

2026 Benefits Guide

*Position Yourself Perfectly for Open Enrollment –
Nov. 7 - Nov. 21, 2025*

Take the guesswork out of 2026 benefits for you and your family!



Timbercrest



Eder Financial

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2026 Benefits Guide

*Position Yourself Perfectly for Open Enrollment –
Nov. 7 - Nov. 21, 2025*

This Benefits Guide includes a summary of your benefits.

For complete benefit details, please refer to your insurance contract/policy, which you can find online in your Benefits Administration System.



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At Eder Financial, we strive to offer you quality health and ancillary insurance products with a commitment to fast, friendly service. We enjoy serving you. Please let us know how we can help. For more information contact insurance@eder.org or visit www.ederfinancial.org.

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A Message from the President

Hello Friend!

I'd like to thank you for being one of Eder Financial's valued customers.

We strive to bring you the best plan options at competitive rates so you and your family can have peace of mind that you're well cared for. We believe in providing you with the same coverage we provide for ourselves and our own families because we are in this insurance plan together. You are an important partner with us.

Please know that Eder Financial is committed to providing you with the best plan options and service. You can find an explanation of the benefit features in the **Introduction** section, so you'll have the information you need to make the best coverage decisions for you and your family.

Thank you again. We look forward to continue providing our concierge service to you now and in the future!

Sincerely,

Nevin Dulabaum

Nevin Dulabaum
President
Eder Financial



Please review the following features to help you make the most informed decisions when you choose your insurance benefits.

- **Plain English explanations** of why you might need specific coverage
- **Health facts and statistics** to enable you to better weigh your plan options before deciding
- **Notes section in the margin of every page** so you can jot down important information and reference it later
- **Glossary of healthcare terms and definitions** to better understand your coverage and benefits
- **Color-coded pages for each section** to make it easier to navigate between sections
- **Links to websites** embedded within pages so you can go directly to a specific web page to sign up, enroll, or obtain more information
- **And much more!**

Thank you for being a valued customer!





Notes

Eligibility and Enrollment

Am I Eligible?

You are eligible to enroll in the benefits described in this Benefit Guide on the first day of the month following 60 days of continuous employment and if you are working 20 or more hours per week.

Check with your benefits contact to confirm the effective date of your benefits, or if you have questions about your eligibility.

Are My Dependents Eligible?

Eligible dependents include:

- ✓ Lawful spouse as determined under the laws of the state in which you reside;
- ✓ Your children at birth;
- ✓ Your spouse's children, who are in your spouse's custody, reside in your home, and are dependent on your spouse for support;
- ✓ Children that are legally adopted by you or placed with you for purpose of adoption prior to age 18;
- ✓ Children for whom you have legal guardianship, who are in your custody, residing in your home, and are dependent on you for support;
- ✓ Married/unmarried, student/non-student children through the date that he/she reaches age 26 for all lines of coverage;
- ✓ Children who are incapable of self support due to severe physical or mental handicap so long as they become incapable of self support while covered as a dependent. You must be legally responsible for this dependent's support or care;
- ✓ Children for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO). A court order for a dependent must be sent to your benefits contact or finance person. The order will not be implemented before being issued by a court or state administrative process.

TIP: If your dependent is no longer eligible for coverage, you must notify your benefits contact within 30 days of eligibility change to ensure they do not lose the right to elect continuation of coverage.



How Do I Enroll?

The **MyBenefitCHOICE** enrollment website (ederfinancial.mybenefitchoice.com) **How-To-Enroll Guide** will take you step-by-step through the registration and enrollment processes to determine the Eder Health and Life Benefits programs that are best suited for you and your family.

- ✓ Once you've reached the **MyBenefitCHOICE** website, follow the steps outlined next to register for a new account, or sign in to your existing account.
- ✓ You can also find these steps in the **How-To-Enroll Guide** posted to the **MyBenefitCHOICE** website under **Get Answers/Enrollment & Eligibility**.



1 All Users

- Go to ederfinancial.org, select **Health and Life Benefits**, then **Member Portal**.

OR

- Log in directly to ederfinancial.mybenefitchoice.com.

 **Register and Log in**

2 New Users

Under **MyBenefitCHOICE**, select **Register**.

