United Laboratories, Inc.'s Benefits At A Glance

August 1, 2024 — July 31, 2025

United Laboratories, Inc. provides their employees and eligible dependents with a comprehensive benefits package. All full-time employees regularly scheduled to work at least 30 hours per week are eligible to participate in our benefits program.

Coverage for new employees begins on the 1st of the month following 30 days of employment for all benefits, except Short-Term Disability. Short-Term Disability Coverage starts on the 1st of the month following 12 months of continuous full-time active work. The following pages provide a brief overview of available benefits. In addition to covering yourself, you may also choose to cover eligible dependents including your spouse or civil union partner and dependent children under the age of 26 regardless of marital status for medical, dental, vision and voluntary life coverage.

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

BlueCross BlueShield of Illinois

Medical

United Laboratories, Inc. offers you a choice between 5 plans: HMO plan, PPO plan, Blue Choice PPO plan, 80% HSA plan and 100% HSA plan. Medical plans are administered by BlueCross BlueShield of Illinois (BCBSIL). All plans include prescription drug coverage.

	Blue Advantage HMO Plan[A]	PPO Plan	
Medical	(Employees residing in Chicago metro area only)		
Benefit Provision	In-Network Only	In-Network	Out-of-Network[B]
Calendar Year Deductible			
Deductible-Single / Family	$1,000 / $3,000	$2,500 / $7,500	$5,000 / $15,000
Medical Out-of-Pocket Maximum			
Out-of-Pocket Maximum- Single / Family	*Includes deductible, coinsurance for essential health benefits and all applicable copays* $3,000 / $9,000	$5,500 / $10,200	$11,000 / $20,400
Coinsurance			
Payment After Deductible	Plan pays 80%	Plan pays 80%	Plan pays 60%
Office Visits			
Preventive Care	No charge	No charge	60% after deductible
Virtual Visit (MDLive)	Not available	$30 copay	Not available
Primary Care	$50 copay	$30 copay	60% after deductible
Specialist	$70 copay	$50 copay	60% after deductible
Other Services			
Lab & X-Ray	Plan pays 100%	Complex imaging: 80% after deductible All Other: $30 PCP or $50 Specialist copay	60% after deductible
Inpatient Services	$200 copay per visit, then plan pay 80% after deductible	80% after deductible	$300 admission copay, then plan pays 60% after deductible
Outpatient Surgery	$150 copay per visit, then plan pay 80% after deductible	80% after deductible	60% after deductible
Outpatient Rehabilitation Services	$50 copay (60 visits/calendar year combined all therapies)	80% after deductible (unlimited visits)	60% after deductible (unlimited visits)
Urgent Care	$50 PCP or $70 Specialist copay (must be affiliated with medical group)	80% after deductible	60% after deductible
Emergency Room	$250 copy per visit then plan pay 80% after deductible (copay waived if admitted on an inpatient basis)	$150 copay, then 100% (copay waived if admitted on an inpatient basis)	

[A] Requires selection of a Primary Care Physician and Medical Group.
[B] Non-network providers may balance bill you for medical charges that exceed BlueCross BlueShield of Illinois in-network discounted rates.

Pharmacy (Prime Therapeutics)[A]			
All CVS pharmacies (including those located in Target stores) are excluded from the BCBSIL PPO pharmacy network. CVS pharmacies remain in the HMO pharmacy network.			
Pharmacy Out-of-Pocket Maximum			
Out-of-Pocket Maximum – Single/Family	Included in the Medical Out-of-Pocket Maximum	$1,000 / $3,000	Not Applicable
Retail	*(30-day supply)*	*(30-day supply)*	*(30-day supply)*
		Preferred Network/Non-Preferred Network[B]	*Covered at 75% of contracted pharmacy amount*
Preferred Generic	Plan pays 100%	$10 copay/$15 copay	$15 copay
Non-Preferred Generic	$10 copay	$10 copay/$15 copay	$15 copay
Preferred Brand	$50 copay	$40 copay/$50 copay	$50 copay
Non-Preferred Brand	$100 copay	$60 copay/$70 copay	$70 copay
Select Oral Contraceptives	$0 copay	$0 copay	$0 copay
Mail Order	(90-day supply)	(90-day supply)	(Not applicable)
Preferred Generic	Plan pays 100%	$20 copay	
Non-Preferred Generic	$30 copay	$20 copay	
Preferred Brand	$150 copay	$80 copay	
Non-Preferred Brand	$300 copay	$120 copay	Not applicable
Preferred Specialty (30-day supply)	$150 copay	Covered at applicable copay	
Non-Preferred Specialty (30-day supply)	$250 copay	Covered at applicable copay	
Select Oral Contraceptives	$0 copay	$0 copay	

[A] If an insured selects a brand name drug when there is a generic equivalent available, the member will pay the applicable copay plus the cost difference between the selected drug and the generic equivalent.
[B] There are three levels of benefits. 1. Preferred Network Pharmacies – Walgreens, Walmart, Albertsons/Osco and Access Health/Independents 2. Non-Preferred Network Pharmacies – All other in-network pharmacies 3. Non-Network – Examples include CVS/Target and some independent pharmacies.

