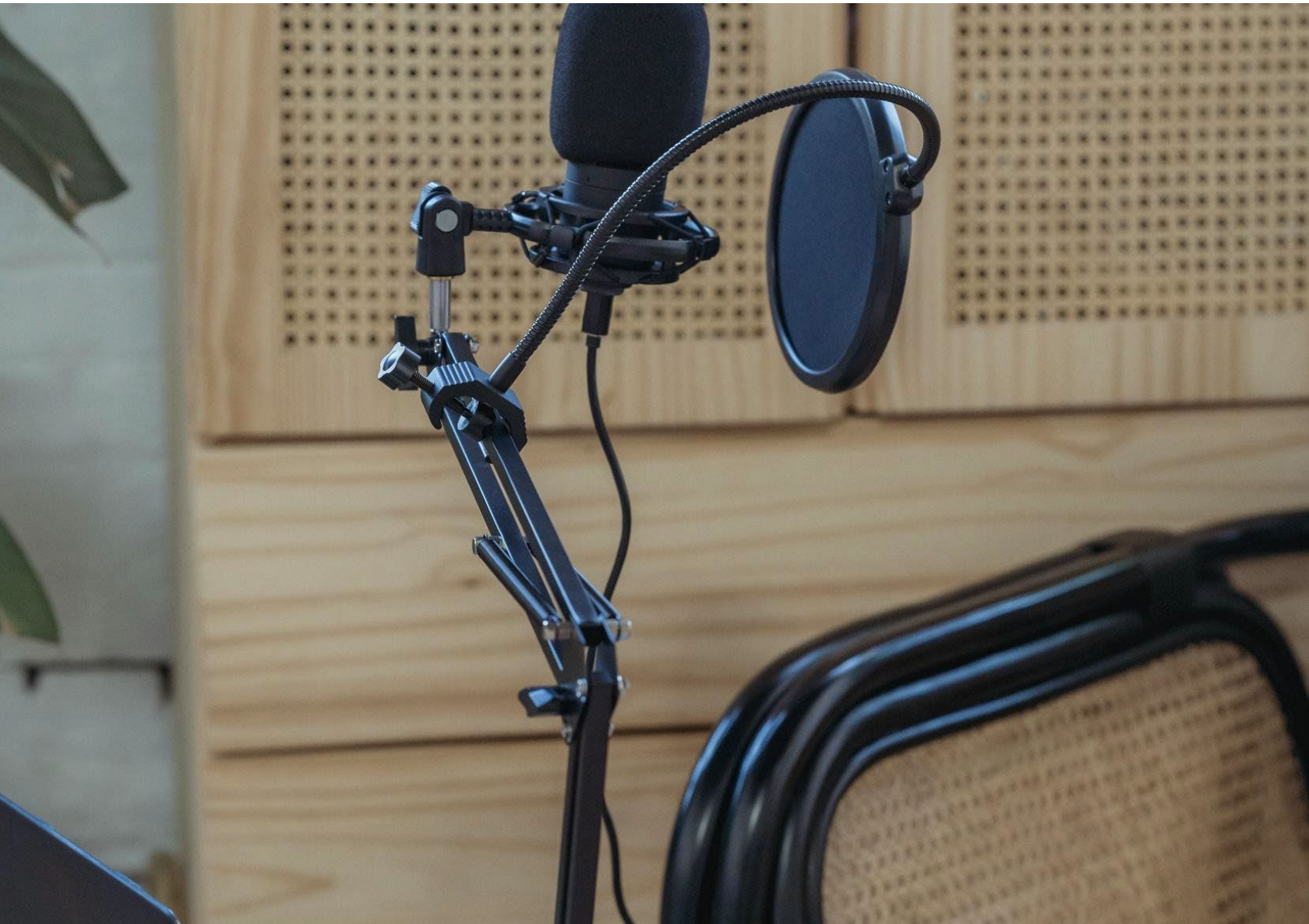




2026 Benefits Guide

[ENTER](#)

Contents

GETTING STARTED

- 4 What's New for 2026?
- 5 Who's Eligible for Benefits?
- 6 Changing your benefits
- 7 Enrolling in your Benefits
- 8 Health Advocate

MEDICAL, DENTAL & VISION

- 10 Cigna LocalPlus Network
- 12 Cigna \$7,000 OAP/LocalPlus HSA Plan
- 13 Cigna \$5,500 OAP/LocalPlus Plan
- 14 Cigna \$4,250 OAP/LocalPlus Plan
- 15 Choose a Medical Plan with Confidence
- 16 Prescriptions Breaking Your Budget?
- 17 Prescription Benefits – FAQs
- 19 Cigna DPPO Dental Plan
- 20 Cigna DHMO Dental Plan
- 21 Important Information Regarding the Cigna Dental Care (DHMO) Dental Plan
- 21 How to Find an In-Network Dentist
- 23 EyeMed Vision Plan
- 24 Health Savings Account (HSA)
- 25 Healthcare Flexible Spending Account (FSA)

ENGAGE IN YOUR HEALTH

- 27 First Stop Health
- 28 Hinge Health
- 29 Know Where to Go
- 30 How to Find an In-Network Provider
- 31 Alternative Facilities
- 32 Preventive Care

LIFE & DISABILITY

- 34 Basic Life and AD&D Insurance
- 35 Long-Term Disability Insurance

VOLUNTARY PLANS

- 37 Voluntary Life and AD&D Insurance
- 38 Voluntary Short-Term Disability Insurance
- 39 Voluntary Health-Related Plans
- 40 ASPCA Pet Insurance
- 41 PerkSpot

VOLUNTARY PLANS

- 43 Commuter Reimbursement Account (CRA) Transportation and Parking Plans
- 44 Dependent Care FSA
- 45 Alliant Medicare Solutions
- 46 401(k) Retirement
- 47 401(k) FAQs
- 48 Employee Stock Purchase Plan (ESPP)
- 49 ESPP FAQs

WELLBEING & BALANCE

- 51 Employee Assistance Program (EAP)
- 52 Mental Health Resources

TIME AWAY FROM WORK

- 54 Paid Time Off (PTO)
- 56 Bereavement Leave
- 57 Post-Pregnancy Pay Policy
- 58 Secondary Caregiver Pay Policy

IMPORTANT PLAN INFORMATION

- 60 Your Benefit Costs
- 62 Plan Contacts
- 63 Glossary

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



Getting Started

2026 Benefits

January 1st - December 31st

No matter where you are in your career, Townsquare Media supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, as well as life, disability, retirement, and additional benefits.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Take a look at what's available to make the most of your benefits package.

WHAT'S NEW FOR 2026?

Medical and Dental Contributions

Employee medical and dental contributions will see a slight increase this year to help maintain our high-quality coverage and access to top-tier provider. See the “Your Benefit Costs” section of this guide on page 60 for more information.

Voluntary Life and AD&D Guaranteed Issue Amounts Increased

As of 01/01/2026 the Voluntary Life and AD&D coverage through NY Life guaranteed issue amount has increased for employees and spouses. See the “Voluntary Life and AD&D” section of this guide on page 37 for more information

Open Enrollment for Voluntary Life and AD&D, and Voluntary Short-Term Disability Insurance

FOR THIS OPEN ENROLLMENT PERIOD

ONLY: Employees who did not elect Voluntary Life and AD&D, and/or Voluntary Short-Term Disability insurance when first eligible, can elect during this Open Enrollment period without needing to submit an EO! See the “Voluntary Life and AD&D” section of this guide on page 37 for details on guaranteed issue Coverage Limits for Employee and Spouse, and page 38 for information regarding “Short-Term Disability” insurance.

Health Savings Account Contribution Limits

The amount you can contribute to a Health Savings Account (HSA) is limited to the maximum contribution amount set by the Internal Revenue Service (IRS) for the calendar year, which has increased for 2026. See the “HSA Contribution Limits” section of this guide on page 24 for more information.

Flexible Spending Account Contribution Limits

The amount you can contribute to a Medical Flexible Spending Account (FSA) Limited Flexible Spending Account (LFSA) is limited to the maximum contribution amount set by the Internal Revenue Service (IRS) for the calendar year, which has increased for 2026. See the “FSA Contribution Limits” section of this guide on page 25 for more information.

Commuter Reimbursement Account (CRA) Transportation and Parking Plans Contributions Limits

The amount you can contribute to a Commuter Reimbursement Account (CRA) Transportation and Parking Plan is limited to the maximum contribution amount set by the Internal Revenue Service (IRS) for the calendar year, which has increased for 2026. See the “CRA Contribution Limits” section of this guide on page 43 for more information.



WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are *eligible if you are an active, full-time employee working 30 or more hours per week.

Eligible dependents

- **Legally married spouse. (*Spousal Affidavit required to be completed if enrolling your Spouse in Townsquare Media's Cigna Medical Plan... Please See Below*).
- **Registered Domestic Partner (RDP), where applicable by state law. (*Notarized Domestic Partner Affidavit is required to be completed if enrolling your Domestic Partner in Townsquare Media's Cigna Medical Plan... Please See Below*).
- Natural, adopted or stepchildren, or children of a Domestic Partner up to age 26.
- Children over age 26 who are disabled and depend on you for support.
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the benefit booklets for each benefit.

Who is not eligible

Members who are not eligible for coverage include (but are not limited to):

- Parents, grandparents, and siblings.
- Employees who work less than 30 hours per week, temporary/part-time employees, contractors, interns (those not on Townsquare Media payroll), or employees residing outside the United States.

When you can enroll

You can enroll in benefits as a *new hire, or during the annual Open Enrollment period (*if the new hire waiting period has been satisfied by January 1st*). New hire coverage begins on the first day of the month following **two full** months of active, full-time employment. You must enroll within 30 days of becoming eligible.

If you miss the enrollment deadline, you'll need to wait until the next Open Enrollment (the one time each year that you can make changes to your benefits for any reason), unless you experience a qualifying Life Event during the year, *with substantiation provided*.

**After serving Townsquare Media's New Hire eligibility waiting period of first day of the month following two full months of active, full-time employment.*

***If your Spouse or Domestic Partner has medical insurance available to them through their own employer's group plan, then they will **not** be eligible for coverage through Townsquare's Medical/Rx insurance plan.*

CHANGING YOUR BENEFITS

Click to play video



LIFE HAPPENS

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

THREE RULES APPLY TO MAKING CHANGES TO YOUR BENEFITS DURING THE YEAR:

1. Any change you make must be consistent with the change in status.
2. You must make the change within 30 days of the date the event occurs.
3. All proper documentation is required to cover dependents (marriage certificates, birth certificates, etc.).

Outside of Open Enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act.

You must submit your change within 30 days after the event.

Dependent Verification

Making changes to dependents is subject to eligibility verification in order to ensure only eligible individuals are participating in our plans. You will be required to provide proof of one or more of the following within 30 days of their eligibility:

- Marriage Certification or License
- Domestic Partners Affidavit
- Birth Certificate
- Final decree of divorce
- Court documents showing legal responsibility for adopted children, foster children or children under legal guardianship
- Physician's written certification of disabling condition (for dependent children over age 26 incapable of self-support)

If you do not supply the proper documentation to make changes to dependents within the 30-day period, you will not be able to add the dependent(s) until the next open enrollment period.

ENROLLING IN YOUR BENEFITS



ExponentHR is an online system that enables you to make all your benefit decisions in one place. All employees of Townsquare Media are able to log into ExponentHR. You use single sign on with no credentials that are specific to ExponentHR, but you will use your Townsquare Media Microsoft credentials.

Do I need to enroll?

Your current benefit elections for Medical, Dental, Vision and Voluntary coverages are rolled over into the new plan year by default. If you do not want to make any changes to your current elections, your benefits will remain the same as they were in 2025.

Please note, if you are enrolled or enrolling in a Healthcare Savings Account (HSA), Flexible Spending Account (FSA), Dependent Care Flexible Spending Account (DCFSA), and/or Commuter Reimbursement Account (Transportation or Parking plan), you must log in to ExponentHR to elect your 2026 contributions.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- **Log in** to ExponentHR (<https://www.exponenthr.com/service/EmpLogon.asp>)
- **Add** your personal and dependent information.
- **Select** your benefit plans for the coming year.
- **Review** your choices and costs before finalizing.

HEALTH ADVOCATE



Health Advocate is completely confidential and offered at no additional cost for eligible employees and their dependents. (**Effective 04/01/2026**)

Phone: 866-611-8295

Email: answers@HealthAdvocate.com

- Monday – Friday: 8 AM – 10 PM (EST)
- 24/7 phone support
- Connect with an Advocate on the Member Portal:
healthadvocate.com/townsquare

Scan QR code to download



Registration code: TOWNSQUARE

Call • Email • Message • Live Chat 

NEED HELP WITH YOUR BENEFITS AND HEALTHCARE?

Your Health Advocate is here to save you time, money and frustration by answering your questions, maximizing your benefits, and navigating the system on your behalf. Here's how.

Answers to any Question About Your Benefits

From “How does my deductible work?” to “How can I get a new ID card?” – no question is too big or too small. You bring the questions; your Advocate has the answers.

Here to Help

Access help for health and insurance issues like clarifying coverage and transferring records.

More Ways to Save

Learn about ways to save money on medical, dental, and vision care so you and your wallet can both stay healthy.

