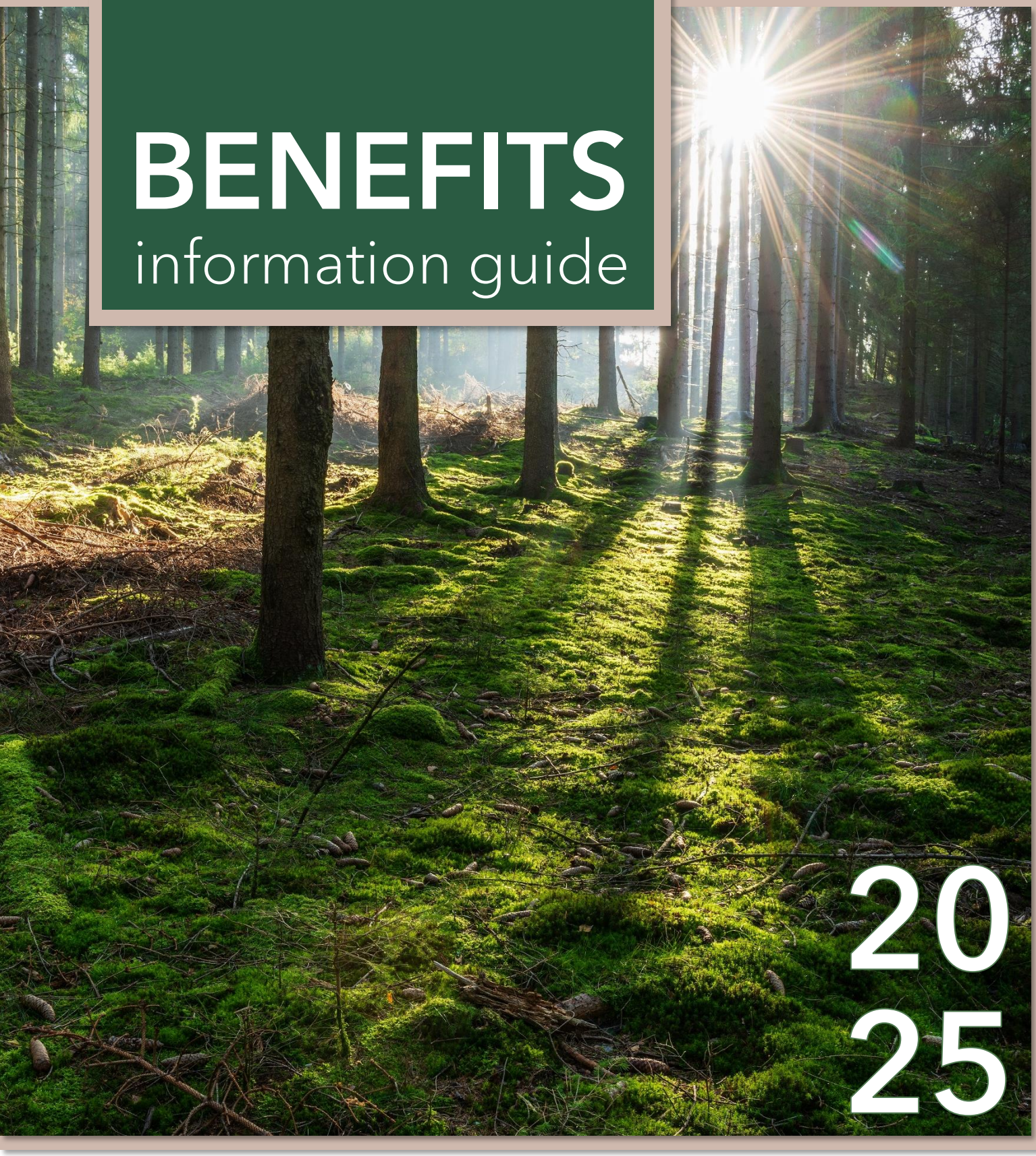
SALT™
DENTAL PARTNERS

BENEFITS
information guide



2025

Discover Your Benefits

Let's explore your benefit plan options, programs and resources.

Guidelines/Evidence of Coverage

The benefit summaries listed on the following pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 32 for more details.

Eligibility & Enrollment

Time to answer some questions…

Who can enroll?