Blue Advantage HMO Plan An HMO requires that you select a medical group and primary care physician (PCP) from the BCBSIL directory. Covered females may select a Woman's Principal Health Care Provider (WPHCP) in addition to her PCP. All care must be provided or coordinated by your PCP, WPHCP or medical group.

PPO Plan A Preferred Provider Organization (PPO) offers an extensive national network of physicians and hospitals that have agreed to provide services at discounted rates. You may visit any doctor in any practice or specialty without a referral, but you are covered at a higher level if you receive care form a provider in the BCBSIL network.

HMO Customer Service: (800) 892-2803 — www.bcbsil.com
PPO Customer Service: (800) 541-2768 — www.bcbsil.com/member
Prime Therapeutics: (800) 423-1973 — www.myprime.com

Medical Payroll Deductions (Weekly)

	HMO Plan	PPO Plan
Employee	$67.63	$185.18
Employee + Spouse	$152.30	$380.24
Employee + Child(ren)	$111.85	$279.26
Family	$189.98	$474.32

United Laboratories, Inc. offers you a choice between 5 plans: HMO plan, PPO plan, Blue Choice PPO plan, 80% HSA plan and 100% HSA plan. Medical plans are administered by BlueCross BlueShield of Illinois (BCBSIL). All plans include prescription drug coverage.

	Blue Choice PPO Plan[A]		
Medical			
Benefit Provision	Blue Choice Network	PPO Network	Out-of-Network[B]
Calendar Year Deductible			
Deductible-Single / Family	$500 / $1,500	$1,500 / $4,500	$3,000 / $9,000
Medical Out-of-Pocket Maximum			
Out-of-Pocket Maximum- Single / Family	*Includes deductible, coinsurance for essential health benefits and all applicable copays* $4,000 / $10,200	$5,600 / $10,200	$12,000 / $26,400
Coinsurance			
Payment After Deductible	Plan pays 90%	Plan pays 70%	Plan pays 50%
Office Visits			
Preventive Care	No charge	No charge	50% after deductible
Virtual Visit (MDLive)	$20 copay	$20 copay	Not available
Primary Care	$20 copay	$50 copay	50% after deductible
Specialist	$40 copay	$100 copay	50% after deductible
Other Services			
Lab & X-Ray	Complex imaging: 90% after deductible All Other: $20 PCP or $40 Specialist copay	Complex imaging: 70% after deductible All Other: $50 PCP or $100 Specialist copay	50% after deductible
Inpatient Services	$250 copay, then 90% after deductible	$500 copay, then 70% after deductible	$600 copay, then 50% after deductible
Outpatient Surgery	$200 copay, then 90% after deductible	$400 copay, then 70% after deductible	$500 copay, then 50% after deductible
Outpatient Rehabilitation Services	90% after deductible (unlimited visits)	70% after deductible (unlimited visits)	50% after deductible (unlimited visits)
Emergency Treatment			
Urgent Care	$75 copay		
Emergency Room	$400 copay, then 90% after deductible (copay waived if admitted on an inpatient basis)		

[A] Employees outside of Illinois use the PPO Network and receive the Blue Choice benefit level

[B] Non-network providers may balance bill you for medical charges that exceed BlueCross BlueShield of Illinois in-network discounted rates.

Pharmacy (Prime Therapeutics)[A]		
All CVS pharmacies (including those located in Target stores) are excluded from the BCBSIL PPO pharmacy network.		
Pharmacy Out-of-Pocket Maximum		
Out-of-Pocket Maximum – Single/Family	$1,000 / $3,000	Not Applicable
Retail[B]	*(30-day supply)*	*(30-day supply)*
	Preferred/Non-Preferred[C]	*Covered at 75% of contracted pharmacy amount*
Preferred Generic	$0 copay/$5 copay	$5 copay
Non-Preferred Generic	$10 copay/$15 copay	$15 copay
Preferred Brand	$35 copay/$45 copay	$45 copay
Non-Preferred Brand	$75 copay/$85 copay	$85 copay
Select Oral Contraceptives	$0 copay	$0 copay
Mail Order[B]	(90-day supply)	(Not applicable)
Preferred Generic	$0 copay	
Non-Preferred Generic	$20 copay	
Preferred Brand	$70 copay	
Non-Preferred Brand	$150 copay	
Preferred Specialty (30-day supply)	$150 copay	Not applicable
Non-Preferred Specialty (30-day supply)	$150 copay	
Select Oral Contraceptives	$0 copay	

[A] If an insured selects a brand name drug when there is a generic equivalent available, the member will pay the applicable copay plus the cost difference between the selected drug and the generic equivalent.

