2024-2025 Benefits Booklet

Prepared by Endeavor Risk Advisors for
Panoramic Doors, LLC

PANORAMIC DOORS

Introduction

As an employee of Panoramic Doors, LLC enjoying your work and making valuable contributions to business are equally vital. The health, satisfaction and security of you and your family are important, not only to your well-being, but ultimately, in terms of achieving the goals of our organization.

For the 2024 - 2025 plan year, Panoramic Doors, LLC has worked hard to offer a competitive total rewards package that includes valuable and competitive benefits plans. These programs reflect our commitment to keeping our staff healthy and secure. We understand that your situation is unique, and Panoramic Doors, LLC is offering an overall benefits package that can be shaped and molded by you to fit your needs.

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

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

ENDEAVOR | RISK
ADVISORS

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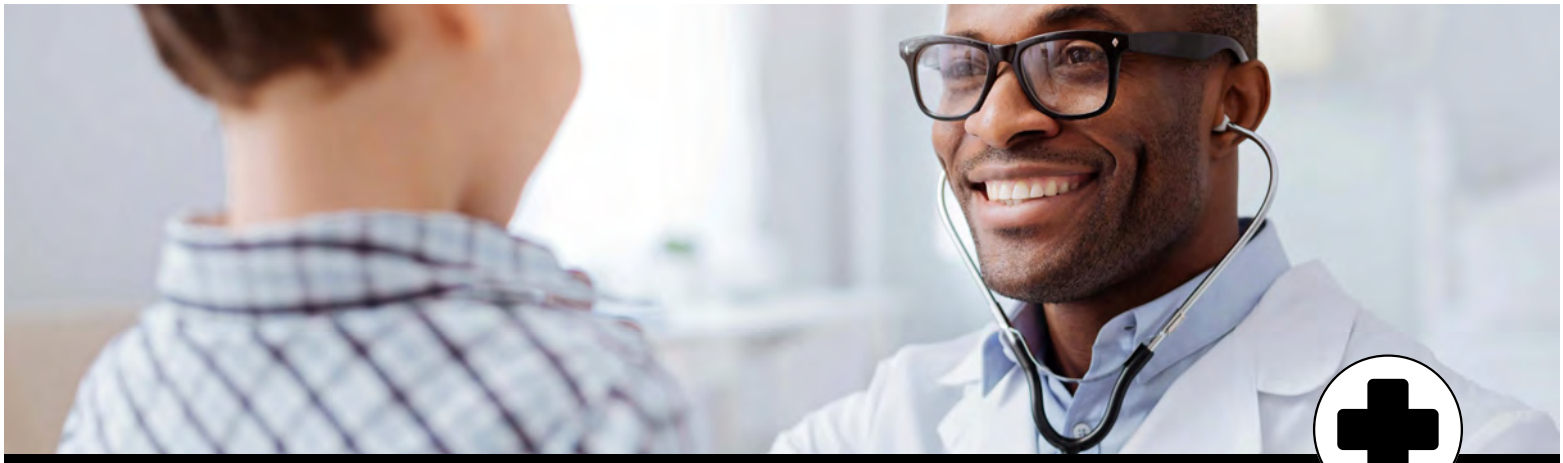
New York Life	800-225-5695	www.newyorklife.com
Freshbenies	855-647-6762	www.freshbenies.com

*Please note that all enrollment is completed online via PayChex. Your payroll deduction costs are listed online when enrolling.



Medical plan info

Annual Deductible

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

Out-of-Pocket Maximum

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

Copays and Coinsurance

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount, and are usually due at the time you receive care. Coinsurance is your share of the allowed amount charged for a service, and is generally billed to you after the health insurance company reconciles the bill with the provider.

Plan Types

- EPO/PPO – A network of doctors, hospitals and other health care providers
- HMO - A network that requires you to select a Primary Care Physician (PCP) who coordinates your health care.
- POS - Combines aspects of a PPO and HMO
- HDHP - A plan that has higher annual deductibles in exchange for lower premiums

Medical

Summary of Coverage

Cigna Plan 1 - OAP PPO Plan with Elective Abortions

	In Network	Out of Network
Individual Deductible	$3,000	$6,000
Family Deductible	$6,000	$12,000
Individual Max Out of Pocket	$6,000	$12,000
Family Max Out of Pocket	$12,000	$24,000
Co-Insurance	80%	50%
Primary Care Office Visit	$25 copay	50% after deductible
Specialist Office Visit	$50 copay	50% after deductible
Urgent Care	$75 copay	$75 copay
Emergency Room	$300 copay	$300 copay
Inpatient Services	20% after deductible	50% after deductible
Outpatient Services	20% after deductible	50% after deductible
Prescription Drugs	$15/$40/$75	50%
Specialty Drugs	20% after deductible	50% after deductible