All employees who regularly work at least 24 hours per week are eligible to participate in the benefits program. You may choose to enroll your family members – including a legal spouse and any dependent child(ren) – and any other individual described in an eligible class for that benefit. You may be able to enroll a domestic partner and your domestic partner's child(ren) and may be required to enter into a registered domestic partnership or other official domestic partnership arrangement with a state in order to elect coverage for them.

You may be unable to pay for and/or receive employer contributions on a tax-free basis for the cost of coverage for your domestic partner and their child(ren) if any do not qualify as your tax dependent(s). It may be possible for a registered domestic partner and/or their child(ren) to qualify as your tax dependents for state tax purposes even when they do not qualify as your federal tax dependent(s).

When does coverage begin?

Eligible employees: You are eligible to enroll on your date of hire, but your coverage will not be effective until the first of the month following 30 days from your date of hire.

Your enrollment choices remain in effect through the end of the benefits plan year, January 1, 2025 – December 31, 2025. If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status event during the plan year. Please check with your plan administrator and your Section 125 plan document on any applicable status change events that would allow you to make a mid-year election change.

How do I get started with my enrollment?

Available as an app within the App Store or GooglePlay!

- You will need your credentials (created by you during the new hire process) to access the benefit enrollment portal.
- Go to www.workforcenow.adp.com
- Click on "User Login" tab and log in.
- Once you are logged into the system, mouse over the "Myself Tab", navigate to "Benefits" and select "Enrollments".
- Read the enrollment instructions and select the "Start" button towards the bottom of the page.

What if my needs change during the year?

You are permitted to make changes to your benefits after the open enrollment period if you have a qualifying life event (QLE) recognized under federal law. If you or an eligible individual experience a QLE, you may be able to add or drop coverage for yourself and other eligible individuals, as well as add, drop, or change coverage if you timely submit your request for an election change following the QLE.

The ability to make election changes following a QLE is time sensitive and may vary based on the specific event. Please contact Human Resources for more information about QLEs and permitted election changes. QLE examples are:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Death of a dependent
- You or your spouse's loss or gain of coverage or a significant change in existing coverage through our organization or another employer; and
- Medicare or Medicaid enrollment

You may experience a QLE if you have a special enrollment opportunity to enroll in the Public Health Insurance Marketplace (i.e. Covered California or another state-run marketplace or Healthcare.gov). Please contact Human Resources to learn if this QLE is available to you.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of status change events, please refer to the "Legal Information Regarding Your Plans" contents.

Do I have to enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as from a State or Federal Health Insurance Exchange.

For information regarding Healthcare Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

You may elect to "waive" medical, dental, and vision coverage if you have access to coverage through another plan. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on January 1, 2025, unless a change in status event occurs.

Medical

Which plan type is right for you?

PPO / OAP	HDHP
A Preferred Provider Organization (PPO) Plan contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. Using providers that belong in the plan's network will provide a higher benefit, but you have the flexibility to see a provider outside the network, generally for an additional cost.	A High-Deductible Health Plan (HDHP) combines traditional medical coverage with a Health Savings Account (HSA). As evident by the name, this plan has a higher deductible you must reach before the plan kicks in.
Advantages • Set copays for services such as office visits and prescriptions • No referrals required for specialists	 • Tax advantages with an HSA. • Lower monthly premiums
Out-of-pocket costs You'll be responsible for copays and coinsurance, but your deductible will be lower than the HDHP plan.	 Your out-of-pocket expenses may be mostly upfront, since you'll need to satisfy your deductible before your plan kicks in.
Ideal if... ... you prefer flexibility and provider options, and if you're comfortable paying more out of your paycheck and less out of pocket for your deductible.	 ... you don't usually need much care throughout the year, this plan might be right for you. Make sure you have funds set aside to pay towards the deductible.
Note: You may choose in or out-of-network care. However, in-network care provides you a higher level of benefit.	

Please note, the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan.

Have questions on which Cigna plan is right for you?

Call a Cigna One Guide representative at 888-806-5094.

Your personal guide will help you:

- Easily understand the basics of health coverage
- Identify the types of health plans available to you.
- Check if your doctors are in-network to help you avoid unnecessary costs.
- Get answers to any other questions you may have about the plans or provider networks available to you.

