

2026

ARC Health

Employee Benefits Guide



**True
partnership**



**Equity
ownership**



**Practice
optimization**

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IMPORTANT BENEFITS INFORMATION

Benefits Overview

Arc Health is proud to offer a comprehensive benefits package to eligible, full-time employees who work approximately 30 hours per week. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

You share the costs of some benefits (medical and dental), and ARC Health provides other benefits at no cost to you (life, accidental death & dismemberment). In addition, there are voluntary benefits with group rates that you can purchase through payroll deductions.

Eligibility

If you are classified as a full-time employee working at approximately 30 hours per week, you and your eligible family members may participate in all benefit plans. Benefits will be effective the first of the Month Following or Coinciding following 30 Days.

For purposes of these benefits, eligible family members include:

- Your legal spouse, domestic partner (both same and opposite sex and common law)
- Your child who is less than 26 years of age. Children include natural or legally adopted, a stepchild, the child of your domestic partner, or a child who is less than 26 and has been placed under your legal guardianship
- Your child, who satisfies the above definition of a child, age 26 or older, and who is:
 - Mentally or physically incapable of earning a living, and
 - Primarily supported by you

Electing Benefits

Elections made now will remain in effect until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.

Examples of qualifying life events include:

- Turning 26 and losing coverage from parent's plan
- Losing health insurance coverage due to job loss
- Getting married or divorce
- Having a baby or adopting a child

Termination of Coverage

Your benefits coverage will terminate at the end of the month following:

- The date in which you terminate employment for any reason including death
- The date in which you no longer meet the eligibility requirements
- The date in which contribution payments are not received
- The date any benefit plan is terminated
- The date you enter the armed forces on active, full-time duty except as covered under USERRA

Section 125

Per the IRS Section 125 regulation, ARC Health will deduct your payroll for the employee portion of medical, dental and vision benefits. You are automatically set up this way unless you notify HR in writing. The benefit election amounts will be adjusted automatically pursuant to any premium changes rendered by the insurance carriers. For a copy of the Section 125 Plan Document, please contact Human Resources.

MEDICAL

Coverage to Build a Foundation of Good Health

We understand the importance of good health as the foundation for a productive life at home and at work. That is why we offer you the choice of plans through Anthem Blue Cross Blue Shield and Kaiser Permanente to fit your needs and budget. In addition, there are two plans offered through Premera and they are only for those eligible employees living in Washington.

Important Terms to Know

Preventive Care: The plan pays 100% for in-network preventive care.

Annual Deductible: For non-preventive care there is an annual deductible that must be met. The annual deductible is per person up to the Family deductible.

Coinsurance: After the deductible is met your in-network coinsurance payment is either 0% or 20% and the plan covers the other 100% or 80%.

Copay: Flat dollar amount paid to the provider regardless of cost of services.

Out-of-Pocket Maximum: This is the most that you will have to pay for covered services in a plan year. All medical and prescription drug deductibles, copayments and coinsurance apply toward the out-of-pocket maximum. Once you meet the out-of-pocket maximum then the plan pays 100% of your eligible expenses, including the cost of all office visits and prescription drugs, for the remainder of the year.

Cost per pay: The pre-tax dollar amount is withheld from each bi-weekly pay (24/year).



MEDICAL BENEFITS | ANTHEM PPO + HRA

Comprehensive and preventive health care coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. ARC Health offers you a choice of plans through Anthem Blue Cross Blue Shield and Kaiser Permanente.

The tables below summarize the key features of the medical plans. The copay and coinsurance amounts listed reflect the amount you pay. Please refer to the official plan documents for additional information on coverage and exclusions.