Appeal Denied Claims

Your Advocate will review a denied claim to determine whether it was coded incorrectly and begin the appeals process.

Review Bills for Errors

Mistakes with your medical bills DO happen, but you shouldn't have to pay for them! Your Advocate will carefully review your bills for errors and expedite corrections.

Exploring your Options

Explore the latest treatments and get second opinion's so you can have piece of mind and be confident in your care.

Preventive Care

Your Advocate can explain how these important checks are covered by your benefits.

Find a Doctor

Your Advocate can help you find an in-network doctor or specialist and even make appointments on your behalf.



We're not an insurance company. Health Advocate is not a direct healthcare provider, and is not affiliated with any insurance company or third party provider. ©2026 Health Advocate HA-M-2401027-1FLY



MEDICAL

Our Plans

- Cigna \$7,000 High-Deductible OAP/Local Plus HSA Compatible Plan
- Cigna \$5,500 OAP/Local Plus Plan
- Cigna \$4,250 OAP/Local Plus Plan



All About Medical Plans

WHICH PLAN IS RIGHT FOR YOU?

Townsquare Media offers multiple medical plans with two different networks, Cigna LocalPlus Network and Cigna Open Access Plus Network.

The LocalPlus In-Network plan provide access to a network that is smaller than our national Open Access Plus (OAP) network. In this plan you have access to in-network benefits only from the health care providers and facilities in the LocalPlus network when in a LocalPlus network service area.

The LocalPlus® plan delivers a cost-effective solution designed to be flexible and help you control health care costs – without sacrificing the quality and convenience you want and expect.

How the plan works.

Cigna collaborates with health care communities to create local networks¹ of health care providers, specialists and hospitals that deliver value and results right where you live.

How you can save.²

- In your local area, or when in any LocalPlus network area, you must receive care from a health care professional or facility in this network to receive in-network coverage.
- If you're temporarily away from your local area or another LocalPlus network area, you have extra peace of mind knowing you can access in-network providers or hospitals through our nationwide Away From Home Care feature.
- If you choose to go outside the LocalPlus network when one is available (or outside the Away From Home Care feature when LocalPlus isn't available), you will receive out-of-network coverage. Your share of the costs may be higher than what you would pay for in-network care.

Get healthy. Stay healthy.

You'll also have access to wellness services and programs to help you stay on the path to good health, including:

- Well visits, preventive care screenings and immunizations.
- Sick visits and specialist, in-hospital and outpatient care.
- Nationwide in-network coverage in case of an emergency.

Cigna makes it easy.

LocalPlus is designed to deliver cost-effective, quality care and peace of mind for today's busy, on-the-go families. Here are some of the many ways the LocalPlus plan can help you get more value for your health care dollar.

- More quality providers makes it easier to choose and use quality care.
- Primary care provider (PCP) selection is encouraged to help guide your care, but it is not required.
- You get access to the Cigna Healthcare national network of labs, behavioral providers, convenience care clinics and virtual care services.
- 70% potential savings by using in-network national labs (Labcorp or Quest).
- You don't need a referral to see a specialist.

24/7/365 service – personalized for you.

- Live customer service, including translation services available in over 150 languages.
- 24-hour Health Information Line, which lets you speak with a nurse advocate.
- Helpful decision-support tools, available on [myCigna.com](https://mycigna.com)®
- And the myCigna® App.



Is your provider in the LocalPlus network?

If you're already a LocalPlus customer

1. Go to myCigna.com and sign in with your user ID and password. (If you're not already registered for myCigna.com, click on "Register Now" to sign up.)
2. Click on the "Find Care & Costs" tab.
3. Select from several ways to search providers, including by doctor name and type.
4. Follow the on-screen prompts to see providers in the LocalPlus network.

LocalPlus is available in these areas:⁸

Arizona	Columbus, Macon, NW & NE GA, Savannah	Missouri	Tennessee
Phoenix		Kansas City	Statewide
Tucson		St. Louis	Texas
California	Illinois	Nevada	Austin, Dallas/ Fort Worth, Houston, San Antonio
Northern	Chicago/ NW Indiana	New Jersey	Utah
Southern	Kansas	Northern	NE Utah
Colorado	Wichita	Southern	Salt Lake City
Front Range, Mountain & West	Maryland	New York	Washington
Florida	Statewide	NYC Metro & Long Island	Statewide
Orlando, South FL & Tampa	Massachusetts	Oregon	Minnesota
Georgia	Statewide (excl. Dukes and Nantucket Counties)	Statewide (excl. Malheur County)	Minneapolis/ St. Paul (New)
		Rhode Island	
		Statewide	

If you're not yet a LocalPlus customer

1. Go to Cigna.com.
2. Click on "Find a Doctor."
3. Under "How are you Covered?" click on "Employer or School."
4. Enter your location in the search box. Then select the type of search you'd like to perform and follow the prompts to search for a provider.
5. Confirm your location under "I Live in" and click "Continue."
6. Choose "LocalPlus" from the list of medical plans to see providers in the LocalPlus network.

1. Massachusetts residents: The LocalPlus network is smaller than the Cigna Healthcare national Open Access Plus (OAP) network. In this plan, you have access to in-network benefits only from the healthcare professionals and facilities in the LocalPlus network when in a LocalPlus network service area. Please consult the limited network directory or visit the online directory at Cigna.com to determine which doctors and hospitals are included in the LocalPlus network. For a paper directory, ask your employer. Texas residents: Open Access Plus and LocalPlus plans are considered Preferred Provider plans with certain managed care features, and Open Access Plus-IN and LocalPlus IN plans are considered Exclusive Provider Plans with certain managed care features.
2. You will be responsible for paying a deductible, any applicable copays, and/or a percentage of your covered in-network or out-of-network costs until you reach the out-of-pocket maximum.
3. Not all services are covered. For example, immunizations for travel are generally not covered. Other non-covered services/supplies may include any service or device that is not medically necessary or services/supplies that are unproven (experimental or investigational). Routine medical care received outside of the U.S. is generally not covered. You may need precertification for hospital stays and some types of outpatient care. Coverage is subject to your plan's deductible, copay or coinsurance requirements. For the specific coverage terms of your plan, refer to your plan documents.
4. Cigna Healthcare provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs.
5. Savings based on average Labcorp/Quest costs compared to labs done at other ancillary, outpatient hospital and non-par labs. Dates of service: January–June 2021.
6. These health advocates are trained nurses. They have a current nursing license in at least one state. When working as a health advocate, they are not practicing nursing or giving medical advice.
7. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com.
8. This listing is not all-inclusive and is as of October 2023; subject to change.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and complete details of coverage, see your plan documents or contact a Cigna Healthcare representative. The health care professionals and facilities that participate in the Cigna Healthcare network are independent contractors solely responsible for the treatment provided to their patients. They are not agents of Cigna Healthcare. Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (Bloomfield, CT). TN policy form: HP-POL43/HC-CER1

Cigna \$7,000 High-Deductible OAP/LocalPlus HSA Compatible Plan

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	In Network	Out of Network
Deductible	Individual (Employee Only): \$7,000 Individual (within a Family): \$7,000 Family: \$14,000	Individual (Employee Only): \$14,000 Individual (within a Family): \$14,000 Family: \$28,000
Out-of-pocket maximum	Individual (Employee Only): \$7,000 Individual (within a Family): \$7,000 Family: \$14,000	Individual (Employee Only): \$14,000 Individual (within a Family): \$14,000 Family: \$28,000
Preventive Care	No Charge (Plan pays 100%)	50% after deductible
Office visit	0% after deductible	50% after deductible 50% after deductible (specialist)
Online visit	0% after deductible	50% after deductible
MDLIVE Urgent Care, Primary Care Services, Specialty Care Services	0% after deductible	Not Available
Chiropractic <i>Annual Limit: 35 Visits</i>	0% after deductible	50% after deductible
Lab and X-ray	0% after deductible	50% after deductible
Urgent care	0% after deductible	50% after deductible
Emergency room	0% after deductible	50% after deductible
Hospitalization	0% after deductible	50% after deductible
Outpatient surgery	0% after deductible	50% after deductible
Prescription Drugs – Through Cigna		Out of Network
Deductible	Combined with Medical	Not Covered
Annual out-of-pocket maximum	Combined with Medical	Not Covered
Generic	0% after deductible	Not Covered
Brand name	0% after deductible	Not Covered
Specialty	0% after deductible	Not Covered
Mail order	0% after deductible	
Generic	0% after deductible	Not Covered
Brand name	0% after deductible	Not Covered

Those who are enrolled in Cigna \$7,000 HDHP OAP/LocalPlus HSA-Compatible Plan will have prescription drug coverage through Cigna.

Cigna \$5,500 OAP/LocalPlus Plan

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	In Network	Out of Network
Deductible Embedded	Individual: \$5,500 Family: \$16,500	Individual: \$8,500 Family: \$25,500
Out-of-pocket maximum Embedded	Individual: \$8,080 Family: \$18,160	Individual: \$14,500 Family: \$29,000
Preventive Care	No Charge (Plan pays 100%)	50% after deductible
Office visit	\$65 copay per visit \$90 copay per visit (specialist)	50% after deductible 50% after deductible (specialist)
Online visit	\$65 copay \$90 copay (specialist)	50% after deductible
MDLIVE Urgent Care, Primary Care Services, Specialty Care Services	\$65 copay per visit (urgent care) \$65 copay per visit (primary care) \$90 copay per visit (specialist)	Not Available
Chiropractic <i>Annual Limit: 35 Visits</i>	\$90 copay	50% after deductible
Lab and X-ray	No Charge (Plan pays 100%)	50% after deductible
Urgent care	\$100 copay per visit	50% after deductible
Emergency room	\$400 copay per visit	\$400 copay per visit
Hospitalization	30% after deductible	50% after deductible
Outpatient surgery	30% after deductible	50% after deductible
Prescription Drugs – Through EmpiRx		Out of Network
Deductible	Individual: \$200 Family: \$200	Not Covered
Annual out-of-pocket maximum	Individual: \$1,270 Family: \$2,540	Not Covered
Generic	\$15 copay	Not Covered
Brand name	Preferred: \$40 copay Non-preferred: \$65 copay	Not Covered
Specialty	Preferred: \$40 copay Non-preferred: \$65 copay	Not Covered
Mail order	90-day supply	
Generic	\$37.50 copay	Not Covered
Brand name	Preferred: \$100.00 copay Non-preferred: \$162.50 copay	Not Covered

Cigna \$4,250 OAP/LocalPlus Plan

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	In Network	Out of Network
Deductible embedded	Individual: \$4,250 Family: \$12,750	Individual: \$5,500 Family: \$16,500
Out-of-pocket maximum embedded	Individual: \$7,000 Family: \$14,000	Individual: \$12,500 Family: \$25,000
Preventive Care	No Charge (Plan pays 100%)	50% after deductible
Office visit	\$65 copay per visit \$90 copay per visit (specialist)	50% after deductible 50% after deductible (specialist)
Online visit	\$65 copay \$90 copay (specialist)	50% after deductible
MDLIVE Urgent Care, Primary Care Services, Specialty Care Services	\$65 copay per visit (urgent care) \$65 copay per visit (primary care) \$90 copay per visit (specialist)	Not Available
Chiropractic <i>Annual Limit: 35 Visits</i>	\$90 copay	50% after deductible
Lab and X-ray	No Charge (Plan pays 100%)	50% after deductible
Urgent care	\$100 copay per visit	50% after deductible
Emergency room	\$400 copay per visit	\$400 copay per visit
Hospitalization	30% after deductible	50% after deductible
Outpatient surgery	30% after deductible	50% after deductible
Prescription Drugs – Through EmpiRx		Out of Network
Deductible	Individual: \$200 Family: \$200	Not Covered
Annual out-of-pocket maximum	Individual: \$1,000 Family: \$2,000	Not Covered
Generic	\$15 copay	Not Covered
Brand name	Preferred: \$40 copay Non-preferred: \$65 copay	Not Covered
Specialty	Preferred: \$40 copay Non-preferred: \$65 copay	Not Covered
Mail order	90-day supply	
Generic	\$37.50 copay	Not Covered
Brand name	Preferred: \$100.00 copay Non-preferred: \$162.50 copay	Not Covered

CHOOSE A MEDICAL PLAN WITH CONFIDENCE

- Cigna One Guide Service Can Help!

We understand how confusing and overwhelming it can be to review your health plan options. And we want to help by providing the resources you need to make a decision with confidence. That's why **Cigna One Guide® service is available to you now.**

Call a One Guide ® representative during pre-enrollment to get personalized, useful guidance.

Your personal guide will help you:

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

The best part, during the enrollment period, your personal guide is just a call away.

Don't wait until the last minute to enroll!

Call **1-800-244-6224** to speak with a Cigna One Guide representative today.

Access Cigna One Guide – after enrollment – in the way that's most convenient for you:



myCigna.com or
the myCigna App



Live chat



Phone

After enrollment, the support continues for Cigna Healthcare customers.

One Guide service will be there to guide you through the complexities of the health care system, and help you avoid costly missteps. Our goal is a simpler health care journey for you and your family.

