Catch-up Contributions (age 55-65)	\$1,000



[Click here](#) to watch a video about HSA limits. (ER cont.)



HEALTH SAVINGS ACCOUNT (HSA)

Key Features of the HSA

Triple-Tax Advantage

- You contribute funds pre-tax through convenient payroll deductions. This means the money comes out of your paycheck before income tax is calculated. So, you get to keep a bigger portion of your paycheck.
- HSA funds grow tax free, and unused funds roll over year to year. So, the more you save, the more your account will grow—just like a bank savings account.
- If you need to use your HSA funds, you can withdraw them tax free to pay for qualified health care expenses now and in the future—even in retirement.

Control

You own and control the money in your HSA. You decide how or whether you want to spend it. You can use it to pay for doctor's visits, prescriptions, braces, glasses—even laser vision correction surgery.

Investment Opportunities

Once you reach and maintain a minimum threshold, you can make investments to help your money grow tax free.

Savings Potential

Your HSA is like a “health care 401(k).” There is no “use it or lose it” rule. Your account grows over time as you continue to roll over unused dollars from year to year.

Portability

Your HSA is yours for life. The money is yours to spend or save, even if you change health plans,¹ retire or leave the organization.

Qualified Health Care Expenses

- Qualified medical, dental and vision expenses not covered by the plans, as defined by the IRS in [Publication 502](#)
- COBRA premiums
- Qualified long-term care insurance and expenses
- Health insurance premiums when receiving unemployment compensation
- Medicare and retiree health insurance premiums (not Medicare Supplement premiums)
- Medigap insurance premiums

Important Notes

- You must meet certain eligibility requirements to have an HSA: You a) must be at least 18 years old, b) must be covered under a qualified HDHP, c) must not be enrolled in Medicare and d) cannot be claimed as a dependent on another person's tax return. For more information, please refer to IRS [Publication 969](#).
- Adult children must be claimed as dependents on your tax return for their medical expenses to qualify for payment or reimbursement from your HSA.



[Click here](#) to watch a video about how an HSA works.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

The flexible spending accounts (FSAs), provided through WEX, are tax-advantaged accounts that can help you cover certain qualified out-of-pocket expenses. Each account works in much the same way but has different eligibility requirements, list of qualified expenses and contribution limits. You may choose to enroll in the following accounts.

	Health Care FSA (HCFSA)	Limited-Purpose FSA (LPFSA)	Dependent Care FSA (DCFSA)
Eligibility Requirements	You must be benefits eligible; enrollment in an HCFSA disqualifies you from making or receiving HSA contributions	You must be benefits eligible; most employers also require enrollment in a qualified high-deductible health plan	Available to all employees
Examples of Qualified Expenses	• Coinsurance • Copayments • Deductibles • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia • Prescriptions	• Dental and vision coinsurance only • Dental and vision deductibles only • Dental treatment • Eye exams/eyeglasses • LASIK eye surgery • Orthodontia	• Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or daycare centers • Care of household members who are physically or mentally incapable of caring for themselves and who qualify as your federal tax dependent
Annual Contribution Limit	\$3,400	\$3,400	\$7,500 per family (or \$3,750 each if you are married and file separate tax returns)

Important FSA Rules

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

- **You must enroll each year to participate.**
- **HCFSA:** Unused funds of up to \$680 from one year can carry over to the following year. Carryover funds will not count against or offset the amount that you can contribute annually. Unused funds over \$680 will **not** be returned to you or carried over to the following year.
- **LPFSA:** This type of account can be used toward eligible dental and vision expenses only.
- **DCFSA:** Unused funds will NOT be returned to you or carried over to the following year.



[Click here](#) to watch a video about how an FSA works.



[Click here](#) to watch a video comparing an HSA and an FSA.



401(K) RETIREMENT SAVINGS ACCOUNT

Plan for retirement by contributing to the Scorpion 401(k) Retirement Savings Plan, administered by ADP, on a pre-tax or after-tax basis. It offers a wide variety of investment funds so you can choose what best meets your needs. In addition, the Plan offers a Self-Directed Brokerage Account.

Auto Enrollment

If you are a new hire, you will be automatically enrolled at a 3% contribution rate. You will be given the opportunity to opt out or change your contribution rate.

Advantages of Contributing

The 401(k) Retirement Savings Plan helps you meet your financial goals with the following advantages:

- Tax savings on pre-tax contributions
- You may contribute 1% - 90% of your pay
- 2026 IRS Maximum: \$24,500
- Catch-up contributions age 50 and over - \$7,500
- Choice of investment funds
- Convenient payroll deductions

Roth Contributions

In addition to the traditional pre-tax contribution, you may contribute on an after-tax basis or ROTH. You can choose to contribute to both traditional and ROTH depending on your specific needs.

Receiving Benefits

Because 401(k) plans are designed for retirement savings, there are rules that specify when you can receive funds from the plan.

Before age 59½, you may withdraw funds only if you:

- Leave Scorpion
- Become disabled
- Experience a financial hardship

Any funds you receive before age 59½ may be subject to current taxes and possibly a financial penalty.

Loans

You can borrow from your 401(k) assets at an interest rate of prime +1. The loan terms are as follows:

- \$1,000 minimum/\$50,000 maximum or 50% of your vested account balance
- Maximum loan term is five years for general use, 30 years for residential loans

Rollovers

Consolidate retirement accounts with a rollover. Savings from your previous qualified retirement plan(s) or a Rollover Individual Retirement Account (IRA) are accepted into the Plan. Consolidating retirement accounts can be beneficial to your long-term retirement planning. Access to your savings in one place can save time and make it easier to track your progress. If you ever have a financial need, you will have access to these assets as part of your overall account balance.

