

2027 Continental Benefits Enrollment Guide



This course details benefits eligibility, outlines the benefits available, and shares how to enroll in benefits at Continental. Click the "*Start Course*" button to begin.

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Welcome and Benefits Overview



Welcome to Your Continental Benefits Enrollment Guide – Plan Year 2027

At Continental, we recognize that a comprehensive benefits program is an important part of your total compensation. That's why we're

committed to offering a competitive benefits package that supports the health, financial well-being, and peace of mind of you and your family.

This Benefits Enrollment Guide is designed to help you understand the benefit programs available to you and make informed decisions about the coverage that best meets your needs.

Benefits Outlined in This Guide

The benefits described in this guide are effective until December 31, 2027.

Healthcare Coverage —

- Medical insurance
 - Core POS HDHP
 - Enhanced HMO
 - Premier POS
- Virtual Care
- Health Savings Account (HSA)
- Flexible Spending Account (FSA)
 - Healthcare FSA
 - Limited Purpose FSA
 - Dependent Care Account
- Dental insurance
 - EPO
 - PPO

- Vision insurance

Supplemental Insurance

- Life and Accidental Death and Disability (AD&D)
- Disability Coverage
- Accident
- Critical Illness
- Hospital Indemnity

Additional Benefits and Team Member Perks

- 401(k)
- TravelConnect
- LifeKeys
- Employee Assistance Program
- Working Advantage

Important Information

This Benefits Enrollment Guide provides a summary of the benefit programs available to eligible Continental Team Members. It does

not replace the official plan documents, summary plan descriptions, insurance policies, certificates, or contracts governing the plans.

If there is any difference between this guide and the official plan documents, insurance policies, or applicable laws, the official plan documents, policies, and applicable laws will govern.

Continental reserves the right to amend, modify, or terminate any benefit plan at any time, subject to the terms of the applicable plan documents and governing law.

We encourage you to review this guide carefully and keep it as a reference throughout the year.

In the sections that follow, we'll answer some of the most common questions about benefits enrollment and provide information to help you understand your options and make your benefit elections.

CONTINUE

Lesson 2 of 18

Prepare Benefits Counselors



Rachel Scott





Have questions or need help enrolling?

Prepare Benefits Counselors are available to provide personalized support throughout the enrollment process. Counselors are specially trained on Continental's benefits programs and the bswift enrollment platform, enabling them to help you understand your options, compare plans, and complete your elections with confidence.

Call 202-780-4898 to speak with a Benefits Counselor from October 12 - 26.

Looking for answers on your own schedule? Prepare Benefits also offers **Answers on Demand**, an AI-powered resource trained on Continental's benefit plan documents. The tool is available 24/7 and can provide fast, reliable answers to many common benefits questions.

Answers on Demand: *[Link Coming Soon]*

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Who Is Eligible for Benefits?



Benefits Eligibility

Eligibility for benefits varies by benefit type and is outlined below.

Union Team Members: If you are covered by a Collective Bargaining Agreement (CBA), please refer to your applicable CBA for information regarding your benefits, eligibility, and any provisions that may differ from those described in this guide.

Healthcare and Supplemental Benefits

You are eligible to enroll in health care and supplemental benefits if you:

☐

Are a **full-time Team Member** regularly scheduled to work **30 or more hours per week**.

☐

Have completed **30 days of active employment**.

Eligible Dependents

The following family members may be eligible for health care and supplemental benefits subject to the eligibility requirements of each plan:

Legal Spouse

A person to whom you are legally married and whose marriage is recognized under applicable federal and state law.

Dependent Child(ren)

Your biological child, adopted child, stepchild, or eligible child for whom you have legal guardianship, who meets the plan's eligibility requirements for dependent. Dependent children may remain covered under Continental's benefit plans based on the age limits



You may be asked to provide documentation verifying dependent eligibility, such as a copy of a marriage certificate, birth certificate, adoption

or guardianship documentation, or other applicable court documents.

Important: If you do not enroll in your health care or supplemental benefits during your initial eligibility period, you must wait until the next annual Open Enrollment period unless you experience a Qualified Life Event (QLE) that permits a mid-year election change.

401(k) and Roth Savings Plan

You are eligible to participate in the Continental 401(k) and Roth Savings Plan if you:

- Are an **active Team Member** who is **21 years of age or older**.
- Have completed **one month of active employment**.

Eligibility begins on the **first day of the month following one month of active employment**. Once eligible, you may enroll or change your contribution election at any time, subject to the terms of the Plan.

CONTINUE

When You Can Enroll or Make Changes to Your Benefits



In general, there are three opportunities to enroll in or make changes to your benefits:

- As an eligible new hire
- During the annual Open Enrollment period
- After experiencing a Qualified Life Event (QLE)

1. Eligible New Hires

- **Health Care and Supplemental Benefits**
 - Coverage becomes effective on the **first of the month following 30 days of active employment.**

- You must submit your benefit elections within **30 days of your date of hire**. If you do not enroll within this timeframe, you must wait until the next Open Enrollment period unless you experience a Qualified Life Event.
- **401(k) and Roth Savings Plan**
 - You become eligible to participate on the **first of the month following your date of hire**.
 - You may enroll or change your contribution election at any time after you become eligible.

2. Open Enrollment

Open Enrollment is the annual opportunity to enroll in or make changes to your **health care and supplemental benefits**.

Benefit elections made during Open Enrollment become effective **January 1** and remain in effect through **December 31**, unless you experience a Qualified Life Event that allows a mid-year election change.

3. Qualified Life Events (QLEs)

Outside of Open Enrollment, you may only enroll in or make changes to your benefits if you experience a **Qualified Life Event (QLE)**.

Requests to enroll or make benefit changes due to a QLE must be submitted within **30 days of the event date**, unless the QLE is due to the loss of Medicaid or Children's Health Insurance Program (CHIP) coverage. In that case, you have **60 days** from the date that coverage ends to request a change.

Supporting documentation must also be submitted within the applicable **30- or 60-day** timeframe. Only benefit changes that are consistent with the qualifying event are permitted.

Loss of Health Coverage —

- Losing existing health coverage
- Losing eligibility for Medicare, Medicaid, or the Children's Health Insurance Program (CHIP)
- Losing health coverage through a spouse, parent, or other family member
- Exhaustion of COBRA continuation coverage

Changes in Household —

- Marriage

- Divorce or legal separation
- Birth of a child
- Adoption or placement for adoption
- Foster child placement
- Death of a spouse or dependent

Changes in Employment or Eligibility —

- Change in employment status affecting benefit eligibility
- Employee or spouse gains or loses employment
- Change in dependent eligibility (such as reaching the maximum dependent age)

Government Program Changes —

- Gaining or losing eligibility for Medicare, Medicaid, or CHIP
- Becoming eligible for state premium assistance through Medicaid or CHIP

Change in Residence —

- Permanent move that results in new health plan options becoming available or your current plan no longer being available (for example, moving outside

your plan's service area)

Legal or Court-Ordered Changes —

- Qualified Medical Child Support Order (QMCSO)
- Court order requiring a dependent to be added to or removed from coverage

Documentation for Qualified Life Events (QLEs)

To process a Qualified Life Event request, documentation is required to verify the event and confirm eligibility for the requested benefit change.

Continental reserves the right to request additional documentation as necessary to ensure the request complies with the terms of the Plan, IRS Section 125 regulations (when applicable), and applicable federal and state laws.

Examples of Acceptable Qualified Life Event Documentation —

Qualified Life Event	Examples of Acceptable Documentation
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Marriage	Marriage certificate or marriage license issued by the state or county
Divorce or Legal Separation	Final divorce decree, legal separation agreement, or court order
Birth of a Child	Birth certificate, hospital birth record, or proof of live birth from the hospital (if the birth certificate is not yet available)
Adoption or Placement for Adoption	Adoption decree, placement agreement, court order, or documentation from the adoption agency
Foster Child Placement	Placement order or documentation from the foster care agency or court
Death of a Spouse or Dependent	Death certificate
Loss of Other Group Health Coverage	Letter from the previous employer or insurance carrier showing the coverage termination date, COBRA exhaustion notice, Certificate of Creditable Coverage (if available), or notice of coverage termination
Gain of Other Group Health Coverage	Letter from the new employer or insurance carrier confirming the effective date of coverage
Employee or Spouse Employment Change Affecting Eligibility	Employer letter verifying the employment status change, reduction or increase in hours, or eligibility change

Loss or Gain of Medicaid or CHIP Eligibility	Notice from the state Medicaid or CHIP agency showing the effective date of the loss or gain of coverage
Court-Ordered Coverage	Qualified Medical Child Support Order (QMCSO) or other court order requiring coverage
Dependent No Longer Eligible	Documentation verifying the dependent's loss of eligibility (for example, reaching the plan's limiting age or no longer meeting eligibility requirements)
Change of Residence (when eligibility is affected)	Lease agreement, mortgage statement, utility bill, or government-issued correspondence showing the new address
Becoming Eligible for Medicare	Medicare entitlement letter or Medicare card showing the effective date of Part A and/or Part B coverage
Losing Medicare Eligibility	Documentation from the Social Security Administration or Centers for Medicare & Medicaid Services showing the termination of Medicare coverage

Qualified Life Event	Examples of Acceptable Documentation
Marriage	Marriage certificate or marriage license issued by the state or county

Divorce or Legal Separation	Final divorce decree, legal separation agreement, or court order
Birth of a Child	Birth certificate, hospital birth record, or proof of live birth from the hospital (if the birth certificate is not yet available)
Adoption or Placement for Adoption	Adoption decree, placement agreement, court order, or documentation from the adoption agency
Foster Child Placement	Placement order or documentation from the foster care agency or court
Death of a Spouse or Dependent	Death certificate
Loss of Other Group Health Coverage	Letter from the previous employer or insurance carrier showing the coverage termination date, COBRA exhaustion notice, Certificate of Creditable Coverage (if available), or notice of coverage termination
Gain of Other Group Health Coverage	Letter from the new employer or insurance carrier confirming the effective date of coverage
Employee or Spouse Employment	Employer letter verifying the employment status change, reduction or increase in hours, or eligibility change

Change Affecting Eligibility	
Loss or Gain of Medicaid or CHIP Eligibility	Notice from the state Medicaid or CHIP agency showing the effective date of the loss or gain of coverage
Court-Ordered Coverage	Qualified Medical Child Support Order (QMCSO) or other court order requiring coverage
Dependent No Longer Eligible	Documentation verifying the dependent's loss of eligibility (for example, reaching the plan's limiting age or no longer meeting eligibility requirements)
Change of Residence (when eligibility is affected)	Lease agreement, mortgage statement, utility bill, or government-issued correspondence showing the new address
Becoming Eligible for Medicare	Medicare entitlement letter or Medicare card showing the effective date of Part A and/or Part B coverage
Losing Medicare Eligibility	Documentation from the Social Security Administration or Centers for Medicare & Medicaid Services showing the termination of Medicare coverage

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Documentation Guidelines

- Documentation must clearly identify the individual(s) involved.
- Documentation must verify both the qualifying event and the event date.
- Copies of documents are generally acceptable unless original documents are specifically required.
- Documentation must be submitted within the applicable **30- or 60-day** deadline unless otherwise required by the Plan or applicable law.
- Additional documentation may be requested if the information provided is incomplete or insufficient to verify eligibility.

