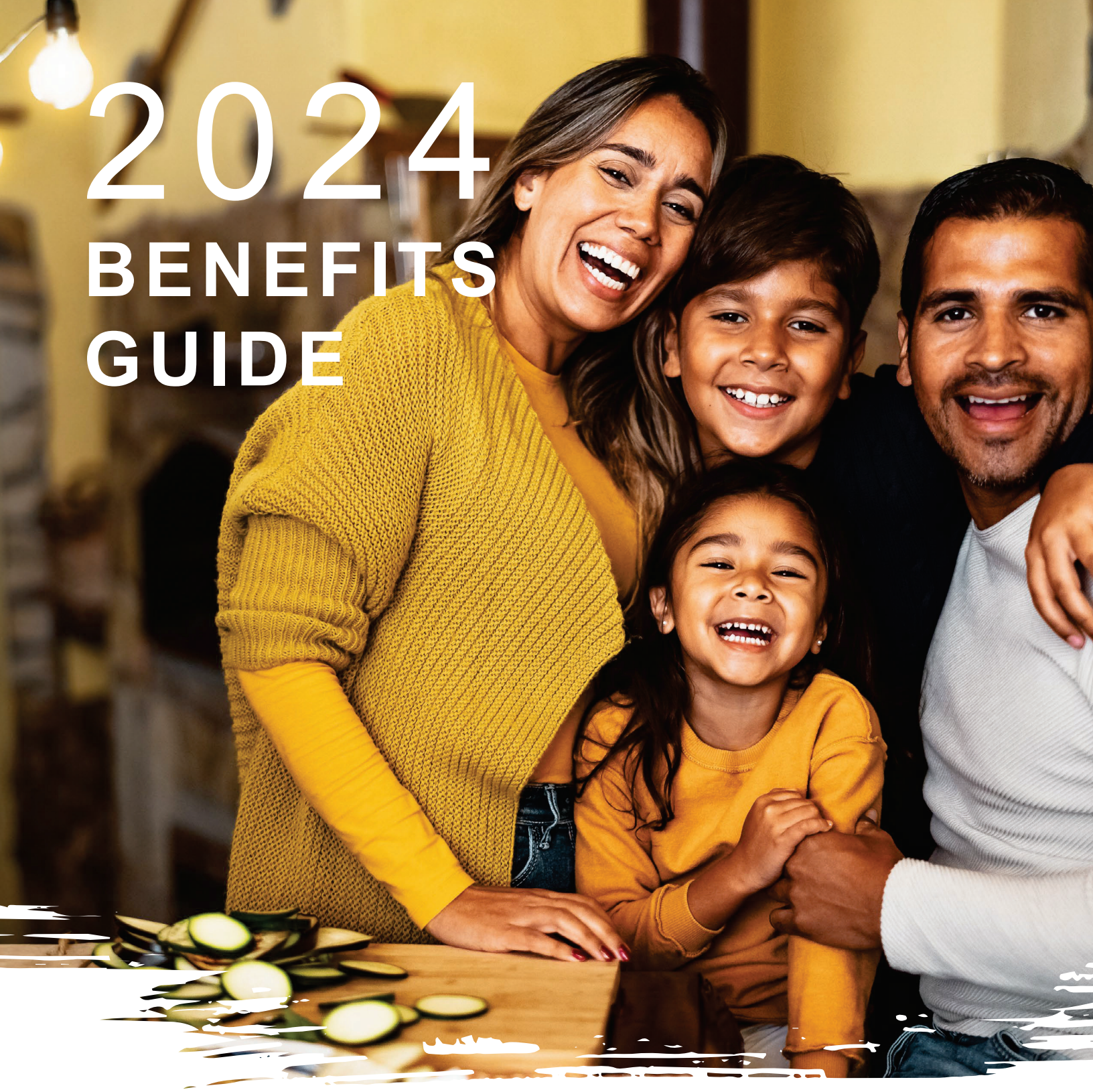
2024 BENEFITS GUIDE



PCTEL®

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Welcome to Your PCTEL, Inc. 2024 Benefits!

Your needs, and those of your family, are unique to you. That's why PCTEL provides a comprehensive and flexible benefits program that you can customize to fit your personal situation. Our program offers you and your family important healthcare coverage and financial security.

Some of the benefits we offer are paid for in full by PCTEL For others, it is a shared contribution between you and the company. Other benefits are also available to you at reasonable group rates.

Your benefits are an important part of your total compensation at PCTEL Please take the time to review and evaluate all the options available to you and your family.

We have created a video to further explain your benefits, click **here** to view. Also, refer to page 5 for more specific online enrollment instructions.

This guide is not intended to be a complete description of the insurance coverage offered, nor is it a binding contract. Controlling provisions are provided in each benefit plan policy. Should there be a difference between this guide and the official plan documents, the official plan documents will govern.

More information about specific terms and conditions of each plan is included in the Summary Plan Description (SPD) and Summary of Benefits and Coverage (SBC).

Benefits Overview

Company-Paid Benefits

- Basic Life/AD&D—Lincoln Financial Group
- Short Term Disability—Lincoln Financial Group
- Long Term Disability—Lincoln Financial Group
- Vision—EyeMed (tied to medical enrollment)
- Business Travel Accident—Chubb
- Employee Assistance Program (EAP)—Workplace Solutions
- Gap Plan—Transamerica (tied to HDHP medical plan)

Benefit Options Requiring Employee Contributions

- Medical/Rx—BlueCross BlueShield of Illinois
  - HMO (IL only)
  - High Deductible Option with HSA
  - Low PPO Option
- Dental—MetLife
- Voluntary Life—Lincoln Financial Group
- Voluntary AD&D—Lincoln Financial Group
- Flexible Spending Accounts (FSA)—ADP
- Identity Theft Protection—LifeLock
- Pet Insurance—Nationwide
- Additional Protection Benefits
  - Accident Insurance—MetLife
  - Critical Illness—MetLife
  - Hospital Indemnity Insurance—MetLife

Additional Benefits and Programs

- Financial Wellness—SoFi
- 529 College Savings Plan—College Bound Fund
- 401(k) Retirement Savings Plan—Empower

Open Enrollment

Open enrollment is your once-a-year opportunity to review your benefit plan elections and make adjustments that meet the needs of you and your family. Changes at any other time will require a Qualified Life Event. See page 5 for more information.

Changes made to most benefits during open enrollment will go into effect January 1st. Exceptions apply for Voluntary Life elections that require evidence of insurability (EOI).

A Note About Healthcare Reform

If you choose to purchase individual coverage through the Marketplace, you should know that because PCTEL's medical insurance meets specific ACA requirements, you may not be eligible to receive a federal subsidy.