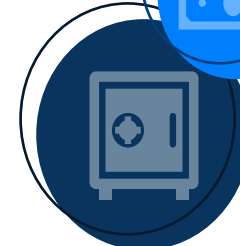
Making Changes

You may change the amount you are contributing to your 401(k) and your investment allocations at any time.

- ADP Mobile Solutions App
- My.ADP.com
- 1-866-695-7526



[Click here](#) to watch a video about how a retirement plan works.



LIFE INSURANCE

Life insurance, provided through UnitedHealthcare, provides your named beneficiaries with a benefit following your death, while accidental death and dismemberment (AD&D) insurance provides a benefit to you following a covered accident that leads to dismemberment (such as the loss of a hand, foot or eye). Should your death occur due to a covered accident, both the life benefit and the AD&D benefit would be payable.

Basic Life and AD&D (employer-paid)

Coverage Tier	Benefit Amount
Employee	\$25,000

Supplemental Life and AD&D (employee-paid)

If you determine you need more than the basic coverage, you may purchase additional insurance for yourself and your eligible family members.

Coverage Tier	Benefit Amount	Guaranteed Issue Amount
Employee	\$10,000 increments; to the lesser of 5x BAE or \$500,000	\$150,000
Spouse	\$5,000 increments; to lesser of 50% of EE amount or \$150,000	\$10,000
Child(ren)	Birth - 6 months \$1,000; 6 months - age 26: increments of \$1,000 up to \$10,000	\$10,000

Note: During your initial eligibility period, you can secure coverage up to the Guaranteed Issue limits without the need for Evidence of Insurability (EOI, or information about your health). Please note that coverage amounts requiring EOI will only go into effect once the insurance carrier approves them.



[Click here](#) to watch a video about how life insurance works.



DISABILITY INSURANCE

Disability insurance, provided through UnitedHealthcare, provides benefits that replace part of your lost income when you cannot work due to a covered illness or injury.

Short-Term Disability

Provided at NO COST to you.	
Benefit Percentage	60%
Weekly Benefit Maximum	\$2,000
When Benefits Begin	After 7th day of disability
Maximum Benefit Duration	12 weeks

Long-Term Disability

Provided at NO COST to you.	
Benefit Percentage	60%
Monthly Benefit Maximum	\$1,500
When Benefits Begin	After 90th day of disability
Maximum Benefit Duration	Social Security Retirement Age

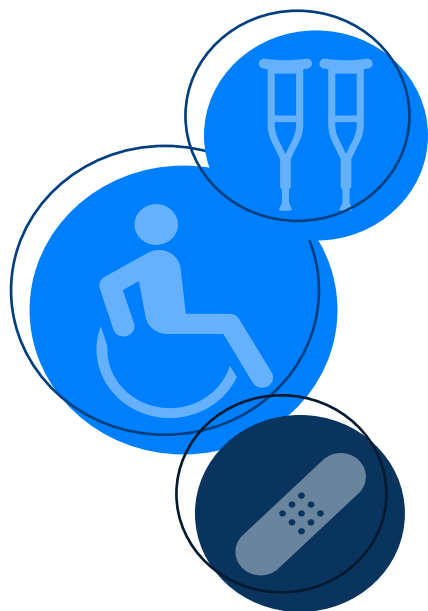
Voluntary (Buy-Up) Long-Term Disability

Provided at an affordable group rate through Unum	
Benefit	60%
Monthly Benefit Maximum	\$5,000**
When benefit begins	After 90th day of disability
When benefit ends	Social Security Retirement Age

**Maximum combined LTD benefit available is \$5,000 (\$1,500 Employer paid, \$3,500 Employee paid)



[Click here](#) to watch a video about how disability insurance works.



VOLUNTARY BENEFITS

Accident Insurance

Accident insurance, provided through UnitedHealthcare, can soften the financial impact of an accidental injury by paying a benefit to you to help cover the unexpected out-of-pocket costs related to treating your injuries. Some accidents, like breaking your leg, may seem straightforward: you visit the doctor, take an X-ray, put on a cast and rest up until you're healed. But treating a broken leg can cost thousands of dollars. When your medical bill arrives, you'll be relieved you have accident insurance on your side.

Accident insurance pays a fixed cash benefit directly to you when you have a covered accident-related injury, like a sprain or bone fracture. Examples of covered expenses include:

- Doctor's office visits
- Diagnostic exams
- Broken leg rehab treatment
- Physical therapy sessions

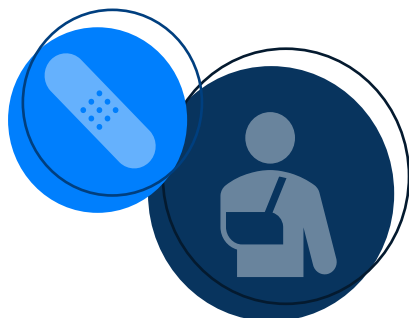
Plan includes a \$50 Annual Wellness Benefit

Accident Insurance in Practice

Situation	Abed broke his leg in a bike accident.
Covered Benefits	• Doctor's office visits • Diagnostic exams • Broken leg rehab treatment • Physical therapy sessions
Total Benefit Paid Directly to Employee	\$4,250



[Click here](#) to watch a video about how an accident plan works.



VOLUNTARY BENEFITS

Critical Illness Insurance

About half of U.S. adults report being unable to pay an unexpected medical bill of \$500 without going into debt.¹ With critical illness insurance provided through UnitedHealthcare, you won't have to. This benefit provides a fixed, lump-sum cash benefit directly to you when you are diagnosed with a covered health condition such as a heart attack or stroke. You can use this benefit however you like, including to help pay for:

- Increased living expenses
- Prescriptions
- Travel expenses
- Treatments

Coverage can be elected in amounts of \$15,000 or \$30,000.