One Guide service provides personalized assistance to help you:

- Resolve health care issues
- Save time and money
- Get the most out of your plan
- Find hospitals and health care providers in your plan's network
- Get cost estimates and avoid surprise expenses
- Understand your bills

App
Store



Google
Play
Store



PRESCRIPTIONS BREAKING YOUR BUDGET?

Click to play video



The formulary drug tiers determine your cost

\$ Generic drugs

\$\$ Brand-name drugs

\$\$\$ Specialty drugs

Important Note: Those who are enrolled in the Cigna \$7,000 HDHP OAP/LocalPlus HSA Compatible Plan have prescription coverage through Cigna.

Understanding the formulary can save you money

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to be as effective as brand-name drug equivalents.

Townsquare Media partners with EmpiRx for your prescription benefits for those enrolled in the Cigna \$5,500 Plan and Cigna \$4,250 Plan. Below is additional information regarding your prescription benefits such as mail order pharmacy and on the next page you will find frequently asked questions.

Why Mail-Order Pharmacy?

- Prescriptions delivered to your doorstep
- Submit your prescriptions and receive the convenience of up to three months (90 days) supply of your maintenance medications

PRESCRIPTIONMART

HOW TO GET STARTED:

Call EmpiRx Health Member Services (1-877-323-0584) for assistance in transferring your current prescription(s).

Online: Fill out your information using our New Patient Enrollment form by registering an account on the EmpiRx Health Member Portal at myempirxhealth.com and navigating to the Mail Order section of the app.

*Ask your physician to e-prescribe to "Prescription Mart," which is EmpiRx Health's Mail Order Pharmacy, or your doctor's office can fax your prescription to 1-409-866-1317.

Important Note: *Prescriptions are NOT refilled automatically

PRESCRIPTION BENEFITS - FAQs

How do I locate a network pharmacy?

You may use your EmpiRx Health ID card at over 68,000 pharmacies nationwide including all major chain pharmacies.

You can find a network pharmacy by logging-in at <https://www.myempirxhealth.com> or by calling **1-877-323-0584**.

What Is the Mandatory Generic program?

All members and their eligible dependents to use cost-effective generic medications (when available) instead of the more expensive brand-name versions. If you or your doctor choose a brand-name medication where a generic is available, in addition to your co-payment and co-insurance amount, you will be responsible to pay the difference between the brand-name and generic medication cost.

What is Prior Authorization?

Prior Authorization is a review of certain high cost or sensitive drugs before they can be filled. EmpiRx Health reaches out to your physician to gather information confirming appropriateness and safety for you.

Who do I call with questions regarding my prescription?

Call an EmpiRx Health Member Services Representative toll-free at **1-877-323-0584**. Representatives are available 24 hours a day, 7 days a week!

What are Quantity Limits?

Quantity limits are a safety review that is in place to ensure you are not being over prescribed or given too much of a single drug. A review is performed to see if the prescription should be dispensed within the FDA approved limit. This can be done right at the pharmacy or by having your prescriber adjust the amount and resubmit the script to the pharmacy

What is Step Therapy?

Step Therapy requires you to use a lower-cost medication prior to using the “second-line”, step two or higher cost medication within the same category. The list of categories requiring step therapy is developed by doctors, pharmacists and experienced medical personnel.

Please note, all changes to a lower-cost medication are confirmed by your prescriber, as your prescriber will need to provide your pharmacy with a new prescription for the first line medication.





Dental

Our Plans

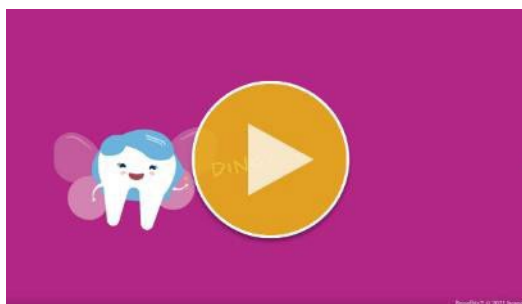
- Total Cigna DPPO Network Plan
- Cigna Dental Care (DHMO)* Plan

Why sign up for dental coverage?

Brushing and flossing are great, but regular exams catch dental issues early. If there's a problem, our dental plan makes it easier and less expensive to get the care you need to maintain your smile.

Find out how it works!

Click to play video



*Only available in geographical areas where there are Cigna Dental Care (DHMO) Network participating General Dentists within a 25 mile radius of the members' home Zip Code.

Total Cigna DPPO Dental Plan

This Network Has Two Tiers: "Cigna DPPO Advantage" and "Cigna DPPO"

Your DPPO plan allows you to see any licensed dentist, but using an in-network dentist may minimize your out-of-pocket. You pay the deductible first, unless you are receiving Diagnostic & Preventive care. The coinsurance (%) shows what you pay after the deductible.

Cigna DPPO Advantage Network

	In Network	Out of Network
Annual deductible	Individual: \$50 Family: \$150	Individual: \$50 Family: \$150
Annual plan maximum	\$1,500 per person	\$1,500 per person
Diagnostic & Preventive	0% no deductible	0% no deductible
Basic restorative services	10% after deductible	30% after deductible
Major restorative services	50% after deductible	50% after deductible
Orthodontia	50% no deductible Children: covered to age 19 Adults: not covered	50% no deductible Children: covered to age 19 Adults: not covered
Orthodontia lifetime maximum	\$1,250	\$1,250

Cigna DPPO

	In Network	Out of Network
Annual deductible	Individual: \$50 Family: \$150	Individual: \$50 Family: \$150
Annual plan maximum	\$1,500 per person	\$1,500 per person
Diagnostic & Preventive	0% no deductible	0% no deductible
Basic restorative services	30% after deductible	30% after deductible
Major restorative services	50% after deductible	50% after deductible
Orthodontia	50% no deductible Children: covered to age 19 Adults: not covered	50% no deductible Children: covered to age 19 Adults: not covered
Orthodontia lifetime maximum	\$1,250	\$1,250

Cigna Dental Care (DHMO)* Plan

*Only available in geographical areas where there are Cigna Dental Care (DHMO) Network participating General Dentists within a 25 mile radius of the members' home Zip Code. There are NO out of network benefits.

Cigna DHMO Plan

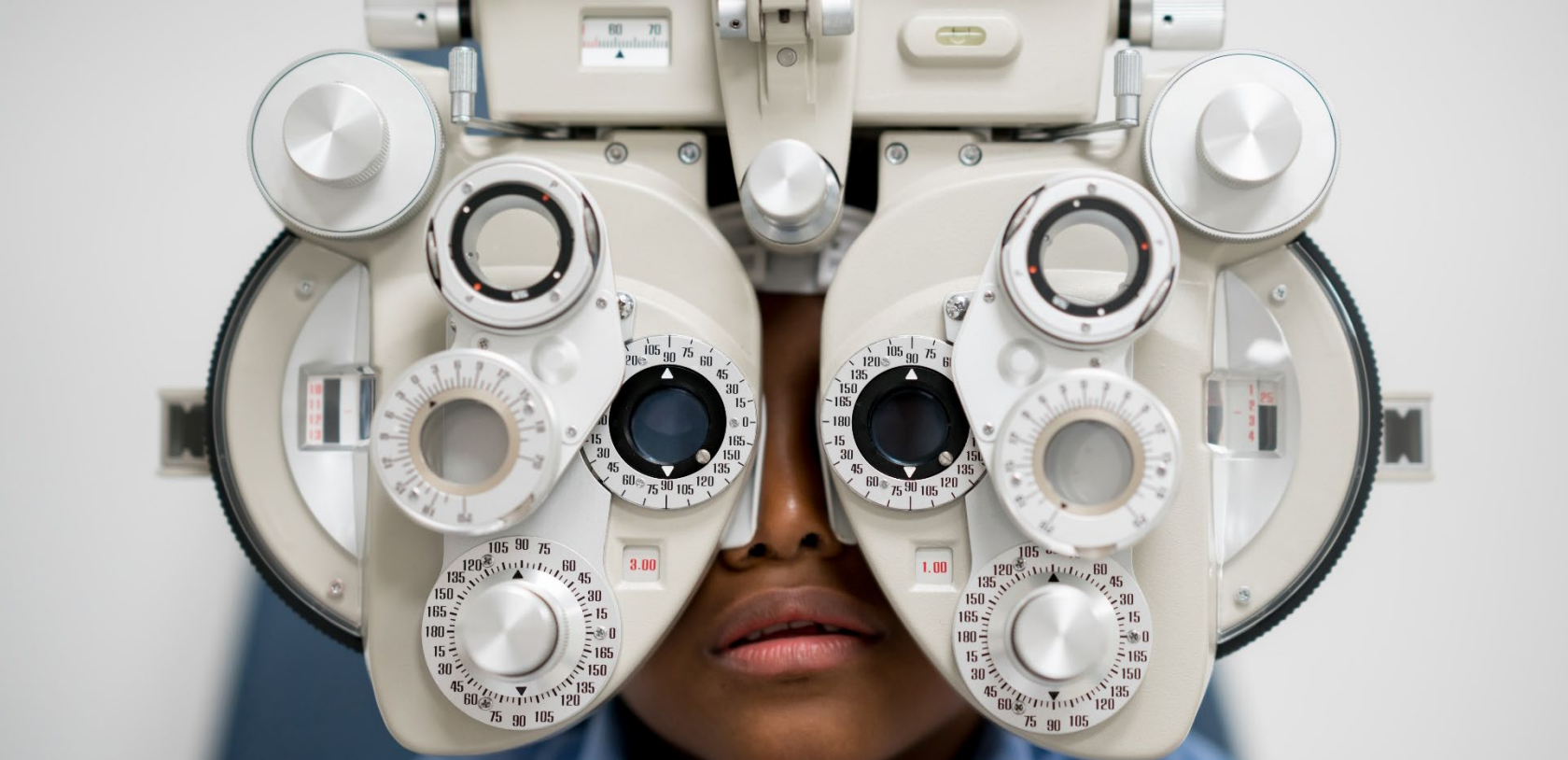
	In Network	Out of Network	Benefit Limitations and Exclusions
Annual deductible	No Deductible	No Deductible	N/A
Annual plan maximum	Not Applicable	Not Applicable	
Diagnostic & Preventive			
<i>Oral Exam</i>	\$0	Not Covered	Oral evaluations are limited to a combined total of 4 comprehensive or periodic evaluations during a 12-month consecutive month period.
<i>Bitewing X-ray</i>	\$0	Not Covered	N/A
<i>Cleaning</i>	\$0	Not Covered	Limited to 2 per year
Basic Services			
<i>Filling</i>	\$0	Not Covered	N/A
<i>Extraction, Erupted Tooth or Exposed Root</i>	\$12	Not Covered	N/A
<i>Root Canal</i>	\$335	Not Covered	N/A
<i>Scaling and Root Planning</i>	\$83	Not Covered	Limited to 4 quadrants per consecutive 12-months
<i>Extraction, Erupted Tooth with Bone Removal</i>	\$53	Not Covered	N/A
Major Services			
<i>Ceramic Crown</i>	\$490	Not Covered	N/A
<i>Removable Partial Denture</i>	\$715	Not Covered	N/A
Orthodontia			
Orthodontia	\$2,040	Not Covered	Co-pay reflects 24 months of active child comprehensive treatment. Cases beyond 24 months require an additional payment by the patient.

Important Information Regarding the Cigna Dental Care (DHMO) Dental Plan

- This Patient Charge Schedule applies only when covered dental services are performed by your Network Dentist, unless otherwise authorized by Cigna Dental as described in your plan documents. Not all Network Dentists perform all listed services, and it is suggested to check with your Network Dentist in advance of receiving services.
- This Patient Charge Schedule applies to Specialty Care when an appropriate referral is made to a Network Specialty Periodontist or Oral Surgeon. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental. Prior authorization is not required for specialty referrals for Pediatric, Orthodontic and Endodontic services. You may select a Network Pediatric Dentist for your child under the age of 13 by calling Customer Service at 1.800.Cigna24 to get a list of Network Pediatric Dentists in your area. Coverage for treatment by a Pediatric Dentist ends on your child's 13th birthday; however, exceptions for medical reasons may be considered on an individual basis. Your Network General Dentist will provide care upon your child's 13th birthday.
- Procedures not listed on this Patient Charge Schedule are not covered and are the patient's responsibility at the dentist's usual fees.
- The administration of IV sedation, general anesthesia, and/or nitrous oxide is not covered except as specifically listed on this Patient Charge Schedule. The application of local anesthetic is covered as part of your dental treatment.
- Cigna Dental considers infection control and/or sterilization to be incidental to and part of the charges for services provided and not separately chargeable.
- This Patient Charge Schedule is subject to annual change in accordance with the terms of the group agreement.
- Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your plan book/certificate of coverage and/or group contract.
- All patient charges must correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.
- The American Dental Association may periodically change CDT Codes or definitions. Different codes may be used to describe these covered procedures.

How to Find an In-Network Dentist

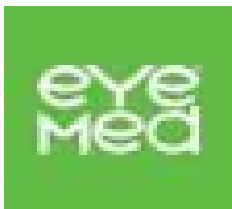
Step 1:	Visit www.cigna.com
Step 2:	Select "Find a Doctor, Dentist or Facility"
Step 3:	Select "Employer or School"
Step 4:	Input the zip code in which you want to find an in-network dentist Select "Doctor by Type"
Step 5:	Select "General Dentist"
Step 6:	Select "Continue as Guest" and then "Continue"
Step 7:	Select a Plan / Network: Total Cigna DPPO – Select "DPPO/EPO" > Total Cigna DPPO DHMO Plan – Select "Cigna Dental Care DHMO" > Cigna Dental Care Access Plus



Vision

Our Plan

EyeMed Vision



Click to play video



Why sign up for vision coverage?