Important: Submission of documentation does not guarantee approval of a requested benefit change. All requests are reviewed in accordance with the terms of the Plan, IRS Section 125 regulations (when applicable), and applicable to federal and state laws.

4. COBRA Continuation of Coverage

When you or a covered dependent loses eligibility for coverage under the Company's group health plans due to certain qualifying events, you may be eligible to continue your coverage for a limited period of time under the **Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985**.

COBRA continuation coverage generally allows eligible individuals to temporarily continue their group health coverage by paying the applicable premium. The length of coverage and eligibility requirements depend on the qualifying event and applicable federal law.

Additional information about COBRA rights, including eligibility, election deadlines, coverage periods, and premium costs, will be provided when a qualifying event occurs.

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Where Do I Enroll?



Where Do I Enroll? Health Care and Supplemental Benefits

You'll make your **health care and supplemental benefit elections** through **Continental's bswift Benefits Portal**.

bswift is a secure, web-based enrollment system that helps protect your personal and health information. The portal is available **24 hours a day, 7 days a week**, so you can review your options and complete your enrollment when it's convenient for you.

How to Enroll in bswift

1. Go to bswift

Visit **Continental's bswift Benefits Portal**:

<http://continentalcafe.bswift.com/>

2. Enter Your Username

Your username is automatically created using this format:

- **First initial + last name + two-digit birth month + two-digit birth day**
 - **Example:** John Smith, born July 19 → **jsmith0719**
- **Hyphenated last names:** Remove the hyphen.
 - **Example:** John Smith-Taylor, born July 19 → **jsmithtaylor0719**

3. Enter Your Temporary Password

Your temporary password is the **last four digits of your Social Security number**.

4. **Create Your Password**

Your new password must:

- Be at least **8 characters**
- Include at least **1 uppercase letter**
- Include at least **1 number**
- Include at least **1 special character** such as **!, @, #, or \$**

Your password cannot:

- Contain more than **3 consecutive characters** from your first or last name
- Contain your username
- Contain your birth date
- Contain your Social Security number

5. **Start Your Enrollment**

Select **Visit the Enrollment Center**, then follow the prompts to **Enroll Now**.

6. **Review Your Employee Information**

Review your personal information and make any necessary corrections. Check **I Agree**, then select **Continue**.

7. **Add Your Dependents**

Add any eligible dependents you want to cover. Check **I Agree**, then select **Continue**.

- **Tip:** Have your dependents' information available before you begin enrollment.

8. **Elect or Waive Each Benefit**

For each benefit, you'll need to either **elect coverage** or **waive coverage**.

- To waive a benefit:** Select **I don't want this benefit (Waive)** and move to the next benefit.
- To review and elect a benefit:** Select **View Plan Options**.
 - If dependent coverage is available, you'll first be asked to select the dependent(s) you want to cover. Check the box next to each dependent, then select **Continue**. You'll then see the plan options available to you.
 - If multiple plans are available, select **View All Plans Side-by-Side** to compare your options.
 - To enroll, select **Select** next to the plan you want.
- Changed your mind? You can select **Waive** to waive the benefit or **Back to Benefits** to return to the main enrollment screen.
- As you make your elections, your **total cost per pay period** will be displayed on the right side of the screen.

e. Once you have made an election or waived **every available benefit**, select **Continue**.

9. **Save and Finish Later**

Need to take a break? No problem. Select **Save and Finish Later** to save your progress and return to your enrollment later.

10. **Finished selecting benefits?**

Select **Continue**

11. **Life Insurance - If Applicable**

If you have selected life insurance, you will be prompted to designate a beneficiary to receive your life insurance benefit.

Important: Take care when naming a minor child as your beneficiary. Life insurance benefits generally cannot be paid directly to a minor without additional legal arrangements, which may delay access to the funds. Consider reviewing your beneficiary designation carefully and consulting a qualified legal or financial professional if you are considering naming a minor.

12. **Review and Submit**

Before you submit your enrollment, take a moment to confirm:

- Your desired coverage is selected
- Your eligible dependents are included
- Unwanted benefits are waived

- Your payroll deductions are correct

When everything looks right, check **I Agree** and select **Save My Enrollment**.

Your enrollment is not complete until you submit your elections.

13. **Save Your Confirmation Statement**

After you submit your enrollment, you'll receive a **Benefits Confirmation Statement** showing your:

- Coverage effective dates
- Benefit election
- Payroll deductions

Save or print your confirmation statement for your records.

Need Help?

If you need technical assistance or have trouble logging in, please contact:

ebm Support

- Email: support@getebm.com
- Phone: 855-400-0792
- Hours: 8:30am to 5:00pm EST

Where Do I Enroll? Continental's 401(k) or ROTH 401(k)

401(k) Enrollment & Plan Information

You'll make your **401(k) or Roth 401(k) election** through **Fidelity NetBenefits**. Your retirement savings election is separate from your health and other benefit elections in bswift.

To enroll or manage your retirement savings:

- Visit **[NetBenefits.com](https://netbenefits.com)** or use the **NetBenefits mobile app**
- Log in or register as a new user
- Text **REGISTERNOW** to **343898**

When registering, you'll need to verify your identity and provide:

- Name
- Date of birth
- Email address and phone number
- Last 4 digits of your Social Security number

Fidelity uses this information to help protect your account and keep your contact information up to date.

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Medical Insurance



An Overview of Our Health Insurance Plans

Effective January 1, 2027, Continental's medical coverage will be through **Priority Health**.

Who Is Priority Health?

Priority Health is a **Michigan-based, nonprofit health insurance company and one of the largest health plans in the state**, serving approximately 1.4 million members. Priority Health has a strong provider network throughout Michigan and specializes in employer-sponsored health coverage.

For Continental team members who **live, work, or receive care outside of Michigan**, Priority Health has a Strategic Alliance with **Cigna Healthcare**. Through this relationship, eligible Priority Health commercial group members can access providers in the **Cigna Open Access Plus (OAP) network** outside Michigan. This provides access to a broad nationwide network of doctors and hospitals while Priority Health remains your health plan and continues to administer your coverage.

In simple terms: Priority Health is your medical carrier, with its primary network in Michigan. Cigna's nationwide network helps extend your access to in-network care when you live, work, or travel outside Michigan.

Introducing Garner

Who Is Garner?

Garner is a **health care navigation and provider-quality company—not an insurance company**. Garner works alongside

your Priority Health medical plan to help you find high-quality doctors and specialists within the Priority Health network.

Garner evaluates providers using clinical quality, patient outcomes, evidence-based care, and cost information to identify providers who meet its standards as **Garner Top Providers**.

Garner covers more than 80 specialties and uses extensive health care data to evaluate providers.

How Does Garner Fit with Your Priority Health Plan?

Think of the two programs as working together:

Priority Health = Your Medical Insurance

Priority Health provides your medical coverage, administers your plan, and gives you access to its provider network.

Garner = Your Provider-Selection Resource

Garner helps you identify high-quality providers within the Priority Health network and can provide additional financial savings when you choose an eligible Garner Top Provider.

When you use the Garner app or website before receiving care, you can search for eligible providers and see which doctors and specialists are recommended by Garner. If you choose an eligible Garner Top Provider, Garner may reimburse eligible out-of-pocket costs according to the terms of the Garner benefit.

Important: You can still receive covered care from other in-network Priority Health providers. Garner is an additional resource designed to help you make informed decisions about where you receive care and potentially reduce your out-of-pocket costs.

Think of it this way:

Priority Health provides your medical insurance.

Garner helps you find quality care within the Priority Health network and may help lower your eligible out-of-pocket costs when you choose a **Garner Top Provider**.

Priority Health

Once enrolled, you can log in to your Priority Health member account to:

- View claims and coverage information
- Find doctors and other healthcare providers
- Access or order ID cards
- Select or change your Primary Care Provider (PCP), when applicable

Your Priority Health ID card will be mailed to the address on file in **bswift**. You can also contact Priority Health Customer Service using the phone number on the back of your member ID card.

Priority Health Member Account: member.priorityhealth.com

Garner

Garner helps you find eligible, high-quality providers within the Priority Health network.

To get started, create your Garner account at:

garner.guide/access-garner

Once your account is set up:

1. Search for a **Garner Top Provider**.
2. Add your selected provider to your **Care Team before your appointment**.
3. Visit your provider and receive care.
4. Follow Garner's reimbursement process for eligible medical expenses.

IMPORTANT: Add Your Top Provider Before Your Appointment

You must add your Garner Top Provider to your Care Team before your appointment. This step is required to qualify for a Garner reimbursement.

If you do not complete this step before your appointment, you will not be eligible for reimbursement.

To learn more about Garner, visit [Garner's Continental Information Page](#).

Need Help with Garner?

You can contact the Garner Concierge:

- **In-app:** Use the chat feature in the Garner app
- **Phone:** 866-761-9586

- **Email:** concierge@getgarner.com
- **Hours:** Monday–Friday, 8:00 a.m.–10:00 p.m. ET

The Garner Concierge can help you find eligible providers, understand how Garner works, and navigate the reimbursement process.

Medical Plan Details

Core POS HDHP —

The **Core POS HDHP** is a High Deductible Health Plan (HDHP) that gives you access to a **Health Savings Account (HSA)**.

Important Medicare Notice: If you are approaching Medicare eligibility, please note that this plan is **not considered creditable coverage for Medicare Part D prescription drug coverage**. If you are eligible for Medicare and want to enroll in Medicare Part D, you generally should enroll during your Initial Enrollment Period or another applicable enrollment period to avoid a potential late-enrollment penalty. Continental cannot provide individualized Medicare enrollment advice.