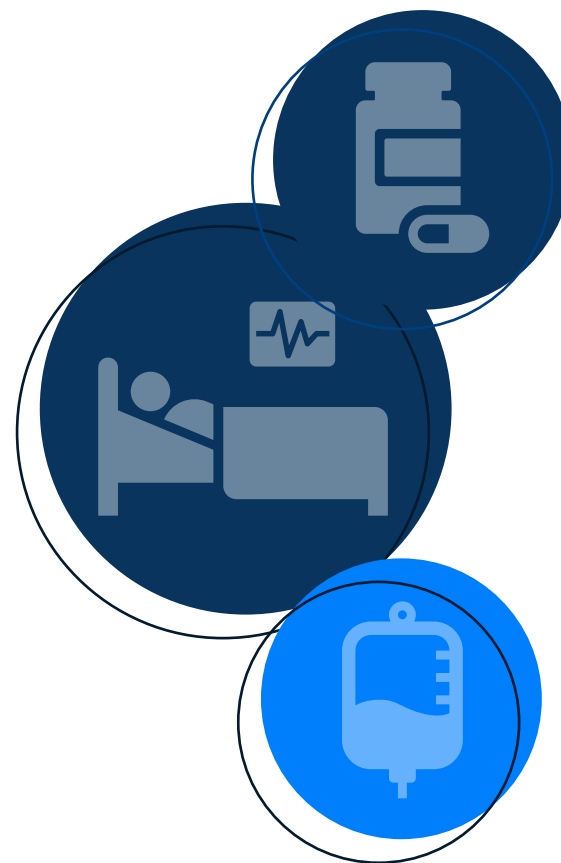
The plan includes an Annual Wellness Benefit.

Critical Illness Insurance in Practice

Situation	Britta had a heart attack while raking leaves.
Covered Benefits	Heart attack diagnosis
Total Benefit Paid Directly to Employee	\$15,000



[Click here](#) to watch a video about how a critical illness plan works.



1. Kaiser Family Foundation. "Americans' Challenges with Health Care Costs." Kaiser Family Foundation, www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs.



VOLUNTARY BENEFITS

Hospital Indemnity Insurance

When you or a dependent need to be hospitalized, your family deserves to focus on their well-being, not the stress of a stint at the hospital, which can cost an average of \$3,025 per inpatient day.¹ Hospital indemnity, provided through UnitedHealthcare, pays a fixed cash benefit directly to you when you experience:

- Hospital admissions
- Hospital stays
- Intensive care unit stays

Benefits: \$1,000 per admit per year / \$100 per day up to 365 days

Plan includes a \$50 Annual Wellness Benefit



Hospital Indemnity Insurance in Practice

Situation	Craig was hospitalized following a car accident.
Covered Benefits	• Hospital admission • Hospital stay • Intensive care unit stay
Total Benefit Paid Directly to Employee	\$2,250



[Click here](#) to watch a video about how a hospital indemnity plan works.

1. Kaiser Family Foundation. "Expenses per Inpatient Day." Kaiser Family Foundation, www.kff.org/health-costs/state-indicator/expenses-per-inpatient-day.



VOLUNTARY BENEFITS

Legal Assistance

Dealing with legal issues can be daunting, but thanks to the legal assistance plan provided through MetLife, you don't have to waste time looking for the right attorney or spend a fortune on legal fees.

The legal plan provides you, your spouse and eligible dependents with fully covered legal services from experienced attorneys. Receive legal services for a wide range of personal matters such as:

- Criminal matters
- Debt
- Divorce
- Estate planning
- Family
- Real estate
- Small claims court
- Taxes

QUESTIONS?

To learn more, visit <https://login.legalplans.com/register>.
For questions, contact MetLife at 800-GET-MET8.

Features

- **In-Office Services** — You will receive access to a nationwide network of credentialed attorneys who can advise and represent you.
- **Telephone Advice** — You can call a network attorney for unlimited legal advice to help prepare documents, letters or a will.
- **Online Resources** — Turn to online tools and useful information to learn more about legal issues and create legally valid documents on your own.



[Click here](#) to watch a video about how legal assistance works.



VOLUNTARY BENEFITS

Identity Theft Protection

Your identity is made up of more than your Social Security number and credit score. It includes the trail of data you leave behind from financial transactions, as well as what you share on social media. That's why we offer identity theft protection, provided through Allstate, for you and your family members.

Features

- \$1 million ID theft insurance
- Dark web monitoring
- High-risk transaction monitoring
- Social media monitoring
- IP address monitoring
- Lost wallet protection
- Solicitation reduction
- Credit monitoring and alerts
- Data breach notifications
- Stolen 401(k) and HSA funds reimbursement



QUESTIONS?

To learn more, visit www.myaip.com.

For questions, contact Allstate at (800) 789-2720.



[Click here](#) to watch a video about how identity theft protection works.



VOLUNTARY BENEFITS

Pet Insurance

Your pet is a member of your family, and they deserve to be covered as one. You have access to discounted rates on pet insurance to help cover the costs of veterinary services. From routine visits to emergencies, gain peace of mind knowing your best friend can receive the care they need without breaking the bank.

Pet insurance, provided through MetLife, reimburses all or part of the cost of covered veterinary expenses, either as a percentage of your cost or based on a schedule of set dollar amounts. You can visit any vet of your choice and customize coverage to meet your needs.

What's Covered?

Coverage varies based on the plan you select. Below are examples of services that may be covered (check plan details to verify).