Even if you have 20/20 vision, an annual eye exam checks the health of your eyes and can detect other health issues. If you do need glasses or contacts, vision coverage helps with the cost.

Visit the plan's website for extra savings on services like LASIK and PRK, and rebates on contact lenses.

EyeMed Vision Plan

You always pay the deductible and copayment (\$). The coinsurance (%) shows what you pay after the deductible.

	In Network	Out of Network
Exam	\$10 copay	Up to \$40 Reimbursed
Frames	\$0 copay; 20% off balance over \$130 allowance per 12 months	Up to \$91 Reimbursed
Standard Plastic Lenses		
<i>Single Vision:</i>	\$20 copay	Up to \$40 Reimbursed
<i>Bifocal:</i>	\$20 copay	Up to \$60 Reimbursed
<i>Trifocal:</i>	\$20 copay	Up to \$80 Reimbursed
<i>Lenticular:</i>	\$20 copay	Up to \$80 Reimbursed
<i>Progressive—Standard:</i>	\$75 copay	Up to \$80 Reimbursed
<i>Progressive—Premium Tier 1-3:</i>	\$105-\$130 copay	Up to \$80 Reimbursed
<i>Progressive—Premium Tier 4:</i>	\$195 copay	Up to \$80 Reimbursed
Lens Options		
<i>Anti Reflective Coating-Standard:</i>	\$45	Up to \$5 Reimbursed
<i>Anti Reflective Coating-Premium:</i>	\$57-\$85	Up to \$5 Reimbursed
<i>Photochromic - Non-Glass:</i>	\$75	Not covered
<i>Polycarbonate – Standard:</i>	\$40	Not covered
<i>Scratch Coating - Standard Plastic:</i>	\$15	Not covered
<i>Tint - Solid and Gradient:</i>	\$15	Not covered
<i>UV Treatment:</i>	\$15	Not covered
<i>All Other Lens Options:</i>	20% off retail price	Not covered
Contacts		
<i>Conventional</i>	\$0 copay; 15% off balance over \$120 allowance	Up to \$91 Reimbursed
<i>Disposable</i>	\$0 copay; 100% off balance over \$120 allowance	Up to \$91 Reimbursed
<i>Medically Necessary</i>	\$0 copay; paid in full	Up to \$300 Reimbursed
Other		
<i>Hearing Care from Amplifon Network</i>	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
<i>LASIK or PRK from U.S. Laser Network</i>	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
Frequency (Adults & Children)		
Exam	Once every 12 months	
Frame	Once every 12 months	
Lenses	Once every 12 months	
Contact Lenses	Once every 12 months	

HEALTH SAVINGS ACCOUNT (HSA)

Click to play videos



Are you eligible?

The HSA is not for everyone. You're eligible only if you are:

- Enrolled in the Cigna HSA compatible plan.
- Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
- Not a tax dependent.
- Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today, and save for expenses you may have in the future.

How the HSA Plan works

- Your HSA account is set up automatically after you enroll.
- You can contribute up to the limit set by the IRS.
 - **Individual:** \$4,400 per year
 - **Family:** \$8,750 per year
 - **Age 55+:** \$1,000 extra per year
- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save the money to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free. You can also use it for regular living expenses, which will be taxable but without penalties.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video



Are you eligible?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high-deductible health plan (like our HDHP plan), you can only participate in the Limited Purpose FSA for dental and vision expenses.

Find out more

- <https://myameriflex.com/>
- [Eligible Expenses](#)
- [Ineligible Expenses](#)

Set aside healthcare dollars for the year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the Ameriflex FSA works

- You estimate what your and your dependents' out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, and certain drugstore items.
- You can contribute up to \$3,400, the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you forfeit the leftover balance at the end of the year.

Potential tax savings

Because FSA contributions are pre-tax, they reduce the total amount of your income the government makes you pay taxes on. Tax savings vary depending on filing status and other variables.

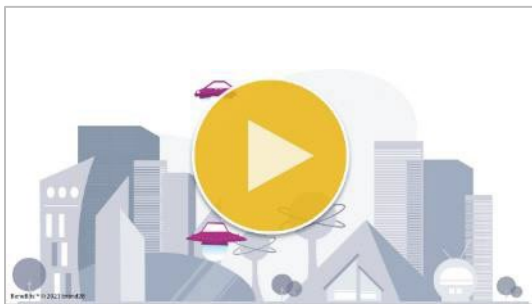


Engage

Click to play videos



Urgent Care vs. ER



Virtual Healthcare

Maximize Your Health Benefits

Knowing how to best use your healthcare coverage can help you improve your health and reduce your expenses. In this section you'll find tips on:

- Finding the right care at the right cost
- Alternatives to hospital care
- Understanding preventive care benefits
- Saving money on prescription drugs

FIRST STOP HEALTH



YOUR PARTNER IN HEALTH AND WELLBEING.

Get convenient care for your body and mind – all via phone or video. Townsquare Media provides First Stop Health to Cigna medical-enrolled employees and their dependents.



Urgent Care Issues



Talk to a provider in minutes for sinus issues, UTI, cold, flu, skin rash and more. Available for all ages!

Prevention & Wellness



Check in on your current health and make a personalized plan to stay healthy and strong.

Mental Healthcare



Ready to feel your best? Get confidential support from a therapist, mental health coach or primary care doctor.

Health Management



Support managing diabetes, high blood pressure, high cholesterol, COPD and more.

Referrals, Tests and More



Our providers can order labs, screenings and provide referrals to in-network specialists.*

ACTIVATE YOUR ACCOUNT



Use the last 4 digits of your SSN to claim your account!

www.firststophealth.com

888-691-7867

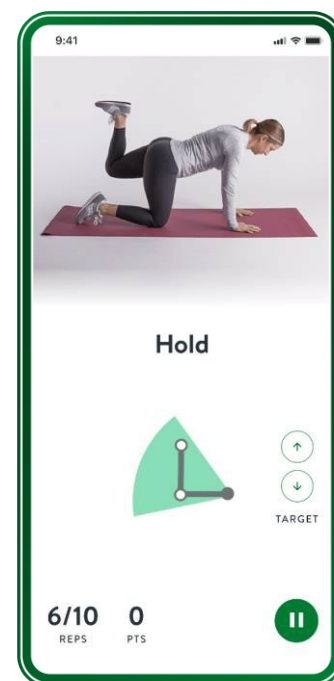
*First Stop Health services are not intended to constitute a health plan. Those under 18 are welcome to use 24/7 virtual urgent care only.
Providers at First Stop Health do not prescribe controlled substances. Costs according to your medical plan may apply for prescriptions, lab orders and other non-FSH services.

With First Stop Health you have access to virtual Urgent Care, Prevention & Wellness, and Mental Healthcare with \$0 Copay!

HINGE HEALTH



CONQUER BACK AND JOINT PAIN WITHOUT DRUGS OR SURGERY!



Hinge Health provides all the tools you need to get moving again from the comfort of your own home. You'll get exercise therapy tailored to your needs, technology for instant feedback in the app, personal coach and physical therapist.

Hinge Health helps with any of the following:

- Conquer pain or limited movement
- Recover from a past injury
- Reduce stiffness in achy joints

Join for your **back, knee, hip, neck, or shoulder**. On average participants cut their pain as much as 68%*!

With Hinge Health you will have access to virtual physical therapy with \$0 Copay!



Scan the QR code to learn more at
www.hinge.health/for-individuals.com
or call (855) 902-2777



Eligibility: Participants must be 18+ and enrolled in a medical plan through their employer.

*Participants with chronic knee and back pain after 12 weeks. Bailey, et al. Digital Care for Chronic Musculoskeletal Pain: 10,000 Participant Longitudinal Cohort Study. JMIR. (2020).

KNOW WHERE TO GO

Where you get medical care can significantly affect the cost. Here's a quick guide to help you know where to go based on your condition, budget, and time.

Visit type	Use it for ...
Nurse line (\$) Often available 24/7 at no cost	• quick answers from a trained nurse: – to determine if immediate care is needed – for home treatment options & advice
Online visit (\$) Often available 24/7	• non-emergency health issues: – cold, flu, allergies, headache, migraine – rashes, skin conditions – minor injuries – mental health concerns
Office visit (\$\$) Typically open during regular business hours	• routine medical care and management: – preventive care – illnesses and injuries – existing conditions
Urgent care (\$\$\$) Typically open with extended evening and weekend hours	• urgent but not life-threatening conditions: – sprains or stitches – animal bites – high fever or respiratory infections
Emergency room (\$\$\$\$) Open 24/7	• life-threatening conditions requiring immediate care: – suspected heart attack or stroke – broken bones – excessive bleeding – severe pain – difficulty breathing

Click to play video



Urgent Care vs. ER

HOW TO FIND AN IN-NETWORK PROVIDER

Is your doctor or hospital in your plan's Cigna Healthcare network? The Cigna Healthcare online directory make it easy to find who (or what) you're look for.

Search your plan's network in four simple steps:



STEP ONE

Go to [Cigna.com](https://www.cigna.com) and click on "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select "Employer or School."

(If you're already a Cigna Healthcare customer, log in to [myCigna.com](https://mycigna.com) or the **myCigna App** to search your current plan's network. To search other networks, use the [Cigna.com](https://www.cigna.com) directory.)



STEP TWO

Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to see your results.



STEP THREE

Answer any clarifying questions, and then verify where you live (as that will determine the networks available).



STEP FOUR

Optional: Select one of the plans offered by your employer during open enrollment.



That's It! You can also refine your search results by distance, years in practice, specialty, languages spoken and more.

Questions? Call the number on the back of your ID Card!

Providers and facilities that participate in the Cigna Healthcare network are independent practitioners solely responsible for the treatment provided to their patients. They are not agents of Cigna Healthcare. Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, see your plan documents.

All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (CHLIC), Connecticut General Life Insurance Company, Cigna Behavioral Health, Inc., and HMO or service company subsidiaries of Cigna Health Corporation, including Cigna HealthCare of Arizona, Inc., Cigna HealthCare of California, Inc., Cigna HealthCare of Colorado, Inc., Cigna HealthCare of Connecticut, Inc., Cigna HealthCare of Florida, Inc., Cigna HealthCare of Georgia, Inc., Cigna HealthCare of Illinois, Inc., Cigna HealthCare of Indiana, Inc., Cigna HealthCare of St. Louis, Inc., Cigna HealthCare of North Carolina, Inc., Cigna HealthCare of New Jersey, Inc., Cigna HealthCare of South Carolina, Inc., Cigna HealthCare of Tennessee, Inc. (CHC-TN), and Cigna HealthCare of Texas, Inc. Policy forms: Medical: OK - HP-APP-1 et al., OR - HP-POL38 02-13, TN - HP-POL43/HC-CER1V1 et al. (CHLIC); GSA-COVER, et al. (CHC-TN). The Cigna Healthcare name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc. 880087 h 08/24 © 2024 Cigna Healthcare. Some content provided under license.

ALTERNATIVE FACILITIES

If you have time to evaluate your options for non-emergency health treatments, these alternative facilities can provide the same results as a hospital at a fraction of the cost.

Procedure	Alternative	Features	Savings*
Surgery	Ambulatory surgical center	• Specializes in same-day surgeries • Cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery and more • Held to same safety standards as hospitals	Up to 50% vs. a hospital stay
Physical therapy	Outpatient facility	• Most cases are suited for outpatient physical therapy • Same types of treatments and similarly skilled therapists as inpatient facilities	40 to 60% vs. a hospital setting
Sleep study	Home testing	• Diagnoses obstructive sleep apnea • Cost is often covered by insurance if considered medically necessary	Up to \$4,500 vs. a lab
Infusion therapy	Home or outpatient infusion	• For drugs that must be delivered by intravenous injections, or epidurals • Delivered by licensed infusion therapy provider • Maintain normal lifestyle and comfort of home or outpatient center	Up to 90% vs. a hospital stay

**Savings estimates are based on in-network facilities and providers*

How to find an alternative treatment facility

Ask your doctor if your treatment must be delivered in the hospital.

You can also search for surgical centers, physical therapy, and similar services on your plan's website, or call member services for assistance. Online tools such as [healthcarebluebook.com](https://www.healthcarebluebook.com) and

[healthgrades.com](https://www.healthgrades.com) help you compare costs and doctor ratings.

Some alternative facilities include a fee to cover overhead costs. To avoid a surprise on your bill, ask about facility fees before you schedule your appointment.

PREVENTIVE CARE



You take your car in for maintenance; why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

Health plans are required to cover a set of preventive services at no cost to you, even if you haven't met your deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Typical screenings for adults

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

Be aware: Not all exams and tests are considered preventive care

Certain screenings may be considered diagnostic, rather than preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

In addition, exams performed by specialists are generally not considered preventive care and may not be covered at 100%.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Preventive Care through First Stop Health: With First Stop Health you have access to a preventive care visit at no cost to you, a \$0 Copay!