Medical

Summary of Coverage

Cigna Plan 2 - OAP PPO Plan without Elective Abortions

	In Network	Out of Network
Individual Deductible	$3,000	$6,000
Family Deductible	$6,000	$12,000
Individual Max Out of Pocket	$6,000	$12,000
Family Max Out of Pocket	$12,000	$24,000
Co-Insurance	80%	50%
Primary Care Office Visit	$25 copay	50% after deductible
Specialist Office Visit	$50 copay	50% after deductible
Urgent Care	$75 copay	$75 copay
Emergency Room	$300 copay	$300 copay
Inpatient Services	20% after deductible	50% after deductible
Outpatient Services	20% after deductible	50% after deductible
Prescription Drugs	$15/$40/$75	50%
Specialty Drugs	20% after deductible	50% after deductible

Medical

Summary of Coverage

Cigna Plan 3 - HDHP HSA Plan with Elective Abortions

	In Network	Out of Network
Individual Deductible	$5,000	$10,000
Family Deductible	$10,000	$20,000
Individual Max Out of Pocket	$6,900	$20,000
Family Max Out of Pocket	$13,800	$40,000
Co-Insurance	80%	60%
Primary Care Office Visit	20% after deductible	40% after deductible
Specialist Office Visit	20% after deductible	40% after deductible
Urgent Care	20% after deductible	40% after deductible
Emergency Room	20% after deductible	40% after deductible
Inpatient Services	20% after deductible	40% after deductible
Outpatient Services	20% after deductible	40% after deductible
Prescription Drugs	10% after deductible	20% after deductible
Specialty Drugs	20% after deductible	40% after deductible

Medical

Summary of Coverage

Cigna Plan 4 - HDHP HSA Plan without Elective Abortions

	In Network	Out of Network
Individual Deductible	$5,000	$10,000
Family Deductible	$10,000	$20,000
Individual Max Out of Pocket	$6,900	$20,000
Family Max Out of Pocket	$13,800	$40,000
Co-Insurance	80%	60%
Primary Care Office Visit	20% after deductible	40% after deductible
Specialist Office Visit	20% after deductible	40% after deductible
Urgent Care	20% after deductible	40% after deductible
Emergency Room	20% after deductible	40% after deductible
Inpatient Services	20% after deductible	40% after deductible
Outpatient Services	20% after deductible	40% after deductible
Prescription Drugs	10% after deductible	20% after deductible
Specialty Drugs	20% after deductible	40% after deductible

Health Savings Account (HSA)

This is how an HSA works:

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

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

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

Why is it a good idea to have an HSA?

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

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

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

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

Refer to your HSA documentation for more information.

Preventative Care

Wellness and Health Management

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

Which preventative care services are covered?

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

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

Telemedicine

Telemedicine is the practice of communicating electronically with a physician, typically via telephone or video chat. The medium has risen in popularity over the past few years, but the coronavirus pandemic has proven just how useful it can be.

During the pandemic, telemedicine has seen a significant increase in utilization. As the pandemic has progressed, many providers and hospitals have encouraged patients to utilize telemedicine instead of coming to the office or the hospital for non-life-threatening care. Given its convenience and ease of use, it's likely that doctors will continue to recommend virtual visits instead of in-person visits when applicable.

How does telemedicine work?

Every provider will deliver telemedicine services a little bit differently. Generally speaking, though, your virtual visit will take place via phone, video call on a laptop, tablet or cellphone; or through an app. The provider will ask you the same questions you'd be asked at an in-person visit and may recommend treatment based on their findings.

What can telemedicine be used for?

Telemedicine, which is commonly referred to as virtual visits, can be used for:

- General, non-life-threatening doctor's visits or consultations
- Mental health consultations or therapy sessions
- Physical therapy sessions, in some cases
- Follow-up appointments

What can't telemedicine be used for?

- Life-threatening or emergency situations
- Situations in which diagnostic care (e.g. blood work, imaging or lab tests) are required
- Situations of severe illness or complex conditions

Is telemedicine free?

Some telemedicine services may be covered under our health plan. Be sure to check your plan's explanation of benefits to avoid any surprise costs.

Refer to your plan documentation for more information.

WHEN LEAVING THE OFFICE IS EASIER SAID THAN DONE.