Accidents, Illness and More:

- Vet exams and diagnostic testing
- Hospitalization and surgery
- Emergency and specialist care
- Prescription pet medications
- Treatment for serious issues and hereditary conditions
- Continuing care for chronic conditions
- Disaster response

Preventive Care:

- Routine exams and immunizations
- Preventive medication
- Spay/neuter surgery
- Teeth cleaning

Exclusions:

- Pre-existing conditions
- Cosmetic procedures
- Injuries caused by cruelty or neglect



[Click here](#) to watch a video about how pet insurance works.

QUESTIONS?

To learn more, visit

For questions, contact MetLife at 800-GET-MET8.



PLAN CONTRIBUTIONS

Your contributions toward the cost of voluntary benefits are automatically deducted from your paycheck after taxes. The amounts will depend upon the plan you select, your age (in some cases) and if you choose to cover eligible family members.

Accident Plan

Coverage	Per Paycheck Contributions
Employee Only	\$4.07
Employee + Spouse	\$6.88
Employee + Child(ren)	\$8.08
Employee _ Family	\$10.90

Critical Illness & Voluntary Life

Coverage	Per Paycheck Contributions
Cost varies based on benefit amount and age, check ADP for rates.	

Legal Plan

Coverage	Per Paycheck Contributions
Employee Only	\$9.00
Employee + Dependents	\$9.00

Hospital Plan

Coverage	Per Paycheck Contributions
Employee Only	\$5.58
Employee + Spouse	\$11.52
Employee + Child(ren)	\$10.68
Employee _ Family	\$17.69

Voluntary Long Term Disability

Coverage	Per Paycheck Contributions
Cost varies based on benefit amount, check ADP for rates.	

ID Theft Plan

Coverage	Per Paycheck Contributions
Employee Only	\$4.59
Employee + Dependents	\$8.28



WELLBEING

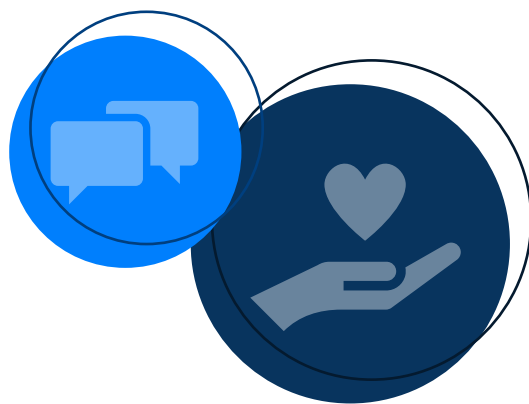


EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life is full of challenges, and sometimes balancing them all can be difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families. The Employee Assistance Program (EAP) is provided at NO COST to you through Unum.

The EAP can help with the following issues, among many others:

- Mental health
- Relationships
- Substance use
- Child and eldercare
- Grief and loss
- Legal or financial issues



EAP Benefits

- Assistance for you and your household members
- Up to 3 in-person or virtual sessions with a counselor per event, per year, per individual
- Unlimited toll-free phone access and online resources

QUESTIONS?

To learn more, visit liveandworkwell.com.

Code: FP3EAP

For questions, contact UnitedHealthcare at (877) 660-3806.



[Click here](#) to watch a video
about how an EAP works.



MENTAL HEALTH BENEFITS

Calm (PPO 750 / PPO1500 / HSA)

As an employee of the Company, you have access to a premium subscription to Calm at no cost. Calm is an app with content tools aligned with the National Institutes of Health's emotional and mental wellness strategies. The app includes:

- Wellness tools specifically designed for you to find balance before, during and after your workday
- Original music from leading artists and serene soundscapes, expertly created to improve focus and maximize relaxation
- Light stretching and physical exercises designed to relax the body and mind
- Guided meditations and mindfulness programs
- Simple breathing exercises

To unlock your free Calm subscription, visit:
<https://www.calm.com/b22/scorpion/subscribe>



[Click here](#) to watch a video about mental health.



MENTAL HEALTH BENEFITS

Talkspace (Surest)

Talkspace is your digital space for private and convenient mental health support. With Talkspace, you can receive counseling, therapy, and medication services from the convenience of your device (iOS, Android, and web).

All care is led by a behavioral health clinician or medical professional. Talkspace's network features thousands of licensed, insured, and verified therapists and specialized prescribers who can support a variety of needs—including, but not limited to:

- Stress
- Anxiety
- Depression
- Eating Disorders
- Substance Abuse
- Sleep
- Chronic Issues
- Relationships
- Healthy Living

To register, visit: [Talkspace.com/surest](https://talkspace.com/surest)



[Click here](#) to watch a video about mental health.

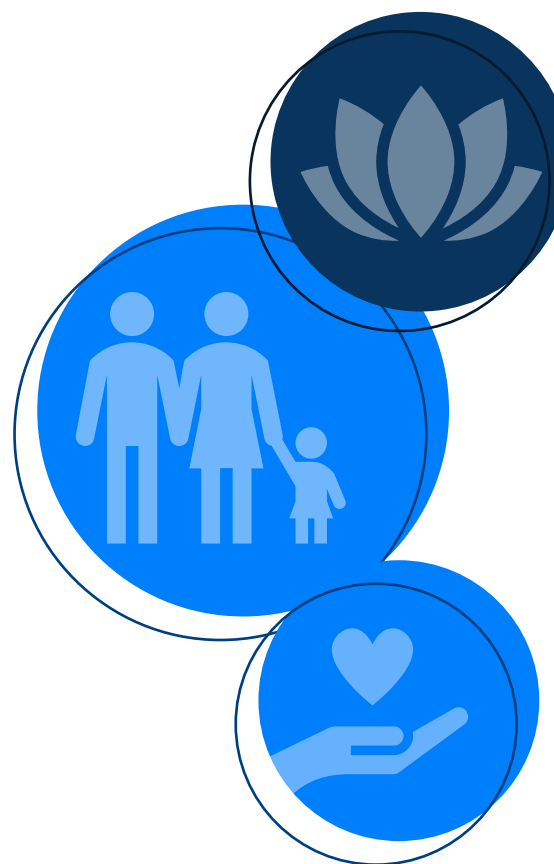


PAID TIME OFF

Whether it's a vacation, a day off here or there, or taking care of a sick child, Scorpion offers flexibility to take the time you need.