| Please refer to the plan documents for details | PPO + HRA | |
|---|-----------------------------------|----------------------|
| | IN-NETWORK | OUT-OF-NETWORK |
| Calendar-Year Deductible (Individual/Family) | \$6,000 / \$12,000 | \$18,000 / \$36,000 |
| HRA Deductible – Employee Pays First | \$3,000 / \$6,000 | N/A |
| HRA Deductible – ARC Pays Last | \$3,000 / \$6,000 | N/A |
| Calendar-Year Out-of-Pocket Maximum (Individual/Family) | \$8,500 / \$17,000 | \$25,500 / \$51,000 |
| Coinsurance | 20% | 50% |
| DOCTOR'S OFFICE | | |
| Primary Care Office Visit | \$35 copay | 50% after deductible |
| Specialist Office Visit | \$70 copay | 50% after deductible |
| Preventive Care (screening, immunizations) | 100% Covered | 50% after deductible |
| Diagnostic Test (x-ray, blood work) | 20% after deductible | 50% after deductible |
| Imaging (CT/PET scans, MRIs) | 20% after deductible | 50% after deductible |
| Urgent Care | \$75 copay | 50% after deductible |
| PRESCRIPTION DRUGS (RETAIL: 30-DAY SUPPLY; MAIL ORDER [EXCEPT SPECIALTY]: 90-DAY SUPPLY) | | |
| Retail—Generic | \$15 / \$25 copay | 50% after deductible |
| Retail—Preferred Brand Drugs | \$50 / \$60 copay | 50% after deductible |
| Retail—Non-Preferred Brand | \$90 / \$100 copay | 50% after deductible |
| Specialty | 25% up to \$350 / 25% up to \$450 | 50% after deductible |
| Mail Order—Generic | \$30 copay | 50% after deductible |
| Mail Order—Preferred Brand | \$125 copay | 50% after deductible |
| Mail Order—Non-Preferred Brand | \$225 copay | 50% after deductible |
| HOSPITAL SERVICES | | |
| Emergency Room | \$400 copay, then 20% | |
| Inpatient and Outpatient Surgery | 20% after deductible | 50% after deductible |
| MEDICAL CONTRIBUTIONS (Per Bi-Weekly [24] Pay Period) | | |
| Employee Only | \$209.82 | |
| Employee + Spouse | \$784.96 | |
| Employee + Child(ren) | \$617.12 | |
| Family | \$1,135.37 | |

MEDICAL BENEFITS | ANTHEM HDHP + HSA

Comprehensive and preventive health care coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. ARC Health offers you a choice of plans through Anthem Blue Cross Blue Shield and Kaiser Permanente.

The tables below summarize the key features of the medical plans. The copay and coinsurance amounts listed reflect the amount you pay. Please refer to the official plan documents for additional information on coverage and exclusions.

| Please refer to the plan documents for details | HDHP + HSA | |
|---|--------------------------------|----------------------|
| | IN-NETWORK | OUT-OF-NETWORK |
| Calendar-Year Deductible (Individual/Family) | \$6,200 / \$12,400 | \$18,600 / \$37,200 |
| Calendar-Year Out-of-Pocket Maximum (Individual/Family) | \$6,900 / \$13,800 | \$20,700 / \$41,400 |
| Coinsurance | 0% | 30% |
| DOCTOR'S OFFICE | | |
| Primary Care Office Visit | 0% after deductible | 30% after deductible |
| Specialist Office Visit | 0% after deductible | 30% after deductible |
| Preventive Care (screening, immunizations) | 100% Covered | 30% after deductible |
| Diagnostic Test (x-ray, blood work) | 0% after deductible | 30% after deductible |
| Imaging (CT/PET scans, MRIs) | 0% after deductible | 30% after deductible |
| Urgent Care | 0% after deductible | 30% after deductible |
| PRESCRIPTION DRUGS (RETAIL: 30-DAY SUPPLY; MAIL ORDER [EXCEPT SPECIALTY]: 90-DAY SUPPLY) | | |
| Retail—Generic | 0% / 10% after deductible | 50% after deductible |
| Retail—Preferred Brand Drugs | 0% / 10% after deductible | 50% after deductible |
| Retail—Non-Preferred Brand | 0% / 10% after deductible | 50% after deductible |
| Specialty | 0% / 10% after deductible | 50% after deductible |
| Mail Order—Generic | 0% / 10% after deductible | 50% after deductible |
| Mail Order—Preferred Brand | 0% / 10% after deductible | 50% after deductible |
| Mail Order—Non-Preferred Brand | 0% / 10% after deductible | 50% after deductible |
| HOSPITAL SERVICES | | |
| Emergency Room | 0% after in-network deductible | |
| Inpatient and Outpatient Surgery | 0% after deductible | 50% after deductible |
| MEDICAL CONTRIBUTIONS (Per Bi-Weekly [24] Pay Period) | | |
| Employee Only | \$60.00 | |
| Employee + Spouse | \$300.72 | |
| Employee + Child(ren) | \$247.40 | |
| Family | \$455.17 | |

MEDICAL BENEFITS | KAISER

Comprehensive and preventive health care coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. ARC Health offers you a choice of plans through Anthem Blue Cross Blue Shield and Kaiser Permanente.