Employees can get care whenever and wherever with minor medical and behavioral/mental health virtual care.

Your employees' lives are demanding. It's hard for them to find time to take care of themselves as it is, never mind when they're not feeling well. That's why health plans through Cigna include access to medical and behavioral/mental health virtual care.

Whether they've got meetings all day or they just don't have the time or energy to go anywhere but home after work, employees can:

- Access care from just about anywhere via video or phone.
- Get minor medical virtual care 24/7/365 – even on weekends and holidays.
- Schedule a behavioral/mental health virtual care appointment online in minutes.
- Access board-certified doctors and pediatricians as well as licensed counselors and psychiatrists.
- Have a prescription sent directly to a local pharmacy, if appropriate.

Convenient, not costly.

Medical virtual care for minor conditions costs less than ER or urgent care center visits, and maybe even less than an in-office primary care provider visit.

Together, all the way.®

Cigna®

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Minor medical virtual care

Board-certified doctors and pediatricians can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and flu
- Constipation
- Diarrhea
- Earaches
- Fever
- Headaches
- Infections
- Insect bites
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections

MDLIVE providers can also conduct virtual wellness screenings.

Behavioral/Mental health virtual care

Licensed counselors and psychiatrists can diagnose, treat and prescribe most medications for nonemergency behavioral conditions, such as:

- Addictions
- Bipolar disorders
- Child/Adolescent issues
- Depression
- Eating disorders
- Grief/Loss
- Life changes
- Men's issues
- Panic disorders
- Parenting issues
- Postpartum depression
- Relationship and marriage issues
- Stress
- Trauma/PTSD
- Women's issues

Virtual care options

Cigna partners with MDLIVE® for minor medical and behavioral/mental health virtual care.* This can be accessed via **myCigna.com**. Aditionally, Cigna's in-network medical and behavioral providers also provide access to virtual medical and behavioral care, including virtual counseling.

Connect with virtual care your way.

- Contact your in-network provider or counselor
- Talk to an MDLIVE medical provider on demand on **myCigna.com**
- Schedule an appointment with an MDLIVE provider or licensed therapist on **myCigna.com**
- Call MDLIVE 24/7 at 888.726.3171

Encourage your employees to access virtual care whenever and wherever they need it.

Cigna®

Virtual medical care is available from MDLIVE. Behavioral/mental health virtual care is available from MDLIVE.

*Cigna provides access to virtual care through national telehealth providers as part of your plan. Providers are solely responsible for any treatment provided to their patients. Video chat may not be available in all areas or with all providers. This service is separate from your health plan's network and may not be available in all areas or under all plan types. A primary care provider referral is not required for this service.

In general, to be covered by your plan, services must be medically necessary and used for the diagnosis or treatment of a covered condition. Not all prescription drugs are covered. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. See your plan materials for costs and details of coverage, including other telehealth/telemedicine benefits that may be available under your specific health plan.

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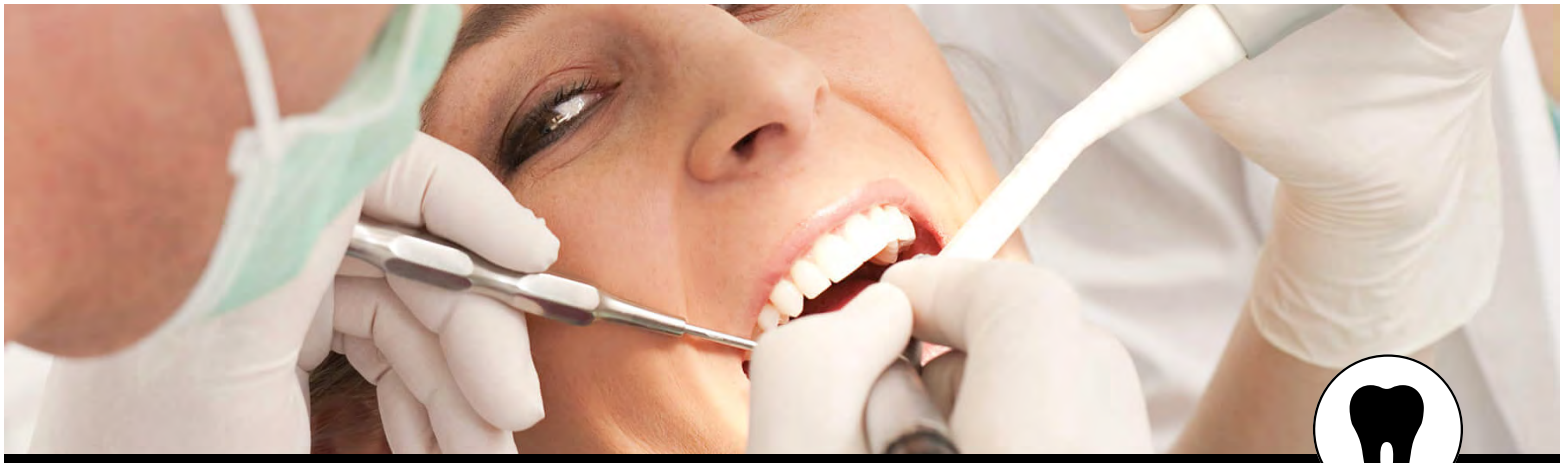