Key Benefits

The Core POS HDHP provides access to the **Priority Health network in Michigan and the Cigna network for team members who live or work outside of Michigan**, while also allowing you to receive covered care from providers outside the network. The plan also includes access to **Garner**, which may provide additional savings when you choose eligible providers.

- **Priority/Cigna deductible:** \$6,500 individual / \$13,000 family
- **Garner deductible:** \$3,500 individual / \$5,500 family

- **Priority/Cigna out-of-pocket maximum:** \$8,500 individual / \$17,000 family
- **Garner out-of-pocket maximum:** \$5,550 individual / \$11,000 family
- **Coinsurance:** 80% plan / 20% team member after the applicable deductible
- **Health Savings Account:** Eligible team members may contribute to an HSA and receive a Continental matching contribution of up to **\$500 for employee-only coverage** or **\$750 for two-person or family coverage**

How the Plan Works

The Core POS HDHP has **no copays for medical services or prescription drugs until you meet the applicable deductible**. You generally pay the full cost of covered services until you meet your deductible.

Once you meet your deductible, the plan generally pays **80% of covered medical expenses**, and you pay the remaining 20% coinsurance, until you reach your annual out-of-pocket maximum.

Your HSA can help you pay eligible out-of-pocket expenses with tax-advantaged dollars.

Primary Care Provider and POS Flexibility

Team members residing in Michigan are required to select a Primary Care Provider (PCP). If you do not select one, Priority Health will assign one to you.

The Core POS HDHP gives you access to the **Priority Health or Cigna network** while also allowing you to receive covered care from providers outside the network.

Unlike the Enhanced HMO, the POS plan allows you to receive covered care from out-of-network providers. However, your costs may be higher when you receive care outside the network.

Understanding Your Network

When you receive care from an **out-of-network provider**, your costs may be higher. The provider may charge more than the amount recognized by Priority Health or Cigna, and you may be responsible for the difference between the provider's charge and the amount the carrier allows, in addition to any applicable deductible and coinsurance. Some out-of-network providers may also require you

to pay the full cost of the services covered upfront and then submit a claim to the carrier for reimbursement.

Before receiving care, confirm whether your provider participates in Priority Health or Cigna network and understand how your costs may differ if you choose an out-of-network provider.

Priority Health/Cigna + Garner

Garner can help you identify eligible high-quality providers and may provide additional savings when you receive care from a qualifying provider.

To maximize the savings available through Garner, use the **Garner app before receiving care** to identify an eligible provider and add the provider to your care team.

Using an eligible Garner provider may give you access to the lower **Garner deductible and out-of-pocket maximum**.

For the Core POS HDHP, eligible medical expenses must exceed the applicable IRS minimum spending requirement—**\$1,750 for individual coverage or \$3,500 for family coverage**—before Garner reimbursement applies.

Do not submit an expense for Garner reimbursement if the expense was already paid or reimbursed using HSA funds. Receiving reimbursement twice for the same expense is not permitted.

Remember

Before scheduling care, use Garner to find eligible providers when possible and confirm whether your provider is in-network. Choosing an eligible Garner provider may help reduce your out-of-pocket costs.

Enhanced HMO Plan —

The **Enhanced HMO plan** provides comprehensive medical coverage at a lower monthly cost, but it has more rules about where you receive care and how you access specialists.

This plan is available only to team members who live in Michigan.

Key Benefits

The Enhanced HMO plan provides access to the **Priority Health network** and requires you to coordinate most of your care through a Primary Care Provider (PCP). The plan also includes access to **Garner**, which may provide additional savings when you choose eligible providers.

- **Priority Health deductible:** \$6,000 single / \$12,000 family
- **Garner deductible:** \$1,000 single / \$2,000 family
- **Priority Health out-of-pocket maximum:** \$10,150 single / \$20,300 family
- **Garner out-of-pocket maximum:** \$5,150 single / \$10,300 family
- **Coinsurance:** 70% plan / 30% team member after the applicable deductible
- **Prescription copays:** Available before you meet the medical deductible

How the Plan Works

The Enhanced HMO plan has **prescription copays before you reach the deductible**. For other medical services, you generally pay the applicable expenses until you meet your deductible.

Once you meet your deductible, the plan generally pays **70% of covered medical expenses**, and you pay the remaining 30% coinsurance, until you reach your annual out-of-pocket maximum.

Primary Care Provider and Referrals

When you enroll in the Enhanced HMO, you will select a **Primary Care Provider (PCP)**. If you do not select a PCP, Priority Health may assign one to you within the first 60 days of coverage.

Your PCP helps coordinate your care and works with a network of providers.

Referrals are generally required to see most specialists.

Each family member enrolled in the medical plan may select their own PCP, or you may select the same PCP for your entire family.

You generally do not need a PCP referral for:

- **OB-GYN care:** Women may see any in-network OB-GYN for routine services, including Pap tests, annual well-woman visits, and obstetrical care.
- **Behavioral health:** You may see an in-network behavioral health provider without a PCP referral.
- **Emergency care:** Emergency services are covered regardless of where you receive care.

Understanding Your Network

The Enhanced HMO has a **restricted provider network**, so it is important to confirm that your doctor, specialist, hospital, or other provider participates in the Priority Health network before receiving care.

Non-emergency care from an out-of-network provider generally is not covered, and you may be responsible for the full cost of the service.

If you need care while traveling outside Michigan, check your benefits and network coverage through your Priority Health member account before receiving care. You can also contact Priority Health Member Services for assistance.

Priority Health + Garner

Garner can help you identify eligible high-quality providers and may provide additional savings when you receive care from a qualifying provider.

To maximize the savings available through Garner, use the **Garner app before receiving care** to identify an eligible provider and add the provider to your care team.

Using an eligible Garner provider may give you access to the lower **Garner deductible and out-of-pocket maximum**.

Remember

Always confirm that your provider is covered under your plan before receiving non-emergency care. Choosing an eligible Garner provider may help reduce your out-of-pocket costs.

Premier Point of Service (POS) Plan —

The **Premier POS plan** gives you access to the **Priority Health network in Michigan and the Cigna network for team members who live or work outside of Michigan**, while also allowing you to receive covered care from providers outside the network.

Key Benefits

The Premier POS plan provides access to the **Priority Health or Cigna network**, depending on where you live or work. The plan also includes access to **Garner**, which may provide additional savings when you choose eligible providers.

- **Priority/Cigna deductible:** \$6,000 single / \$12,000 family
- **Garner deductible:** \$1,000 single / \$2,000 family
- **Priority/Cigna out-of-pocket maximum:** \$8,550 single / \$17,100 family
- **Garner out-of-pocket maximum:** \$3,550 single / \$7,100 family
- **Coinsurance:** 70% plan / 30% team member after the applicable deductible
- **Prescription copays:** Available before you meet the medical deductible

How the Plan Works

The Premier POS plan has **prescription copays before you reach the deductible**. For other medical services, you generally pay the applicable expenses until you meet your deductible.

Once you meet your deductible, the plan generally pays **70% of covered medical expenses**, and you pay the remaining 30% coinsurance, until you reach your annual out-of-pocket maximum.

Primary Care Provider and POS Flexibility

Team members residing in Michigan are required to select a Primary Care Provider (PCP). If you do not select one, Priority Health may assign one to you within the first 60 days of coverage.

The Premier POS plan gives you access to the **Priority Health or Cigna network** while also allowing you to receive covered care from providers outside the network.

Unlike the Enhanced HMO, the POS plan allows you to receive covered care from out-of-network providers. However, your costs may be higher when you receive care outside the network.

Understanding Your Network

When you receive care from an **out-of-network provider**, your costs may be higher. The provider may also bill you for the difference between what Priority Health or Cigna pays and what the provider charges.

Some out-of-network providers may require you to pay for covered services upfront and then seek reimbursement from the carrier.

Before receiving care, confirm whether your provider participates in the Priority Health or Cigna network and understand how your costs may differ if you choose an out-of-network provider.

Priority Health/Cigna + Garner

Garner can help you identify eligible high-quality providers and may provide additional savings when you receive care from a qualifying provider.

To maximize the savings available through Garner, use the **Garner app before receiving care** to identify an eligible provider and add the provider to your care team.

Using an eligible Garner provider may give you access to the lower **Garner deductible and out-of-pocket maximum**.

Remember

Before scheduling care, use Garner to find eligible providers when possible and confirm whether your provider is in-network. Choosing an eligible Garner provider may help reduce your out-of-pocket costs.

Compare Medical Plans

You will see that the benefits grid below contains two deductibles and out-of-pocket maximums per plan for single and family coverage.

The first option is your benefits with Priority Health. If you choose not to use a provider through Garner, this is the amount you will pay.

The second amount listed under the green Garner Benefits line shows the amount you will pay if you use a Garner Top Provider. As you can see, using Garner could help you save thousands of dollars on your health care.