The tables below summarize the key features of the medical plans. The copay and coinsurance amounts listed reflect the amount you pay. Please refer to the official plan documents for additional information on coverage and exclusions.

| | Kaiser* | | |
|---|-----------------------------|----------------------------------|-----------------------------|
| | CO & GA DHMO | CA DHMO | Mid-Atlantic DHMO |
| | In-Network | In-Network | In-Network |
| Calendar-Year Deductible (Individual/ Family) | \$1,500 / \$3,000 | \$1,500 / \$3,000 | \$1,500 / \$3,000 |
| Calendar-Year Out-of-Pocket Maximum (Individual/ Family) | \$4,000 / \$8,000 | \$4,000 / \$8,000 | \$4,000 / \$8,000 |
| Coinsurance | 20% | 20% | 20% |
| DOCTOR'S OFFICE | | | |
| Primary Care Office Visit | \$20 copay | \$20 copay | \$20 copay |
| Specialist Office Visit | \$30 copay | \$30 copay | \$30 copay |
| Preventive Care (screening, immunizations) | 100% Covered | 100% Covered | 100% Covered |
| Diagnostic Test (x-ray, blood work) | \$10 per lab/x-ray | \$10 per lab/x-ray | \$10 per lab/x-ray |
| Imaging (CT/PET scans, MRIs) | \$100 per encounter | 20% after deductible up to \$100 | \$100 per encounter |
| Urgent Care | \$30 copay | \$20 copay | \$30 copay |
| PRESCRIPTION DRUGS (RETAIL: 30-DAY SUPPLY; MAIL ORDER [EXCEPT SPECIALTY]: 90-DAY SUPPLY) | | | |
| Retail—Generic | \$10 copay | \$10 copay | \$10 copay |
| Retail—Preferred Brand Drugs | \$30 copay | \$30 copay | \$30 copay |
| Retail—Non-Preferred Brand | \$60 copay | \$30 copay | \$60 copay |
| Specialty | 20% coinsurance up to \$250 | 20% coinsurance up to \$250 | 20% coinsurance up to \$250 |
| Mail Order—Generic | \$20 copay | \$20 copay | \$20 copay |
| Mail Order—Preferred Brand | \$60 copay | \$60 copay | \$60 copay |
| Mail Order—Non-Preferred Brand | \$120 copay | \$60 copay | \$120 copay |
| HOSPITAL SERVICES | | | |
| Emergency Room | \$200 copay | \$200 copay | \$200 copay |
| Inpatient and Outpatient Surgery | 20% after deductible | 20% after deductible | 20% after deductible |
| MEDICAL CONTRIBUTIONS (Per Bi-Weekly [24] Pay Period) | | | |
| Employee Only | \$60.00 | \$60.00 | \$60.00 |
| Employee + Spouse | \$184.56 | \$184.56 | \$184.56 |
| Employee + Child(ren) | \$114.09 | \$114.09 | \$114.09 |
| Family | \$221.47 | \$221.47 | \$221.47 |

*The Kaiser DHMO plan is only available to those living in Colorado, California, Georgia, and Mid-Atlantic
 Out-of-Network Benefits: Not Covered (except for Emergency Room Services covered as In-Network)
 Please see plan documents for additional information

MEDICAL BENEFITS | PREMIERA PPO

Comprehensive and preventive health care coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. ARC Health offers you a choice of 2 plans through Premiera.

The tables below summarize the key features of the medical plans. The copay and coinsurance amounts listed reflect the amount you pay. Please refer to the official plan documents for additional information on coverage and exclusions.

*Please note Premiera medical plans are only available for those living in Washington state.