Paid time off employees may take

Flexible Time Off (FTO)	Flexible time off, or FTO, is for all eligible Scorpions to take vacations or just a day off. Nothing accrues or expires, and there is no annual maximum. It's meant to give you the flexibility you need to balance work and life. Learn more here.
Sick Time	We offer up to a week or more depending on state specific laws for any Scorpions who need to take care of themselves or a family member when they are sick. Learn more here.
Holidays	We offer the following holidays for all Scorpions: New Year's Eve, New Year's Day, MLK Day, Memorial Day, Juneteenth, Independence Day, Labor Day, Thanksgiving, Day after Thanksgiving, Christmas Eve, and Christmas Day.



PAID LEAVES

Scorpion offers paid leave to support employees through very important times to ensure that employees can take the time to care for themselves and their families.

Paid leaves employees may take

Parental Leave	Scorpion offers employees in all states three weeks of parental leave to any parents for bonding after a birth, adoption, or placement for foster care. For employees in states without state-mandated parental leave programs (e.g., TX, UT, etc), employees can take an additional 3 weeks of leave. A complete list of eligible states will be provided in the parental leave policy Learn more here.
Medical Leave	Scorpions may take medical leave and become eligible to be paid through short-term or long-term disability for certain medical situations that require an employee to be away from work. Learn more here.





ADDITIONAL OFFERINGS



EMPLOYEE DISCOUNTS

BenefitHub

BenefitHub is an exclusive employee discount program that can help you save big on thousands of items daily such as travel, apparel, tickets, auto, electronics, insurance, education, restaurants and so much more! To get started:

- Go to <https://scorpion.benefithub.com/>
- Click on “Any Offer”
- Complete the Sign-Up Form

Questions? Call 866-664-4621 or email customercare@benefithub.com



EMPLOYEE CELL PHONE PROGRAM

Company-wide Cell Phone Plan

Scorpion offers eligible employees a company-sponsored Cell Phone plan for work and personal use.

Scorpion will pay the plan charges, and you will have the opportunity to get a new cell phone covered up to \$1,000 by the company every three years.

Learn more about the program [here](#).



UHC WELLNESS PROGRAM

UHC Rewards (PPO 750 / PPO 1500 / HSA)

Good news—your health plan comes with a new way to earn up to \$300. UnitedHealthcare Rewards is included in your health plan at no additional cost.

With UHC Rewards, the activities you choose are up to you—same goes for ways to spend your earnings.

Here are some ways you can earn:

Reach daily goals

- Track 5,000 steps or 15 active minutes each day, or double it for an even bigger reward
- Track 14 nights of sleep

Complete one-time reward activities

- Go paperless
- Get a biometric screening
- Take a health survey
- Connect a tracker

There are 2 ways to get started!

- UnitedHealthcare® app, select menu, then choose UHC Rewards
- Sign in or register for myuhc.com and select UHC Rewards



FITNESS & WELL-BEING

One Pass Select

One Pass Select lets employees choose the best health options for them

One Pass Select is a subscription-based fitness and well-being program that supports a healthier lifestyle. You can access thousands of gym locations with:

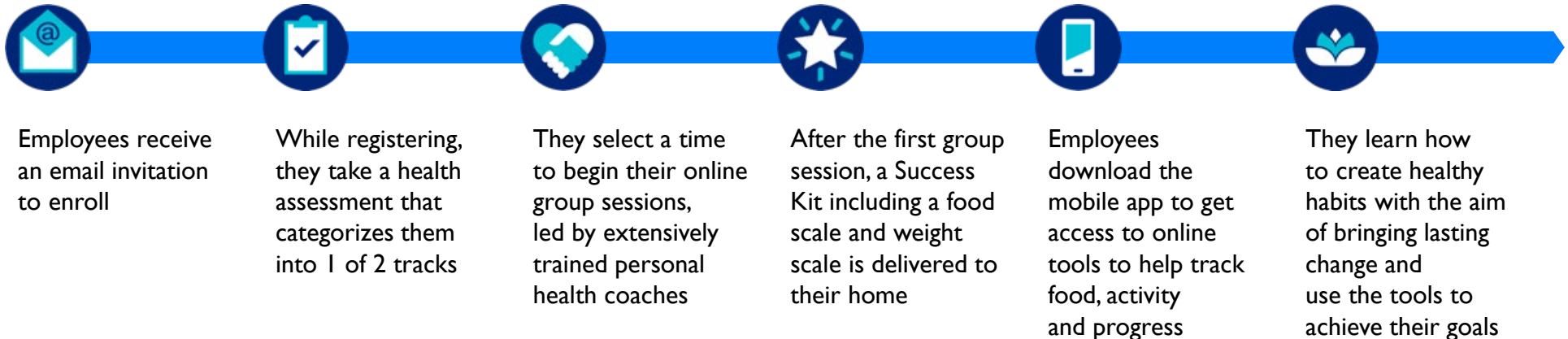
- No long-term contracts or annual gym registration fees
- Flexible fitness options and the ability to use locations nationwide (not limited to 1 gym)
- The ability to add up to 4 family members (ages 18+)
- The option to change tiers monthly
- Cancel at any time (30 days notice required)



WEIGHT MANAGEMENT

Real Appeal

Real Appeal is a personalized program created to support long-term transformation. A customized approach is designed to assist employees on their weight management journey. It may help them reduce health risks, change behavior and save on medical expenses. It's all backed by science and here's how it works:



enroll.realappeal.com

TOBACCO CESSATION

Quit for Life (PPO 750 / PPO 1500 / HSA)

If you use tobacco and have thought about quitting, Quit For Life® on Rally Coach™ may be able to help. Get tools and online resources designed to help you quit — and stay quit — at no additional cost.