In-Network Benefits	Core POS HDHP HSA Eligible	Enhanced HMO	Premier POS
Deductible	\$6,500 Single \$13,000 Family	\$6,000 Single \$12,000 Family	\$6,000 Single \$12,000 Family
Out-of-Pocket Maximum	\$8,550 Single \$17,000 Family	\$10,150 Single \$20,300 Family	\$8,550 Single \$17,100 Family
Garner Benefits	Core POS HDHP HSA Eligible	Enhanced HMO	Premier POS
Deductible	\$3,500 Single \$5,500 Family	\$1,000 Single \$2,000 Family	\$1,000 Single \$2,000 Family

Out-of-Pocket Maximum	\$5,500 Single \$11,000 Family	\$5,150 Single \$10,300 Family	\$3,550 Single \$7,100 Family
Team Member Coinsurance	20% after deductible	30% after deductible	30% after deductible
Preventive	100% Covered	100% Covered	100% Covered
Office Visit	20% after deductible	30% after deductible	30% after deductible
Specialist Visit	20% after deductible	30% after deductible	30% after deductible
Urgent Care Visit	20% after deductible	30% after deductible	30% after deductible
Emergency Room Visit	20% after deductible	30% after deductible	30% after deductible

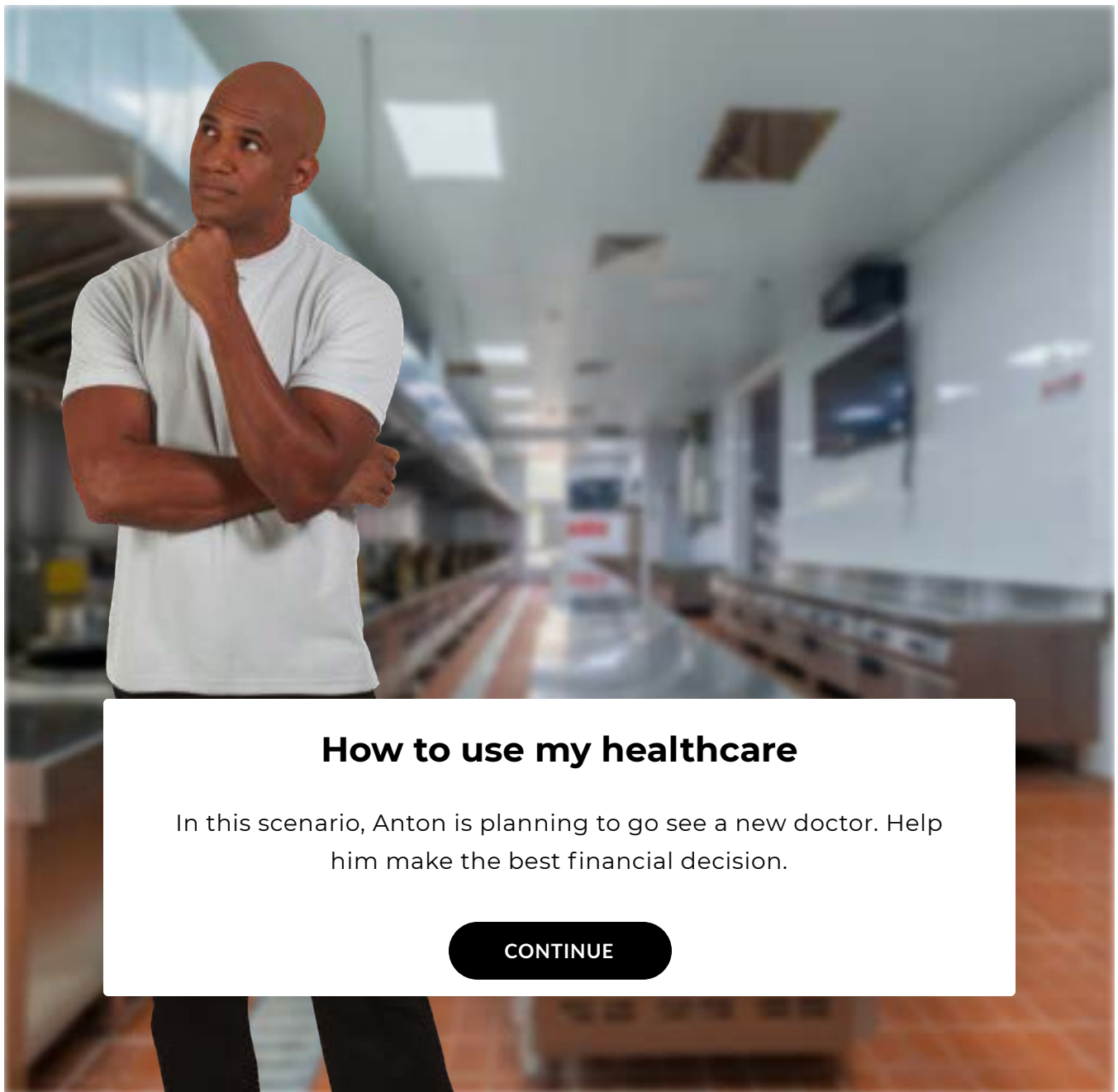
Retail Pharmacy 30-day Supply	Core POS HDHP (after medical deductible)	Enhanced HMO	Premier POS
Tier 1	\$15 Copay	\$15 Copay	\$15 Copay
Tier 2	\$50 Copay	\$50 Copay	\$50 Copay

Tier 3	\$80 Copay	\$80 Copay	\$80 Copay
Tier 4	\$50 Copay	\$50 Copay	\$50 Copay
Tier 5	\$80 Copay	\$80 Copay	\$80 Copay
90-day Supply			
Mail Order	2.5x tier copay	2.5x tier copay	2.5x tier copay
Retail	3x tier copay	3x tier copay	3x tier copay

Bi-Weekly Deductions (26 pays)	Core POS HDHP HSA Eligible	Enhanced HMO	Premier POS
Single	\$85.12	\$109.34	\$135.85
2 Person	\$191.08	\$254.33	\$311.52
Family	\$257.96	\$337.53	\$412.2

Weekly Deductions (52 pays)	Core POS HDHP HSA Eligible	Enhanced HMO	Premier POS
Single	\$42.55	\$54.67	\$67.92

2 Person	\$95.54	\$127.16	\$155.76
Family	\$128.98	\$168.77	\$206.13



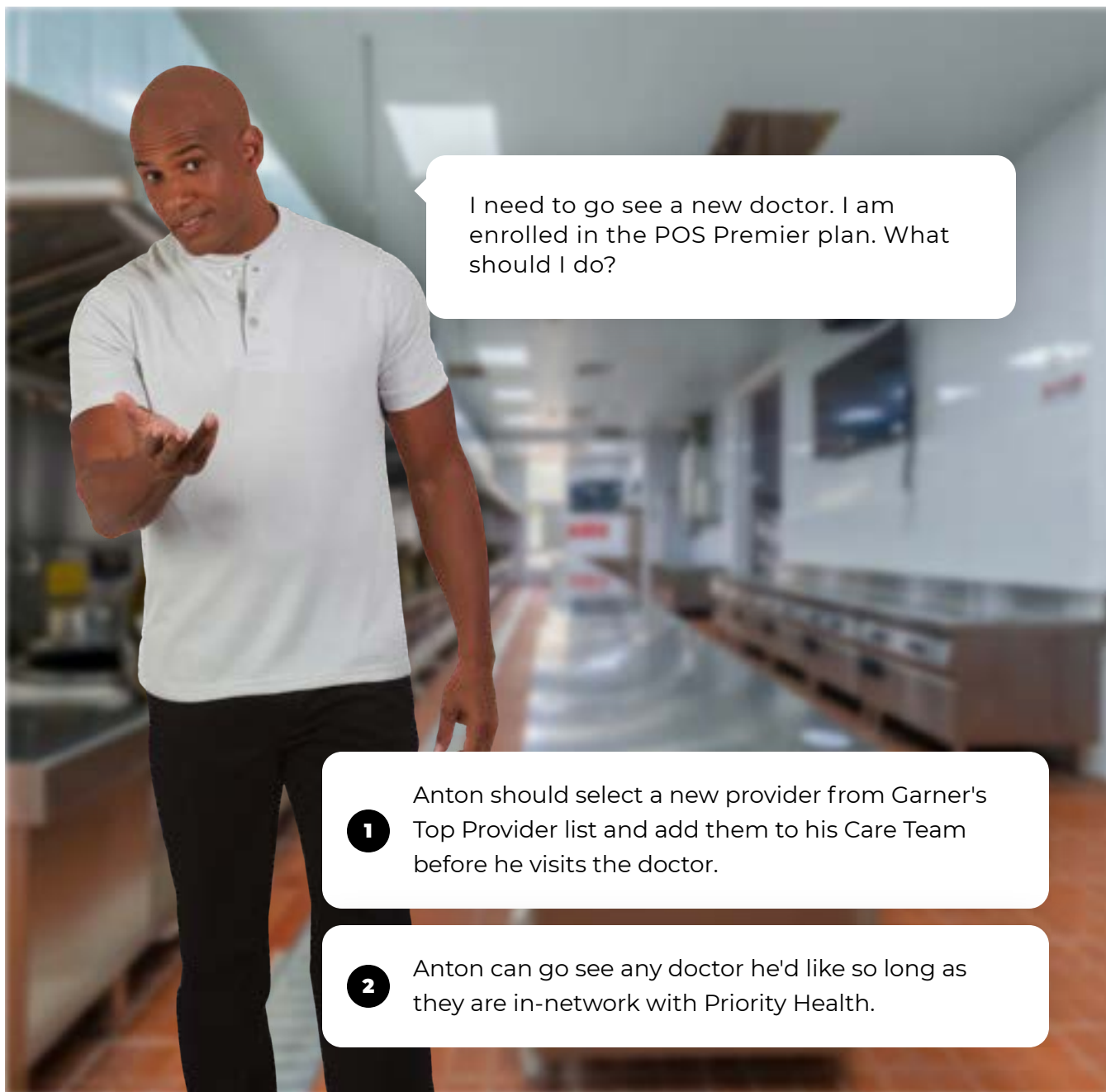
How to use my healthcare

In this scenario, Anton is planning to go see a new doctor. Help him make the best financial decision.

CONTINUE

Scene 1 Slide 1

Continue → Next Slide



I need to go see a new doctor. I am enrolled in the POS Premier plan. What should I do?

1

Anton should select a new provider from Garner's Top Provider list and add them to his Care Team before he visits the doctor.