Additional information is available at **www.healthcare.gov**.

Eligibility and Enrollment

Who is Eligible?

You are eligible for PCTEL benefits if you are:

- An active full-time employee working 30 or more hours per week

Your dependents are eligible if they are:

- Your legal spouse or domestic partner
- Your and/or your domestic partner's child(ren)* up to age 26
- Your disabled child(ren) up to any age (if disabled prior to age 19)*

Spousal Surcharge Notice

If you choose to cover your spouse who has access to medical coverage through their own employer on your insurance plan, you will pay an additional $250 per month. See page 34 for more information.

About Domestic Partner Coverage

To enroll your domestic partner and their dependents for coverage, you will be required to submit:

- Proof of domestic partnership
- Appropriate declaration forms

Under federal law, PCTEL's contribution toward the cost of healthcare coverage for your domestic partner and his or her dependents is considered taxable income to you.

Domestic partner premiums will be deducted on a post tax basis. You may wish to consult with a tax adviser for more information.

* Includes natural, step, legally adopted/or a child placed for adoption, or a child under your legal guardianship

Domestic Partners are defined as:

- You have lived together for at least six months.
- You are not married to anyone else nor have another Domestic Partner.
- You are at least 18 years of age and mentally competent to consent to contract.
- You reside together in the same residence and intend to do so indefinitely.
- You have an exclusive mutual commitment similar to that of marriage.
- You are jointly responsible for each other's common welfare and share financial obligations.
- You can provide all or some of the types of documentation indicated below if requested:
  - Domestic Partner Affidavit
  - Joint mortgage or lease
  - Designation of Domestic Partner as beneficiary for life insurance and retirement contract
  - Designation of Domestic Partner as primary beneficiary in employee's or insured's will
  - Durable property and healthcare powers of attorney
  - Joint ownership of motor vehicle, joint checking account, or joint credit account

When Can You Enroll in Benefits?

You can enroll for benefits:

- Within 30 days of first becoming eligible for benefits
- During the annual open enrollment period
- During the plan year, if you experience a Qualifying Life Event

When Does Coverage Begin?

Benefits for new hires, unless explained otherwise, will become effective on 1st of the month coinciding with or after date of hire.

How Do I Enroll in Benefits?

You must actively enroll in all benefits that require employee contributions. You will be automatically enrolled in all company-paid benefits.

You may enroll online or via the call center:

To enroll (or make changes) to your benefits, you may access the Self-Serve Enrollment website at **https://metlife.benselect.com/PCTEL**.

- Login: Username is based on your legal name in following (case sensitive) format: Firstname. Lastname
- Password is a 6-digit PIN consisting of the employee's last 4 digits of SSN followed by their 2-digit year of birth
- For example, a team member with a SSN of ###-##-8977 and a DOB of 07/05/1983 would have a PIN of 897783
- Once logged in you will be prompted to change your password.
- You may also enroll via the Call Center at **314.788.6926** (open 8am-5pm CST)

Once enrolled you will receive an email within one business day of the completion of your enrollment certifying your elections. If you do not see your confirmation email within one business day, be sure to check your junk and/or spam folder.

Termination of Coverage

If you or a covered dependent no longer meet these eligibility requirements or if your employment ceases, your medical, dental, vision, and Health Care FSA coverage will end on the day you become ineligible. For a child reaching their limiting age of 26 their coverage will end at the end of the month.

You may be eligible to elect COBRA for yourself and your eligible dependents for medical, dental, vision and underspent Health FSA benefits.

Life and Disability coverage will end on the day you become ineligible. Your life coverages are convertible.

You are responsible for informing Human Resources within 30 days if any of your dependents become ineligible for benefits.

Please Note

Federal regulations require PCTEL to obtain the following information during enrollment:

- Social Security numbers for your dependents covered by the medical plan
- Dates of birth and your relationship to your dependents

MAKING BENEFIT CHANGES DURING THE PLAN YEAR

The benefit elections you make during your initial enrollment period will be in effect through December 31, 2024.

If you have a “qualified life event,” you may make changes to certain benefits if you apply for the change and provide supporting documentation to Human Resources within 30 days of the event. Proof of life events are subject to approval by PCTEL.

Changes are generally effective retroactive to the date of the event or first of the month following the event depending on the benefit and event.

Qualifying life events include:

- Your marriage
- Your divorce or legal separation
- Birth, adoption, or placement for adoption of an eligible child
- Death of your spouse, domestic partner, or covered child
- Change in you or your spouse/domestic partner’s work status that affects benefits eligibility (for example, starting a new job, leaving a job, changing from part time to full time, starting or returning from an unpaid leave of absence, etc.)
- Your spouse’s open enrollment
- A change in your child’s eligibility for benefits
- Gain or loss of Medicare or Medicaid during the year

Other qualifying events may also apply. Please contact Human Resources.

Medical Plans

PCTEL offers 3 medical plans through BlueCross BlueShield of Illinois with the following features:

- Option to receive care from in-network or out-of-network providers (PPO options only); higher benefits are paid when using in-network providers. **When in Illinois, the highest benefits are paid when using Tier 1 providers.** Review the Blue Choice Options (BCO) section on the next page for more information.
- Preventive care is covered at 100% when using an **in-network** provider.
- Deductibles and out-of-pocket maximums accumulate on a calendar year.
- If you enroll in the High Deductible PPO option and open a Health Savings Account (HSA), PCTEL will contribute to your account on a quarterly basis to help cover some of your medical plan costs (refer to HSA section for more information).
- For a comparison of the plans, please refer to the Medical Plans Comparison Charts on the following pages. Specific benefit levels and limitations can be found in the plan summaries and Summary of Benefits and Coverage (SBC).
- The HMO plan option is only available in Illinois. You must sign up for a physician and referrals are required.

Finding In-Network Providers

To search for in-network medical providers, log on to **www.bcbsil.com**. When prompted to select a plan, click on either:

- BlueAdvantage HMO® [ADV)
- Blue Choice Options (BCO) [In Illinois]
- Participating Provider Option (PPO) [Outside Illinois]

Blue Choice Options (BCO)

Blue Choice Options is a tiered network plan offered through BCBS of Illinois. There are two levels of in-network coverage depending on the network status of the provider utilized.