| Please refer to the plan documents for details | Premiera* CHOICE PPO | |
|---|---|------------------------------------|
| | IN-NETWORK | OUT-OF-NETWORK |
| Calendar-Year Deductible (Individual/Family) | \$3,000 / \$6,000 | \$6,000 / \$12,000 |
| Calendar-Year Out-of-Pocket Maximum (Individual/Family) | \$6,000 / \$12,000 | \$12,000 / \$24,000 |
| Coinsurance | 30% | 50% |
| DOCTOR'S OFFICE | | |
| Primary Care Office Visit | \$35 copay | 50% after deductible |
| Specialist Office Visit | \$35 copay | Not Covered |
| Preventive Care (screening, immunizations) | 100% Covered | 50% after deductible |
| Diagnostic Test (x-ray, blood work) | 30% after deductible | 50% after deductible |
| Imaging(CT/PET scans, MRIs) | 30% after deductible | 50% after deductible |
| Urgent Care | \$35 copay per visit | 50% after deductible |
| PRESCRIPTION DRUGS (RETAIL: 30-DAY SUPPLY; MAIL ORDER [EXCEPT SPECIALTY]: 90-DAY SUPPLY) | | |
| Generic – Retail / Mail | 0% after deductible | 40% after deductible / Not Covered |
| Preferred Brand Drugs – Retail / Mail | 0% after deductible | 40% after deductible / Not Covered |
| Non-Preferred Brand – Retail / Mail | 0% after deductible | 40% after deductible / Not Covered |
| HOSPITAL SERVICES | | |
| Emergency Room | \$250 copay per visit + 30% after in-network deductible | |
| Inpatient and Outpatient Surgery | 30% after deductible | 50% after deductible |
| MEDICAL CONTRIBUTIONS (Per Bi-Weekly [24] Pay Period) | | |
| Employee Only | \$189.57 | |
| Employee + Spouse | \$682.45 | |
| Employee + Child(ren) | \$572.26 | |
| Family | \$824.62 | |

MEDICAL BENEFITS | PREMERA HDHP

Comprehensive and preventive health care coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. ARC Health offers you a choice of 2 plans through Premera.

The tables below summarize the key features of the medical plans. The copay and coinsurance amounts listed reflect the amount you pay. Please refer to the official plan documents for additional information on coverage and exclusions.

*Please note Premera medical plans are only available for those living in Washington state.

| Please refer to the plan documents for details | Premera* HDHP | |
|---|--------------------------------|-----------------------------------|
| | IN-NETWORK | OUT-OF-NETWORK |
| Calendar-Year Deductible (Individual/Family) | \$6,450 / \$12,900 | \$12,900 / \$25,800 |
| Calendar-Year Out-of-Pocket Maximum (Individual/Family) | \$6,450 / \$12,900 | \$12,900 / \$25,800 |
| Coinsurance | 0% | 0% |
| DOCTOR'S OFFICE | | |
| Primary Care Office Visit | 0% after deductible | 0% after deductible |
| Specialist Office Visit | 0% after deductible | 0% after deductible |
| Preventive Care (screening, immunizations) | 100% Covered | Not Covered |
| Diagnostic Test (x-ray, blood work) | 0% after deductible | 0% after deductible |
| Imaging(CT/PET scans, MRIs) | 0% after deductible | 0% after deductible |
| Urgent Care | 0% after deductible | 0% after deductible |
| PRESCRIPTION DRUGS (RETAIL: 30-DAY SUPPLY; MAIL ORDER [EXCEPT SPECIALTY]: 90-DAY SUPPLY) | | |
| Generic – Retail / Mail | 0% after deductible | 0% after deductible / Not Covered |
| Preferred Brand Drugs – Retail / Mail | 0% after deductible | 0% after deductible / Not Covered |
| Non-Preferred Brand | 0% after deductible | 0% after deductible / Not Covered |
| HOSPITAL SERVICES | | |
| Emergency Room | 0% after in-network deductible | |
| Inpatient and Outpatient Surgery | 0% after deductible | 0% after deductible |
| MEDICAL CONTRIBUTIONS (Per Bi-Weekly [24] Pay Period) | | |
| Employee Only | \$60.00 | |
| Employee + Spouse | \$287.76 | |
| Employee + Child(ren) | \$236.75 | |
| Family | \$435.56 | |

HSA | Rocky Mountain Reserve

What is a Health Savings Account (HSA)?

An HSA is a tax-free savings account that can be paired per the IRS with a qualified high-deductible health plan (HDHP). By law, to open or contribute to an HSA, the medical plan must be a qualified HDHP. This means that the deductible is higher than most traditional health plans. The required deductible is set by the IRS and can change yearly.

You can use the money in your account to pay for qualified medical, dental and vision expenses for you and your tax eligible dependents. You can use your HSA funds to cover eligible expenses for your dependents, even if they are not covered on your medical, dental or vision benefits.

You can also save money in your HSA for future health care expenses. The account grows with interest, and you have investment options after your account reaches a minimum balance of \$1,000. The HSA is an individual bank account and the money in the account is yours to keep, even if you retire from ARC Health or change employers. ARC Health provides you with \$500/single coverage and \$1,000 for all other tiers (contributed on a per paycheck basis) to help meet your plan deductible and fund your health care expenses. A Health Savings Account will be established on your behalf by Rocky Mountain Reserve.