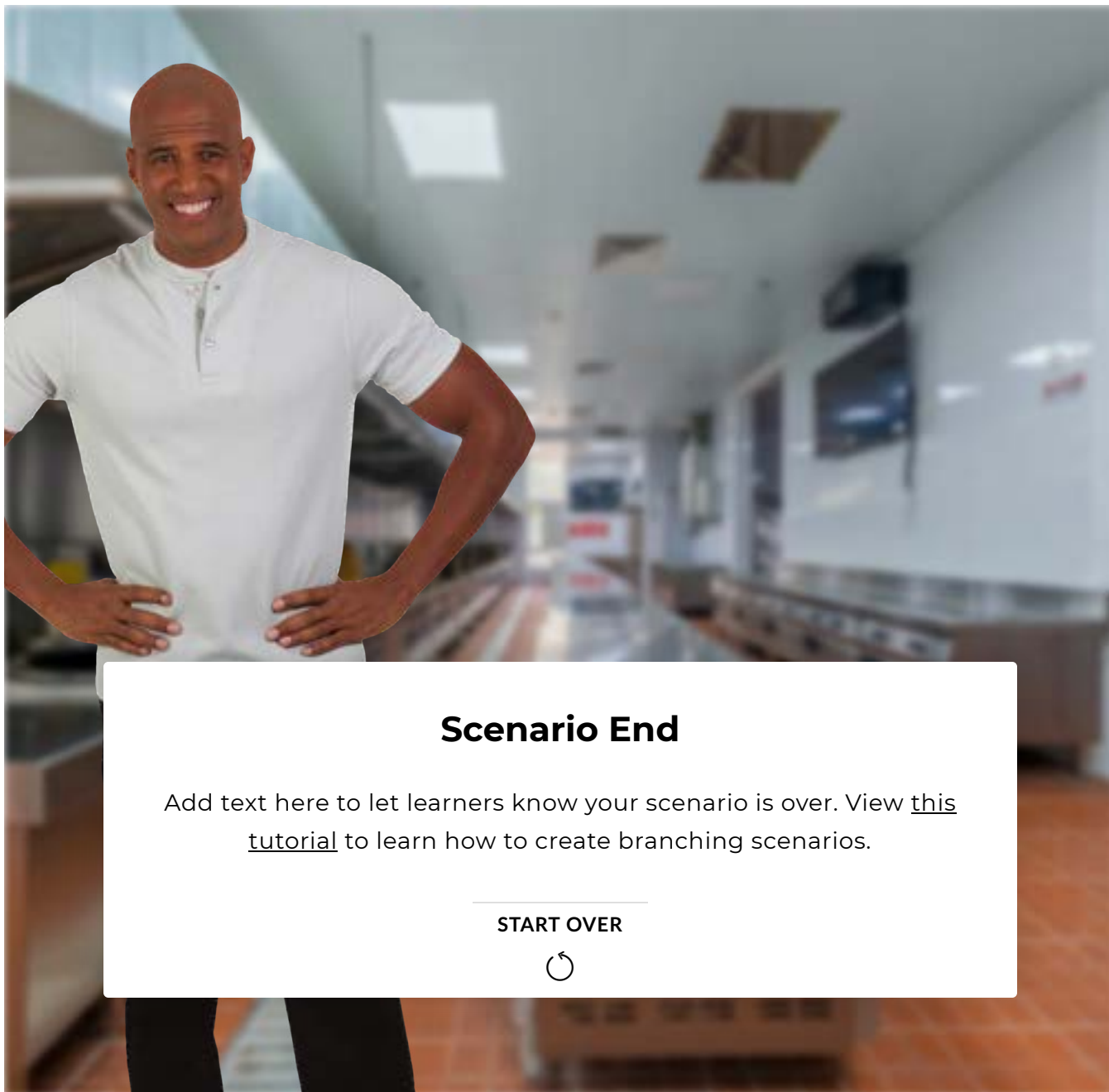
2

Anton can go see any doctor he'd like so long as they are in-network with Priority Health.

Scene 1 Slide 2

0 → Scene 1 Slide 4

1 → Scene 1 Slide 5



Scenario End

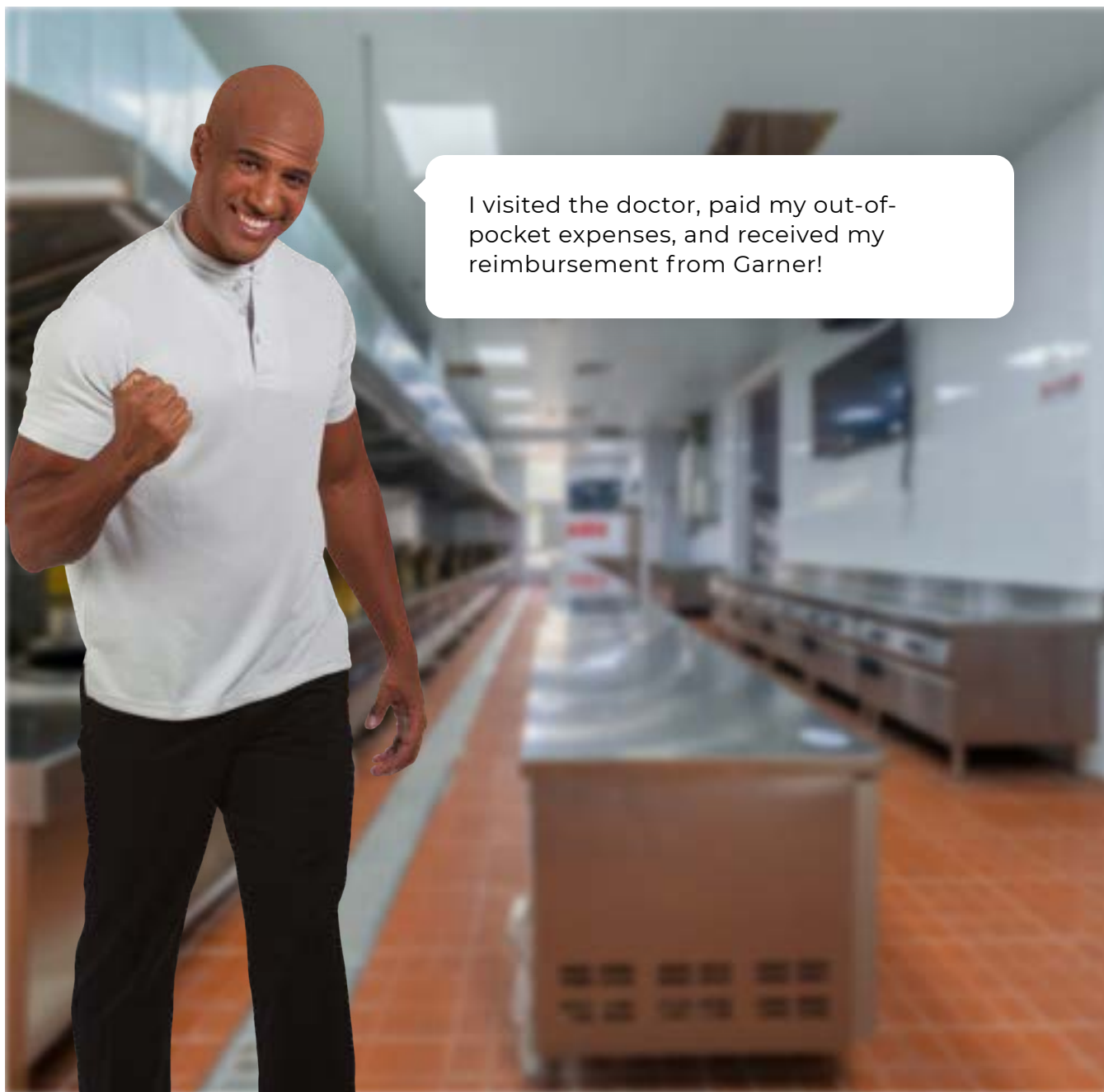
Add text here to let learners know your scenario is over. View [this tutorial](#) to learn how to create branching scenarios.

START OVER

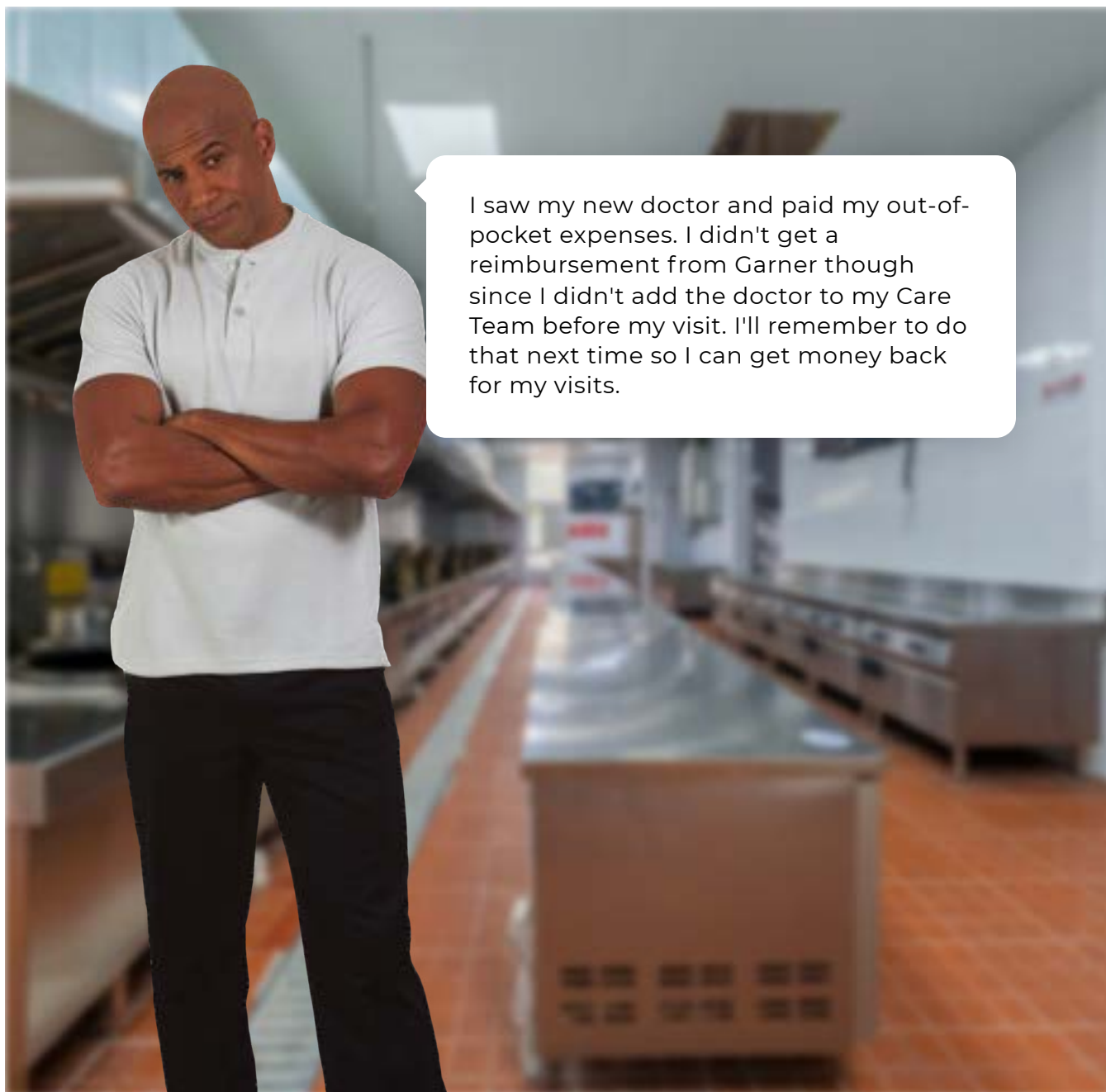


Scene 1 Slide 3

Continue → End of Scenario



Scene 1 Slide 4



I saw my new doctor and paid my out-of-pocket expenses. I didn't get a reimbursement from Garner though since I didn't add the doctor to my Care Team before my visit. I'll remember to do that next time so I can get money back for my visits.