- **Tier 1 (BCO Network):** Provides the lowest member out-of-pocket when using the plan.
- **Tier 2 (PPO Network):** Additional out-of-pocket costs to the member when using the plan.
- You have the choice of providers at time of service. Claims will be paid according to whether the provider is Tier 1 or Tier 2. Many providers that are part of the Illinois PPO network today are in the BCO network and will be Tier 1.
- Deductibles and out-of-pocket limits cross-accumulate between Tier 1 and Tier 2.
- Tier 1 hospitals include: Advocate, Northwestern (except for Lurie), Loyola, Rush University, Northwest Community, and Presence. Tier 2 includes Northshore, University of Chicago, and Lurie Children's Hospital. (Not a complete list. Always check the provider finder for the most current and up to date information. Hospital status does not dictate physician status.)
- **Blue Choice Options is an Illinois-only network. For members who are outside of Illinois, you will have access to the large PPO network and receive the Tier 1 level of coverage.***
- **Out-of-network:** Will always have the highest out-of-pocket costs when using the plan and balance billing can apply

* Exceptions may apply for border state providers like WI/IN who have an Illinois PPO contract in addition to their home state PPO contract. These non-Illinois providers must file electronically, or Tier 2 benefits will apply.

Access to Your Healthcare

After you are enrolled in a PCTEL medical plan, log on to **www.bcbsil.com** and register to access self-service tools and resources to help manage your medical and prescription drug benefits.

Medical Plan Options

BlueCross BlueShield of Illinois	HMO (IL ONLY)	HDHP PPO with HSA	
Company HSA Contribution (per month, deposited quarterly)	N/A	EE Only = $58.15 EE/SP = $117.89 EE/Children = $111.59 EE/Family = $175.22	
In-Network	**You Pay**	**Tier 1—You Pay (BCO network)**	**Tier 2—You Pay (PPO network)**
Plan Year Deductible (individual/family)	N/A	$5,000/$7,000 Deductible is aggregate	$6,000/$7,500 Deductible is aggregate
Member Coinsurance	0%	10%	20%
Plan Year Out-of-Pocket Max[1,2] (individual/family)	$1,500/$3,000 + Rx OOP is embedded	$7,000/$12,000 OOP is embedded	$7,500/$15,000 OOP is embedded
Preventive Care	$0 copay	No charge	No charge
Primary Care Office Visit	$30 copay	10% after ded.	20% after ded.
Specialty Care Office Visit	$50 copay	10% after ded.	20% after ded.
Telemedicine Consultation (must use MDLIVE doctors)	N/A	Approx. $44 until ded. met then 10%	
Urgent Care Facility	$50 copay	10% after ded.	20% after ded.
Emergency Room Care	$100 copay	10% after ded.	10% after ded.
Inpatient Hospital	0%	10% after ded.	20% after ded.
Outpatient Surgery	0%	10% after ded.	20% after ded.
Routine Radiology/Lab	0%	10% after ded.	20% after ded.
Advanced Radiology (MRI, MRA, CAT, PET scan)	0%	10% after ded.	20% after ded.
Out-of-Network	**You Pay**	**You Pay**	
Plan Year Deductible (individual/family)	N/A	$8,000/$16,000 Deductible is aggregate	
Coinsurance	N/A	30% after ded.	
Plan Year Out-of-Pocket Max[1,2]	N/A	$16,000/$32,000 OOP is embedded	

Limitations and maximums may apply. Please refer to the plan summaries and SBCs for more information.

1 Plan year out-of-pocket maximum includes deductibles, copays, and coinsurance. A separate prescription drug out-of-pocket applies on the HMO and Low PPO plans.

2 Tier 1 and 2 deductibles and out-of-pocket maximums cross-accumulate. Out-of-network is a separate bucket.

Embedded and non-embedded plans are important to understand. In aggregate plans the individual deductible will never apply. You or a combination of your family members must satisfy the full family deductible

With embedded plans the out-of-pocket maximum still applies to each individual on the plan. You can satisfy the individual limit and the plan begins covering your eligible expenses. Additionally, once a combination of family members satisfies the full family deductible and out-of-pocket maximum, the plan begins covering all family members' eligible expenses.

BlueCross BlueShield of Illinois	Low PPO	
Company HSA Contribution (per month, deposited quarterly)	N/A	
In-Network	**Tier 1—You Pay (BCO network)**	**Tier 2—You Pay (PPO network)**
Plan Year Deductible (individual/family)	$500/$1,000 Deductible is embedded	$1,500/$3,000 Deductible is embedded
Member Coinsurance	20%	30%
Plan Year Out-of-Pocket Max[1,2] (individual/family)	$2,000/$4,000 + Rx OOP is embedded	$3,000/$6,000 + Rx OOP is embedded
Preventive Care	$0 copay	$0 copay
Primary Care Office Visit	$30 copay	$30 copay
Specialty Care Office Visit	$50 copay	$50 copay
Telemedicine Consultation (must use MDLIVE doctors)	$30 copay	
Urgent Care Facility	20% after ded.	30% after ded.
Emergency Room Care	$100 copay	$100 copay
Inpatient Hospital	20% after ded.	30% after ded.
Outpatient Surgery	20% after ded.	30% after ded.
Routine Radiology/Lab	20% after ded.	30% after ded.
Advanced Radiology (MRI, MRA, CAT, PET scan)	20% after ded.	30% after ded.
Out-of-Network	**You Pay**	
Plan Year Deductible (individual/family)	$5,000/$10,000 Deductible is embedded	
Coinsurance	40% after ded.	
Plan Year Out-of-Pocket Max[1,2]	$10,000/$20,000 OOP is embedded	

Limitations and maximums may apply. Please refer to the plan summaries and SBCs for more information.

[1] Plan year out-of-pocket maximum includes deductibles, copays, and coinsurance. A separate prescription drug out-of-pocket applies on the HMO and Low PPO plans.

[2] Tier 1 and 2 deductibles and out-of-pocket maximums cross-accumulate. Out-of-network is a separate bucket.

Prescription Drugs

When you enroll in a medical plan, you receive comprehensive prescription drug coverage through BlueCross BlueShield's pharmacy manager Prime Therapeutics. Some medications may be subject to prior authorization, quantity limits, or step therapy requirements to be approved for coverage. For a list of approved drugs, log on to your Blue Access for Members (BAM) account at **www.bcbsil.com**.