Dental plan info

Summary of coverage

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

Preventative care

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

Diagnostic care

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

Great for families

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

Specialized treatments

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

Routine care

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

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

Cigna Healthcare Financial Exhibit for:

Panoramic Doors, LLC - Texas

Effective Date: October 01, 2024

This is a summary of benefits for your dental plan.
All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Plan Design	Cigna DPPO Advantage Network**	Out-of-Network
Calendar Year Maximum		
(Class I, II, III Expenses)	$1500, Class I Applies	$1500, Class I Applies
Calendar Year Deductible		
Per Individual	$50	$50
Per Family	$150	$150
Class I Expenses - Preventive & Diagnostic Care		
Oral Exams Cleanings Routine X-rays Fluoride Application	100%, No Deductible	100%, No Deductible
Class II Expenses - Basic Restorative Care		
Sealants Space Maintainers (limited to non-orthodontic treatment) Non-Routine X-rays Emergency Care to Relieve Pain Fillings Oral Surgery - Simple Extractions Brush Biopsy	80%, After Deductible	80%, After Deductible
Class III Expenses - Major Restorative Care		
Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Minor Periodontics Major Periodontics Root Canal Therapy / Endodontics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Crowns/Inlays/Onlays Stainless Steel/Resin Crowns Dentures Bridges	50%, After Deductible	50%, After Deductible
Class IV Expenses - Orthodontia		
	Not Covered	Not Covered
Dental Plan Reimbursement Levels	Based on Contracted Fees	Based on Maximum Allowable Charge Standard schedule (for location of service rendered).
Additional Member Responsibility in excess of Coinsurance	None	Yes, the difference between Billed Charges and the plan reimbursement
Student/Dependent Age	26/26	

P0002 (NS001) Network. Prepared by Underwriting.

Acct #: 00630490

Cigna Healthcare Financial Exhibit for:

Panoramic Doors, LLC - Texas

Effective Date: October 01, 2024

Cigna Dental Choice / Indemnity Exclusions and Limitations:

Procedure	Exclusions & Limitations
Exams	Two per calendar year
Prophylaxis (cleanings)	Two per calendar year
Fluoride	1 per calendar year for people under 19
X-Rays (routine)	Bitewings: 2 per calendar year
X-Rays (non-routine)	Full mouth: 1 every 3 calendar years. Panorex: 1 every 3 calendar years
Model	Payable only when in conjunction with Ortho workup
Minor Perio (non-surgical)	Various limitations depending on the service
Perio Surgery	Various limitations depending on the service
Crowns and Inlays	Replacement every 5 years
Prosthesis over Implants	1 per 5 years if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Bridges	Replacement every 5 years
Dentures and Partials	Replacement every 5 years
Relines, Rebases	Covered if more than 6 months after installation
Adjustments	Covered if more than 6 months after installation
Repairs - Bridges	Reviewed if more than once
Repairs - Dentures	Reviewed if more than once
Sealants	Limited to posterior tooth. One treatment per tooth every three years up to age 14
Space Maintainers	Limited to non-Orthodontic treatment. No frequency limit for participants under age 19.
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as Covered Expenses.
Missing Tooth Provision	The amount payable is 50% of the amount otherwise payable until insured for 12 months; thereafter, considered a Class III expense
Late Entrant Limit	50% coverage on Class III and IV (if applicable), for 12 months
Pre-Treatment Review	Available on a voluntary basis when extensive work in excess of $200 is proposed

Benefit Exclusions:

* Services performed primarily for cosmetic reasons
* Replacement of a lost or stolen appliance
* Replacement of a bridge or denture within five years following the date of its original installation
* Replacement of a bridge or denture which can be made useable according to accepted dental standards
* Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
* Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
* Bite registrations; precision or semi-precision attachments; splinting; Surgical implant of any type
* Instruction for plaque control, oral hygiene and diet
* Dental services that do not meet common dental standards
* Services that are deemed to be medical services
* Services and supplies received from a hospital
* Charges which the person is not legally required to pay
* Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service
* Experimental or investigational procedures and treatments
* Any injury resulting from, or in the course of, any employment for wage or profit
* Any sickness covered under any workers' compensation or similar law
* Charges in excess of the reasonable and customary allowances
* To the extent that payment is unlawful where the person resides when the expenses are incurred;
* Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
* For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
* To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
* To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.
* In addition, these benefits will be reduced so that the total payment will not be more than 100% of the charge made for the Dental Service if benefits are provided for that service under this plan and any medical expense plan or prepaid treatment program sponsored or made available by your Employer.

***** In Texas, the insured dental product offered by CGLIC and CHLIC is referred to as the Cigna Dental Choice Plan, and this plan utilizes the national Cigna Dental PPO network.***

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

Benefits are insured and/or administered by Cigna HealthCare.

Did you know that all of Cigna's dental plans include the Cigna Dental Oral Health Integration Program? This program was designed to address research that supports the association of oral health to overall health and provides 100% reimbursement of copays or coinsurance for customers with qualifying medical conditions for program eligible procedures. Additionally, registered program members can receive discounts on prescription dental products targeted at high risk patients as well as articles on behavioral conditions that impact oral health.

Prepared by Underwriting.

Vision plan info

Summary of coverage

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

Preventative care

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

Plans

Vision plans typically cover things like eyeglass frames, lenses, contacts and annual eye exams. In most cases, plans have a set dollar amount that they will pay for certain items. For instance, a plan may pay up to $130 for frames, and anything over that amount is covered by you. Although, your plan specifics may vary.

Coverage

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

Diagnostic care

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

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

Summary of Benefits Cigna Health and Life Insurance Company

Cigna Vision
Panoramic Doors, LLC
C1 - Standard PPO Comprehensive Plan

Welcome to Cigna Vision Schedule of Vision Coverage			
Coverage	**In-Network Benefit*** **	**Out-of-Network Benefit**	**Frequency Period ****
Exam Copay	$10	N/A	12 months
Exam Allowance (once per frequency period)	Covered 100% after Copay	Up to $45	12 months
Materials Copay	$20	N/A	12 months
Eyeglass Lenses Allowances: (one pair per frequency period) Single Vision Lined Bifocal Lined Trifocal Lenticular	 Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay Covered 100% after Copay	 Up to $32 Up to $55 Up to $65 Up to $80	 12 months 12 months 12 months 12 months
Contact Lenses Allowances: (one pair or single purchase per frequency period) Elective Therapeutic	 Up to $130 Covered 100%	 Up to $105 Up to $210	 12 months 12 months
Frame Retail Allowance (one per frequency period)	Up to $130	Up to $71	24 months
** Your Frequency Period begins on January 1 (Calendar year basis)			

Definitions:
Copay: the amount you pay towards your exam and/or materials, lenses and/or frames. (Note: copays do not apply to contact lenses).
Coinsurance: the percentage of charges Cigna will pay. Customer is financially responsible for the balance.
Allowance: the maximum amount Cigna will pay. Customer is financially responsible for any amount over the allowance.
Materials: eyeglass lenses, frames, and/or contact lenses.

- To receive in-network benefits, you cannot use this coverage with any other discounts, promotions, or prior orders.
- If you use other discounts and/or promotions instead of this vision coverage, or go to an out-of-network eye care professional, you may file an out-of-network claim to be reimbursed for allowable expenses.

In-Network Coverage Includes***:
- One vision and eye health evaluation including but not limited to eye health examination, dilation, refraction, and prescription for glasses;
- One pair of standard prescription plastic or glass lenses, all ranges of prescriptions (powers and prisms)
  - Polycarbonate lenses for children under 19 years of age
  - Oversize lenses
  - Rose #1 and #2 solid tints
  - Minimum 20% savings* on all additional lens enhancements you choose for your lenses, including but not limited to: scratch/ultraviolet/anti-reflective coatings; polycarbonate (adults); all tints/photochromic (glass or plastic); and lens styles.
  - Progressive lenses covered up to bifocal lens amount with 20% savings on the difference;

- One frame for prescription lenses – frame of choice covered up to retail plan allowance, plus a 20% savings on amount that exceeds frame allowance;
- One pair of contact lenses or a single purchase of a supply of contact lenses – in lieu of lenses and frame benefit, (may not receive contact lenses and frames in same benefit year). Allowance applied towards cost of supplemental contact lens professional services (including the fitting and evaluation) and contact lens materials

* Provider participation is 100% voluntary; please check with your Eye Care Professional for any offered discounts.
*** Coverage may vary at participating discount retail and membership club optical locations, please contact Customer Service for specific coverage information.