[B] IRS allowable preventive drugs are covered prior to the deductible at the appropriate copay (i.e. statins, high blood pressure, insulin).

[C] There are three levels of benefits. 1. Preferred Network Pharmacies – Walgreens, Walmart, Albertsons/Osco and Access Health/Independents 2. Non-Preferred Network Pharmacies – All other in-network pharmacies 3. Non-Network – Examples include CVS/Target and some independent pharmacies.

Blue Choice PPO Plan A Preferred Provider Organization (PPO) offers an extensive national network of physicians and hospitals that have agreed to provide services at discounted rates. You may visit any doctor in any practice or specialty without a referral, but you are covered at a higher level if you receive care form a provider in the BCBSIL network.

PPO Customer Service: (800) 541-2768
Prime Therapeutics: (800) 423-1973

www.bcbsil.com
www.bcbsil.com/member
www.myprime.com

Medical Payroll Deductions (Weekly)

	Blue Choice PPO Plan
Employee	$81.60
Employee + Spouse	$167.56
Employee + Child(ren)	$123.06
Family	$209.02

BlueCross BlueShield of Illinois

Medical

United Laboratories, Inc. offers you a choice between 5 plans: HMO plan, PPO plan, Blue Choice PPO plan, 80% HSA plan and 100% HSA plan. Medical plans are administered by BlueCross BlueShield of Illinois (BCBSIL). All plans include prescription drug coverage.

	100% HSA Plan		80% HSA Plan	
Medical				
Benefit Provision	In-Network	Out-of-Network[B]	In-Network	Out-of-Network[B]
HSA Employer Contribution	United Laboratories will deposit on a quarterly basis Single: $425 ($1,700 per year)/Family: $550 ($2,200 per year)		United Laboratories will deposit on a quarterly basis Single: $425 ($1,700 per year)/Family: $550 ($2,200 per year)	
Calendar Year Deductible				
Deductible-Single / Family	$7,500 / $15,000	$15,000 / $30,000	$3,200 / $6,400	$6,400 / $12,800
Medical Out-of-Pocket Maximum				
Out-of-Pocket Maximum- Single / Family	*Includes deductible, coinsurance for essential health benefits and all applicable copays* $7,500 / $15,000	$15,000 / $30,000	$6,200 / $12,400	$18,600 / $37,200
Coinsurance				
Payment After Deductible	Plan pays 100%	Plan pays 100%	Plan pays 80%	Plan pays 60%
Office Visits				
Preventive Care	No charge	100% after deductible	No charge	60% after deductible
Virtual Visit (MDLive)	100% after deductible	Not available	80% after deductible	Not available
Primary Care	100% after deductible	100% after deductible	80% after deductible	60% after deductible
Specialist	100% after deductible	100% after deductible	80% after deductible	60% after deductible
Other Services				
Lab & X-Ray	100% after deductible	100% after deductible	80% after deductible	60% after deductible
Inpatient Services	100% after deductible	100% after deductible	80% after deductible	$300 copay, then 60% after deductible
Outpatient Surgery	100% after deductible	100% after deductible	80% after deductible	60% after deductible
Outpatient Rehabilitation Services	100% after deductible (unlimited visits)	100% after deductible (unlimited visits)	80% after deductible (unlimited visits)	60% after deductible (unlimited visits)
Emergency Treatment				
Urgent Care	100% after deductible	100% after deductible	80% after deductible	60% after deductible
Emergency Room	100% after deductible		80% after deductible	

[B] Non-network providers may balance bill you for medical charges that exceed BlueCross BlueShield of Illinois in-network discounted rates.