Prime Therapeutics	HMO (IL ONLY)	HDHP PPO with HSA	Low PPO
Retail (up to 34-day supply)	You Pay Performance Formulary	You Pay Basic Formulary	You Pay Performance Formulary
Generic	$20 copay	20% after ded.	$30 copay
Formulary	$40 copay	20% after ded.	$50 copay
Non-Formulary	$70 copay	20% after ded.	$80 copay
Specialty	$70 copay	20% after ded.	$80 copay
Out-of-Pocket Maximum (single/family)	$1,000/$2,000 OOP is embedded	Combined with medical	$1,000/$2,000 OOP is embedded
Mail Order (up to 34-day supply)	You Pay Performance Formulary	You Pay Basic Formulary	You Pay Performance Formulary
Generic/Formulary/ Non-Formulary/Specialty	$40/$80/$140/$70	20% after ded.	$60/$100/$160/$80

- Please note, any retail or mail order copays listed for the HSA qualified plan(s) apply only after the medical plan deductible is met. The deductible will not apply to certain medications classified as preventive in accordance with the approved prescription drug list.
- Specialty drugs are limited to a 30-day supply at retail or mail.

Three Ways to Obtain Prescription Drugs

Prime Therapeutics Retail Pharmacy (up to 34-day supply)

www.bcbsil.com
800.423.1973

- Locate a participating retail pharmacy
- View a list of approved drugs

Express Scripts Mail Order (up to 90-day supply)

www.esrx.com/bcbsil
833.715.0942

- Use for maintenance drugs such as medication for high blood pressure, arthritis or diabetes
- Pay less than retail pharmacy for a 90-day supply
- No additional cost for delivery

Accredo Specialty Pharmacy (30-day supply)

www.accredo.com/bcbsil
833.721.1619

- Medications used to treat complex conditions like multiple sclerosis, hepatitis C, and rheumatoid arthritis
- Prescription can only be filled once every 30 days

Transamerica Gap Plan

- This Gap Plan is a secondary insurance plan used to supplement your existing HDHP medical coverage and can help cover gaps in your primary medical plans
- Only employees enrolled in the HDHP with HSA medical plan are eligible for this supplemental insurance. If you are enrolled in the HDHP plan, you will automatically be enrolled in the Gap Plan.
- Benefits are paid based on the HDHP medical plan's Explanation of Benefits (EOB)
- Gap Plan benefits can be used to help cover deductibles and coinsurance from eligible inpatient and outpatient services and may offset deductibles and coinsurance
- If you should separate from the company and are enrolled in the Gap Plan, you may elect to continue this supplemental coverage under COBRA
- Dependents are not eligible to continue the Gap Plan through COBRA if they cease to be an eligible dependent; the benefit is directly connected only to the employee's own election

Gap Plan Benefits		
Benefit	Benefit Option	Annual Plan Maximums
Inpatient Hospital Benefit	Per Person	$5,000
	Maximum	3× per family
Outpatient Benefits	Per Person	$5,000
	Maximum	3× per family
Enhancements	Ambulance benefit (ground/ air)	$2,500, 3x per family
	PT and Chiropractic Rider	$1,000, 3x per family
Supplemental Deductible	Per Insured	$1,600
	Per Family	3× per family

Transamerica
AmWins Rx
Access Prescription Savings Card

- Gives access to over 60,000 pharmacies nationwide
- Up to 65% savings on generics
- Average of 40% savings across brand and generic combined
- Includes all FSA approved medications
  - Free access for everyone
  - Card never expires
  - Open to all family members and even pets

You will receive two ID cards: one from Transamerica for the Gap Plan and one from AmWins for the Rx discount savings.

Expenses Covered by the Transamerica Gap Plan

- Inpatient Hospital Benefits
- Outpatient Hospital Benefits (see below)
- Ambulance
- Physical and Chiropractic Therapy
- Emergency Room (including copay)
- Outpatient Services
  - Radiation therapy or chemotherapy
  - Outpatient surgery, treatment, diagnostic testing
  - Treatment in the ER for an appendicitis, or Kidney Stones
  - Kidney dialysis

Expenses NOT Covered by the Transamerica Gap Plan

- Physician office visits
- Home healthcare, rest care, or rehabilitative care
- Cosmetic surgery
- Dental care
- Eyeglasses, contact lenses, hearing aids
- Prescription drugs
- Mental Health and Substance Abuse Services
- Wellness preventative services (covered by group medical plan)

How to Use Your Gap Plan Benefits

- Watch your mail for a Welcome Package that includes your Gap TransConnect ID card
- **You must present BOTH your BCBSIL medical ID card AND your Transamerica ID card at the time of service**
- Your provider will automatically submit your claim to BCBSIL; you should ask them to also submit your claim to Transamerica as a secondary payer on your behalf
  - If your provider does not submit to Transamerica you may submit yourself—see below for details
- Benefits will be paid to you or the provider to reduce or cover the deductible and coinsurance

Claims may be submitted in two ways:

- By your Provider
  - If your provider submits your claim, benefits for covered services will be paid directly to the provider
- By You
  - If you submit your claim, benefits for covered services will be paid to you and you are responsible for your provider's payment

HOW TO FILE YOUR CLAIM—ONLINE*

1. Log in at https://webtpa.com\member-portal-login; If you're not registered, click "CREATE ACCOUNT" and accept the License Agreement
2. On the Registration Page, enter your information as follows:
   - Member ID Number—as shown on the front of your ID card
   - Use the following format: xxxxxxxxx-01
     - Please note: the "-01" is not reflected on your ID Card, but is required for website registration
   - Home Zip Code
   - Date of Birth (MM/DD/YYYY)
3. Complete the Transamerica Online Claim Submission Form

HOW TO FILE YOUR CLAIM—PHONE/FAX/MAIL

Phone

1. Contact the Claims Customer Service Department at **800.476.4491**
2. Press (1) for Claims and then press (2) to be connected with a claims representative

Fax

1. Fax claim documents to **469.417.1960**
2. Include the insured's name and SSN/Member ID Number (as shown on the front of your ID card)

Mail

3. Mail completed claim documents to:
   - WebTPA
     P.O. Box 310
     Grapevine, TX 76099-0310
   - Include the insured's name and SSN/certificate number

Gap Plan Example—Outpatient $10k (Employee Coverage)

Without Gap Plan—Current HDHP	BCO/PPO
Outpatient Hospital Bill	$10,000
Joe Pays His Full $1,500/$2k Deductible (BCO/PPO)	$1,500/$2,000
Health Insurance Pays Remaining 90%/80%	$7,650/$6,400
Joe Pays Coinsurance Payment (10%/20% of remaining)	$850/$1,600
Joe's Total Out-of-Pocket Costs: BCO/PPO	**$2,350/$3,600**

Without the Gap Plan, Joe must cover his full deductible before health insurance will begin to pay benefits. Plus, he'll need to cover 10%/20% of any remaining costs for coinsurance.