Your personal guide is just a call away!

Prescription Drug (Rx) Benefits

Many FDA-approved prescription medications are covered through the benefits program. Tiered prescription drug plans require varying levels of payment depending on the drug's tier.

All plans utilize Cigna's Standard Formulary. To search for your medications on the formulary:

- visit www.cigna.com, click on **Member Guide**, and then scroll down to **Prescriptions**.
- Click to **View Drug List**, and then select **Look up Drug Lists for Employer Plans**.
- From the dropdown select **Standard**, and then you can search for your prescriptions.

Generic formulary (Tier 1): Generic drugs contain the same active ingredients as their brand-name counterparts but are less expensive.

Brand name medications (Tier 2): A brand-name medication can only be produced by one specified manufacturer and is proven to be the most effective in its class.

Non-preferred prescriptions (Tier 3): Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list. This is because there is an alternative proven to be just as effective and safe, but less costly. Ask your doctor or pharmacist for additional information regarding the generic option.

Specialty prescriptions (Tier 4): Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

Why pay more for prescriptions?

Use Mail Order

Save time and money by utilizing a mail order service for maintenance medications. A 90-day supply of your medication will be shipped to you, instead of a typical 30-day supply from a walk-in pharmacy.

Shop Around

Some pharmacies, such as those at warehouse clubs or discount stores, may offer less expensive prescriptions than others. Call ahead to determine which pharmacy provides the most competitive price.

Over-the-Counter Options

For common ailments, over-the-counter drugs may provide a less expensive alternative that serves the same purpose as prescription medications.

Finding a Provider

Open Access Plus Network

- Visit www.cigna.com and click on **Find a Doctor**
- Click **Employer or School**
- Enter your ZIP Code and select **Doctor by Type**, **Doctor by Name**, or **Health Facilities and Group Practice**s and enter what you would like to search for and click **Search**
- Click **Continue as Guest**, then click **Continue**
- Select **Open Access Plus, PA Plus, Choice Fund OA Plus**
- You will see the results of your search

Need to see a doctor on demand?

MDLIVE

With telehealth, you can connect with leading board-certified physicians for many non-emergency illnesses through the internet, video chat or telephone. By leveraging these virtual visits, you can avoid emergency rooms or urgent care centers and quickly refill your prescriptions so you can get back on your feet in no time.

If your telehealth doctor prescribes you medication, MDLive will ensure you are able to conveniently pick up your prescription in your local area.

Through MDLive, telehealth services are $0 on the PPO plans and covered at 100% after deductible for on-demand visits on the HDHP plan for all dependents on your health plan. Costs may vary for mental health visits.

Start your eVisit today!

- Online: www.myCigna.com
- Call: 888.726.3171

Plan Highlights	Cigna OAP 1000	Cigna OAP 3000	Cigna OAP 5000	Cigna HDHP 6000
	In-network (Open Access Plus)	In-network (Open Access Plus)	In-network (Open Access Plus)	In-network (Open Access Plus)
Annual Calendar Year Deductible				
Individual	$1,000	$3,000	$5,000	$6,000
Family	$2,000	$6,000	$10,000	$12,000
Maximum Calendar Year Out-of-pocket [1]				
Individual	$6,000	$6,000	$6,000	$6,000
Family	$12,000	$12,000	$12,000	$12,000
Professional Services				
Primary Care Physician (PCP)	$30 Copay	$30 Copay	$30 copay	0% after deductible
Specialist	$60 Copay	$60 Copay	$65 copay	0% after deductible
Telehealth Visit	MDLIVE: No charge	MDLIVE: No charge	MDLIVE: No charge	0% after deductible
Preventive Care Exam	No Charge	No Charge	No Charge	No Charge
Diagnostic X-ray and Lab	20% after deductible	20% after deductible	30% after deductible	0% after deductible
Complex Diagnostics (MRI/CT Scan)	20% after deductible	20% after deductible	30% after deductible	0% after deductible
Hospital Services				
Inpatient	20% after deductible	20% after deductible	30% after deductible	0% after deductible
Outpatient Surgery	20% after deductible	20% after deductible	30% after deductible	0% after deductible
Urgent Care	$50 Copay	$50 Copay	$50 Copay	0% after deductible
Emergency Room	$250 Copay	20% after $250 Copay	30% after $250 Copay/visit	0% after deductible
Mental Health & Substance Abuse				
Inpatient	20% after deductible	20% after deductible	30% after deductible	0% after deductible
Outpatient	$60 Copay/visit	$60 Copay/visit	$65 copay	0% after deductible
Retail Prescription Drugs (30-day supply)				
Tier 1 (Preferred Generic Drugs)	$5 copay	$5 copay	$15 copay	0% after deductible
Tier 2 (Preferred Brand Drugs)	$10 Copay	$10 Copay	$45 copay	0% after deductible
Tier 3 (Non-preferred Brand Drugs)	You pay 30%	$10 Copay	You pay 30%	0% after deductible
Tier 4 (Specialty Drugs)	You pay 30%	You pay 30%	You pay 30%	0% after deductible
Mail Order Prescription Drugs (90-day supply)				
Tier 1 (Preferred Generic Drugs)	$20 Copay	$20 Copay	$45 copay	0% after deductible
Tier 2 (Preferred Brand Drugs)	$20 Copay	$20 Copay	$135 copay	0% after deductible
Tier 3 (Non-preferred Brand Drugs)	You pay 30%	$20 Copay	You pay 30%	0% after deductible