Scene 1 Slide 5

Medical and Prescription Tools and Resources

Priority provides resources to help you make well-informed choices for care and make best use of your healthcare dollars. This easy, online platform lets you find a

new doctor, compare health care costs and more.

ADD FORMULARY LINK HERE. Visit prior to January 1 to confirm your drugs are covered. If your prescription is not covered, work with your doctor.

Primary Care Provider Designation and NPI:

- Michigan members enrolled in a medical plan will need to designate a PCP.
- Out-of-state members do not have a PCP designation requirement.

The best ways to obtain a PCPs NPI is to:

- Use the universal provider look-up tool and search within the appropriate state.
 - NPPES NPI Registry
- Contact the provider's office directly.
- Request a PCP listing from the incumbent carrier that includes NPI information.



2027 Priority Benefits OE Guide.pdf

8.3 MB



Priority Health

Register online to access your Priority account, view your health insurance details, find doctors, check claims, and more. Take charge of your health.

PRIORITY HEALTH

Garner

Once you have an account, search for a Top Provider and add them to your Care Team. **You must add the Top Provider to your Care Team before your appointment.**

GARNER

Summary of Benefits

SBCs

To view current SBCs, visit the bswift resources document library

SUMMARIES

Important Terms to Know

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service (sometimes called “copay”). The amount can vary by the type of covered health care service.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 30%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For

Out-of-Pocket Maximum

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health

In-Network

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

Out-of-Network

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain

CONTINUE

24/7 Virtual Care



The Priority Health medical plans include 24/7 virtual health care! There is no appointment needed. You and your family members (that are enrolled in a Continental medical plan) can get fast, convenient, affordable online health care when using this benefit.

What is an Online Doctor?

With unique and secure technology, Spectrum Health makes it possible to see a doctor, face to face, without you having to leave your home, on your smartphone, desktop computer, or telephone. With video, providers can look, listen and engage with you to diagnose your health concerns and provide an effective treatment plan.

You can use Spectrum Health for minor, nonemergency illnesses, such as: sinus & respiratory infections, colds, flu, seasonal allergies, urinary tract infections, pink eye, and rashes.

Two Convenient Ways to Receive Care with Spectrum Health:

Spectrum Health on-demand video visits are available when you're in the state of Michigan. How it works:

1. Log into your member account at member.priorityhealth.com, select virtual care and then click get started with the Spectrum Health app.
2. Select download the Spectrum Health app or visit mychart.spectrumhealth.org
3. Log in or create an account and select on-demand video visit.
4. You'll be asked a few health questions including a brief description of your current symptoms, and will need to complete the eCheck-in process before beginning your visit. Then, select **begin video visit** to be connected with a provider.

When you reside or travel outside Michigan, access virtual care through **MDLIVE**.
How it works:

1. Connect with MDLIVE one of three ways:

- Log into your member account at member.priorityhealth.com, click virtual care, click get started with MDLIVE.
- Download the MDLIVE: Talk to a Doctor 24/7 app.
- Call MDLIVE at 800-400-6354.
- Provide your Priority Health ID number on the front of your card.

2. Click or ask to schedule your appointment.

3. You'll be asked a few health questions, including a brief description of your current symptoms.

4. You'll be connected to a care provider.

If you need a prescription, it'll be sent to your local pharmacy. And, Spectrum Health will send all of the information to your primary care doctor so they have the details they need to help you be your healthiest.

CONTINUE

Health Savings Account (HSA)



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Access to this content has been restricted.
Contact your internet service provider for help.

What Is a Health Savings Account (HSA)?

An HSA is a special, tax-free piggy bank for your medical bills. You put money in, use it to pay for things like doctor visits or prescriptions, and take it with you even if you change jobs. The HSA is administered through Health Equity. If you already have a Health Equity card, you can continue to use it. New cards will be issued in January.

You can use your HSA for a variety of health-related costs. The general rule of thumb from the **IRS** is that the money must be spent to prevent, diagnose, alleviate, or treat a physical or mental illness.

Your HSA funds rollover from year-to-year and may be invested.

Please note that in order to make contributions to the HSA, you have to be enrolled in the Core POS HDHP - HSA Plan.

You should not receive reimbursements from Garner to claims you paid using HSA dollars. This is referred to as double-dipping and is prohibited by the IRS.

Maximum Annual Contributions

- **2027 Single:** \$4,500 per year per employee
- **2027 Family:** \$9,000 per year per family
- **Catch-Up Contribution (Age 55 and up):** \$1,000

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the security of your
connection.**

Access to this content has been restricted.
Contact your internet service provider for help.



Don't forget Continental's contribution to your account when you calculate how much you can contribute!

Continental will match your contributions up to \$500 for Single coverage and up to \$750 for 2-person or Family coverage.

What are the advantages of an HSA?

A Health Savings Account is an account you own. Any unused funds remain in the account. Funds can be deposited pre-tax, funds accrue tax-free, funds can be invested, and withdrawn funds are not taxed if they are used to cover eligible expenses.

Examples of Eligible HSA Expenses

Medical



- Deductibles
- Copays
- Prescriptions
- Hospital costs
- Medicare Part A, B, C and D

Dental —

- Deductibles
- Copays
- Orthodontia

Vision —

- Prescription glasses
- Prescription sunglasses
- Contact lenses and products

Visit <https://healthequity.com/hsa-qme> to search for even more eligible expenses!

HSA like a pro

Stretch your dollars further and put more money in your pocket. Health Savings Accounts empower you to save more, spend smarter and invest in your healthcare.

HSA GUIDE

CONTINUE

Flexible Spending Account (FSA)



What Is a Flexible Spending Account (FSA)?

An FSA provides you the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars. Different from an HSA, FSA funds are available on your first day of coverage and you pay the amount back through payroll deductions. **The funds also do not rollover from year to year, so only choose an amount you will spend within the plan year. Otherwise, you might**

lose money. You cannot stop or change contributions to your FSA during the year unless you have a qualifying event.

Our FSA is administered by Health Equity.

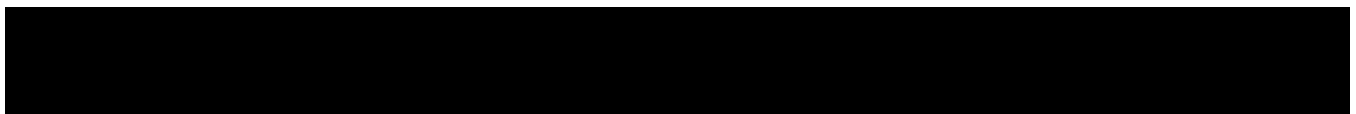
Continental offers three types of FSAs:

- Health Care FSA- used to reimburse out-of-pocket medical expenses incurred by you and your dependents
 - **You cannot have an HSA and a Health Care FSA during the same plan year**
- Limited Purpose FSA- used to reimburse out-of-pocket dental and vision expenses incurred by you and your dependents
- Dependent Care FSA- is used to reimburse expenses related to the care of eligible dependents while you and your spouse work

You should not receive reimbursements from Garner to claims you paid using HSA dollars. This is referred to as double-dipping and is prohibited by the IRS.

Maximum Annual Contributions

- **Healthcare:** \$3,500
- **Limited Purpose:** \$3,500
- **Dependent care:** \$7,500 per year per family



Do Unused FSA Funds Rollover?

Continental offers a rollover of \$700 for the 2027 plan year. Any unused funds above the \$700 rollover allowance will be forfeited.

Examples of Eligible FSA Expenses

Medical —

- Deductibles
- Copays
- Prescriptions
- Hospital costs

Dental —

- Deductibles
- Copays
- Orthodontia

Vision —

- Prescription glasses

- Prescription sunglasses
- Contact lenses and products

Physician Prescription Not Required

- Bandages and wraps
- Braces and supports
- First aid supplies
- Diabetic supplies
- Diagnostic tests and monitors
- Wheelchair, walker, cane

Dependent Care Eligible Expenses

- Daycare centers
- In-home daycare
- Summer day camp
- Nursery and preschool programs

Visit <https://healthequity.com/hsa-qme> to search for even more eligible expenses!

It Pays to be Strategic

An FSA empowers you to keep more of your hard-earned money. Plan your spending, know the rules and unlock amazing tax savings.

[FSA GUIDE](#)

[CONTINUE](#)

Dental Insurance



Dental Plan

Staying healthy includes obtaining quality dental care for you and your family. Continental's dental plans are provided through Delta Dental of Michigan, which includes an extensive network of providers and offers flexibility based upon where you choose to access care. You may access more information at www.deltadentalmi.com or by calling 800-870-9988.

In-Network Benefits	EPO*/** Delta Dental EPO Network Only	PPO Delta Dental PPO Network
Deductible	\$0 Single \$0 Family	\$0 Single \$0 Family
Preventive	Fee Schedule	100% covered
Basic	Fee Schedule	80% covered
Major	Fee Schedule	50% covered
Annual Maximum	No Maximum	\$1,000
Orthodontia	Not covered	Not covered
Network Details	- You must receive dental care from a Delta Dental EPO Dentist in order to receive benefits. You do not need to select a primary care dentist. - For EPO providers visit www.deltadentalmi.com - Select Delta Dental EPO to search for in-network providers	- You can choose any dentist, but will save the most by using a provider that participates in the Delta Dental PPO - For PPO providers visit www.deltadentalmi.com - Select Delta Dental PPO to search for in-network providers

		\$50 deductible applies when you receive services from a Delta Dental Premier or Nonparticipating Dentist
--	--	---

Bi-Weekly Deductions (26 pays)	EPO	PPO
Single	\$6.98	\$12.88
2 Person	\$12.93	\$25.39
Family	\$23.52	\$38.80

Weekly Deductions (52 pays)	EPO	PPO
Single	\$3.49	\$6.44
2 Person	\$6.46	\$12.70
Family	\$11.76	\$19.40



***EPO Disclaimer**

When electing the Delta Dental EPO, you will be asked to acknowledge that you have reviewed the Delta Dental EPO Summary of Dental Plans and the Member Copayment Schedule for the list of Covered Services and Copayments. These are located in the bswift resources documents library. Additionally, that you understand that all dental care must be received by a Delta Dental EPO Dentist in order to receive benefits.