With Gap Plan—new $5k HSA Plan	BCO/PPO
Outpatient Hospital Bill	$10,000
Joe Pays $1,500 towards his $1,500 deductible for the Gap Plan	$1,500
Joe's Gap Plan pays max allowed towards remaining deductibles	$3,500
Joe owes remaining portion towards HDHP deductible	$0/$1,000
Health Insurance Pays Remaining 90%/80%	$4,500/$3,200
Joe pays the remaining coinsurance amount, since outpatient coverage max is 70% ($3,500)	$500/$800
Joe's Total Out-of-Pocket Costs: BCO/PPO	**$2,000/$3,300**

With the Gap Plan, the amount Joe would normally pay toward his deductible is reduced and so is his coinsurance amount he would pay.

Gap Plan Example—Outpatient $10k (Family Coverage)

Without Gap Plan—Current HDHP	BCO/PPO
Outpatient Hospital Bill	$10,000
Joe Pays His Full $3k/$4k Aggregate Deductible (BCO/PPO)	$3,000/$4,000
Health Insurance Pays Remaining 90%/80%	$6,300/$4,800
Joe Pays Coinsurance Payment (10%/20% of remaining)	$700/$1,200
Joe's Total Out-of-Pocket Costs: BCO/PPO	**$3,700/$5,200**

Without the Gap Plan, Joe must cover his full deductible before health insurance will begin to pay benefits. Plus, he'll need to cover 10%/20% of any remaining costs for coinsurance.

With Gap Plan—new $5k HSA Plan	BCO/PPO
Outpatient Hospital Bill	$10,000
Joe Pays $3,000 towards his $3,000 deductible for the Gap Plan	$3,000
Joe's Gap Plan pays max allowed towards remaining deductibles	$3,500
Joe owes remaining portion towards HDHP $7k/$7.5k deductible	$500/$1,000
Health Insurance Pays Remaining 90%/80%	$2,700/$2,000
Joe pays the remaining coinsurance amount, since outpatient coverage max is 70% ($3,500)	$300/$500
Joe's Total Out-of-Pocket Costs: BCO/PPO	**$3,800/$4,500**

With the Gap Plan, the amount Joe would normally pay toward his deductible is reduced and so is his coinsurance amount he would pay.

Where to Seek Care

MDLIVE—PPO/HSA Plans Only

The HDHP with HSA and Low PPO medical plans include MDLIVE visits, which provides 24-7-365 access to board-certified primary care doctors and pediatricians by secure video chat or phone. For an illness or injury that is not an emergency, MDLIVE's Telemedicine program offers a convenient, cost-effective alternative to hospital emergency rooms and urgent care clinics.

MDLIVE is not intended to replace your relationship with your doctor, but rather provides access to healthcare when reaching the doctor is difficult or inconvenient.

Doctors in the MDLIVE can diagnose, recommend treatment and write short-term prescriptions for minor, non-life-threatening conditions including, but not limited to:

- Acne
- Allergies
- Arthritic pain
- Bronchitis
- Cold/flu symptoms
- Ear infections
- Headaches/ migraines
- Insect bites
- Sinus infections
- Nausea/stomach aches
- Pink eye
- Skin infections
- Sore throat
- Upper respiratory infections

Covered members may access MDLIVE services from MDLIVE's doctors.

You can register for and access MDLIVE services via the MDLIVE app and at **www.mdlive.com**.

The cost for a MDLIVE visit can be found on the Medical Plans Comparison Chart on the previous page.

How to Use MDLIVE

1. Download the MDLIVE app, go online to **www.mdlive.com**, or call **800.400.MDLIVE**.
2. Register and complete your account profile, including a brief medical history for you and your enrolled family members.
3. Video chat or talk with a doctor from home, work, or when traveling.

BENEFITS OF TELEMEDICINE VISITS

- Less time away from work
- No travel expenses or time
- Less interference with child or elder care responsibilities
- No exposure to other potentially contagious patients

Emergency Care vs. Urgent Care

When you need help in a hurry, you have choices. Of course, when it's a **life-threatening problem, you should call 911 or go straight to the nearest hospital emergency room (ER).**

In the ER, true emergencies are treated first, so unless your life is in danger, you'll wait—sometimes for hours. The ER is also the most expensive option for care.

For non-life-threatening problems, call your doctor, call MDLIVE, or go to an urgent care center.

HMO members (IL only), if possible, should try to call your PCP before going to the hospital ER. However, if that is not possible, you should notify you PCP of any emergency treatment received. Your PCP must provide or coordinate your follow up care.

Go to Urgent Care	Go to Emergency Room
Moderate fever	Heart attack or stroke
Colds, cough, or flu	Chest pain or intense pain
Bruises and abrasions	Shortness of breath
Cuts and minor lacerations	Severe abdominal pain
Minor burns and skin irritations	Head injury or other major trauma
Eye, ear, or skin infections	Loss of consciousness
Sprains or strains	Major burns or severe bleeding
Possible fractures	One sided weakness or numbness
Urinary tract infections	Open fractures
Respiratory infections	Poisoning or suspected overdose

Member Programs from BCBS

(FOR HSA AND PPO PLAN MEMBERS ONLY UNLESS NOTED)

Learn to Live

Online programs through Learn to Live at no added cost for:

- Stress, anxiety, and worry
- Depression
- Social anxiety
- Insomnia
- Substance abuse

- Available to employees and their family members 13 and older
- Programs in English and Spanish
- Personal coaching by phone, text, or email

Get started with a mental health assessment:

- Log in to Blue Access for Members℠
- Choose Wellness, then find Digital Mental Health

Hinge Health

Hinge Health provides a digital, 12-week, coach-led musculoskeletal program based on proven non-surgical care guidelines. The program is delivered to you using mobile and wearable technology.

- Access to a personal health coach
- Convenient exercise therapy in your own home
- Education articles to help you understand your condition and treatment options
- No cost to eligible members and dependents

Hinge Health will contact you about how to sign up for this program.

Livongo

Diabetes Management and Hypertension Management Solutions

- Welcome kit with smart glucose meter or connected blood pressure cuff
- Digital and live coaching through meter, phone, and the Livongo mobile app
- Services covered as preventive with no out-of-pocket costs

If you are eligible, Livongo will contact you about how to sign up for this program.

Wondr

Metabolic Syndrome Reversal Program

- Online program and mobile app allows members access anywhere at any time
- Builds behavioral skills (no dieting) to promote long-term weight loss and risk reduction
- Integration with activity trackers and voice-controlled/smart speakers
- Services covered as preventive with no out-of-pocket cost

For more information or to sign up for this program, click **here** (including HMO plan members).