Life & Disability

Name Your Beneficiaries

If the worst happens, your beneficiary—the person (or people) on record with the life insurance carrier—receives the benefit. Make sure that you name at least one beneficiary for your life insurance benefit, and change your beneficiary as needed if your situation changes.

Is your family protected?

Life, AD&D, and Disability insurance can fill financial gaps due to a loss of income. Consider your day-to-day costs and bills during a pregnancy or illness-related disability leave, or how you would manage large expenses (housing, education, loans, credit cards, etc.) after the death of a spouse or partner.

If you need more

In addition to company-provided coverage, we offer voluntary coverage that you can purchase for yourself, your spouse, and your children. See the Voluntary Plans section for details.

BASIC LIFE AND AD&D INSURANCE

Townsquare Media pays for the full cost of your Basic Life and AD&D benefit through New York Life.



Basic Life and AD&D

Basic life insurance pays your beneficiary a lump sum if you die. AD&D (Accidental Death & Dismemberment) coverage provides a benefit to you if you suffer from loss of a limb, speech, sight, or hearing, or to your beneficiary if you have a fatal accident. The cost of coverage is paid in full by Townsquare Media.

Basic Life

1-time annual salary rounded up to the next highest \$1,000 up to a maximum of \$100,000.

AD&D

1-time annual salary rounded up to the next highest \$1,000 up to a maximum of \$100,000.



Age Based Reductions: If you are age 65 or older, your Life Insurance Benefits are payable as follows:

Age	Percentage of Benefit Amount
65 but less than 70	65% of Benefit Amount
70 but less than 75	45% of Benefit Amount
75 but less than 80	30% of Benefit Amount
80 or over	20% of Benefit Amount

Benefits reductions will be effective on January 1st coinciding with or following your attainment of age as specified in schedule above.

LONG-TERM DISABILITY INSURANCE



Things to know about LTD insurance

- It can protect you from having to tap into your retirement savings.
- You can use LTD benefits however you need, for housing, food, medical bills, etc.
- Benefits can last a long time—from weeks to even years—if you remain eligible.



LTD benefits cushion the financial impact of a disability

Long-term disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

If you qualify, LTD benefits begin after 90 days of disability. Payments may be reduced by state, federal, or private disability benefits you receive while disabled. Townsquare Media pays for the cost of this coverage.

Long-Term Disability Benefit

Monthly Benefit Amount	60% of your monthly earnings, rounded to the nearest dollar up to a maximum of \$10,000
Benefits Begin	After 90 days of disability
Minimum Disability Benefit	The greater of \$100 or 10% of your monthly benefit prior to any reduction for other income benefits

Age When Disability Begins	Maximum Benefit Period
Age 62 or under	Your 65th birthday or the date the 42nd Monthly Benefit is payable, if later.
Age 63	The date the 36th Monthly Benefit is payable.
Age 64	The date the 30th Monthly Benefit is payable.
Age 65	The date the 24th Monthly Benefit is payable.
Age 66	The date the 21st Monthly Benefit is payable.
Age 67	The date the 18th Monthly Benefit is payable.
Age 68	The date the 15th Monthly Benefit is payable.
Age 69 or older	The date the 12th Monthly Benefit is payable.



Voluntary Plans

Our Plans

- Voluntary Life and AD&D Insurance
- Voluntary Short-Term Disability Insurance
- Voluntary Accident Insurance
- Voluntary Critical Illness Insurance
- Voluntary Hospital Indemnity Insurance

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. You can also choose not to sign up for voluntary benefits at all—it's up to you.

VOLUNTARY LIFE AND AD&D INSURANCE



Guaranteed issue

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health for the insurance company to approve the amount of coverage.

FOR THIS OPEN ENROLLMENT PERIOD ONLY: Employees who did not elect Voluntary Life and Voluntary AD&D when first eligible can enroll in Voluntary Life and Voluntary AD&D Insurance up to the guaranteed issue limits without needing to submit an EOI!



Protecting those you leave behind

Voluntary life insurance allows you to purchase additional life insurance to protect your family's financial security.

Voluntary AD&D insurance allows you to purchase accidental death and dismemberment coverage that pays your beneficiary if you have a fatal accident. If you experience a serious injury such as a loss of a limb, speech, sight or hearing, the plan pays a benefit to you.

Coverage is available for your spouse and/or children if you purchase coverage for yourself.

Voluntary Life and AD&D

Employee \$10,000 increments up to a maximum of \$500,000. Guaranteed issue of \$200,000, an increase from previous years where the GI was \$150,000.

Spouse or Domestic Partner \$5,000 increments up to a maximum of \$500,000. Guaranteed issue of \$50,000, an increase from previous years where the GI was \$25,000.

Spousal Life Insurance Benefits cannot exceed 100% of the employee's Life Insurance

Children An amount elected in increments of \$10,000 up to a maximum of \$10,000.

The maximum benefit for a Dependent Child who is less than 6 months old is \$500.

Age Based Reductions: If you are age 65 or older, your Life Insurance Benefits are payable as follows:

Ages	Percentage of Benefit Amount
65 but less than 70	65% of Benefit Amount
70 but less than 75	45% of Benefit Amount
75 but less than 80	30% of Benefit Amount
80 or over	20% of Benefit Amount

VOLUNTARY SHORT-TERM DISABILITY INSURANCE



Short-Term Disability Benefits

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

Short-Term Disability payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability. You pay for the cost of this coverage.

Voluntary Short-Term Disability

Weekly benefit amount	60% of weekly earnings, up to a maximum of \$1,500
Benefits begin	After 14 days of disability due to accident or 14 days due to sickness
Maximum payment period	13 Weeks

Expect the Unexpected

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.



Guaranteed Issue

FOR THIS OPEN ENROLLMENT PERIOD

ONLY: Employees who did not elect Voluntary Short-Term Disability insurance when first eligible can elect during this Open Enrollment period without needing to submit an EOI.

VOLUNTARY HEALTH-RELATED PLANS



Things to consider

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

Accident Insurance

Accident insurance from MetLife helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, as well as physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

Critical Illness Insurance

Critical illness insurance from MetLife can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

Hospital Indemnity Insurance

Hospital indemnity insurance from MetLife can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide.



Monthly Rates for these Voluntary Health-Related Plans can be found on page 61.

ASPCA PET INSURANCE FOR TSM



Pets are members of the family too. When your pet gets sick, bills can add up faster than expected. Pet insurance prevents you from needing to weigh your pet's health against your bank account. Most plans offer coverage for costs associated with both accidents and illnesses—even medications. ASPCA Pet Health Insurance provides coverage for this program. You can enroll in this program anytime. Please note, this benefit is not available through ExponentHR and must be elected online at [ASPCA.com](https://www.aspcapetinsurance.com).

With ASPCA Pet Health Insurance, you will now be able to create a customized benefit package for your pet!

The following are included with your ASPCA Pet Insurance Benefit:

- Exams
- Illnesses
- Hereditary Conditions
- Cancer
- Dental disease
- Behavioral Issues

You will have the ability to customize the following options:

- **Annual Limit** – from \$5,000 to unlimited
- **Reimbursement Percentage** – 70%, 80%, or 90% of your vet bill
- **Deductible** – select \$100, \$250, or \$500. You will only need to satisfy it once per a 12-month period
- **Add Preventive Care** – get reimbursed schedule amounts for vaccines, dental cleanings and preventive screenings
- **Select Accident-Only Coverage** – if you are just looking to have some protection when your pet gets hurt, you can choose that too!

**ASPCA[®] PET HEALTH
INSURANCE**

Please Note: This pet insurance discount program is not available for enrollment in ExponentHR. For more information, and/or to obtain a quote, go to:

<https://www.aspcapetinsurance.com/TownsquareMedia>

Or Call 1-877-343-5314

Priority Code: EB18TownsquareMedia

PERKSPOT



ONE-STOP SHOP

- Single point of entry for employee discounts and perks
- Accessible from computers, tablets and your smart phone
- Use it for everyday items
 - Clothing
 - Cell Phones
 - Jewelry
 - Groceries
 - Pet Supplies
 - Insurance
 - Movie Tickets
 - Cell Phones
 - Gifts
 - Sporting Equipment
 - Gyms
 - Dining Out



PerkSpot is an online savings resource available to Townsquare employees.

It's the place to find discounts and rebates on goods and services from many of the best-known brand names in the U.S, such as AMC theatres, Costco, target and much more. PerkSpot keeps its database up to date with current discounts and deals daily

<https://pslogin.perkspot.com/>





Financial Wellness

Plans To Help You Save

- Commuter Reimbursement Account (CRA)
- Dependent Care Flexible Spending Account (DCFSA)
- Alliant Medicare Solutions
- 401(k) Retirement Savings Plan

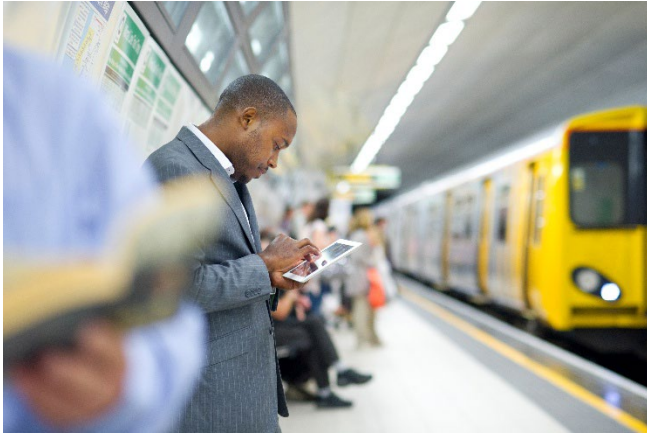
Is it time for a financial wellness checkup?

Are you worried about money—making your paycheck last? Paying down debt? Making a big purchase like a car or home? What about retirement?

Ignoring your financial health can take a toll on your quality of life today and in the future. And worrying about money can make you stressed, even to the point of physical illness.

We offer benefits and resources to help you make the most of your money. You can reduce your tax burden, and work toward your retirement goals.

SAVE ON WORK-RELATED COMMUTER EXPENSES



Commuter Reimbursement Account (CRA) Transportation and Parking Plans

Do you have out-of-pocket commuting expenses for public transportation, van pooling, or for worksite parking? If so, you can save on taxes by enrolling in our Commuter Reimbursement Account Plans, administered by Ameriflex.

What do you need to know?

- Participants may use pre-taxed dollars for eligible commuter expenses such as:
 - **Parking:** Expenses incurred to park your vehicle near employer premises or location from where you commute via mass transit, carpool or commuter. Contribute up to \$340 a month.
 - **Transportation:** Expenses incurred to use mass transit (light rail, subway) to and from your place of work. Contribute up to \$340 per month.
- Transportation Plan participants may only access funds by use of the Ameriflex Mastercard
- You may access funds **AFTER** you have contributed money to your account, this benefit is **NOT** front loaded.
- You may change your Transit/Parking contributions at any time via the ExponentHR portal.
 - *It must be at least five days prior to the next pay period*
- Elections can be updated monthly
 - Elect only what you need ... Per IRS regulation, money left in a Commuter Reimbursement Account Plan is forfeited when you leave Townsquare Media.

PAYING FOR DAYCARE? MAKE IT TAX-FREE!

Click to play video



Every opportunity to save

The biggest deduction from your paycheck is likely federal income tax. Why not take a bite out of taxes while paying for necessary expenses with tax-free dollars?

Dependent Care FSA—up to \$7,500 per year tax-free

A dependent care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care. This program is administered by AmeriFlex.

Here's how the DCFSA Plan works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before- and after-school care programs, preschool, and summer day camp for children younger than 13.

The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to \$7,500 per household per year. You can pay your dependent care provider directly from your FSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

Estimate carefully!

You can't change your FSA election amount mid-year unless you experience a qualifying event. Money contributed to a dependent care FSA must be used for expenses incurred during the same plan year. Unspent funds will be forfeited.

Turning 65? Know your Medicare Options



Alliant Medicare Solutions is a no-cost service available to you, your family members, and friends nearing age 65.

amspremier.com
(877) 329-4281

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you turn 65

Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How does it work?

- Call Alliant Medicare Solutions on this dedicated line for Townsquare Media at **(877) 329-4281** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
- Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
- If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll later.

Find out more



[Your Guide to Medicare](#)



[Medicare 101](#)



[Social Security Planning](#)

SAVE NOW, ENJOY LATER

Click to play video



What are your plans?

Many of us can't plan past the weekend, never mind thinking about a retirement nest egg. Our 401(k)-retirement plan will help you set a retirement savings goal and stick to it.

The important thing is to start now and set aside what you can, even if you think it's too small an amount.

Based on the schedule below, once you reach your one year of service, (if you leave the company) you will receive 33.3% of the match. After three years of employment, you will be eligible for 100% of it. Therefore, you get the employer match now, but if you leave the company before you reach three years of service, you will not be eligible to receive all of it.