- You'll need your Social Security number, date of birth and zip code.
- Create a username and password.
- Confirm your personal information, benefits and beneficiaries.

Next time you visit the website, you will enter your username and password on the login page to access your information.

3 Existing Users

Enter your username and password, then select **Log In**, to access your information.

If you forget your username or password, use **Forgot your Username or Password?** at the bottom of the login page to reset your username or password.

Additional Support

If you have questions or need help during the enrollment process, please contact the Eder Health and Life Benefits Service Center at contact.center@milliman.com or **800-217-0067**. Representatives from our strategic partner, Milliman, are available Monday through Friday from 7 a.m. to 7 p.m. Central Time.

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Where Can I Find Benefit Plan Information and My Plan Documents?

Go to the **Get Answers** section of the **MyBenefitCHOICE** website shown below:

✓ Review Enrollment & Eligibility and Benefit Plan Information

On the **Get Answers** page, you will find your Benefits Guide, eligibility information, How-To-Enroll Guide, benefit plan documents, videos, links to medical, dental, vision, life insurance, and more.

MyBenefitCHOICE

Home | Get Answers

GET ANSWERS

Enrollment & Eligibility
 Unsure of how to enroll or what the eligibility rules are? Find enrollment guides and instructions or dependent eligibility here.

Benefit Plan Information
 Documents, videos and links to health plans for medical, dental and vision benefits.

Leaving your Organization

Review Enrollment & Eligibility and Benefit Plan Information

On the **Get Answers** page, you will find your benefits guide, eligibility information, How-To-Enroll Guide, benefit plan documents, videos, links to medical, dental, vision, life insurance, and more.



When Can I Enroll?

You can enroll from Friday, Nov. 7, 2025 through Friday, Nov. 21, 2025.

The benefits you elect during open enrollment will take effect Jan. 1, 2026 and continue through Dec. 31, 2026.

How Do I Change My Elections and Add Dependents After Enrolling?

Once open enrollment closes, you will not be able to change your benefit elections until the next open enrollment period unless you have a qualifying event, such as a change to family status or insurance coverage, which include the following:

- ✓ Your marriage, divorce, or legal separation
- ✓ The birth, adoption, or placement for adoption of a child
- ✓ Your child becomes eligible or ineligible for coverage
- ✓ Death of a dependent
- ✓ A court issued Qualified Medical Child Support Order (QMCSO) requiring the plan to provide medical coverage
- ✓ Involuntary loss of previously held health insurance coverage

Remember: You only have 30 days to make changes after a qualifying event.

You need to make any changes to your benefit elections or change dependents after a qualifying change in status within 30 days of the event. The change must be consistent with the status change. For example, if you have a baby, you can add the baby as a dependent, but you could not drop coverage for your spouse.



Notes



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Accident Insurance

Do you really want to risk running out of money if you're in an accident?

- Take control of your future and get the cash you and your family will need if there's an accident – *or accidental death*.

What is Accident Insurance?

- Have you or a family member ever had an automobile, bicycle, or skiing accident?
- How about a slip and fall on icy, wet, or uneven sidewalks, stairs, or hallways?

Did you know that accidents are the 3rd leading cause of death in US¹?

- *Even if you think you won't be in an accident and you have plenty of money, why take a chance?*

Accident insurance pays you or your designee a lump-sum benefit for expenses like these that your medical insurance only partially covers, or doesn't cover:

- ✓ Emergency room services
- ✓ Medical procedures
- ✓ Wheelchair, braces, crutches, walkers
- ✓ Ambulance transportation
- ✓ Occupational and physical therapy
- ✓ Paralysis benefits
- ✓ Transportation to and from appointments
- ✓ And much more



Why Should I Buy Accident Insurance If I Already Have Other Types of Insurance?

Accident insurance is your secret reserve giving you cash when you need it to pay the expenses that other insurances do not cover.

REMEMBER: You buy insurance to protect your future²:

- **Life insurance** ... in case you die.
- **Disability insurance** ... in case an illness stops you from working.
- **Medical insurance** ... in case you get sick or want preventive care.
and ...
- **Accident insurance**...in case you and your family need money to pay expenses caused by a covered accident.
 - Accident insurance can even pay death benefits if your employer's plan includes this provision.