Pharmacy (Prime Therapeutics)[A]				
All CVS pharmacies (including those located in Target stores) are excluded from the BCBSIL HSA pharmacy network.				
Pharmacy Out-of-Pocket Maximum				
Out-of-Pocket Maximum Single/Family	Included in the Medical Out-of-Pocket Maximum			
Retail[B]	*(30-day supply)*	*(30-day supply)*	*(30-day supply)*	*(30-day supply)*
	Preferred/Non-Preferred[C]	*Covered at 50% of contracted pharmacy amount*	Preferred/Non-Preferred[C]	*Covered at 50% of contracted pharmacy amount*
Preferred Generic	100% /100%	100%	90% /80%	80%
Non-Preferred Generic	100% /100%	100%	90% /80%	80%
Preferred Brand	100% /100%	100%	80%/70%	70%
Non-Preferred Brand	100% /100%	100%	70%/60%	60%
Select Oral Contraceptives	$0 copay	$0 copay	$0 copay	$0 copay
Mail Order[B]	(90-day supply)	(Not applicable)	(90-day supply)	(Not applicable)
Preferred Generic	100%		90%	
Non-Preferred Generic	100%		90%	
Preferred Brand	100%		80%	
Non-Preferred Brand	100%		70%	
Preferred Specialty (30-day supply)	100%	Not applicable	60%	Not applicable
Non-Preferred Specialty (30-day supply)	100%		50%	
Select Oral Contraceptives	$0 copay		$0 copay	

[A] If an insured selects a brand name drug when there is a generic equivalent available, the member will pay the applicable copay plus the cost difference between the selected drug and the generic equivalent.

[B] IRS allowable preventive drugs are covered prior to the deductible at the appropriate copay (i.e. statins, high blood pressure, insulin).

[C] There are three levels of benefits. 1. Preferred Network Pharmacies – Walgreens, Walmart, Albertsons/Osco and Access Health/Independents 2. Non-Preferred Network Pharmacies – All other in-network pharmacies 3. Non-Network – Examples include CVS/Target and some independent pharmacies.

HSA Plan A high deductible health plan (HDHP) is a consumer-directed health plan combining a high-deductible PPO plan with a health savings account (HSA) that you can fund with tax-free dollars. For 2024, the IRS limit for pre-tax HSA contributions are $4,150(s)/$8,300(f). For 2025, the IRS limits are $4,300/$8,550(f). Funds in your HSA can pay for covered healthcare expenses and may also be applied toward your deductible.

HSA Customer Service: (800) 541-2768
Prime Therapeutics: (800) 423-1973

www.bcbsil.com
www.bcbsil.com/member
www.myprime.com

Medical Payroll Deductions (Weekly)

	100% HSA Plan	80% HSA Plan
Employee	$54.08	$63.90
Employee + Spouse	$111.05	$131.22
Employee + Child(ren)	$81.56	$96.37
Family	$138.52	$163.68

Dental

Our Group Dental Plans are administered by Delta Dental of Illinois.

Dental PPO Plan		
In-Network[A]	Premier Network[B]	Out-of-Network[C]
Calendar Year Deductible		
$75 per individual		
Calendar Year Maximum		
$1,500 per insured		
Preventive/Diagnostic		
Oral exams (2 per 12 months), bitewing x-rays (2 per 12 months), cleanings (2 per 12 months), fluoride treatment (to age 19 – 1 per 12 months), sealants, space maintainers		
90% of reduced fee *deductible does not apply*	80% of Max. Plan Allowance after deductible	80% of Max. Plan Allowance after deductible
Basic		
Fillings, oral surgery, periodontics, endodontics		
80% of reduced fee after deductible	70% of Max. Plan Allowance after deductible	70% of Max. Plan Allowance after deductible
Major		
Crowns, fixed/removable bridges, partial/full dentures, implants		
50% of reduced fee after deductible	50% of Max. Plan Allowance after deductible	50% of Max. Plan Allowance after deductible
Lifetime Orthodontia Maximum		
$1,500 per insured		
Orthodontia (children to age 26)		
50% of reduced fee	50% of Max. Plan Allowance	50% of Max. Plan Allowance

[A] You will not be "balance billed" for charges exceeding Delta's allowed PPO fees
[B] You will not be "balance billed" for charges exceeding Delta's Maximum Plan Allowances (MPAs)
[C] You are responsible for charges exceeding MPAs

Dental Payroll Deductions (Weekly)

	PPO Plan
Employee	$3.69
Employee + Spouse	$7.38
Employee + Child(ren)	$7.38
Family	$8.86

Customer Service: (800) 323-1743
www.deltadentalil.com

Vision

Our Group Vision Plan is with UnitedHealthcare.