Health Savings Account (HSA)

ONLY AVAILABLE FOR THOSE ENROLLED IN THE HIGH DEDUCTIBLE PPO WITH HSA OPTION

A Health Savings Account (HSA) is a tax-advantaged savings vehicle available to individuals covered by a High Deductible Health Plan (HDHP). Funds in the account are used to pay for qualified medical, dental, and vision expenses.

An HSA is a great way to save for the future. You can set aside money from each paycheck now and save funds to cover healthcare expenses that come up later. Plus, your contributions are free from federal income tax, so you're stretching your healthcare dollars while lowering your taxable take-home pay amount.

PCTEL will also make contributions to your HSA if you are covered on the PCTEL plan and open an HSA account. This is "free money" for you to use to pay for eligible healthcare expenses.

HSA funds can only be used for yourself, your spouse and your taxable dependents. Expenses for domestic partners and/or other dependents who do not qualify as tax dependents are not reimbursable under the HSA.

Advantages of an HSA

- Balance rolls over each year and accrues interest, so you won't lose your contributions
- Triple tax savings you do not pay federal tax* on:
  - Contributions to the account
  - Spending on qualified expenses
  - Interest that accrues
- Account is portable, so the funds are yours even if you change medical plans next year or leave PCTEL in the future
- Use the funds for eligible medical, dental, or vision expenses, including coinsurance costs, prescriptions, glasses, orthodontia, and more now or in the future
- Money left in the savings account earns tax free interest*
- If you have a First American Bank HSA, once your account balance reaches $1,000 in the checking account portion of your HSA, you can then perform an account sweep and move any additional funds into an array of investment options made available to you.

* Tax treatment of HSAs for state tax purposes may vary by state.

Who Can Open an HSA?

You can contribute to an HSA if you:

- Are covered under an HSA-qualified high deductible health plan (HDHP)
- Are not enrolled in Medicare*, TRICARE, or TRICARE for Life
- Cannot be claimed as a dependent on someone else's tax return
- Have not received Veterans Affairs (VA) benefits within the past 3 months
- You (or your spouse) do not contribute to a Healthcare FSA

* Enrollment in Medicare Part A may be retroactive by up to 6 months when you begin taking Social Security retirement after your Social Security Normal Retirement Age (SSNRA). This may affect your HSA eligibility.

Other restrictions and exceptions may also apply. For more information, visit **www.irs.gov/pub/irs-pdf/p969.pdf**.

Funding and Enrolling in an HSA

You have the option to contribute to your HSA through pre-tax payroll contributions.* You can change the amount you contribute to your HSA at any time during the plan year.

To open your HSA, you must first enroll in High Deductible PPO medical plan. Then you can open your account directly with First American Bank* using their easy online application process. **www.firstambank.com/HSA**

It is important to note that expenses are not eligible for reimbursement until your HSA has been established.

Once your HSA is opened, you will need to provide your account information to Human Resources to establish the company contribution and any additional personal payroll contributions. Remember to designate a beneficiary for this account.

* Our preferred partner is First American Bank, however, you can choose to open an HSA through another financial institution.

2024 HSA Contributions and Limits

Each year, you can contribute up to the IRS annual limit for HSAs (which includes PCTEL's contribution). PCTEL will contribute to your HSA on a quarterly basis up to the annual amounts listed below.

	2024 IRS Contribution Limit	2024 PCTEL Contributions	2024 Pre-Tax Limit YOU Can Contribute*
Employee Only	$3,850	$697.80	$3,152.20
Employee + Spouse	$7,750	$1,414.68	$6,335.32
Employee + Child(ren)	$7,750	$1,339.08	$6,410.92
Employee + Family	$7,750	$2,102.64	$5,647.36

* If you are age 55 or older, you may contribute an additional $1,000 in catch-up contributions.

IMPORTANT! If you use your HSA funds for non-qualified expenses, the purchase amount will be subject to tax, plus a 20% penalty if you are younger than age 65. To view a list of qualified expenses, visit **www.firstambank.com/HSA**.

How to Save $$$!

When Using Your Medical and Prescription Plans

Use In-Network Doctors

By using in-network doctors, clinics, hospitals, and pharmacies, you pay the lowest cost for care. When you visit out-of-network doctors, our health plan covers less of the cost.

Choose the Right Type of Care

When you need care, know your options. Urgent care centers, online doctor visits, or a call to the medical plan nurse line can help save time and money. Use freestanding imaging centers for MRIs, CT scans, and other imaging.

Use Your Preventive Care Benefits

Most preventive care services are covered at 100% when you use in-network providers. Getting regular exams, screenings, and immunizations can save you a lot of money in the long run by catching problems early or preventing them altogether.

Use Home Delivery

Rather than visiting a pharmacy month after month, save time by having the medication delivered to your home.

You can also save money by getting up to a 90-day supply for less than what you would pay through a retail pharmacy. And because shipping is free, you'll also save on gas money!

BlueCross BlueShield's home delivery partner is Express Scripts. For more information, visit **www.esrx.com/BCBSIL** or call **833.715.0942**.

Ask Your Doctor for Generic Drugs

The next time you need a prescription, ask your doctor if it is appropriate to use a generic drug rather than a brand name drug. Generic drugs contain the same active ingredients, are identical in dose, form, administrative method, AND are less expensive than their brand name counterparts.

If you must take a brand name drug, ask your doctor for samples or coupons. Also check the drug manufacturer's website for available rebates and discounts.

Search GoodRx for Cheaper Prices

Drug prices sometimes vary significantly between pharmacies. GoodRx collects and compares prices for every FDA approved prescription drug at more than 70,000 pharmacies.

Access GoodRx at **www.goodrx.com** to find the lowest price pharmacy near you and/or print FREE coupons. You can also get coupons on-the-go through Good Rx's mobile app—just show your phone to the pharmacist.

DISCLAIMER: Use of GoodRx is in lieu of insurance. Any expenditures using a GoodRx coupon or a discount card will not be applied to your insurance plan.

Benefit Definitions

What is a Premium?

A premium (also referred to as a contribution) is the cost you pay for health insurance, whether you use medical services or not. Premiums are deducted directly from your paycheck.

What is a Deductible?

A deductible is the amount you pay out of your pocket before your insurance pays. The deductible runs from January 1st-December 31st each year. Once you have met that dollar amount, you have met the requirements for the plan year.

- **Embedded:** If you cover any dependents, each family member has their own deductible that applies toward the family maximum. No one person will pay more than the individual amount (same applies for the out-of-pocket maximum).
- **Aggregate:** If you cover any dependents, the individual amount is not applicable. The family deductible will apply and can be met by one individual or a combination of family members (same applies for the out-of-pocket maximum).

What Does a Copay Pay For?