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Spending Accounts

Make your money work for you.

Health Savings Account (HSA)

By enrolling in the Cigna HDHP 6000 plan, you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified healthcare expenses, such as your deductible, copayments, and other out-of-pocket expenses.

If you enroll on the HDHP plan, SALT Dental will contribute $500 annually, or $20.83 per pay period, to your Health Savings Account.

What to know about your Health Savings Account

What are the benefits?	• HSA funds can grow on a tax-free basis, subject to state law. Please consult your tax advisor for applicable tax laws in your state. • An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified healthcare expenses (tax regulations vary by state). • You may enjoy lower monthly premium payments on your High-Deductible Health Plan (HDHP) as compared to a traditional PPO medical plan.
How do I become eligible to contribute to an HSA?	• You become eligible to contribute to an HSA if you are covered under a HDHP, you are not enrolled in non-qualified health insurance outside of SALT Dental Collective's plan, you are not enrolled in Medicare, you are not claimed as a dependent on someone else's tax return (excluding a spouse), you have not received any hospital care or medical services from the Veterans Administration, in the last three months (unless these services were related to a service-connected disability) and you are not enrolled in a general Healthcare Flexible Spending Account (Health FSA) or a general Health Reimbursement Arrangement (HRA).
How do I get started?	• The most convenient way to pay for qualified expenses is to utilize the debit card. You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account. It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS. • You can enroll in your HSA account through ADP. • You will need to activate your online account before you can activate your Lively debit card. Once the HSA account is activated, you can manage and access your account at any time by visiting livelyme.com. If questions arise regarding account activation, contact Lively or visit livelyme.com. Consult your tax advisor for taxation information or advice.
A few rules to keep in mind…	• For 2025, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $4,300 if you are enrolled in the HSA-PPO for employee-only coverage, and $8,550 for employees with dependent coverage. • It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax. • There is a 20% penalty for using HSA funds on non-qualified healthcare expenses if you are under age 65. For more details about what is considered a qualified healthcare expense, visit www.irs.gov. • Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon the maximum annual contribution limit for that calendar year, multiplied by the **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would be eligible to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first becomes HSA eligible on September 1st of that applicable year. However, under the Full-Contribution Rule, an employee is allowed to contribute the maximum annual contribution amount to his/her/their HSA, regardless of the number of months he/she/they were eligible to contribute to an HSA in that year, if he/she/they are eligible to contribute to an HSA on December 1 of the year and continues to be eligible to contribute to an HSA until December 31st of the following year (i.e., for all subsequent days until December 31st of the following year).

(1) Please consult your tax advisor for applicable tax laws in your state.