Vision Payroll Deductions (Weekly)

	PPO Plan
Employee	$0.69
Employee + Spouse	$1.62
Employee + Child(ren)	$1.33
Family	$2.19

Warby Parker: UnitedHealthcare vision members have access to Warby Parker's comprehensive network. Members can purchase eyeglasses or sunglasses, with prescription lenses included, for $25 or less! Warby Parker also offers contact lenses at the in-network benefit. For more information, visit www.warbyparker.com/united or call (888) 492-7297.

Customer Service: (800) 638-3120
www.myuhcvision.com

PPO Plan	
In-Network	Out-of-Network
Exam	
$10 copay	$40 allowance
Frequency: 1 x every 12 months from last date of service	
Frames	
$130 allowance, plus a 30% discount on overage at select providers	$45 allowance
Frequency: 1 x every 24 months from last date of service	
Eyeglass Lenses	
Single Vision/Bifocal/Trifocal	
$25 copay	$40/$60/$80 allowance
Frequency: 1 x every 12 months from last date of service	
Contact Lenses	
Elective	
$105 allowance	$105 allowance
Necessary	
$25 copay	$210 allowance
Frequency: 1 x every 12 months from last date of service (in lieu of eyeglasses)	

Life and Ad&d

United Laboratories provides you with basic term life insurance at no cost to you. An additional benefit may be payable for accidental death or non-work-related dismemberment. Should you desire more coverage, or should you desire coverage for your dependents, voluntary life insurance is also available for purchase. Basic life and AD&D, voluntary employee life and AD&D and dependent life insurance coverage is offered through Lincoln Financial.

Disability

If you become disabled due to a non-work-related illness or injury, disability benefits may be payable. For periods of disability lasting between 15 days and 90 days, United Laboratories sponsors short term disability coverage through Lincoln Financial at no cost to you.

Group Life /Ad&d (100% Employer Paid)
Benefit Amount:
$10,000 **Note:** Employees must elect medical coverage to be eligible.

Voluntary Life /Ad&d
Employee Life Benefit Amount:
Increments of $10,000 up to the lesser of 5X salary or $500,000
Employee Guarantee Issue (if you elect coverage at your initial eligibility date):
Lesser of 5X salary or $150,000
Spouse Life Benefit Amount:
Increments of $10,000 up to the lesser of 50% of employee amount or $250,000
Spouse Guarantee Issue (if you elect coverage at your initial eligibility date):
Lesser of 100% of employee's voluntary amount or $20,000
Child(ren) to Age 26:
15 days to 6 months: $1,000 6 Months to Age 26: $5,000 or $10,000
Voluntary AD&D Benefits
Employees must elect Vol. Life to elect Vol. AD&D. If elected, Vol. AD&D amount will be equivalent to the employee, spouse and child Vol. Life amount

Customer Service:
Life & Disability: (800) 423-2765
www.lincolnfinancial.com

Short Term Disability (100% Employer Paid)
Benefit Amount:
60% of weekly earnings up to $2,500 per week

Voluntary Life/Ad&d Rates (Monthly)

Life Rates per $1,000 (Spouse rates based on spouse's age)	Employee/Spouse
Under Age 30	$0.09
Age 30-34	$0.09
Age 35-39	$0.12
Age 40-44	$0.20
Age 45-49	$0.29
Age 50-54	$0.49
Age 55-59	$0.85
Age 60-64	$1.34
Age 65-69	$2.09
Age 70-74	$3.35
Age 75 & over	$5.92
Employee, Spouse and Child(ren) Ad&d Rate per $1,000	
$0.05	
Child(ren) Voluntary Life Rate per $5,000/$10,000	
$1.00/$2.00	

Tax Favored Accounts

Health Care Flexible Spending Account (FSA)

The healthcare FSA enables you to put aside pre-tax dollars to pay for out-of-pocket expenses you may incur for medical, dental, vision and pharmacy care. For 2024/2025, the maximum contribution you may elect for your healthcare FSA is $3,200. Any unused FSA contributions from the 2024/2025 policy year up to $640 can be carried over to the 2025/2026 policy year.

Dependent Care FSA

The dependent care FSA enables you to put aside pre-tax dollars to pay for child and elder care expenses. For 2024/2025, the maximum contribution you may elect for your dependent care FSA is $5,000.

Customer Service: (800) 473-9595
www.benefitresource.com

Health Savings Account (HSA)

A Health Savings Account is a tax-advantaged, portable savings account that is offered if you enroll in the BCBSIL HSA medical plan. For 2024, the IRS limit for pre-tax HSA contributions are $4,150(s)/$8,300(f). For 2025, the IRS limit for pre-tax HSA contributions are $4,300/$8,550. You can use your account to pay for qualified medical, dental and vision expenses. The HSA is administered by Benefit Resource, Inc.