Schedule of 401(k) Benefits:

- Less than 1 year of employment: 0%
- At your 1-year anniversary you are 1/3rd vested in the match: 33.3%
- At your 2-year anniversary you are 2/3rd vested in the match: 66.6%
- At your 3-year anniversary you are totally vested in the match: 100%

401(k) retirement savings plan—up to \$24,500 per year (or more)

Our 401(k)-retirement savings plan helps you save for retirement. The plan offers tax savings NOW through pre-tax contributions. All regular full-time employees 21 or older are eligible to join the plan once you complete 2 months of employment at Townsquare Media.

You may elect to defer a percentage of your eligible compensation into the Plan from 1% - 60%. The percentage of your eligible compensation you elect will be withheld from each payroll and contributed to your account with Fidelity. You may elect pre-tax contributions and/or Roth Deferral contributions.

Townsquare Media's 401(k) retirement plan is through Fidelity Investments. For more details, please refer to the Summary Plan Description (SPD) that is posted on ExponentHR. Once eligible, to enroll and select your investment options, call Fidelity Investment Retirement Benefits at 1-800-835-5097, or log in to Fidelity NetBenefits at www.401K.com and register.

401(k) retirement savings plan— Employer Match & Vesting Schedule

Townsquare Media's employer match is automatically calculated every payroll and is deposited into your Fidelity Investment 401(k) plan account, along with your deferral every pay date.

The current match is \$0.25 for each dollar you contribute, up to 4% of your eligible earnings. You will be able to see the match amount on your paycheck stub.

KEEP IN MIND, that even though you will receive the match now, you aren't vested yet. Vesting refers to the portion of the match an employee is entitled to if the employee leaves the company and is based on the employee's tenure.

TOWNSQUARE MEDIA 401(K) RETIREMENT PLAN

Townsquare Media offers a 401(k) Plan through Fidelity Investments. All Full-time employees who are age 21 or older will be eligible to participate in the Plan effective the 1st of the month following 2 full months of completed employment. Townsquare offers a Company match to further enhance this benefit, contributing 25¢ for each dollar you defer up to 4% of your eligible contributions per pay period to your 401(k) account.

To enroll, simply login to your Fidelity account by logging into office.com and selecting the Fidelity NetBenefits app (the first time you will need to select it in “All Apps” from the menu icon on the upper left corner) or you can log in directly to Fidelity NetBenefits. If you have not logged in before, you will need to “Register as a new user”. If you do not have your login information, click “Forgot login?”. Or you can contact a Fidelity Customer Service representative directly at 1-800-835-5095 for assistance.

Once logged in, you can elect your deferral percentage, make your investment fund elections and designate your beneficiary(ies). All of the information regarding the different investment options, retirement calculators, etc. will be available to you for your reference.

401(k) FREQUENTLY ASKED QUESTIONS (FAQs)

WHEN ARE YOU ELIGIBLE TO PARTICIPATE?

- All **Full-time** employees who are age 21 or older will be eligible to participate in the Plan effective the 1st of the month following 2 full months of completed employment.
- **Part-time** employees are eligible to participate in the plan on the first entry date after they have reached age 21 **and** have completed at least 1,000 Hours of Service during the computation period (which is 12 consecutive months from their hire date) or have completed at least 1,000 Hours of Service during the computation period (which is 12 consecutive months from the Plan Year beginning on January 1st) after the first year of employment.
- **Rehired** employees - - Once you become a Participant, you are eligible to participate in the Plan until you terminate your employment. If you terminate your employment after you have met the eligibility requirements, and are later re-employed by your Employer, you will again be eligible to participate in the Plan when you complete one hour of service.

HOW DO YOU ENROLL?

To enroll, simply login to your Fidelity account by logging into office.com and selecting the Fidelity NetBenefits app (the first time you will need to select it in “All Apps” from the menu icon on the upper left corner) or you can log in directly to [Fidelity NetBenefits](#). If you have not logged in before, you will need to “Register as a new user”. If you do not have your login information, click “Forgot login?”. Or you can contact a Fidelity Customer Service representative directly at 1-800-835-5095 for assistance.

Once logged in, you can elect your deferral percentage, make your investment fund elections and designate your beneficiary(ies). All of the information regarding the different investment options, retirement calculators, etc. will be available to you for your reference.

EMPLOYEE STOCK PURCHASE PLAN (ESPP)

Townsquare Media's Employee Stock Purchase Plan ("ESPP"), provides eligible employees opportunity to buy TSQ stock at a minimum 10% discount and become a stockholder to share in the Company's financial success.

During the two "offering periods" each calendar year, eligible employees can elect to contribute a percentage of their gross earnings from 3%-15%, with after-tax payroll deductions. Contributions accumulate through the offering period and will be used to purchase shares at the discounted rate.

Eligible Employees: Part-time and Full-time employees who have been employed with the Company for a minimum of six months prior to the Plan start date that they want to enroll, can do so during the two "offering periods" each calendar year.

Human Resources will send an email before the enrollment period opens for the next offering period so watch your inbox! Enrollment for the January 1, 2026 - June 30, 2026 offering period will be in December 2025. Enrollment for the July 1, 2026 – December 31, 2026 offering period will be in June 2026.



ESPP FREQUENTLY ASKED QUESTIONS (FAQs) – Continued

- **HOW IS THE PURCHASE PRICE DETERMINED?** - 10% discount to the lowest market closing price on either the first or last day of the 6-month plan period.

EXAMPLE: For each offering period, the plan will select the lower measurement date closing price and apply a 10% discount to that lower stock price.

For example, if the stock is \$12.00 on January 1, 2026 and appreciates to \$15.00 on June 30, 2026, the 10% discount is applied to the lower price.

Thus, $\$12.00 - \$1.20$ (10%) = \$10.80 is the price that you would pay per share even though the current price is \$15.00

This equates to a **28%** discount to the current stock price

However, if on January 1 the stock price is \$12.00 and on June 30 it is \$10.00, the discount is applied to the lower \$10.00 price and thus the purchase price is $\$10.00 - \$1.00 = \$9.00$. Still at a 10% discount!

WHAT HAPPENS WHEN I LEAVE TOWNSQUARE? - If employment ceases prior to the shares being delivered, any amounts contributed within that offering period are repaid to you within 30 days from the date of separation.

FOR THE PERCENTAGE I CHOOSE TO CONTRIBUTE, WHAT EARNING IS IT CALCULATED FROM?

- Regular straight-time earnings or base salary, bonuses and commissions, before the deduction for any salary deferral contributions to any tax-qualified or nonqualified deferred compensation plan (i.e. 401k), **including** overtime, shift differentials, vacation pay, salaried production schedule premiums, holiday pay, jury duty pay, funeral leave pay, paid time off, military pay, prior week adjustments and weekly bonus, but **excluding** education or tuition reimbursements, imputed income arising under any group insurance or benefit program, travel expenses, business and moving reimbursements, income received in connection with any stock options, restricted stock, restricted stock units or other compensatory equity awards and all contributions under any employee benefit plan.

AFTER ENROLLING, ARE CONTRIBUTIONS WITHDRAWN EVENLY PER PAYCHECK THROUGHOUT

- **THE OFFERING PERIOD?** Since it's a percentage of earnings it will depend on your compensation per paycheck.

WILL SHARES BE ALLOWED TO BE TRANSFERRED INTO A BROKERAGE OF CHOICE AFTER DISBURSEMENT?

- Yes. The ESPP is administered by Fidelity and they will set up a brokerage account for you, but you can transfer to your own if/when you choose.

WILL PARTIAL/FRACTIONAL SHARES BE DISTRIBUTED IF THE SHARE PRICE DOES NOT DIVIDE INTO WHOLE SHARES OF YOUR ELECTION?

- Any balance less than the Purchase Price per Share as of such Exercise Date shall be carried forward to the next Offering Period, unless the Participant has elected to withdraw from the Plan.

****Investing involves risk, including risk of loss. Please note that tax information is general in nature and should not be considered tax or legal advice. Townsquare and Fidelity do not provide legal or tax advice. Consult an attorney or tax professional regarding any specific legal or tax situation.***



Wellbeing & Balance

“The key to keeping your balance is knowing when you've lost it. ”

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, substance use disorder, mental health and family issues.
- Maximize your physical well-being.
- Take time to spend with family and friends, take care of personal business, or just for yourself.

Taking care of yourself helps you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

EMPLOYEE ASSISTANCE PROGRAM (EAP)



Contact the EAP

Phone: (877) 622-4327

Website: www.mycigna.com

Employer ID: townsquaremedia

Click to play video



The EAP is here to help

If you're dealing with a little stress and anxiety or a lot, a relationship or substance use issue, financial worries, or the responsibility of caring for others, the employee assistance program through Cigna can help.

Help for you and your household

There are times when everyone needs a little help or advice, or assistance with a serious concern. The EAP through Cigna can help you handle a wide variety of personal issues, such as emotional health, substance use disorder, parenting and childcare needs, financial coaching, legal consultation, and elder care resources.

Best of all, contacting the EAP is completely confidential and free for any member of your immediate household.

No-cost EAP resources

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- In-person or video counseling for short-term issues; up to 5 visits
- Unlimited web access to helpful articles, resources, and self-assessment tools.

Counseling

- Relationship challenges
- Emotional distress
- Job stress
- Communication issues
- Interpersonal conflict
- Alcohol or drug use
- Loss and grief

Parenting & childcare

- Quality referrals
- Family day care centers
- Infant centers and preschools
- Before- and after-school care
- 24-hour care

Elder care

- Help finding care resources for elderly or disabled relatives

Financial

- Money/debt management
- Identity theft resolution
- Tax issues

Legal

- Local attorney referrals
- Family law (marital, child custody, adoption)
- Estate planning
- Landlord/tenant
- Immigration
- Personal Injury
- Consumer protection
- Real estate
- Bankruptcy

Online resources

- Self-help tools to enhance resilience and well-being
- Information and links to various services and topics

MENTAL HEALTH RESOURCES

Too often, stigma around mental health prevents people from getting the support they need. But challenges with mental health are very common—every year, 1 in 5 U.S. adults experiences a mental health issue. Regardless of age, ethnicity, background, or income, people from all walks of life can struggle with their mental health.

If you or any of your dependents are experiencing feelings of isolation, depression, or despair, please make use of the mental health services available to you through our medical plans. And through our telemedicine provider, you can connect to a mental health provider within minutes, from any location, at any time.

In-network mental health services*

Plan	Outpatient	Inpatient
Cigna \$7,000 High-Deductible OAP/Local Plus HSA Compatible Plan	You pay 0% after deductible	You pay 0% after deductible
Cigna \$5,500 OAP/LocalPlus Plan	\$65.00 copay per office visit	30% coinsurance after deductible –Hospital
Cigna \$4,250 OAP/LocalPlus Plan	\$65.00 copay per office visit	30% coinsurance after deductible –Hospital

**If your preferred mental health provider is out-of-network, services may cost more, or may not be covered under certain plans. Refer to the complete medical plan tables earlier in this guide for more information on out-of-network coverage.*



myCigna.com[®] guided navigation

Our digital portal includes guided navigation that provides you with customized, convenient care options (digital, coaching, virtual, and in person)



Happify[™] offered through Cigna Healthcare

Increase resilience through games, guided meditations, and other activities. This digital self-guidance tool reduces stress while encouraging confidence²



iPrevail offered through Cigna Healthcare

On-demand peer coaching and personalized learning to help boost your mood and improve mental health care²

1. All Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Evernorth Care Solutions, Inc., and Evernorth Behavioral Health, Inc. Use and distribution limited solely to authorized personnel.
2. Program services are provided by independent companies/entities and not by Cigna Healthcare. Programs and services are subject to all applicable program terms and conditions. Program availability is subject to change.



Time Away from Work

- Paid Time Off (PTO)
- Bereavement Leave
- Volunteer Time Off (VTO)
- Post-Pregnancy Pay Policy
- Secondary Caregiver Pay Policy

2026 PAID HOLIDAYS

Townsquare Media provides 9 paid holidays per year for all full-time, benefit-eligible employees. Additional holidays may be designated at the company's discretion.

New Year's Day	Jan. 1
Memorial Day	May 25
Independence Day	July 4
Labor Day	Sept. 7
Thanksgiving	Nov. 26
The Friday Following Thanksgiving	Nov. 27
Christmas	Dec. 25

2 Personal Holidays*

**Personal holidays should be scheduled at the beginning of the year and entered in ExponentHR.*

PAID TIME OFF (PTO)

Townsquare Media, Inc. provides employees with paid time off (PTO). PTO may be used for vacation, sick time, or other personal matters.

ELIGIBILITY: All full-time regular employees who work thirty (30) hours per week or more are eligible to start accruing PTO immediately upon hire. Employees scheduled to work between 30-40 hours per week will receive PTO on a pro-rated basis. Part-time employees who work less than 30 hours per week will not receive PTO. PTO is accrued on a per pay period basis and is available to use as accrued.

DEPOSIT INTO YOUR LEAVE ACCOUNT: All eligible employees will accrue hours of PTO for every pay period worked, up to a maximum accrual based on their annual accrual rate.

Once you reach the maximum accrual amount, you will not accrue any additional PTO until you use some of the accrued but unused PTO and the amount falls below the maximum accrual amount. You will not receive retroactive credit for any period of time in which you did not accrue PTO because you accrued the maximum amount.

LEAVE USAGE AND REQUESTS FOR LEAVE: Company encourages you to use your PTO time. You will be required to use all available paid leave balances prior to taking any unpaid time off.