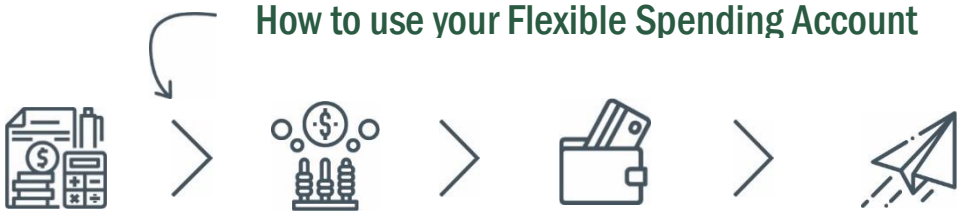
Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible healthcare and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
Healthcare FSA	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • Maximum contribution for 2025 is $3,300.
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Eligibility rules require that if you are married, your spouse needs to be working, looking for work or attending school full-time. • Maximum contribution for 2025 is $5,000.

For more details about using an FSA, contact Human Resources.

How to use your Flexible Spending Account



1. Determine your estimated FSA healthcare expenses for the plan year
2. Set up annual (pre-tax) deductions from your paycheck
3. Use FSA debit card or submit a claim to your administrator with receipts as proof of your incurred eligible expenses
4. Use it or lose it! FSA funds don't roll over to the next year, but you can carryover a max of $640 of your Healthcare FSA. There is no carryover for the Dependent Care FSA.

Dental Plan

A smile is the nicest thing you can wear.

Using the PPO Plan

The Dental PPO plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists. To determine whether your dentist is in or out of your insurance network, go to www.cigna.com and search the Total network, or call Cigna.

"I need specific dental care! How much does it cost?"

Plan Highlights	Cigna Dental PPO Base $1500	Cigna Dental PPO Buy-Up $3000
	In-network (Total Network)	In-network (Total Network)
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Annual Maximum	$1,500	$3,000
Preventive	0%	0%
Basic Services	20%	20%
Major Services	50%	50%
Orthodontia Services		
Adult	Not Covered	Not covered
Child	Not Covered	50%
Lifetime Maximum	Not Covered	$2,000
Out-of-Network Reimbursement	MAC	90th percentile

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Vision Plan

Keep a clear focus on your sight.

Vision coverage is offered by Aetna as a Preferred Provider Organization (PPO) plan. As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To locate an in-network vision provider, visit www.Cigna.com, at the top of the page select "Find a Doctor, Dentist or Facility," and click on Cigna Vision serviced by EyeMed Directory from the Additional Directories drop down listing.

"I need specific vision care! How much does it cost?"

Plan Highlights	Cigna Vision PPO
	In-network (EyeMed)
Exam – Every 12 months	$10 Copay
Retinal Screening	$20 copay
Lenses – Every 12 months	
Single	$25 Copay
Bifocal	$25 Copay
Trifocal	$25 Copay
Frames – Every 24 months	$150 allowance + 20% discount on remaining balance
Additional Pairs of Glasses	20% discount
Contacts – Every 12 months, in lieu of lenses & frames	
Therapeutic	Covered in Full
Cosmetic	$150 allowance
LASIK	Log-in to www.myCigna.com for available discounts

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Supplemental Health Plans

Be prepared for the unexpected.

Critical Illness Coverage

Critical illness coverage offered on a voluntary basis through Mutual of Omaha pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you and you may use the funds as you see fit.

What can critical illness coverage pay for?

- Medical expenses, such as copays, deductibles or co-insurance
- Lost income
- Everyday expenses such as groceries and utilities
- Alternative treatments
- Lodging and travel to a specialist

What are examples of covered illnesses or conditions?

- Cancer
- Heart Attack
- Stroke
- Alzheimer's
- Kidney Failure
- Organ Transplant

100% Employee-paid

If you elect the voluntary critical illness plan, 100% of the cost is deducted through payroll deductions.

Monthly post-tax rates are outlined below:

Benefit options

Election	Benefit Amounts & Guaranteed Issue
Employee	$5,000 to $50,000 in increments of $5,000 (All Guaranteed Issue)
Spouse	$1,000 to $50,000 in increments of $1,000, not to exceed the amount you elect (All Guaranteed Issue)
Child(ren)	$10,000 (Guaranteed Issue)

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For additional information or to obtain a full schedule of benefits contact Human Resources.