Protect your future with accident insurance today – evaluate your options on the next page.



Notes

Citations:
2 Reliance Standard. (2019, February). Emergency Management Alliance, Voluntary Accident Insurance.



ACCIDENT INSURANCE OPTIONS

Plan Design	Plan A	Plan B	Plan C
Coverage Type	On and off the job (24 hr)	On and off the job (24hr)	On and off the job (24hr)
Portability	Included	Included	Included
Children Age Limits	Up to age 26	Up to age 26	Up to age 26

Plan Provisions	Plan A	Plan B	Plan C
Accident Emergency Room Treatment	\$150	\$200	\$250
Accident Follow-up Visit-Doctor	\$50	\$75	\$100
Air Ambulance	\$500	\$750	\$1,000
Ambulance	\$100	\$150	\$200
Appliance - Wheelchair, leg or back brace, crutches, walker, walking boot that extends above the ankle or brace for the neck	\$100	\$150	\$200
Blood / Plasma / Platelets	\$200	\$300	\$400
Burns (2nd Degree / 3rd Degree)	\$800 for 2nd degree \$6,400 for 3rd degree	\$1,600 for 2nd degree \$12,800 for 3rd degree	\$3,200 for 2nd degree \$25,600 for 3rd degree
Burn - Skin Graft	25% of burn benefit	25% of burn benefit	25% of burn benefit
Coma	\$5,000	\$7,500	\$10,000
Concussions	\$100	\$150	\$200
Dislocations	Up to \$1,600 for Non-surgical \$3,200 for surgical repair	Up to \$2,400 for Non-surgical \$4,800 for surgical repair	Up to \$3,200 for Non-surgical \$6,400 for surgical repair
Diagnostic Exam (Major)	\$100	\$200	\$400
Emergency Dental Work	\$150 for Crown; \$50 for Extraction	\$300 for Crown; \$75 for Extraction	\$400 for Crown; \$100 for Extraction
Eye Injury	\$100 for removal of foreign object, \$200 for surgical repair	\$150 for removal of foreign object, \$300 for surgical repair	\$200 for removal of foreign object, \$400 for surgical repair
Family Medical Leave	Included	Included	Included
Fracture	Up to \$2,500 for Non-surgical \$5,000 for surgical repair	Up to \$3,750 for Non-surgical \$7,500 for surgical repair	Up to \$5,000 for Non-surgical \$10,000 for surgical repair
Hospital Admission	\$500	\$1,000	\$1,500
Hospital Confinement	\$200/day - up to 365 days	\$250/day - up to 365 days	\$350/day - up to 365 days
Hospital ICU Admission	\$1,000	\$1,500	\$2,250
Hospital ICU Confinement	\$400 / day - up to 30 days	\$500 / day - up to 30 days	\$700 / day - up to 30 days
Initial Physician's Office / Urgent Care Facility Treatment	\$50	\$75	\$100
Knee Cartilage	\$300	\$450	\$800
Laceration	\$400	\$600	\$800
Lodging - The hospital must be more than 50 miles from the insured's residence	\$100/day - up to 30 days if more than 100 miles from residence	\$150/day - up to 30 days if more than 100 miles from residence	\$200/day - up to 30 days if more than 100 miles from residence
Occupational or Physical Therapy	\$25/session - up to 6 sessions	\$35/session - up to 6 sessions	\$50/session - up to 6 sessions
Paralysis Benefits	\$10,000 quadriplegia; \$5,000 paraplegia/hemiplegia	\$15,000 quadriplegia; \$7,500 paraplegia/hemiplegia	\$20,000 quadriplegia; \$10,000 paraplegia/hemiplegia
Prosthetic Device / Artificial Limb	1: \$500; 2 or more: \$1,000	1: \$750; 2 or more: \$1,500	1: \$1,000; 2 or more: \$2,000
Rehabilitation Unit Confinement	\$50 / day - up to 30 days	\$100 / day - up to 30 days	\$150 / day - up to 30 days
Ruptured Disc with Surgical Repair	\$500	\$750	\$1,000
Surgery - Abdominal or Thoracic	\$1,000	\$1,500	\$2,000
Surgery - Exploratory or Arthroscopic	\$100	\$150	\$200
Tendon / Ligament / Rotator Cuff	\$600	\$900	\$1,500
Transportation - Benefit is paid if you have to travel more than 50 miles one way to receive special treatment at a hospital or facility due to a covered accident	\$300, if more than 100 miles from residence	\$450, if more than 100 miles from residence	\$600, if more than 100 miles from residence





Notes

Disability Insurance

Why Do I Need Disability Insurance?¹

Having a disability is more common than you think.