You must request PTO from your Manager as far in advance as possible, but at least four (4) weeks in advance. The Company will generally grant requests for PTO when possible, taking business needs into consideration. All On-Air talent and Brand Directors must have approval by the Director of Content or Market Presidents for any PTO requests during the Spring or Fall ratings period.

When multiple employees request the same time off, their length of employment/seniority may determine priority in scheduling PTO times.

You may submit a request for PTO through ExponentHR at any time during the year, but keep in mind that your PTO balance cannot go negative more than 40 hours unless you are on an approved leave of absence. For Non-Exempt employees, PTO must be used in increments of one (1) hour. For Exempt employees, PTO must be used in four (4) hour increments. The maximum number of consecutive PTO hours that can be taken is forty (40), unless approved in advance by your supervisor. PTO is paid at the employee's current base salary or base hourly rate and does not include overtime, bonuses or any other type of supplemental or premium pay. PTO is not counted as hours worked in the computation of overtime.

DURING A LEAVE OF ABSENCE: Employees will be required to use available accrued paid time off and take a minimum of negative 40 hours PTO. Employees may also be able to take additional negative PTO in accordance with the PTO Accrual Schedule concurrently during leave for any family or medical leave reason, and for their own serious health condition, where permissible under local, state, and federal law. Once your negative balance is at the maximum allowed, you will not be able to take any additional PTO until you accrue hours back to less than negative 40.

You will not accrue PTO during unpaid leaves of absence, or other periods of inactive service, unless PTO accrual is required by applicable federal, state, or local law.

PAID TIME OFF (PTO) – CONTINUED

CARRYOVER: You may not carry over unused PTO to the following year. Any unused PTO will be forfeited at the end of the calendar year*.

Employees will be allowed to carry over up to 40 hours into the following calendar year in the event that:

- The employee is expecting a baby in the first half of the year and is not eligible for post-pregnancy pay.
- You have a scheduled medically necessary procedure that will require you to be out of work for more than one week in the first half of the year. Documentation from the medical provider will be required.

(*) State law may prohibit certain provisions of this policy. In those cases, individual state laws supersede the provisions in question.

SEPARATION OF EMPLOYMENT: Accrued, but unused PTO will not be paid out at termination unless state law dictates otherwise. Keep in mind that if you leave the company and have taken PTO in advance, you may owe the company the dollar amount of PTO taken but not yet accrued. *Any PTO used during an employee's notice period must be pre-approved by employee's immediate supervisor and the Townsquare Media Human Resources Dept. **PTO cannot be used on the final day of employee's notice period.***

PTO ACCRUAL SCHEDULE

Length of Service	Accrual Per Month (Semi-Monthly Payroll)	Accrual Per Pay Period (Biweekly)	Total Annual Accrual	Accrual Cap	Negative PTO Allowance*
Upon hire through 2 complete years of service.	10 hours (or 1.25 days per month)	4.615 hours per pay period	120 hours (15 days)	120 hours (15 days)	Up to 40 hours
Beginning of 3 rd year of service through 9 complete years of service	13.33 hours (or 1.66 days per month)	6.15 hours per pay period	160 hours (20 days)	160 hours (20 days)	Up to 80 hours
Beginning of 10 th year of service and service going forward	16.66 hours (or 2.08 days per month)	7.69 hours per pay period	200 hours (25 days)	200 hours (25 days)	Up to 12 hours

* Your PTO balance cannot go negative more than 40 hours unless you are on an approved leave of absence.

BEREAVEMENT LEAVE

Townsquare Media, Inc. recognizes the importance of taking leave when there is a death in the family. Where bereavement leave is not required by law, the Company will provide bereavement leave as follows:

If a member of your immediate family(*) passes away, you are given a reasonable amount of time off to attend a funeral and take care of personal matters. The Company grants up to five (5) paid days off (up to 8 hours maximum per day) in addition to any PTO you may be eligible for and wish to use. Part-time employees, who are scheduled to work 20 hours or more and have a set weekly schedule, will receive a pro-rata amount of bereavement time. For extended family members(**), the Company grants up to three (3) paid days off (up to 8 hours maximum per day). You must personally inform your supervisor of your bereavement leave and when you expect to return to work. In addition, you may be asked to provide evidence of your loss. You may take additional unpaid time with the permission of your supervisor.

Pay for time excused under this policy will be at your normal salary rate. Such pay will be made only for time excused from your regularly assigned work schedule.

(**) – *Extended family includes aunts, uncles, nieces, nephews and cousins.*

(*) – *Immediate family includes your spouse or domestic partner, children, parents, grandparents, grandchildren, siblings, and corresponding step-related and in-laws.*

VOLUNTEER TIME OFF (VTO)

At Townsquare, we understand the value of giving back to the communities we work and live in that give us so much. We want to create meaningful, purposeful community engagement opportunities while also helping those in need. In 2026, we will be continuing our Volunteer Time Off program:

- Employees become eligible for this benefit after 90 days of employment and it is only available to **Full-Time Employees**
- Employees get access to three (3) half days to be used throughout the year to volunteer at their favorite organizations or charities
- Requests for VTO should be made at least two weeks in advance
- Requests for VTO require manager approval in ExponentHR and proof of participation
- Usage of the time does not affect PTO
- Manager approval and proof of participation is required
- The program resets each year, and the volunteer time cannot be accrued

You can elect VTO in a drop down when creating time off in Exponent HR

POST-PREGNANCY PAY POLICY

Employees who have given birth or adopted a child are eligible to receive up to eight weeks of paid time off during their FMLA or non-FMLA leave.

An employee is eligible for Townsquare Media's post-pregnancy pay benefit if they are the primary caretaker of the child, have been employed for at least one year and have worked for at least 1,250 hours over the previous 12 months. The paid leave will run concurrently with FMLA or non-FMLA leave.

Temporary and part-time employees are not eligible for post-pregnancy pay under this policy.

- If ineligible for Post-Pregnancy pay and have been with company for 3 months, then eligible for Secondary Caregiver Pay Policy.*

Basic Entitlement:

- If employee has completed 2 years of service, the eligible employee will receive 8 weeks of paid leave compensated at 100 percent of salary while within their available leave period. (Commissioned Account Executives will continue to receive commissions along with any draws or guarantees.)
- If employee has completed 1 to 2 years of service, the eligible employee will receive 6 weeks of paid leave compensated at 100 percent of salary while within their available leave period.
- The payment will start as of the date of birth or adoption of the child.
- Employees with voluntary short-term disability or state disability may use paid leave to cover the elimination period and use the remaining paid leave after their disability benefit ends.
- If employee has exhausted paid leave and is remaining on leave, in accordance with the Paid Time Off (PTO) policy, employees are required to use any accrued PTO hours and take a minimum of negative 40 hours PTO. Employees may be able to take additional negative PTO in accordance with the PTO Accrual Schedule before taking time off without pay.
- Insurance benefits will continue during the paid leave and per pay period deduction amounts will be withheld from the paid post-pregnancy leave paychecks.
- Post-pregnancy pay is taxable and will be included in taxable earnings on Form W-2.
- PTO does not continue to accrue while on paid leave.

SECONDARY CAREGIVER PAY POLICY



Townsquare is a family friendly company, and we encourage new parents who don't qualify for PostPregnancy Pay to take days off to be with their family during this exciting time.

Basic Entitlement:

- New parents are eligible to receive up to 80 hours of paid time off following their child's birth to be with their new baby and expanding family.
- Employee must be working as a full-time employee for at least three (3) months in order to be eligible.
- If ineligible for Post-Pregnancy pay and have been with the company for three (3) months, then you're eligible for Secondary Caregiver Pay Policy*.
- Time off must be taken within three (3) months of when the baby is born and must be requested in accordance with Townsquare's Employee Handbook.
- Time off is to be entered in ExponentHR to the Time Tracking/Leave Reporting page. In the "Type" of leave dropdown, select Secondary Caregiver Pay.
- Time off must be approved by the employee's manager, and it is for a maximum of 80 hours.

Employee Responsibilities: Only two weeks of paid Secondary Caregiver Leave can be taken in a nine-month period. There is no additional time give for twins.

*Total paid time off under Post-Pregnancy Pay and/or Secondary Caregiver Pay cannot exceed 8 weeks of paid time off.



Important Plan Information

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit costs for 2026.
- Contact information for our benefit carriers and vendors.
- A Benefits Glossary to help you understand important insurance terms.

YOUR BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover for your medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis—before federal, state, and social security taxes are calculated—reducing your taxable income.

Medical Cost Per Semi-Monthly Paycheck	Cigna HDHP \$7,000 LocalPlus HSA Plan	Cigna HDHP \$7,000 OAP HSA Plan	Cigna HDHP \$7,000 LocalPlus HSA Plan	Cigna HDHP \$7,000 OAP HSA Plan
	<i>If your annual salary is less than \$41,000</i>		<i>If your annual salary is more than \$41,000</i>	
Employee Only	\$77.69	\$77.69	\$162.68	\$169.19
Employee + Spouse	\$340.26	\$353.87	\$340.26	\$353.29
Employee + Child(ren)	\$307.97	\$320.29	\$307.97	\$320.29
Employee + Family	\$485.55	\$495.26	\$485.55	\$495.36

Medical Cost Per Semi-Monthly Paycheck	Cigna \$5,550 LocalPlus Plan	Cigna \$5,550 OAP Plan
--	------------------------------	------------------------

Employee Only	\$189.01	\$222.57
Employee + Spouse	\$345.97	\$411.81
Employee + Children	\$319.37	\$384.15
Employee + Family	\$469.18	\$580.57

Medical Cost Per Semi-Monthly Paycheck	Cigna \$4,250 LocalPlus Plan	Cigna \$4,250 OAP Plan
--	------------------------------	------------------------

Employee Only	\$293.04	\$330.77
Employee + Spouse	\$538.77	\$612.32
Employee + Children	\$504.04	\$576.20
Employee + Family	\$742.62	\$859.48

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify Townsquare Media if your domestic partner is your tax dependent.

YOUR BENEFIT COSTS

Dental Cost Per Semi-Monthly Pay Period	Cigna DPPO Advantage Plan	Cigna DHMO Plan
Employee Only	\$17.51	\$5.02
Employee + Spouse	\$27.78	\$9.19
Employee + Children	\$39.02	\$10.02
Employee + Family	\$50.17	\$12.53

Vision Cost Per Semi-Monthly Pay Period	EyeMed Vision Plan
Employee Only	\$3.51
Employee + Spouse	\$6.70
Employee + Children	\$7.05
Employee + Family	\$10.22

Tier Coverage	Accident Insurance Monthly Benefit Costs	Hospital Indemnity Insurance Monthly Benefit Costs
Employee Only	\$4.78	\$9.24
Employee + Spouse	\$9.55	\$20.08
Employee + Children	\$11.27	\$14.69
Employee + Family	\$13.47	\$25.53

Voluntary Critical Illness - Monthly Premium per \$1,000 of Coverage

Attained Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
< 25	\$0.25	\$0.44	\$0.41	\$0.60
25 – 34	\$0.31	\$0.52	\$0.46	\$0.68
35 – 44	\$0.53	\$0.86	\$0.69	\$1.02
45 - 54	\$0.97	\$1.52	\$1.13	\$1.68
55 +	\$1.84	\$2.79	\$2.00	\$2.95

PLAN CONTACTS AND RESOURCES

Benefit	Carrier	Phone Number	Website
Enrollment Support	Health Advocate	866-611-8295	www.healthadvocate.com
Medical	Cigna	800.244.6224	www.myCigna.com
Prescription Drug	EmpiRx Health	877-323-0584	www.empirxhealth.com
Virtual Physical Therapy	Hinge Health	855-902-2777	www.hinge.health.com
Virtual Health	First Stop Health	888-691-7867	www.firststophealth.com
Dental	Cigna	800-244-6224	www.myCigna.com
Vision	EyeMed	866-723-0513	https://member.eyemedvisioncare.com/member/en
Flexible Spending Account / Dependent Care Account / Commuter Benefits	Ameriflex	888-868-3539	https://myameriflex.com/
Life & AD&D	New York Life	888-842-4462	www.newyorklife.com
Long Term Disability	New York Life	888-842-4462	www.newyorklife.com
Employee Assistance Program (EAP)	Cigna	877-622-4327	www.myCigna.com
Voluntary Life & AD&D	New York Life	888-842-4462	www.newyorklife.com
Voluntary Short-Term Disability	New York Life	888-842-4462	www.newyorklife.com
Voluntary Accident Insurance	MetLife	877-638-2862	www.metlife.com
Voluntary Critical Illness Insurance	MetLife	877-638-2862	www.metlife.com
Voluntary Hospital Indemnity	MetLife	877-638-2862	www.metlife.com
401(k) Retirement	Fidelity	800-835-5095	https://www.fidelity.com/

2026

Annual Notices

TABLE OF CONTENTS

Medicare Part D Notice 64

Women’s Health and Cancer Rights Act 66

Newborns’ and Mothers’ Health Protection Act.....66

HIPAA Notice of Special Enrollment Rights 66

Availability of Privacy Practices Notice.....67

Michelle’s Law.....68

Premium Assistance under Medicaid and the Children’s Health Insurance Program (CHIP) 68

ACA Disclaimer.....72

Illinois Consumer Coverage Disclosure Act 73

The ‘No Surprises’ Rules.....75

Nondiscrimination in Health Programs and Activities 75



Medicare Part D Notice

Important Notice from c About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Cigna and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Townsquare Media has determined that the prescription drug coverage offered by the Cigna Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your Townsquare Media coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Townsquare Media is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Townsquare Media prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Townsquare Media and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Townsquare Media changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit [medicare.gov](https://www.medicare.gov)
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at [socialsecurity.gov](https://www.socialsecurity.gov), or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 11/01/2025

Name of Entity/Sender: Diana Underwood

Contact-Position/Office: benefits@townsquaremedia.com – 203-851-0900

Address: 1 Manhattanville Rd Suite 202, Purchase, NY 10577

Phone Number: 201-861-0900

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply. If you would like more information on WHCRA benefits, call your plan administrator 201-861-0900

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 208-861-0900.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Townsquare Media health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Townsquare Media health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 31 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Townsquare Media health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan

coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Townsquare Media describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting benefits@townsquaremedia.com.