Get coach support

Connect with a coach who will help create a personalized Quit Plan and guide you at every step



Access anytime, anywhere

Manage triggers with help from coach-led group sessions, trackers, text support, and more, all at your fingertips



View quit recommendations

Get real-life tips and plan your path to quit with recommended daily goals, articles and videos

Get started

Go to [Myuhc.com](https://myuhc.com) > Health & Wellness > My Health & Wellness > Programs > Quit Smoking



TOBACCO CESSATION

Pivot (Surest)

If you use tobacco and have thought about quitting, Pivot may be able to help. Get tools and online resources designed to help you quit — and stay quit — at no additional cost.



Pivot makes the journey easier

Personalized and non-judgmental, Pivot offers a choice of tools and support.

- Pivot App
- SmartSensor*
- Free supply of Nicotine Replacement Therapy (NRT)*
- Unlimited access to personal coaching
- Online community

*NRT and the Pivot Sensor are only available to those who smoke cigarettes.



Scan the box with your phone's camera or visit pivot.co/surest and use access code **surest**

Do you vape, chew, or smoke cigars?
Pivot can help with that too!



RESOURCES



BENEFIT TERMINOLOGY

Allowed amount

This is the amount agreed upon between the provider and the insurance company for the service provided. It is almost always less than the billed amount, which is why enrollees see different amounts on their Explanation of Benefit statements (EOBs). For example, a provider may charge \$120 per hour of psychotherapy, but the insurance company pays them \$95—the allowed amount for that service.

Balance billing

When an out-of-network provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. An in-network provider cannot balance bill you for the covered services.

Beneficiary

A person who is designated as the recipient of proceeds from an insurance policy.

Coinsurance

Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Consider an example in which the medical plan's allowed amount for a medical service is \$100 and you've met your deductible. If your plan pays 70%, then you are responsible for the remaining 30%, which is \$30.

Copayment

Oftentimes referred to as a "copay," this is the amount you are responsible for paying when seeing a doctor, picking up a prescription, or visiting an urgent care facility or emergency room.

Deductible

The amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. For example, if your individual deductible is \$1,500, your plan will not pay anything for certain medical services until you have paid \$1,500. The deductible may not apply to all services, such as services that are covered by a copay.

Dependent

Dependents are usually an immediate relative, such as a spouse or child (up to age 26, as per the ACA), who is eligible to be included on your health insurance policy. The Company also allows domestic/civil union partners to be listed as dependents.

Dependent care FSA

A flexible spending account (FSA) is designed to provide tax-exempt funds that can be used to offset qualifying expenses for children and elderly dependents. Eligible dependent care expenses include daycare, before- and after-school care, summer day camps and eldercare for dependents claimed on your income taxes. Funds deposited in an FSA must be spent in the same year in which they are set aside, or they are forfeited. This rule is often referred to as "use it or lose it."

Diagnostic test

Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.



BENEFIT TERMINOLOGY

Durable medical equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs or crutches.

Eligible expense

Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “payment allowance” or “negotiated rate.” If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. See balance billing.

Embedded deductible

Once a person covered under a family plan reaches the individual embedded deductible, all covered expenses for that individual will be paid at the coinsurance amount even when the family deductible may not have been satisfied. For example, Select Plus PPO 1500 features an in-network family deductible of \$3,000. If one member of the family satisfies the individual \$1,500 deductible, the medical carrier will pay 90% of the remaining in-network expenses. Once another person or a combination of persons meet the remaining \$1,500 the embedded family deductible is considered satisfied.

Embedded out-of-pocket maximum

Once a person covered under a family plan reaches the individual embedded out-of-pocket maximum, all covered expenses for that individual will be paid at 100% even when the family out-of-pocket maximum may not have been satisfied. For example, Select Plus PPO 1500 features a family out-of-pocket maximum of \$8,000. If one member of the family satisfies the individual out-of-pocket maximum of \$4,000, the medical carrier will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the embedded family out-of-pocket maximum is considered satisfied.

Employee contribution

The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

Excluded services

Medical services that your medical plan doesn’t pay for or cover.

Explanation of benefits

Every time you use your health insurance, your health plan sends you a record called an “explanation of benefits” (EOB) or “member health statement” that explains how much you may owe. The EOB also shows the total cost of care, how much your plan paid, and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the “allowed amount”). An EOB is generated for every single health claim, including prescriptions. It is not a bill, but rather a tool members can use to make sure they’re not paying more than their insurer expects them to for services rendered.

BENEFIT TERMINOLOGY

Health care FSA

Funded through pre-tax payroll deductions, a health care flexible spending account (FSA) is a cost-savings tool that allows you to pay for qualified health care-related expenses with pre-tax dollars.

Generic drugs

Medications that are comparable to brand-name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand-name counterparts. These are typically “Tier 1” drugs in the UHC medical plans.

High-Deductible health plan (HDHP)

A HDHP is a type of health insurance plan that typically offer lower premiums in exchange for higher deductibles. The deductible, which is the amount you must pay out of pocket for covered medical expenses before your insurance begins to pay, is higher for HDHPs compared to traditional PPO plans. These plans allow individuals to pay a lower monthly premium and instead cover more of their medical expenses through out-of-pocket deductibles.