****** The Delta Dental EPO is not available to residents of New York.

Dental Summaries

Dental Summaries

To view the dental summaries, visit the bswift resources document library.

SUMMARIES

CONTINUE

Vision Insurance



Vision Plan

Continental is pleased to offer a Vision Program through Delta Vision. Your network is VSP. The amount you pay depends on whether you visit a network or non-network provider. The benefits below are in-network. may access more information at www.vsp.com or by calling 800-877-7195.

Benefit	In-Network	Out-Of-Network
Exam Copay Covered Once Every 12 Months	\$10 Copay	Reimbursement up to \$45***
Frames Covered Once Every 24 Months	\$25 Copay \$130 Allowance 20% off remaining balance*	Reimbursement up to \$70**
Lenses Covered Once Every 12 Months		
Single Vision	\$25 copay	Reimbursement up to \$30***
Lined Bifocal		Reimbursement up to \$50***
Lined Trifocal		Reimbursement up to \$65***
Lenticular		Reimbursement up to \$100***
Contact Lenses* Covered Once Every 12 Months *In Lieu of Glasses Lenses		

Fitting and Evaluation	\$60 Copay	Not Available
Elective	Covered up to \$130	Reimbursement up to \$105***
Medically Necessary**	\$20 Copay; Covered in full for certain conditions	Reimbursement up to \$210***



*Based on applicable laws; benefits may vary by doctor location.

**Necessary contact lenses are prescribed to correct extreme visual problems that cannot be corrected with regular lenses.

***Less any applicable copay.

If a member chooses contact lenses, they will be eligible for lenses 12 months and frames 24 months from the date the contact lenses were obtained.

Please note the vision plan does not cover prescription sunglasses or non prescription lenses.

Bi-Weekly Deduction (26 pays)	Vision
Single	\$2.33

2 Person	\$4.65
Family	\$7.50

Weekly Deduction (52 pays)	Vision
Single	\$1.16
2 Person	\$2.33
Family	\$3.75

Use it!

If you purchase vision insurance, but never use it, you have wasted your money.
Make sure you get your annual eye exam.

In-Network Providers

While you are free to visit out-of-network providers, **you'll get the most out of your benefit by seeing an In-Network Provider.**

Additional Savings

- **Frames discount over allowance** - An extra \$20 allowance on Featured Framed Brands for frames.
- **Additional pair** - 20% savings on unlimited additional pairs of prescription glasses and/or nonprescription sunglasses from any VSP network provider within 12 months of exam.
- **LASIK** - Average 15% off the regular price. Discounts only available from contracted facilities.
- **Retinal Imaging** - Routine retinal screening covered after a maximum copay of \$39.
- **Essential Medical Eye Care** - Retinal imaging for members with diabetes covered-in-full. Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and

more. Coordination with your medical coverage may apply. Ask your VSP network doctor for details.

- **Low vision** -Pre-approved low-vision supplemental testing covered every two years. 75% coverage for approved low-vision aids, up to \$1,000 (less any amount paid for supplemental testing) every two years.
- **Eyconic** - Go to eyeconic.com for an easy-to-use, convenient online eyewear option that integrates with your in-network benefits.
- **TruHearing** - Save up to 60% on digital hearing aids with TruHearing. Visit vsp.com/offers/special-offers/hearing-aids for details.

Vision Summary

Vision Summary

To view the Vision Summary, visit the bswift resources documents library

SUMMARY

CONTINUE

Life Insurance



Group Plans

Our Group Plans

Life insurance is an important part of your financial well-being, especially if others depend on you for support. Continental provides Basic Life and AD&D coverage at no cost to you through Lincoln Financial.

The amount of your benefit depends on your level of employment, location, and union. Your benefit will be displayed for your review in bswift. All Life plans come with a matching **Accidental death and dismemberment (AD&D)** benefit. AD&D

insurance provides benefits to you or your beneficiary if, due to and accident, you suffer loss of life or limb.



Benefit Age Reductions do apply to this benefit. 35% reduction at age 65. 60% reduction at age 70. 75% reduction at age 75. 85% reduction at age 80.

A vibrant background image featuring a dense collection of open umbrellas in various colors including blue, yellow, orange, pink, and green, set against a clear blue sky. The umbrellas are scattered across the frame, creating a colorful and lively pattern.

Voluntary Plans

True Open Enrollment

This year, Open Enrollment includes a special opportunity to enroll in or increase your Voluntary Life Insurance coverage without completing Evidence of Insurability (EOI), also known as

a medical questionnaire. Normally, team members who elect coverage above certain limits or who did not enroll when first eligible may be required to provide health information for approval by the insurance carrier.

During this Open Enrollment period only, eligible team members may elect available Voluntary Life Insurance coverage without providing Evidence of Insurability. This is a valuable opportunity to review your current coverage and make changes based on your family's needs and financial goals.

This special enrollment opportunity will only be available during this year's Open Enrollment period. Once Open Enrollment ends, team members who wish to enroll in or increase coverage in the future may be required to complete Evidence of Insurability and receive carrier approval.

If you have submitted EOI to Lincoln in the past and been denied, you will not be able to receive coverage under this Open Enrollment event.

Voluntary Life Insurance

You may purchase units of \$10,000 to a max of five (5) times annual salary or \$500,000. As a new hire, you may purchase up to \$300,000 without submitting Evidence of Insurability (EOI). This new hire exception to EOI requirements is called the guaranteed issue amount.

You may also purchase voluntary life for your spouse or children if you have coverage for yourself.

You may elect a spouse benefits of 50% the amount you elected for yourself.

Guaranteed issue for spousal coverage is \$30,000 and spouses can be enrolled in up to \$250,000 available in \$5,000 increments. Children can be enrolled for \$10,000.

Electing child coverage will provide a benefit for all you eligible children but only cost you one premium.

How to Complete EOI

Evidence of Insurability (EOI) may be required when you elect coverage above the plan's guaranteed issue amount or request an increase to your existing coverage. EOI is completed through **Lincoln Financial** and may include questions about your health, medical conditions, and medications.

How to Complete EOI

1. Log in to Lincoln Financial at LincolnFinancial.com or through the Lincoln Financial Mobile App.
2. First-time users: Register using Company Code 1087733.
Follow the prompts to enter your personal information, verify your identity, and create a username and password.
1. Review your information and **confirm the correct coverage type** is displayed.
2. Select **Complete Evidence of Insurability**.

3. Complete the required questions, which may include:

- General information, such as birthdate, height, and weight
- Questions about diagnoses and prescribed medications
- Additional medical information, such as diagnosis dates and treatments, if applicable

1. Review your answers, electronically sign, and submit your application.

2. Save your confirmation for your records.

What happens next?

Lincoln Financial will notify you of the application outcome. You may be automatically approved, or Lincoln may contact you if additional information is needed. **Coverage requiring EOI is not effective until Lincoln approves the application.**



Benefit Age Reductions do apply to this benefit. 35% reduction at age 65. 60% reduction at age 70. 75% reduction at age 75. 85% reduction at age 80. Spouse coverage amounts are reduced by 35% when the covered team member reaches age 65.



Please enter a beneficiary in bswift. Your beneficiary will receive the benefits of a life insurance plan. You may select multiple beneficiaries and indicate the percentage of the benefit you would like each to receive. Not listing a beneficiary causes a delay in the payment of these benefits that can burden your loved ones.

Life Summaries

Life Summaries

To view the Life insurance summaries, visit the bswift resources document library

SUMMARIES

CONTINUE

Disability Coverage



Disability Benefits

Disability insurance is designed to help replace a portion of your income if you become unable to work due to a nonwork-related illness or injury. Benefit-eligible team members may elect Short-Term Disability (STD) and/or Long-Term Disability (LTD) coverage administered by Lincoln Financial Group.

Premiums for these coverages are **100% team member-paid** using **post-tax dollars**, which means that any benefits you receive are **nontaxable** at the time of claim.

Short-Term Disability

Benefit	—
----------------	---

70% of weekly salary to a maximum of \$1,000

Duration of Benefits	—
-----------------------------	---

Up to 13 weeks

Waiting Periods	—
------------------------	---

8-day elimination period for accident and illness

Pre-Existing Limitation	—
--------------------------------	---

3/12.

A 3/12 pre-existing limitation means that any disability resulting from a condition for which you received treatment during the 3 months prior to your coverage effective date will not be covered until you have been insured under the plan for 12 consecutive months. After that time, the exclusion no longer applies.

Disabilities caused or contributed to by a pre-existing condition are excluded from coverage unless specific time requirements are met.

A pre-existing condition is any sickness or injury for which you received medical treatment, consultation, care, or services — including diagnostic tests or prescribed medications — during a specified period before your coverage began.

Voluntary Long-Term Disability

Benefit —

60% of monthly salary up to a maximum of \$5,000 per month

Duration of Benefits —

Social Security Normal Retirement Age
(The U.S. full retirement age is 65 for people born before 1960 and 67 for those born in or after 1960.)

Waiting Periods —

91-day elimination period for accident and illness

Pre-Existing Limitation —

3/12.

A 3/12 pre-existing limitation means that any disability resulting from a condition for which you received treatment during the 3 months prior to your coverage effective date will not be covered until you have been insured under the plan for 12 consecutive months. After that time, the exclusion no longer applies.

Disabilities caused or contributed to by a pre-existing condition are excluded from coverage unless specific time requirements are met.

A pre-existing condition is any sickness or injury for which you received medical treatment, consultation, care, or services — including diagnostic tests or prescribed medications — during a specified period before your coverage began.



New York State Leave Law

New York State provides several important leave benefits to support team members during times of personal or family health needs. This includes **New York State Disability Benefits (DBL)** for off-the-job injuries or illnesses and **Paid Family Leave (PFL)** for bonding with a new child, caring for a seriously ill family member, or managing responsibilities when a family member is called to active military service.

In addition to these state-mandated programs, Continental Cafe offers a Short Term Disability (STD) plan that provides additional coverage. The following section outlines how these programs work individually and how they coordinate to provide protection in the event you're unable to work due to injury or illness. Your Lincoln Financial Short Term Disability is offset by any state benefits.