Copayments, or copays, are pre-set dollar amount you are expected to pay for office visits, procedures, or prescription drugs under your insurance plan. Once the copay has been met, the insurance company pays all remaining costs.

What Does Coinsurance Mean?

Coinsurance is a set percentage of service costs that you will be expected to pay once you have met your annual deductible.

When your annual deductible is met, your insurance provider pays for their portion of the full cost of the service and you pay the coinsurance, or remaining percentage.

What Counts Towards My Out-of-Pocket Maximum?

An out-of-pocket maximum is an annual cap on the dollar amount you are expected to pay out of your own pocket for services (including deductibles, copays, and coinsurance) throughout the plan year.

Once you meet the out-of-pocket amount, your insurance provider will cover 100% of remaining medical expenses for the year.

Dental

PCTEL offers dental through MetLife. Your choice of dentists can determine the cost savings you receive. In-network providers are paid directly by MetLife and agree to accept negotiated fees as “payment in full” for services rendered.

When you use out-of-network providers, MetLife will apply the applicable percentage of the allowed amount and you are responsible for paying the balance of the bill.

To search for in-network providers, go to **www.metlife.com/mybenefits** and begin your search or call **800.ASK.4MET** (**800.275.4638**).

MetLife	PPO	
	In-Network	Out-of-Network
Calendar Year Maximum* (plan pays)	Up to $2,500	
	You Pay	You Pay
Calendar Year Deductible* (applies to basic and major services)	$50 individual/$150 family	
Preventive Services (i.e., cleanings, exams, bitewing x-rays)	0%	0%**
Basic Services (i.e., fillings, simple extractions)	10%	20%**
Major Services (oral surgery, endodontics, periodontics, implants)	40%	50%**
Orthodontia (adult and child)	50%	50%**
Orthodontia Lifetime Maximum (per person)	$2,500	$2,500

* Plan deductibles and maximums accumulate on a calendar year and reset on January 1st of each year.

** You are responsible for the difference between the Usual and Customary fee and the dentist’s billed charges.

Important Information!

If you do not enroll in dental benefits when you are first eligible, your next chance to enroll will be during the next open enrollment period unless you experience a qualifying event and notify Human Resources within 30 days.

Vision

Routine eye exams are important for maintaining good vision and can also provide early warning of other health conditions. The EyeMed vision plan provides coverage for exams, glasses, and contact lenses, as shown below.

In-network coverage is provided when you use the EyeMed providers. To search for providers, log on to **www.eyemed.com** and use their provider locator (choose the Insight Network) or call **866.800.5457**.

- If you enroll in any PCTEL medical plan, you will be automatically enrolled in vision.
- PCTEL pays 100% of the cost of vision benefits offered by EyeMed.
- Our plan with EyeMed includes their Freedom Pass. This allows you to purchase any available frame, any brand, at any price point for no out-of-pocket expense from Target Optical. Lenses would be covered per the schedule of benefits.

EyeMed Insight Network	Frequency	In-Network You Pay	Out-of-Network Your Reimbursement
Eye Exam	Once every calendar year	$10 copay	Up to $50
Frame	Once every other calendar year	$130 allowance + 20% off balance	Up to $98
Standard Plastic Lenses (single vision, bifocal, trifocal)	Once every calendar year	$25 copay	See plan summary
Progressive Lenses	Once every calendar year	$80-$200 copay	Up to $70
Contacts—instead of lenses	Once every calendar year	$120 allowance + 15% off balance	Up to $120

Please see the EyeMed benefit summary for additional details.

Flexible Spending Accounts (FSA)

An FSA allows you to set money aside for certain eligible expenses and draw from it throughout the year to pay for those expenses. The money is set aside pre-tax, reducing your taxable income. Three types of accounts are available:

- Health Care*
- Limited Purpose Health Care—HSA plan participants only
- Dependent Care*

Money cannot be transferred between the accounts (i.e., you cannot use money from your Health Care FSA to pay for dependent care expenses and vice versa).

Please be conservative with your elections as any unused balances at the end of 2024 will be forfeited.

* You do not need to be covered on any PCTEL benefit plans to enroll in the Health Care or Dependent Care FSA options.

Health Care FSA

NOT AVAILABLE TO HSA PLAN PARTICIPANTS

This FSA allows you to submit eligible **medical, dental, and vision** expenses for reimbursement. You can deposit up to $3,200 to the Health Care FSA for the 2024 calendar year.

Limited Purpose Health Care FSA

AVAILABLE TO HSA PLAN PARTICIPANTS ONLY

Using this account in conjunction with the HSA gives you the opportunity to save additional pre-tax money. You can use the Limited Purpose Health Care FSA for eligible **dental and vision** expenses only. You can contribute up to **$3,200** for the 2024 calendar year in this account.

Dependent Care FSA

AVAILABLE TO ALL BENEFIT-ELIGIBLE EMPLOYEES

Dependent Care FSAs are used to pay for the costs of dependent care that enable you to work. This care may be for a child under age 13 and for older dependents, including children, spouses and parents who are physically or mentally unable to care for themselves and who live with you for more than half the year.

Eligible expenses include daycare, before-school and after-school care, babysitters, and elder daycare. For the 2024 calendar year, you can deposit up to **$5,000** to a Dependent Care FSA ($2,500 if you are married and filing separately).

How the FSA Works

As a new hire (and again during open enrollment), you select the amount of money you wish to deposit into the Health Care (or Limited Purpose Health Care) and/or the Dependent Care Account for the entire plan year. The plan year for the FSA benefit is **January 1st to December 31st**. The total amount is then equally divided by the number of pay periods remaining in that year and that amount is deducted from each paycheck. The money is set aside in your FSA account(s).

As you incur eligible expenses, you file a simple claim form (along with copies of your receipts) and are reimbursed for such expenses from the account.

Employees who enroll in the Health Care (or Limited Purpose Health Care) FSA will receive an FSA debit card to pay for qualified purchases, eliminating the need to submit a paper claim and wait for reimbursement.

The FSA plans are administered by ADP. To register and log into your FSA account(s), go to **www.wageworks.com**.

Life Insurance

Basic Life/AD&D

Having appropriate life insurance coverage is a critical part of planning for your family's current and future financial needs. Proceeds from life insurance can help with salary replacement, mortgage protection, cost of childcare, debt repayment, and children's education expenses.

PCTEL provides Basic Life insurance coverage of 2x your salary to a maximum of $200,000. Benefit amount begins to reduce at age 65.

This coverage includes an Accidental Death and Dismemberment (AD&D) provision that also pays 2x your salary to a maximum of $200,000 in the event of accidental death and certain other conditions.