The Cigna LocalPlus plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child’s eligibility would end earlier for another reason.

Extended coverage is available if a child’s leave of absence from school—or change in school enrollment status (for example, switching from full-time to part-time status)—starts while the child has a serious illness or injury, is medically necessary and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child’s physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended notify benefits@townsquaremedia.com in writing as soon as the need for the leave is recognized. In addition, contact your child’s health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

Premium Assistance under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866- 444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com | Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

ARKANSAS – Medicaid

Website: <http://myarhipp.com/> | Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program website: <http://dhcs.ca.gov/hipp>

Phone: 916-445-8322 | Fax: 916-440-5676 | Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: <https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711

CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>

CHP+ Customer Service: 1-800-359-1991 | State Relay 711

Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/> | HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidptprecovery.com/flmedicaidptprecovery.com/hipp/index.html>

Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162, press 1

GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra> | Phone: 678-564-1162, press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program All other Medicaid Website: <https://www.in.gov/medicaid/> | <http://www.in.gov/fssa/dfr/> | Family and Social Services Administration Phone: (800) 403-0864 | Member Services Phone: (800) 457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: [Iowa Medicaid | Health & Human Services](#) | Medicaid Phone: 1-800-338-8366

Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](#) | Hawki Phone: 1-800-257-8563

HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](#)

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/> | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)

Website: <https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx> | Phone: 1-855-459-6328

Email: KIHIPPI.PROGRAM@ky.gov

KCHIP Website: <https://kynect.ky.gov> | Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003 | TTY: Maine relay 711

Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofa/applications-forms>

Phone: 800-977-6740 | TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa> | Phone: 1-800-862-4840 | TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: <https://mn.gov/dhs/health-care-coverage/> | Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm> | Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>
Phone: 1-800-694-3084 | email: HSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: <http://www.ACCESSNebraska.ne.gov>
Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: <http://dhcfp.nv.gov> | Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program>
Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/> | Phone: 800-356-1561
CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: <http://www.njfamilycare.org/index.html> CHIP
Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <https://medicaid.ncdhhs.gov/> | Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <https://www.hhs.nd.gov/healthcare> | Phone: 1-866-614-6005

OKLAHOMA – Medicaid and CHIP

Website: <http://www.insureoklahoma.org> | Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: <http://healthcare.oregon.gov/Pages/index.aspx> | Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html> | Phone: 1-800-692-7462
CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](#) | CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/> | Phone: 1-855-697-4347 or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid

Website: <https://www.scdhhs.gov> | Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov> | Phone: 1-888-828-0059

TEXAS – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Texas Health and Human Services](#)
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>
Email: upp@utah.gov | Phone: 1-888-222-2542 |
Adult Expansion Website: <https://medicaid.utah.gov/expansion/>
Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>
CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website: [Health Insurance Premium Payment \(HIPP\) Program | Department of Vermont Health Access](#)
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select> or
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/> | Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <https://dhhr.wv.gov/bms/> or <http://mywvhipp.com/>
Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm> | Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/> | Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human
Services Centers for Medicare & Medicaid
Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebbsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 (9.96% in 2026) of your modified adjusted household income.

Illinois Consumer Coverage Disclosure Act

The Consumer Coverage Disclosure Act requires employers to notify Illinois employees which of the Essential Health Benefits listed below are and are not covered by their employer-provided group health insurance coverage. Refer to the [Access to Care and Treatment Benchmark Plan](#) and the [Pediatric Dental Plan](#) to reference the pages listed below.

Employer Name:	Townsquare Media			
Employer State of Situs:	Illinois			
Name of Issuer:	Cigna			
Plan Marketing Name:	Cigna LocalPlus			
Plan Year:	2026			
Ten (10) Essential Health Benefit (EHB) Categories:				
• Ambulatory patient services (outpatient care you get without being admitted to a hospital) • Emergency services • Hospitalization (like surgery and overnight stays) • Laboratory services • Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy) • Pediatric services, including oral and vision care (but adult dental and vision coverage aren’t essential health benefits) • Pregnancy, maternity, and newborn care (both before and after birth) • Prescription drugs • Preventive and wellness services and chronic disease management • Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)				
2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury—Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23–24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15–16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Yes
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24–25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25–26 & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes

19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants—Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8–9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Yes
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26–27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29–34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31–32	Yes
36	Mammography—Screening	Preventive and Wellness Services	Pgs. 12, 15 & 24	Yes
37	Osteoporosis—Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate—Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12–13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22 & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

The ‘No Surprises’ Rules

The “No Surprises” rules protect you from surprise medical bills in situations where you can’t easily choose a provider who’s in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you’re no longer in need of emergency care. These are called “post-stabilization services.” You shouldn’t get this notice and consent form if you’re getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren’t required to sign the form and shouldn’t sign the form if you didn’t have a choice of health care provider or facility before scheduling care. If you don’t sign, you may have to reschedule your care with a provider or facility in your health plan’s network.

[View a sample notice and consent form](#) (PDF).

This applies to you if you’re a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

Nondiscrimination in Health Programs and Activities

Townsquare Media complies with all applicable federal civil rights laws, including Section 1557 of the Affordable Care Act (Section 1557). Townsquare Media does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)) (or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes).

In compliance with Section 1557 and other federal civil rights laws, we provide individuals the following in a timely manner and free of charge:

- **Language assistance services.** Townsquare Media will provide language assistance services for individuals with limited English proficiency (including individuals’ companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Language assistance services may include:
 - Electronic and written translated documents
 - Qualified interpreters
- **Appropriate auxiliary aids and services.** Townsquare Media will provide appropriate auxiliary aids and services for individuals with disabilities (including individuals’ companions with disabilities) to ensure effective communication. Appropriate auxiliary aids and services may include:
 - Qualified interpreters, including American Sign Language interpreters

- Video remote interpreting
- Information in alternate formats (including but not limited to large print, recorded audio, and accessible electronic formats)
- Qualified readers
- **Reasonable modifications.** Townsquare Media will provide reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits.

If you believe Townsquare Media has failed to provide these services or has discriminated in another way on the basis of race, color, national origin, sex, age, or disability, you can:

- File a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf> or via mail at:
 - U.S. Department of Health & Human Services
 - 200 Independence Avenue, S.W. – 509F
 - Washington, D.C. 20201

Glossary

Accumulation Period

The period of time during which you can incur eligible expenses toward your deductible, out-of-pocket maximum, and visit limitations. The accumulation period for your deductible and OOP maximum may differ from the period for visit limitations.

Aggregate Deductible

A type of family deductible in which a family must meet the entire family deductible before the plan covers eligible expenses for any individual.

Aggregate Out-of-Pocket Max

A type of family out-of-pocket maximum in which a family must meet the entire family out-of-pocket maximum before the plan pays 100% of eligible expenses for any individual.

Allowed Amount

The maximum amount your insurance plan will pay for an eligible expense. In-network providers cannot bill you for more than the allowed amount.

Ambulatory Surgery Center

A healthcare facility that specializes in same-day surgical procedures.

Annual Limit

The maximum dollar amount or number of visits your plan will cover for a specific service during a plan year. If you reach an annual limit, you must pay all associated costs for that service for the rest of the plan year.

Balance Billing

Balance billing is when an out-of-network provider bills you for more than your plan's allowed amount. For example, if the provider charges \$100 but the plan's allowed amount is only \$70, an out-of-network provider can bill you for the \$30 difference. Balance billing may not be allowed for all services; consult your insurance plan documents for details.

Beneficiary

The people or entities you select to receive a benefit if you die. You must name beneficiaries for life, AD&D, and retirement plans to ensure the money is distributed according to your wishes.

Brand-Name Drug

A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. Your coinsurance for brand-name drugs may be higher if there is a generic equivalent available.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that allows you to temporarily keep your health insurance after your employment ends, based on certain qualifying events. If you elect COBRA coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim

A request for payment that you or your provider submits to your insurance plan after you receive services.

Coinsurance

The percentage of the allowed amount you must pay for an eligible expense. Coinsurance will always add up to 100%. For example, if the plan pays 70% of the allowed amount, your coinsurance is 30%. If your plan has a deductible, you pay 100% of most costs until you have paid the deductible amount.

Copayment (Copay)

A flat fee you pay for some services, such as a doctor's office visit. You pay the copayment at the time you receive care. In most cases, copays do not count toward your deductible.

Deductible

The dollar amount you must pay for eligible expenses before your insurance starts covering a portion. The deductible does not apply to preventive care or certain other services.

Dental Basic Services

Services such as fillings, routine extractions, and some oral surgery procedures.

Dental Diagnostic & Preventive

Generally includes routine cleanings, oral exams, X-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to twice a year.

Dental Major Services

Complex or restorative dental work such as crowns, bridges, dentures, inlays, and onlays.

Eligible Expense

Also referred to as a covered service, this is a service or product for which your insurance plan will pay a portion of the allowed amount. Your plan will not cover any portion of the cost if the expense is not eligible, and the amount you pay will not count toward your deductible.

Embedded Deductible

A type of family deductible in which the plan covers eligible expenses for each person as soon as they reach their individual deductible.

Embedded Out-of-Pocket Max

A type of family out-of-pocket maximum in which the plan pays 100% of eligible expenses for a person as soon as they reach their individual out-of-pocket maximum.

Glossary

Excluded Service

A service for which your insurance will not pay any portion of the cost. These services may also be referred to as “ineligible,” “not covered,” or “not allowed.”

Formulary

A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a preferred drug list.

Generic Drug

A drug that has the same active ingredients as a brand-name drug but is sold under a different name. For example, atorvastatin is the generic name for medicines with the same formula as the brand-name drug Lipitor.

Grandfathered

A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

In Network

Also known as participating providers, in-network providers have a contract with your insurance plan. They are usually the lowest-cost option because they have agreed not to charge you more than the allowed amount, and your insurance will cover a bigger portion of eligible expenses than with out-of-network providers.

Mail Order

A medical or prescription drug plan feature allowing a 90-day supply of medicines you take routinely to be delivered by mail.

Out of Network

Also known as nonparticipating providers, out-of-network providers do not have a contract with your insurance plan. They are typically a higher-cost option because they can charge you more than your plan’s allowed amount, and your insurance will cover a smaller portion of eligible expenses than with in-network providers. Some plans do not cover out-of-network services at all.

Out-of-Pocket Costs

Healthcare expenses you are responsible for paying, whether from your bank account, credit card, or from a health savings account such as an HSA, FSA or HRA. These costs include any deductibles, copays, and coinsurance you pay for eligible expenses, along with the cost of any services your insurance does not cover.

Out-of-Pocket Maximum

The maximum amount of money you will have to spend on eligible expenses during a plan year. Once you spend this amount, your plan covers 100% of eligible expenses for the rest of the plan year.

Outpatient Care

Care from a hospital or clinic that doesn’t require you to stay overnight.

Participating Pharmacy

Also known as an in-network pharmacy, a participating pharmacy has a contract with your medical or prescription drug plan. You will typically pay lower prescription costs at a participating pharmacy.

Plan Year

A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug

A list of prescription drugs your insurance will cover at the highest benefit level. The list, also known as a “formulary,” is based on an evaluation of effectiveness and cost. Your coinsurance may be higher for drugs that are not on this list, or your insurance may not cover them at all.

Preventive Care

Routine healthcare services that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Provider (PCP)

Your main doctor. Some insurance plans require you to name a PCP, who will direct or approve all of your healthcare and referrals.

Provider

A doctor, dentist, physician’s assistant, nurse, hospital, lab, or other healthcare professional or facility that provides healthcare services.

Telehealth/Telemedicine

A virtual visit with a provider using video chat on a computer, tablet or smartphone.

Usual, Customary, and Reasonable (UCR)

The cost of a medical service in a geographic area based on what providers in the area usually charge for the same or a similar medical service. Your plan may use the UCR amount as the allowed amount.

Urgent Care

Care for an illness, injury, or condition that needs attention right away but is not severe enough to require the emergency room. Treatment at an urgent care center generally costs less than an emergency room visit.

Vaccinations

Also known as “immunizations,” vaccinations are biological preparations that help prevent or reduce the severity of specific diseases.

Voluntary Benefit

An optional benefit offered by your employer for which you pay the entire premium, usually through payroll deduction.