If your weekly Lincoln benefit is \$1,000 and your New York Disability Benefits is \$250, you will receive one check from Lincoln for \$750 and one from NYDBL for the \$250.

Disability Summaries

Disability Summaries

To view the Disability summaries, visit the bswift resources document library

SUMMARIES

CONTINUE

Worksite Benefits



Worksite coverage fills gaps left by medical insurance and help to pay for care, housing, recovery, and more.

Worksite benefits, like accident, critical illness, and hospital indemnity plans, are supplemental insurance policies. They don't replace health insurance; instead,

they're designed to provide extra cash directly to the policyholder, which can help offset out-of-pocket expenses not covered by traditional health insurance.

1

Voluntary Accident insurance helps deliver financial security for the unexpected—allowing you to protect your budget against unforeseen expenses if you suffer an accidental injury. You can use the cash benefits from this coverage to help meet copayments and other expenses while you recover, or any other way you see fit. Since no one can predict an accident, there are no pre-existing exclusions for this benefit.

Accident coverage is provided by Lincoln Financial Group and pays you based on a schedule of benefits corresponding to your accident. One accident can generate multiple payments. For example, if you fall down the stairs and fracture your lower arm and wrist and go to the doctor to get an x-ray, you can receive \$2,150 for the arm, \$1,600 for the wrist, \$150 for your initial urgent care visit, and \$250 for your initial x-ray.

2

Voluntary Critical Illness insurance is a group policy form that includes coverage for heart attack, stroke, cancer, and other critical illnesses. Benefit amounts are available at various levels. You can choose \$10,000 to \$20,000 for team members. You can also add coverage for your dependents. Spouse: \$5,000 to \$10,000. Child: 25% of Team Member Amount.

Critical Illness coverage is provided by Lincoln Financial Group and has no pre-existing limitations. This means the plan covers health issues you had before your policy started, without denying care, charging extra, or setting benefit limits for those medical problems. **Receive a \$50 wellness benefit every year you and any covered family members complete a single covered exam or screening.**

Voluntary Hospital Indemnity insurance covers you if you are admitted for a covered sickness or injury. The benefit pays you based on the type of admission (regular hospital or intensive care) and pays for again based on how many days you stay in the hospital (this is referred to as "confinement").

This benefit is provided by Lincoln Financial Group and has no pre-existing limitations. This means the plan covers health issues you had before your policy started, without denying care, charging extra, or setting benefit limits for those medical problems. This includes delivery and complications of pregnancy.

Monthly Rates

Benefit	Single	Team Member + Spouse	Team Member + Child(ren)	Family
Accident	\$14.05	\$22.93	\$24.64	\$33.42
Critical Illness	Critical Illness rates are based on your age and the amount of benefit you elect. Rates will calculate in bswift			

	for your review.			
Hospital Indemnity	\$17.02	\$36.67	\$25.91	\$47.44

Worksite Summaries

Worksite Summaries

To view the Worksite summaries, visit the bswift resources document library

SUMMARIES

CONTINUE

401(k)

An aerial photograph of a small boat moving through vibrant green water, leaving a white wake. The text is overlaid on the left side of the image.

What better way to plan and save for your retirement than participating in a 401(k) plan?

Investing in Your Future

By participating in a 401(k), you will make elective deferrals from your paycheck before taxes or after taxes and deposit those funds into an investment account in mutual funds that could include money market investments, bonds, and stocks.

Plan Overview

Continental offers a traditional 401(k) or Roth 401(k) plan. Fidelity Investments is the provider for our 401(k) plans.

New for 2027! Continental contributes to your plan at a rate of sixty cents (\$0.60) for every dollar you contribute, up to the first five percent (5%) of your elected contribution. All plan expenses are paid from plan assets.

You can make contributions from your paycheck on a pre-tax or post-tax basis. You can make 401(k) contributions up to 100% of your compensation, subject to the annual maximum amount allowed by law (projected to be \$25,500 in 2027).

If you are 50 years of age or older, you can make an additional **catch-up contribution** (up to \$8,000 in 2027).

If you are 60 to 63, you can make an additional **enhanced catch-up contribution**. This special provision allows for an increased limit, projected to be \$11,750 in 2027.

New for 2027! The employer match is 100% vested immediately. Any amount you previously contributed will be accelerated to 100% vesting January 1, 2027.

Employees 21 years of age or older are eligible to enroll the first of the month following one month of active employment.

Where to Find More Information

To receive plan materials or to enroll, please contact Fidelity Investments at (800) 294-4015 or register as a new user at:
<https://netbenefits.fidelity.com/index.htm>

Please allow up to two (2) weeks for your information to be available in Fidelity's system. Fidelity representatives can assist with enrollment, payroll deductions, and rollovers from other retirement plans.

For further assistance, you may also contact Continental's Financial Advisor, **CAPTRUST at Work**: (800) 967-9948

To learn more about financial guidance resources, visit CAPTRUST.

CAPTRUST AT WORK

To schedule an appointment with an advisor, visit the CAPTRUST Scheduler.

SCHEDULER

CONTINUE

Additional Benefits



1

TravelConnect - When you are traveling more than 100 miles from home for business or personal travel, know that resources are available 24/7 to help you with emergency evacuations, child transportation, lost or stolen travel documents, language translation, provider referrals and more. This program is provided at no cost to you. **Call 866-525-1955 or visit [MyOnCallPortal.com](https://myoncallportal.com), 24/7. Use Group ID: *LFGTravel123*.**

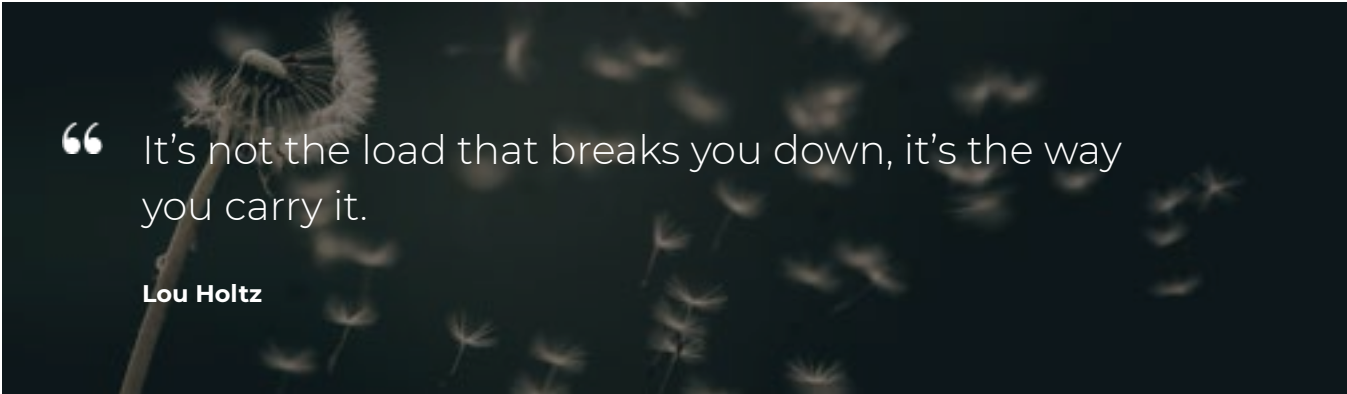
2

Life Keys - LifeKeys services are available at no cost to you.

Services provided include discounts on shopping and entertainment, important life matters such as legal, financial, family and career, ID theft resources and information, online will preparation, assistance for your beneficiaries in the event of your death. **Call 855-891-3684 or visit [GuidanceResources.com](https://www.guidanceresources.com), select *Register*, and enter *LifeKeys*.**

CONTINUE

Employee Connect



“ It’s not the load that breaks you down, it’s the way you carry it.

Lou Holtz

Life Is Full of Challenges

Whether your needs are big or small, your Team Member Assistance Program is there for you. It can help you and your family find solutions and restore your piece of mind.

You have access to confidential clinical and work-life consultation by phone 24/7, five free in-person counseling sessions, legal and financial consultations. To access the Team Member Assistance Program, call 888-628-4824, download the GuidanceNow mobile app, or go online to www.guidanceresources.com. Register using our web ID, *LFGSupport*. Use *LFGSupport1* as your temporary password.

CONTINUE

Summary and Contact Information



Bringing It All Together

To access more details about plan offerings, visit Continental's benefit portal:

<http://continentalcafe.bswift.com/>. This site provides you with detailed information about your benefit programs and allows you to enroll, or request changes to your enrollment due to a qualified life event, online.

For technical support with bswift, contact support@getebm.com or call 855-400-0792.

Key Reminders

1

Enrollment must be completed through bswift

2

New Team Members are eligible the first of the month following 30-days of employment. *Examples: Team Member hired August 1 becomes benefits eligible September 1. A Team Member hired August 2 becomes benefits eligible October 1.*

3

We strongly recommend completing your enrollment in bswift prior to your eligibility date so your deductions begin on time

Additional Contact Information



Medical and Prescriptions

Call the number on the back of your card or visit priorityhealth.com



Create you account at garnerguide.com/direct-Priority-Health.

To learn more about Garner, visit <https://garnerguide.com/continental>.

You can message the Garner

The logo for HealthEquity, featuring the word "HealthEquity" in white text on a purple rectangular background.

HealthEquity®

**Health Savings Account &
Flexible Spending Account**

866-346-5800

www.healthequity.com

The logo for Delta Dental, featuring a white triangle icon followed by the words "DELTA DENTAL" in white text on a green rectangular background.

DELTA DENTAL®

Dental

800-524-0149

www.deltadentalmi.com



Vision

800-877-7195

www.vsp.com



**Life, Disability, Critical
Illness, and FMLA**

800-423-2765

www.lincolffinancial.com



Employee Assistance Program

888-628-4824

www.guidanceresources.com

Username: LFGSupport

Temporary Password:

LFGSupport1



401(k) and ROTH

800-294-4015

<https://netbenefits.fidelity.com>

Stephen Bratta - Financial Advisor

249-939-4545

stephen.t.bratta@ampf.com



586-939-3600

benefits@continentalserves.com

For questions regarding mid-year benefit changes, qualifying events, changes to benefit deduction amounts, payroll questions related to your employee benefit coverages or retirement election.



Continental Benefit Advocacy

502-785-4225

Help@AliumInsurance.com

Provide a description of your issue and include your name, company, and phone number. *Please do not send Protected Health Information.*

Thank you for completing this course!