- Protect yourself today against personal bankruptcy, mortgage foreclosure, and poverty with disability insurance.

Can you guess how many Americans became disabled in the last 10 minutes?

- Almost 500...that's an estimated 72,000 people a day!

Disabilities aren't just due to accidents – they're also caused by back injuries, cancer, heart disease, and other illnesses.

What are My Odds of Becoming Disabled?

- ✓ 1 out of 3 Americans between ages 35 – 65 will become disabled for more than 90 days.
- ✓ 1 out 5 people under 65 will be unable to work for at least a year due to an illness or accident.
- ✓ **PLUS** - 1 in 7 people will be disabled for 5+ years.

Your chances of becoming disabled increase with age.

Why Should I Care About Disability Insurance?

Every year, 350,000 Americans go bankrupt because of injuries and unexpected illnesses:

- ✓ **62% of all bankruptcies** in the U.S. are from the inability to pay medical expenses, and
- ✓ **50% of mortgage foreclosures** are due to these bankruptcies

Be Sure to Name a Beneficiary

Don't forget to name a beneficiary for your Disability Insurance benefits. You are automatically the beneficiary if you cover your spouse and/or eligible children.

DID YOU KNOW?

You have a 27% chance of living in poverty when you have a severe disability.



Notes

Disability insurance pays your lost income when workers' compensation doesn't:

- ✓ Workers' compensation insurance only applies to injuries you sustain at work, not anywhere else
- ✓ **CAUTION** - Statistics show that there are almost twice as many off-the-job injuries as on-the-job injuries

Do I Need Short-Term or Long-Term Disability Insurance, or BOTH?

Having BOTH short-term and long-term disability is your best bet to protect your income if you are injured or ill because:

- ✓ Long-term disability won't start until 90 calendar days after your illness or injury, if approved.
 - You won't have any income for 3 months until your long-term disability kicks in.
- ✓ Short-term disability covers you first, before long-term disability takes effect.
 - You'll get up to 11 total weeks of coverage, that's almost 3 months.
 - Long-term disability then takes over when your short-term disability benefits end.

SHORT-TERM DISABILITY BENEFITS

Benefit	Description
Weekly benefit amount	60% of eligible predisability weekly earnings up to \$1,250 per week
When benefits begin	Benefits are paid from the 15th consecutive day of a qualifying disability
When benefits end	Up to 11 weeks of benefit based on medical necessity

LONG-TERM DISABILITY BENEFITS*

Benefit	Description
Monthly benefit	66.67% of monthly earnings to a maximum benefit of \$5,000 per month
When benefits begin	After 90 days or the date your insured short-term disability (STD) payments end, if applicable
When benefits end	Generally when you reach retirement age, but your age at the time of injury/illness may affect the end date

IMPORTANT TIP!

Sign up for short- and long-term disability insurance today - **BEFORE** you are injured or become ill - because the insurance won't cover pre-existing conditions.



* In the event of a disability, if you are over age 70 and receive Social Security Benefits, you won't be eligible for a benefit payout from Long-Term Disability Insurance.



Employee Assistance Program (EAP)

Your well-being, productiveness, and happiness depend on balancing your life at home and your life at work.

It's difficult to be on task at work when you are worrying about problems at home. You can't devote sufficient time to yourself and your family if you are feeling overwhelmed by the demands of your job.

If you are enrolled in Eder Financial's Disability Insurance, you automatically receive Employee Assistance Program benefits.

Your benefit package includes a confidential Employee Assistance Program at no cost to you.

You have unlimited access (24/7) to consultants by telephone, as well as resources and online tools for help with short-term problems. When you call in, you will speak with Master's level counselors who are able to help with the following concerns:

- ✓ Locate child care and eldercare services
- ✓ Mental health services (3 visit limit)
- ✓ Financial planning
- ✓ Work conflicts
- ✓ Personal or work relationships, parenting, divorce, bereavement
- ✓ Referral to a local attorney
- ✓ And much more

You also have unlimited website access where you can find books, articles, and guides.