Health savings account (HSA)

An employer- and employee-funded savings plan that reimburses you for qualified out-of-pocket medical expenses. Funded through pre-tax payroll deductions by the employer and employee, HSAs are only available to people enrolled in a qualified high-deductible health plan. Unspent balances aren’t forfeited; they roll over and accumulate over time.

In-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network coinsurance costs you less than out-of-network coinsurance payments.

In-network provider

The facilities, providers and suppliers our health insurance carrier has contracted with to provide medical services. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Mail order Rx

The Company’s medical carrier offers this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can obtain a 90-day supply at one time versus a 30-day supply at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your copay is cheaper through mail order.

Medically necessary

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

Member health statement

Every time you use your health insurance, your health plan sends you a record called a “member health statement” or an “explanation of benefits” (EOB) that explains how much you may owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the “allowed amount”).

BENEFIT TERMINOLOGY

Negotiated rate

Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “payment allowance” or “eligible expense.” If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

Network

The facilities, providers and suppliers a health insurance carrier has contracted with to provide medical services at a pre-negotiated discount. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Non-preferred brand-name drugs

Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand-name drug or a generic. These are typically “Tier 3” drugs in the UHC medical plans.

Non-preferred provider

A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see a non-preferred provider.

Open Enrollment

A period during which a health insurance company is required to accept applicants without regard to health history.

Out-of-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network coinsurance costs you more than in-network coinsurance. An out-of-network provider can balance bill you for charges over the allowed amount.

Out-of-network provider

A provider who doesn’t have a contract with your health insurer or plan to provide services to you. You’ll pay more to see an out-of-network provider.

Out-of-pocket maximum

The most you pay during a policy period (a calendar year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-counter drug

A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Payment allowance

Amount on which payment is based for covered medical services. This may be called “allowed amount maximum,” “negotiated rate” or “eligible expense.” If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.



BENEFIT TERMINOLOGY

Preauthorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Preferred/brand-name drug

These are medications for which generic equivalents are not available. They have been on the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs. These are typically "Tier 2" drugs in the Company's medical plans.

Preferred provider

A provider who has a contract with your health insurer or plan to provide services to you at a pre-negotiated discount.

Prescription drugs

Medications you can only obtain with a prescription from your doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor, Vicodin and Albuterol can only be obtained with a prescription. The opposite of an over-the-counter drug.

Prescription drug coverage

Coverage that helps pay for prescription drugs and medications covered under a health insurance carrier's formulary. A formulary is the list of FDA-approved drugs covered under a medical plan. Each drug is classified into a tier and each tier determines the copayment you will pay for the drug. These tiers typically, but not always, are: Generic (Tier 1), Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty.

Your cost will depend on the level of drug specified by your doctor. A generic drug is a medication whose active ingredients, safety, dosage, quality and strength are identical to that of its brand-name counterpart. Preferred brand-name drugs generally do not have a generic equivalent, while those listed as non-preferred brand-name drugs generally do have a generic or preferred brand-name equivalent.

Your copay for preferred brand-name drugs is less than the copay for non-preferred brand-name drugs because you don't have the generic option available to you.

Premium (Insurance)

The fees paid to an insurance carrier to provide coverage. These fees are usually shared between you and the Company, though there are insurance benefits the Company pays for entirely, while there are others that you pay for yourself.

Premium (Medical)

The amount that is paid for your medical coverage. You and the Company share this cost, which is paid monthly to the insurance carrier.

Pre-tax deduction

Payments deducted from your gross pay before Medicare, federal, and state taxes are calculated, thus reducing your taxable wages and tax liability.

BENEFIT TERMINOLOGY

Prior approval/authorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Post-tax deduction

Payments deducted from your net pay after Medicare, federal and state taxes are calculated, thereby having no impact on your taxable wages and tax liability.

Preventive care

Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventive.

Primary care physician (PCP)

A physician who directly provides or coordinates a wide range of medical services for a patient. Primary care physicians include medical doctors, doctors of osteopathic medicine, internists, family practitioners, general practitioners, OB/GYNs and pediatricians. The opposite of a specialist.

Provider

A physician, health care professional or health care facility, certified or accredited as required by state law.

Qualifying life event (QLE)

QLEs are major events in an enrollee's life that allow them to make specific changes to their insurance policy outside of an annual Open Enrollment period. This usually includes the birth or adoption of a child, marriage, divorce, death of a spouse or change in the spouse's employment or insurance status. These changes must typically be made within 31 days of the QLE.

Special enrollment period

Special enrollment periods allow you to make changes to your insurance plan or sign up for a new policy outside of Open Enrollment. They're almost always triggered by QLEs.

Specialist

A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a primary care physician. For example, a dermatologist is considered a specialist.

Specialty drugs

Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

Telehealth

Telehealth is the use of telecommunication technologies through which you and your personal physician, who is treating you and knows your health history, can talk live over the phone or video chat, by appointment, during regular office hours. Services such as medication management, regular visits and online counseling are particularly well suited to Telehealth, since consistent and regular visits with your physician typically improve outcomes.

BENEFIT TERMINOLOGY

Telemedicine

Telemedicine is the use of telecommunication technologies where you and an on-call physician can talk live (24/7/365) over the phone or video chat. Services that are particularly well-suited to telemedicine include the discussion of symptoms, receiving a diagnosis, learning your treatment options and minor health issues such as pink eye or sore throat. Prescription can also be facilitated through telemedicine. Please note that each time you reach out for telemedicine services, you might speak with a different physician.

Urgent care

An illness or injury serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Wellness

Wellness refers to a healthy state of being.