Coverage for **Therapeutic** contact lenses will be provided when visual acuity cannot be corrected to 20/70 in the better eye with eyeglasses and the fitting of the contact lenses would obtain this level of visual acuity; and in certain cases of anisometropia, keratoconus, or aphakis; as determined and documented by your Vision eye care professional. Contact lenses fitted for other therapeutic purposes or the narrowing of visual fields due to high minus or plus correction will be covered in accordance with the Elective contact lens coverage shown on the Schedule of Benefits.

Healthy Rewards® - Vision Network Savings Program:

- When you see a Cigna Vision Network Eye Care Professional*, you can save 20% (or more) on additional frames and/or lenses, including lens options, with a valid prescription. This savings does not apply to contact lens materials. See your Cigna Vision Network Eye Care Professional for details.

What's Not Covered:

- Orthoptic or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Any injury or illness when paid or payable by Workers' Compensation or similar law, or which is work-related
- Charges in excess of the usual and customary charge for the Service or Materials
- Charges incurred after the policy ends or the insured's coverage under the policy ends, except as stated in the policy
- Experimental or non-conventional treatment or device
- Magnification or low vision aids not shown as covered in the Schedule of Vision Coverage
- Any non-prescription (minimum Rx required) eyeglasses, includes frame, lenses, or contact lenses
- Spectacle lens treatments, "add-ons", or lens coatings not shown as covered in the Schedule of Vision Coverage
- Prescription sunglasses
- Two pair of glasses, in lieu of bifocals or trifocals
- Safety glasses or lenses required for employment not shown as covered in the Schedule of Vision Coverage
- VDT (video display terminal)/computer eyeglass benefit
- Claims submitted and received in excess of twelve (12) months from the original Date of Service

How to use your Cigna Vision Benefits

(Please be aware that the Cigna Vision network is different from the networks supporting our health/medical plans).

1. Finding a doctor
There are three ways to find a quality eye doctor in your area:

1. Log into myCigna.com,"Coverage", select Vision page. Click on Visit Cigna Vision. Then select "Find a Cigna Vision Network Eye Care Professional" to search the Cigna Vision Directory.
2. Don't have access to myCigna.com? Go to Cigna.com, top of the page select "Find A Doctor, Dentist or Facility", click Cigna Vision Directory, under Additional Directories.
3. Prefer the phone? Call the toll-free number found on your Cigna insurance card and talk with a Cigna Vision customer service representative.

2. Schedule an appointment
Identify yourself as a Cigna Vision customer when scheduling an appointment. Present your Cigna or Cigna Vision ID card at the time of your appointment, which will quickly assist the doctor's office with accessing your plan details and verifying your eligibility.