You can find services for eldercare, childcare, along with camps, schools, and more. You'll also get access to financial calculators.

You and your immediate family may contact the EAP for toll-free assistance at 855-775-4357. Be sure to provide your group name as Eder Financial.

You can also go to the EAP website at www.myassistanceprogram.com/rsli. Go to the Comprehensive Member Portal & App section to login or create a new account using the company code provided on the screen.

Notes

DID YOU KNOW?

Many people who qualify for EAP benefits never use them, even though benefits are FREE.

The EAP also provides you with:

- A Member Portal with Instant Access to Care
- An Online Financial Wellness Center
- Self-Care Assessments & Soft Skills Courses
- Access to 1,000+ Articles, Podcasts, Well-Being Materials, and More
- Exclusive Marketplace Discounts

Learn more today at rsli.mylifeexpert.com.



Eder Financial



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www.ederfinancial.org
Toll Free: 800-746-1505

Local: 847-695-0200
Fax: 847-742-6336
E-mail: insurance@eder.org

Need Help?

Please contact Eder Financial with any questions.

You can also contact individual insurance plans shown in the table below.

Thank you for being a valued customer!

	CARRIER	PHONE	WEBSITE
EDER ACCIDENT INSURANCE	Reliance Standard	Contact Eder Financial (800) 746-1505	www.ederfinancial.org
EDER DISABILITY INSURANCE	Reliance Standard	Contact Eder Financial (800) 746-1505	www.ederfinancial.org
EDER EMPLOYEE ASSISTANCE	Reliance Standard	(855) 775-4357	www.myassistanceprogram.com/rsl

Important Note:

The information in this benefits guide is a general outline of the benefits offered to the employees served by Eder Financial Insurance Services and its affiliate companies. The benefits program is effective Jan. 1, 2026 for eligible employees and their dependents. Specific details and plan limitations are provided in the Evidence of Coverage (EOC), which is based on the official Plan Documents that may include policies, contracts, and plan procedures. The EOC and Plan Documents contain all the specific provisions of the plans. In the event that the information in this benefits guide differs from the Plan Documents, the Plan Documents will prevail. This document also functions as a summary of material modifications to supplement the summary plan descriptions for Eder Medical Plan, effective Jan. 1, 2026. For members participating in the biometric screening component of WellNow Rewards, no personally identifiable results are shared with Eder Financial Medical Plan or its employees. Biometric screening information is intended for your personal use in consultation with your primary care physician.



Eder Financial offers Medicare Supplemental Insurance* to those who qualify for Medicare coverage.

- ✔ A Medicare Supplement is an insurance policy that typically pays for copayments, coinsurance, deductibles, and other costs after Medicare Parts A & B process their share of your medical bills.
- ✔ You may have also heard of Medigap insurance, which is another name for Medicare Supplement insurance.

Having additional healthcare coverage from a Medicare Supplement gives you peace of mind, knowing that your medical bills will be paid, especially when Medicare Parts A and B won't pay for all medical expenses. For example, this may happen when you need emergency care outside of the US, or when you exhaust your Medicare Part A hospital benefits.

Contact Eder Financial at insurance@eder.org
to learn more or to sign up.

** Eder Financial has partnered with United Amercan Insurance Company to offer Medicare supplement plans. United American was founded on 1947 and has been providing Medicare Supplement coverage since 1966, which is when Medicare started. United American has more than 167,000 covered individuals nationwide and insures more than 500 retiree groups, with an A+ rating, the highest rating from AM Best.*



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Benefits of Eder Financial's Medicare Supplement Plan:

- There are no health qualifications, and all pre-existing conditions are covered from the first day of your coverage.
- Keep your coverage if you relocate because your plan is valid in all 50 states and US possessions.
- Choose any Medicare participating doctor or hospital for your services.

HELP: If you are struggling to make your Medicare Supplement payments and are a current or former employee of a Church of the Brethren church, district, or camp, you may qualify for grants through the Church Workers' Assistance Plan. One type of grant could pay part, or all, of your Medicare Supplement premium.