Accident Insurance Plan

Accident insurance offered on a voluntary basis through Mutual of Omaha provides coverage for specific injuries and treatments resulting from a covered accident. The amount of the benefit paid depends on the type of injury and care received.

How can accident insurance help?

Since benefits are paid directly to you, you choose how to use them, such as paying medical bills, subsidizing lost income, or covering everyday expenses.

What are some common covered benefits?

- Emergency room visit
- Ambulance
- Doctor visits
- Hospital admission
- Surgery
- Medical equipment
- Outpatient therapy
- Diagnostic imaging

Covered Event/Injury	Benefit Amount
Ambulance (ground)	$300
Emergency room care	$300
Physician follow-up ($75 x 2)	$100
X-ray	$75
Broken tooth (repaired by crown)	$400
Total benefit paid by Kathy's Accident Plan	**$1,175**

Here's an example of how Accident Insurance can help support you.

Kathy's daughter, Molly, plays soccer. During a recent game, she collided with a player, was knocked unconscious and taken to the emergency room (ER) by ambulance. The ER doctor diagnosed a concussion and a broken tooth. He ordered an x-ray scan to check for facial fractures due to swelling. Molly was released to her primary care physician for follow-up treatment and her dentist repaired her broken tooth with a crown. Thanks to Accident Insurance, Kathy will receive $1,100 to help pay for Molly's expenses associated with her accident.

Please note the above is an illustration only and does not reflect your plans actual benefits. Please refer to the plan documents for more detailed information.

100% Employee-paid

If you elect the voluntary accident insurance plan, 100% of the cost is deducted through payroll deductions.

Monthly post-tax rates are outlined below:

Election	Cost Per Pay Period
Employee Only	$5.01
Employee + Spouse	$7.43
Employee + Child(ren)	$8.38
Family	$13.32

Want to learn more?

If you're considering this type of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For additional information or to obtain a full schedule of benefits contact Human Resources.

Life & Disability

Protection for your loved ones.

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional life and AD&D coverage for you and your dependents is available on a voluntary basis through payroll deductions from Mutual of Omaha.

For employees:	Increments of $10,000 up to a $500,000 maximum with a guarantee issue benefit of 5x your annual earnings or $150,000, whichever is less if you enroll in the plan within 30 days of your initial eligibility.
For your spouse:	Increments of $5,000 up to a $100,000 maximum with a guarantee issue benefit of $30,000 if you enroll in the plan within 30 days of your initial eligibility.
For your child(ren):	Increments of $2,500 up to a $10,000 maximum with a guarantee issue amount of $10,000.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

If you do not enroll in the plan within the initial enrollment period, **any** amount of supplemental life insurance will require proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Short Term Disability

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Short Term Disability (STD) Employee Paid	• Administered by Mutual of Omaha, STD coverage provides a benefit equal to 60% of your earnings, up to $3,750 per week for a period up to 11 weeks. • The plan begins paying these benefits after you have been absent from work for 14 consecutive days.

Please note, the state you reside in may provide a partial wage-replacement disability insurance plan.

Employee Assistance Program (EAP)

Your free and confidential go-to resource.

We can all use an extra helping hand from time to time. Whether you need support with a personal relationship or professional challenge, or you're seeking guidance on a particular subject, the Employee Assistance Program (EAP) provides the tools you need to thrive. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Number of sessions	3 face-to-face sessions per year per household
How to access	Phone or face-to-face sessions
Topics may include	Mental Health Support: • Marital, relationship or family problems. • Bereavement or grief counseling. • Substance abuse and recovery. Community Support: • Childcare and eldercare. • Legal services and Identity theft. • Financial support. • Educational materials.

To get started:

- Phone: 877.622.4327
- Online: www.myCigna.com
  - Employer ID: saltdental (needed for initial registration only)
  - If you're already registered on www.myCigna.com, simply log in and go to the EAP link under the Review my Coverage tab.

Retirement Options

Your 401(k) Plan Option

Administered by Fidelity, the 401(k) plan allows you to plan for your future by investing a portion of each paycheck. Once you become eligible, you may elect to have a percentage of your paycheck withheld and invested in your 401(k) account, subject to federal law and plan guidelines. You are eligible to contribute to the plan immediately, and eligible to receive matching contributions after 6 months of service.