Basic Life and AD&D insurance is administered by Lincoln Financial Group and is paid for by PCTEL. You are automatically enrolled in these benefits.

Basic Dependent Life

PCTEL will pay for Basic Life coverage for your dependents, including your legal spouse or domestic partner and your children.

- Spouse/Domestic Partner coverage—$5,000
- Child coverage Birth to 6 months—$100
- Children 6 months to 19 (26 if full-time student)—2,500

According to federal law, only the first $50,000 of employer-paid life insurance is not taxable. Premium paid by PCTEL for coverage levels over $50,000 will be taxable to you and will be included on your year-end W-2 statement.

Value-Added Benefits with Lincoln

LifeKeys Services:

Includes grief, legal, and financial counseling for beneficiaries, funeral planning, and online will preparation and other legal documents.

For assistance, call **855.891.3684**.

TravelConnect Services:

Helps travelers with the unexpected that may take place while traveling more than 100 miles away from home, including emergency medical assistance, legal, and communication assistance. Assistance is available 24 hours a day, 7 days a week.

For a complete list of TravelConnect services, access to plan documents and international calling instructions, visit **www.mysearchlightportal.com** and enter the group ID: LFGTravel123.

Voluntary Life Insurance

Voluntary Life

As a new hire, you can purchase Voluntary Life insurance for you, your legal spouse/domestic partner, and dependent children without providing medical information up the guarantee issue (GI) amounts (see chart). To cover your spouse/domestic partner or children you must be enrolled. If you leave PCTEL, this coverage can be taken with you.

Employee and spouse/domestic partner amounts applied for over the GI as a new hire will require you to provide Evidence of Insurability (EOI) for review and approval by Lincoln Financial Group.

Voluntary Life Amounts Available	
Employee	Increments of $10,000 to a maximum of $500,000 Newly-eligible guarantee issue: $150,000
Spouse/Domestic Partner	Increments of $5,000 to $500,000 not to exceed 100% of employee election Newly-eligible guarantee issue: $50,000
Child (to age 19 or 26 if a full-time student)	Increments of $2,000 up to $10,000 Birth to 6 months of age: $1,000 Guarantee issue: $10,000

Guarantee issue amounts require that Employees must be actively at work to enroll. Dependents (spouses/domestic partners/children) confined to home or hospital care can not apply.

If you elect not to enroll when you are first offered coverage, you can enroll during open enrollment however you are limited to a maximum of 2 increments for yourself ($20,000) and spouse/domestic partner ($10,000) without needing to supply EOI.

For currently enrolled employees, annually during open enrollment you may be able to increase your current elections by two increments without EOI, however, limitations may apply.*

Voluntary AD&D

Employees can also elect to purchase Voluntary AD&D coverage based on the same options shown above. You do not need to enroll in the Voluntary Life to purchase Voluntary AD&D and if you are enrolled in the Voluntary Life, your AD&D election does not need to match. In order to purchase coverage for your dependents you must be enrolled. Evidence of Insurability does not apply for Voluntary AD&D.

Employees pay the full cost of Voluntary Life and Voluntary AD&D insurance on an after-tax basis. Benefit amounts reduce beginning at age 65. Please refer to the benefit summary for details

* If you submitted EOI in the past and were declined for medical reasons, you may be required to submit EOI.

Disability Insurance

If you were to be out of work due to an injury or illness, could you and your family survive without a paycheck? Disability insurance is essentially “paycheck” insurance, ensuring you will receive a portion of your income if you were out of work due to injury or illness. Short-Term Disability (STD) provides a weekly benefit, while Long-Term Disability (LTD) pays a monthly benefit after STD insurance has been exhausted.

PCTEL offers STD and LTD insurance at no cost to you. Administered by Lincoln Financial Group, you are automatically enrolled in these benefits.

Short-Term Disability (STD) Insurance

STD benefits become payable when you are unable to work due to an injury or illness unrelated to work. If you remain disabled and meet the plan’s disability requirements, you will continue to receive a percentage of your weekly earnings until the benefit duration has ended.

STD benefits integrate with state mandated disability plans.

Benefit Begins	1st day for accident 8th day for illness
Benefit Amount	66.67% of your weekly salary to a maximum of $2,000 per week
Benefit Duration	Up to 13 weeks

Long-Term Disability (LTD) Insurance

LTD insurance offers a monthly benefit to help replace lost income if you experience a disability lasting longer than 90 days. Proof of disability is required.

Benefit Begins	After 90 days of qualified disability
Benefit Amount	66.67% of current monthly salary to a maximum of $10,000 per month
Benefit Duration	Own occupation coverage is 24 months; if approved, benefits could extend to your Social Security Normal Retirement Age (SSNRA)

LTD claims for newly-covered employees will be denied if you received medical treatment, medical advice, care or services, or took prescribed drugs or medicines in the 3 months prior to the effective date of this coverage and the disability began in the first 12 months after your effective date of coverage.

Additional Protection Benefits

PCTEL offers additional voluntary benefit plans through MetLife. These plans are **not medical insurance** and do not replace your medical coverage, but rather pay cash directly to you in addition to any benefits you receive from your health plan.

Insurance policies available for purchase (through after-tax payroll deductions) include **Critical Illness, Accident, and Hospital Indemnity**. These benefits may help fill the gap until you meet your medical plan deductible.

All MetLife benefit plans are portable, which means you can take these benefits with you if you leave the company.

Rates are based on age, tobacco status and policy elected and are only available once per year during open enrollment. Cash benefits are also paid for certain health screening tests (wellness incentive of $75).

Critical Illness Insurance

Group Critical Illness insurance is designed to help you offset the costs of certain covered critical illnesses. If diagnosed, you will receive a lump-sum cash benefit that you can use for any expense, including deductibles, copays, transportation, or medical supplies. Covered critical illnesses include heart attack, major organ failure, stroke, blindness, and permanent paralysis; optional cancer coverage is available. Cash benefits are also paid for certain health screening tests (wellness incentive of $75).

Accident Insurance

Accident insurance pays a cash benefit when you or your covered family members suffer injuries sustained in an accident. Covered injuries include fractures, burns, concussions, tears, lacerations, broken teeth, and eye injuries. Additional benefits may be paid, including ambulance, emergency care, testing, and therapy. This covers you for both on-the-job and off-the-job accidents. Cash benefits are also paid for certain health screening tests (wellness incentive of $75).

These benefits can be used to pay for hospital deductibles, doctor visits, emergency room care, or any other expense you may have.

Hospital Indemnity Insurance

This is a voluntary plan that provides a payment to you in the event you are hospitalized.