Contact Diane Parrott at 847-622-3361 or CWGrants@eder.org to see if you qualify for assistance.



Allowed amount

The maximum amount a plan will pay for a service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

Annual limit

A cap on the benefits your insurance company will pay in a year while you’re enrolled in a particular insurance plan. These caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated costs for the rest of the year.

Benefits

The items or services covered under an insurance plan. Covered benefits and excluded services are defined in the insurance plan’s coverage documents.

Brand name (drugs)

A drug sold by a drug company under a specific name or trademark and that is protected by a patent. Brand name drugs may be available by prescription or over the counter.

Chronic disease management

An integrated care approach to managing illness, which includes screenings, check-ups, monitoring and coordinating treatment, and patient education. It can improve your quality of life while reducing your healthcare costs if you have a chronic disease by preventing or minimizing the effects of a disease.

Claim

A request for payment that you or your provider sends to your health insurance company after you receive care.

Coinsurance

The percentage of costs of a covered service you pay (20%, for example) after you’ve paid your deductible.

Copayment

A fixed amount (\$20, for example) you pay for a covered service after you’ve paid your deductible.

Covered health service

A service could be an office visit, test, prescription, or another medical treatment your health insurance covers. Before you seek care, check to make sure the service is covered.

Deductible

The amount you pay for covered services before your insurance plan starts to pay. With a \$2,000 deductible, for example, you pay the first \$2,000 of covered services yourself.

After you pay your deductible, you may pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.

Dependent

A child or other individual for whom a parent, relative, or other person may claim a personal exemption tax deduction.

Dependent coverage

Insurance coverage for family members of the policyholder, such as spouses, children, or partners.

Disability

A limit in a range of major life activities. This includes activities like seeing, hearing, walking, and tasks like thinking and working. Because different programs may have different disability standards, please check the program you’re interested in for its disability standards. The list of activities mentioned above isn’t exhaustive.

Drug list

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a formulary.

Emergency services

Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded services

Services that your insurance or plan doesn’t pay for or cover.



Family Medical Leave Act (FMLA)

The Family Medical Leave Act (FMLA) entitles eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

Fee for service

A method in which doctors and other providers are paid for each service performed. Examples of services include tests and office visits.

Formulary

A list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. Also called a drug list.

Generic drugs

A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs. The Food and Drug Administration (FDA) rates these drugs to be as safe and effective as brand-name drugs.

Group health plan

In general, a health plan offered by an employer or employee organization that provides health coverage to employees and their families.

Health coverage

Legal entitlement to payment or reimbursement for your healthcare costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, or the Children's Health Insurance Program (CHIP).

Health insurance

A contract that requires your health insurer to pay some or all of your healthcare costs in exchange for a premium.

High deductible health plan (HDHP)

A plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more healthcare costs yourself before the insurance company starts to pay its share (your deductible). A high deductible plan (HDHP) can be combined with a health savings account (HSA), allowing you to pay for certain medical expenses with money free from federal taxes.

In-network coinsurance

The percent (for example, 20%) you pay of the allowed amount for covered services to providers who contract with your insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

In-network copayment

A fixed amount (for example, \$15) you pay for covered services to providers who contract with your insurance or plan. In-network copayments usually are less than out-of-network copayments.

In-network provider

A doctor, hospital, or other provider in the plan's network. Network providers accept the plan's payment plus member cost-sharing as payment in full. You pay less when you use an in-network provider instead of an out-of-network provider. With the exception of care for emergent and urgent conditions, if the plan does not offer out-of-network coverage, you must see an in-network provider for all covered services.

Inpatient care

Healthcare that you get when you're admitted as an inpatient to a healthcare facility, like a hospital or skilled nursing facility.

Job-based health plan

Coverage that is offered to an employee (and often his or her family) by an employer.

Large group health plan

In general, a group health plan that covers employees of an employer that has 51 or more employees. In some states large groups are defined as 101 or more.

Lifetime limit

A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a \$1 million lifetime cap) or



limits on specific benefits (like a \$200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services.

Medically necessary

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

Mental Health Parity Act

Also called the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). A federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

Network

The facilities, providers and suppliers your insurer or plan has contracted with to provide services.

Network plan

A plan that contracts with doctors, hospitals, pharmacies, and other providers to provide members of the plan with services and supplies at a discounted price.