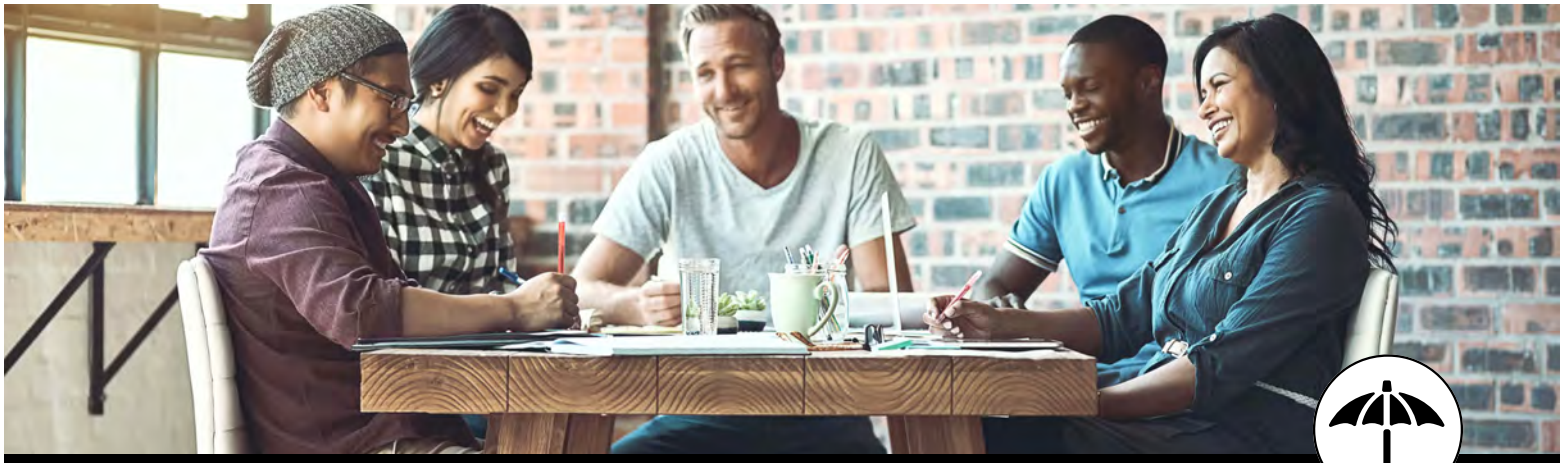
3. Out-of-network plan reimbursement

How to use your Cigna Vision Benefits

Send a completed Cigna Vision claim form and itemized receipt to: Cigna Vision, Claims Department: PO Box 385018, Birmingham, AL 35238-5018.

To get a Cigna Vision claim form:
• Go to **Cigna.com** and go to Forms, Vision Forms
• Go to **myCigna.com** and go to your vision coverage page

Cigna Vision will pay for covered expenses within ten business days of receiving the completed claim form and itemized receipt.



Group Life Insurance

Summary of Coverage

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

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

Life insurance isn't a fun thing to think about, but, if you have people who depend on you for financial support, then life insurance is really about protecting them in case something happens to you—your designated beneficiary would collect a financial benefit upon your death.

Group life insurance coverage is a employer-sponsored safety net in case the worst happens, with no out-of-pocket costs to you. If you believe you need additional coverage, you may wish to enroll in voluntary life insurance as well.

Voluntary Life Insurance

Summary of Coverage

Plan Features	Basic Life - Voluntary
Employee guarantee issue amount	The lesser of 5 x annual earnings or $100,000
Minimum benefit amount	$10,000
Maximum benefit amount	The lesser of 5 x annual earnings or $500,000
AD&D benefit	1 x Life Insurance amount
Spouse guarantee issue amount	$25,000
Dependent guarantee issue amount	$10,000
The following shows how much benefits are reduced at certain ages.	
Age band	**Benefit reduction**
Age 65 Age 70	65% of coverage 50% of coverage

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

Voluntary life insurance is similar to group life insurance, except it is paid for by you. It can provide additional financial security to you family in case the worst happens.

With voluntary life insurance, you pay a monthly premium and then your beneficiaries receive a guaranteed amount in the event of your death. Plans are typically flexible and allow you to set your contribution and payment amounts, allowing you more control.

While this type of insurance isn't fun to think about, it can be a vital lifeline for your family.

Disability Insurance Short-term

Summary of Coverage

Plan Features	Short Term Disability
Employee benefit amount	66.67% of weekly earnings to a max of $2,500
Minimum Hours Requirement	30 hours per week
Elimination period (Accident)	7 days
Elimination period (Sickness)	7 days
Benefit duration	25 weeks

Group Short-Term disability is 100% covered by the employer.

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

Short-term disability (STD) coverage begins within one to 15 days of the event causing your disability. The coverage allows you to continue to receive pay at a fixed weekly amount or a set percentage of your income.

STD typically lasts for about 10 to 26 weeks, although this varies by policy.

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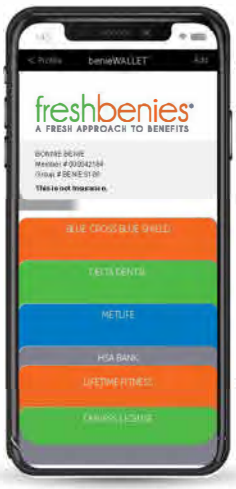

Telehealth

Your 24/7 Dr. BFF. It's like having a best friend who's a family doctor! Up to 70% of medical issues can be solved by phone. Reach out 24/7 for $0 visit fee with a U.S. primary care doctor and get a prescription written, if medically necessary[†].

Prescription Savings

Get your drug on (sale)! Fewer medications are covered under today's medical plans. Use our pricing tool to save an average 79% on generic and 34% on brand name[††] prescriptions at over 60,000 pharmacies nationwide.

Dental Savings

Smile at the savings. Save an average 20-40%[†††] on dental services from cleanings, whitening and root canals to braces and more at thousands of available dental practice locations nationwide.