[Click here](#) to watch a video about benefits terms.



BENEFIT SPOT

Benefits Information on the Go

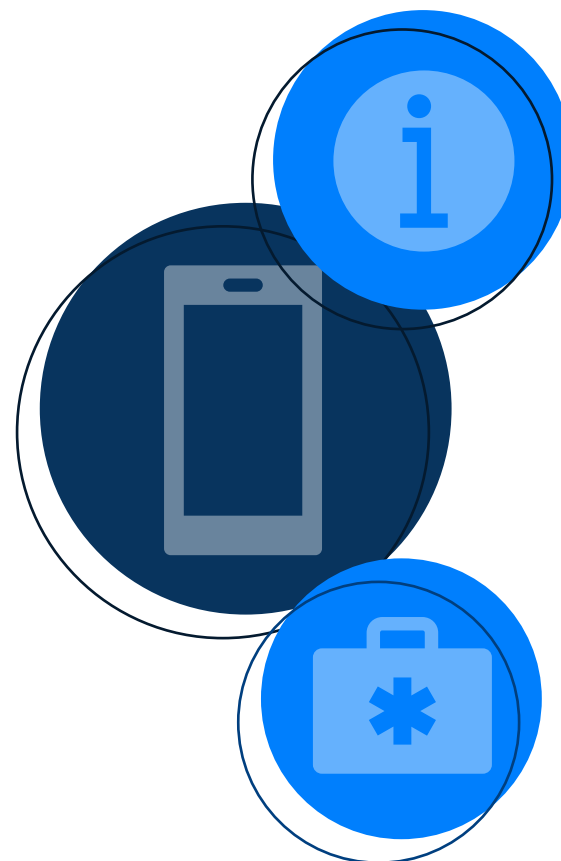
With Benefit Spot, you can access your benefits anytime, anywhere, even when away from work.

Use Benefit Spot to:

- Access your Benefits Guide
- Watch educational videos
- Find benefit contact information
- Estimate costs for common health care procedures
- And more.

Download the app by searching “Benefit Spot” in the Apple App Store or Google Play or scan the QR code below.

When you launch the app, enter company code “**Scorpion-UT**” to access your plan information. (**Note:** The company code is case-sensitive.)



DOMESTIC PARTNER DISCLAIMER

Is My Domestic Partner Eligible?

Your domestic partner is eligible for coverage under the Company's plans if you meet one of these requirements:

- You have an active registered domestic partnership with a governmental body, or
- You both meet all of the following:
 - Are age 18 or older and legally competent
 - Have cohabitated for at least six months
 - Are not married to anyone else (even if legally separated)
 - Are not related by blood
 - Have financial interdependence, as demonstrated by joint ownership of real estate, bank accounts, mortgage, credit obligations, mutual beneficiary designations or powers of attorney

Dependent children of your domestic partner are also eligible for coverage if they are:

- Unmarried
- Primarily dependent on you or your partner for support
- Living with you (unless waived for student status)
- Meet age, student and incapacity requirements for the plan

Imputed Income and Tax Implications

If you add a family member to your coverage who is not considered a dependent under federal income tax law, your share of the cost of coverage must be paid on an after-tax basis. Your employer's share of the cost of benefits is also treated as taxable income, which is known as imputed income. The IRS considers health coverage for a domestic partner and/or their children a taxable benefit with imputed income that is subject to federal income tax and any other required payroll taxes.

Changes in Domestic Partnerships

When enrolling your domestic partner in coverage, you agree that you will notify the Company of any changes in your partnership status that would make your partner and/or their children ineligible for coverage. You must submit a Notice of Change in Domestic Partnership within 30 days of the change. Termination of coverage for domestic partners (and, in some cases, for children of domestic partners) is not a qualifying event for the purpose of continuing coverage under COBRA.



IMPORTANT CONTACTS

Coverage	Carrier	Phone Number	Website/Email
Medical	UnitedHealthcare	PPO: (866) 633-2446 HSA: (866) 314-0335 Surest: (866) 683-6440	PPO/HSA: www.myuhc.com Surest: www.surest.com
Health Savings Account (HSA)	Optum	(800) 791-9361	www.optumbank.com
Dental	UnitedHealthcare	(877) 816-3596	www.myuhc.com
Vision	UnitedHealthcare	(800) 638-3120	www.myuhc.com
Flexible Spending Accounts (FSAs)	WEX	(866) 451-3399	www.wexinc.com/login
Life/AD&D	UnitedHealthcare	(888) 299-2070	www.myuhc.com
Disability	UnitedHealthcare	(888) 299-2070	www.myuhc.com
Employee Assistance Program (EAP)	UnitedHealthcare	(877) 660-3806	www.liveandworkwell.com Code: FP3EAP
401(k) Retirement Plan	ADP	(866) 695-7526	www.mykplan.com
Voluntary Benefits	UnitedHealthcare	(800) 539-0038	www.myuhc.com
	Allstate Identity Protection	(800) 789-2720	www.myaip.com
	MetLife Legal Plan	800-GET-MET8	https://login.legalplans.com/register
	MetLife Pet Insurance	800-GET-MET8	www.metlife.com/getpetquote
Employee Discounts	BenefitHub	(866) 664-4621	https://scorpion.benefithub.com/

BENEFITS FEEDBACK?

Please contact Amy Pugliese at amy.pugliese@scorpion.co or Levi Sheppard at levi.sheppard@scorpion.co

BENEFITS WEBSITE

Our benefits website www.workforcenow.adp.com can be accessed anytime you want additional information on our benefits programs.

QUESTIONS?

For questions about any of your benefits please email Benefits@scorpion.co or you can contact Amy Pugliese our People Operations & Benefits Specialist at (661) 568-7645