Out-of-network coinsurance

The percentage (for example, 40%) you pay of the allowed amount for covered services to providers who don't contract with your insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network copayment

A fixed amount (for example, \$30) you pay for covered services from providers who don't contract with your insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network provider

Provider who does not have a contract with your health insurer to provide services to you at a discount. You will generally pay more to see an out-of-network provider. If you have an EPO or HMO plan, you are not covered for out-of-network services (except for emergency and urgent care services).

Out-of-pocket costs

Your expenses that aren't reimbursed by insurance. Out-of-pocket costs include deductibles, coinsurance, and copayments for covered services plus all costs for services that aren't covered.

Out-of-pocket estimate

An estimate of the amount that you may have to pay on your own for services. The estimate is made before your plan has processed a claim for services.

Out-of-pocket maximum/limit

The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance for in-network services, your plan pays 100% of the costs of covered benefits.

The out-of-pocket limit doesn't include:

- Your monthly premiums
- Anything you spend for services your plan doesn't cover
- Out-of-network services
- Costs above the allowed amount for a service that a provider may charge

Physician services

Healthcare services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan allowance

The set amount your plan will pay for a health service, even if your provider bills for more.

Plan year

A 12-month period of benefits coverage under a plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer.

Policy year

A 12-month period of benefits coverage under an individual insurance plan. This 12-month period may not be the same as



the calendar year. To find out when your policy year begins, you can check your policy documents or contact your insurer.

Pre-existing condition

A health problem, like asthma, diabetes, or cancer, you had before the date that new health coverage starts. Insurance companies can't refuse to cover treatment for your pre-existing condition or charge you more.

Preauthorization

A decision by your insurer or plan that a service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your insurance or plan will cover the cost.

Preferred provider

A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Preferred Provider Organization (PPO)

A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

Premium

The amount you pay for your insurance every month. In addition to your premium, you usually have to pay other costs for your care, including a deductible, copayments, and coinsurance.

Prescription drug coverage

Health insurance or plan that helps pay for prescription drugs and medications.

Prescription drugs

Drugs and medications that, by law, require a prescription.

Skilled nursing facility care

Skilled nursing care and rehabilitation services provided on a continuous, daily basis in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

UCR (usual, customary, and reasonable)

The amount paid for a service in a geographic area based on what providers in the area usually charge for the same or similar service. The UCR amount sometimes is used to determine the allowed amount.

Urgent care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

Wellness program

A program intended to improve and promote health and fitness that's usually offered through the work place, although insurance plans can offer them directly to their enrollees. The program allows your employer or plan to offer you premium discounts, cash rewards, gym memberships, and other incentives to participate. Some examples of wellness programs include programs to help you stop smoking, diabetes management programs, weight loss programs, and preventative health screenings.

Workers' compensation

An insurance plan that employers are required to have to cover employees who get sick or injured on the job.



Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ **See page 24** for more information on these rights and how to exercise them

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

➤ **See page 25** for more information on these choices and how to exercise them

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the healthcare treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ **See pages 25 and 26** for more information on these uses and disclosures



Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.



Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the healthcare treatment you receive

- We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** (This does not apply to long term care plans.)

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.



How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
 - Preventing disease
 - Helping with product recalls
 - Reporting adverse reactions to medications
 - Reporting suspected abuse, neglect, or domestic violence
 - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
 - For workers' compensation claims
 - For law enforcement purposes or with a law enforcement official
 - With health oversight agencies for activities authorized by law
 - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Abide by laws to protect reproductive healthcare information

- We cannot share reproductive protected healthcare information about you when the purpose of the request is to*:
 - Investigate or impose liability for the mere act of seeking, obtaining, providing, or facilitating reproductive healthcare. The reproductive healthcare must also be:
 - Lawful in the state where care was provided.

AND/OR

- Protected, required, or authorized by Federal law, regardless of the state where care was provided.

AND/OR

- Provided by another person or entity (not by us).

*Per the 2024 Privacy Rule, effective June 25, 2024

We never market or sell personal information.



Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective date of notice: October 7, 2025



2026 Benefits Guide

Position Yourself Perfectly for Open Enrollment – Nov. 7 – Nov. 21, 2025



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