ACTIVATE your membership at freshbenies.com where you can chat with AI Assistant Bonnie – she makes it a snap

[†]Initial Telehealth and Behavioral Telehealth visits in DE and AR must be via video. Phone or video available for subsequent visits. In ID, visits are video only. [††]Average savings based on usage data compared to cash prices; average savings for generics are 79%, and 34% for select brand medications; restrictions apply. [†††]Actual costs and savings vary by provider, service and geographical area.

Disclosures: **This plan is NOT insurance.** The plan is not insurance coverage and does not meet the minimum creditable coverage requirements under the Affordable Care Act or Massachusetts M.G.L. c. 111M and 956 CMR 5.00. **It contains a 30 day cancellation period**, provides discounts only at the offices of contracted health care providers, and each member is obligated to pay the discounted medical charges in full at the point of service. The range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider and medical or ancillary service received. Member shall receive a reimbursement of all periodic membership fees if membership is cancelled within the first 30 days after the effective date. Learn more at freshbenies.com. Discount Plan Organization: New Benefits, Ltd., Attn: Compliance Department, PO Box 803475, Dallas, TX 75380, 855-647-6762. Some state restrictions may apply.

freshbenies®
A FRESH APPROACH TO BENEFITS

Behavioral Telehealth: Even more convenient access to experts!

In addition to your freshbenies Telehealth service with $0 primary care visits, your membership includes convenient, discreet access to therapists and psychiatrists - also at $0 visits fees!

Here's how it works:

- Log into your freshbenies app or portal to schedule a Behavioral Health visit online or call the number provided
- Follow the prompts to choose the type of specialist you prefer
- Complete a short intake questionnaire
- Make selections based on provider profiles and your preferences
- Get temporary support or establish an ongoing relationship
- Only psychiatrists can prescribe medication, if they deem necessary

Your Behavioral Telehealth service can help with...

Anxiety **Depression** Family Issues **Stress** PTSD
Panic Disorder **Grief** Marriage Issues AND MORE!

Q&A About Using Your Behavioral Telehealth Service by Recuro

Q: What type of Behavioral Health specialists are available?

Answer: Your options include psychiatrists, psychologists, counselors, clinical social workers, and therapists.

Q: How much does a visit cost?

Answer: Your visits are free for both therapists and psychiatrists - including the initial intake visit.

Q: Do I have to schedule an appointment or can I just call and get the next available time?

Answer: All Behavioral Telehealth visits are scheduled for a specific date and time which you select when initiating a visit.

Q: Can I select my doctor based on preferences such as specialty, gender, language?

Answer: Specialist profiles display information about each Recuro professional, including gender, language and specialty. This information will display when making your specialist selection.

Q: How long is the typical Behavioral Telehealth visit?

Answer: Behavioral Telehealth visits average 45 minutes. Psychiatry visits vary in length based on the patient need.

Q: Is this service available to children under the age of 18?

Answer: Yes! Therapy and psychology visits are available for children 14 and up.

Q: Are there Behavioral Telehealth issues not treated by Recuro?

Answer: There are some medications not provided by Recuro psychiatrists. In some instances, the psychiatrist may determine that a different or higher level of medication is appropriate and this may require an in-person visit referral.

Q: How secure is the communication line and who retains my medical records?

Answer: Confidentiality is taken very seriously. Recuro follows strict protocols to ensure all medical records are kept in a secure environment and are not shared with anyone outside of your specific request or as required by law.

Q: What can be shared with PCPs?

Answer: Recuro doesn't include your Behavioral Telehealth visit information in medical records sent to your primary care provider.

Q: Will I be able to schedule recurring appointments? If so, how far in advance can I schedule?

Answer: At the end of the visit, the provider will schedule a follow-up if they think it's necessary. At this time, only the next visit can be scheduled.

Q: Can I talk to the same specialist each time I request a visit?

Answer: Yes. You can choose to see the same specialist or a different one. It's your choice.

Q: Is there bilingual assistance provided for my visit?

Answer: Provider's languages are displayed on the profile screen when making your selection. If a bilingual specialist isn't available, an interpreter will be provided.

Q: Are there limits to how many visits can be scheduled within a month?

Answer: Not at this time. However, regular evaluation is done to ensure compliance with patient safety standards.

Need help?
Call freshbenies Member Services at 1-855-647-6762, login at www.freshbenies.com or download the freshbenies app!

Panoramic Doors, LLC

2024 - 2025 Employee Benefits Guide

Prepared by Endeavor Risk Advisors for Panoramic Doors, LLC