Enrollment & Account Access

- To enroll in the 401(k) plan, please visit www.401k.com and click on "Register Now" when logging in for the first time. Follow the instructions to enroll online. Call the Retirement Benefits Line if you need assistance at 800.835.5097.
- Check your 401(k) account balance, view your contributions, change your investments and more by visiting www.401k.com or calling 800.835.5097.

Additional 401(k) Information

Contribution Limits: For 2024, the maximum IRS annual contribution limits are allowed for everyone under age 50 and for anyone that is age 50 or over prior to December 31, 2024. If you have multiple employers during the year, these limits are combined for all plans that you contribute to during the year. Restrictions may apply to these limits based on plan documents and annual testing requirements.

Contribution Changes: Check with Human Resources for frequency and process for changing your contributions. You may also stop your contribution entirely at any time. Requests to change or stop your contributions must be made through the provider website or in writing to Human Resources.

Employer Contributions: Your employer will make Safe Harbor matching contributions to your account based on your contributions. The amount will equal:

- 100% of the first 3% of your eligible compensation contributed to the Plan.
- 50% of the next 2% of your eligible compensation contributed to the Plan.

Rollover Contributions: If you have an outside qualified retirement plan or account such as a 401(k), 403(b), 457(b) or IRA, you may be able to transfer that account into your new plan. Please contact Fidelity or Human Resources for additional information.

Termination of Employment: Upon termination of employment from our organization, regardless of reason, you will be entitled to request a full distribution of your vested account balance. This may be done as a rollover to another plan or IRA. You may also request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties which may apply to any payment other than a rollover.

Cost Breakdown

All of your rates in one place.

The rates below are effective January 1, 2025 – December 31, 2025.

Coverage Level	Payroll Deduction
	Cost Per Pay Period
Cigna OAP 1000	
Employee Only	$143.24
Employee and Spouse/Domestic Partner	$548.11
Employee and Child(ren)	$391.50
Employee and Family	$838.03
Cigna OAP 3000	
Employee Only	$94.66
Employee and Spouse/Domestic Partner	$492.34
Employee and Child(ren)	$347.16
Employee and Family	$762.76
Cigna OAP 5000	
Employee Only	$62.93
Employee and Spouse/Domestic Partner	$406.17
Employee and Child(ren)	$275.90
Employee and Family	$636.32
Cigna HDHP 6000	
Employee Only	$43.80
Employee and Spouse/Domestic Partner	$336.66
Employee and Child(ren)	$218.26
Employee and Family	$557.19
Cigna Dental PPO Base	
Employee Only	$4.48
Employee and Spouse/Domestic Partner	$20.83
Employee and Child(ren)	$29.18
Employee and Family	$45.68
Cigna Dental PPO Buy-Up	
Employee Only	$13.45
Employee and Spouse/Domestic Partner	$38.00
Employee and Child(ren)	$50.54
Employee and Family	$75.23
Cigna Vision	
Employee Only	$2.79
Employee and Spouse/Domestic Partner	$5.58
Employee and Child(ren)	$5.63
Employee and Family	$8.99

Directory & Resources

Below, please find important contact information and resources for SALT Dental Collective.

Information Regarding	Group / Policy #	Contact Information	
Enrollment & Eligibility			
Human Resources			HumanResources@saltdentapartners.com
Medical Coverage			
Cigna • HDHP • OAP		800.244.6224	www.cigna.com
Health Savings Account			
Lively		888.576.4837	www.livelyme.com
Flexible Spending Accounts			
Lively		888.576.4837	www.livelyme.com
Supplemental Health			
Mutual of Omaha • Accident • Critical Illness	G000CFHZ	800.877.5176	www.mutualofomaha.com
Dental Coverage			
Cigna		800.244.6224	www.cigna.com
Vision Coverage			
Cigna		888.353.2653	www.cigna.com
Life, AD&D and Disability			
Mutual of Omaha • Voluntary Life and AD&D • Short Term Disability	G000CFHZ	800.877.5176	www.mutualofomaha.com
Benefits Broker / Claims Questions			
Lovitt & Touché, A Marsh & McLennan Insurance Agency LLC Claims Advocate - Maureen Wigham		602.385.7066	Maureen.Wigham@MarshMMA.com

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