2025 IRS Contribution Maximum

| | |
|------------------|--------------------|
| Single | \$4,300 |
| Family | \$8,500 |
| Age 55 and Older | Additional \$1,000 |

2026 IRS Contribution Maximum

| | |
|------------------|--------------------|
| Single | \$4,400 |
| Family | \$8,750 |
| Age 55 and Older | Additional \$1,000 |



Expenses Eligible for Reimbursement from an HSA:

- Alcoholism Treatment
- Ambulance
- Anesthetists
- Arch Supports
- Artificial Limbs
- Blood Tests
- Braces
- Contact Lenses
- Chiropractic Visits
- Crutches
- Dental Treatments/ X-Rays
- Dentures
- Dermatologist Visits
- Diagnostic Testing
- Drug Addiction Therapy
- Eyeglasses
- Hospital Bills
- Hearing Aides
- Insulin Treatments
- Lab Tests
- Operating Room Costs
- Oral Surgery
- Organ Transplant
- Orthopedic Shoes
- Oxygen & equipment
- Physician Services
- Physiotherapist Services
- Postnatal Treatments
- Prenatal Care
- Prescription Drugs
- Psychiatrist Services
- Psychologist Services
- Spinal Fluid Test
- Splints
- Sterilization
- Therapy Equipment
- Vaccines
- Vasectomy
- Vitamins (if prescribed)
- Wheelchairs
- X-Rays

FSA | Rocky Mountain Reserve

A Flexible Spending Account (FSA) allows employees to use pretax dollars for healthcare or child/dependent care expenses not covered by insurance plans. Employees contribute a portion of each paycheck to an FSA and save significantly on taxes. Money in an FSA can be used to pay for out-of-pocket medical, dental and vision expenses or dependent care expenses. Employees do not need to be enrolled in the Employer's Health Plan to have an FSA. The IRS establishes a limit on how much you can contribute to FSA accounts each year.

Healthcare FSA

A Healthcare FSA is a pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan or elsewhere. It's a smart, simple way to save money while keeping you and your family healthy and protected. The IRS sets a limit on how much you can contribute to this account each year. For 2025, the spending limit is \$3,300.

Limited Purpose FSA

A limited purpose FSA (LPFSA) is a flexible spending account that only reimburses you for eligible dental and vision expenses. A LPFSA is available to employees who are enrolled in a high-deductible health plan (HDHP) as well as an HSA. By establishing a LPFSA, you can save money on taxes by using your LPFSA dollars for your dental and vision expenses while preserving your HSA funds for other purposes, including simply saving those funds for the future. The IRS sets a limit on how much you can contribute to this account each year.

Dependent Care FSA

A Dependent Care FSA is a pre-tax benefit account used to pay for dependent care services, such as pre-school, summer day camp, before or after school programs, and child or elder daycare. The IRS sets a limit on how much you can contribute to this account each year. For 2025, the spending limit is \$5,000 if married and filing jointly or head of household or \$2,500 if married and filing separately.

PAYING FOR HEALTHCARE

| | HEALTH SAVINGS ACCOUNT (HSA) | HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA) |
|--|--|--|
| What medical plan can I choose? | HDHP | PPO plan |
| Who can contribute? | ARC Health, you, your spouse and other family members (any contribution made by all parties cannot exceed the IRS annual HSA limit) | You |
| What expenses are eligible? | Medical, prescription drug, dental and vision care (See IRS publication 502 for a full list of eligible expenses) | |
| When can I use the funds? | Funds are available as you contribute to the account | All of the funds you elect for the year are available January 1 |
| Can I use the funds for non-eligible expenses? | Penalty of 20% on the used amount (if 65+ income tax is applied) | No |
| Can I roll over funds each year? | Yes, funds roll over from year to year and are yours to keep (even if you leave the company or retire) | No, you will lose any funds remaining in your account at the end of the year |
| Is the account portable? | Yes, all funds belong to you and will stay with you if you retire or leave ARC Health | No |
| How do I pay for eligible expenses? | With your Rocky Mountain Reserve debit card (you can also submit claims for reimbursement online at www.rockymountainreserve.com) | With your Rocky Mountain Reserve debit card (you can also submit claims for reimbursement online at www.rockymountainreserve.com) |
| How much can I contribute each year? | \$4,300 for individual coverage or \$8,850 for family coverage (this total includes company funding) | The IRS establishes a limit on how much you can contribute to FSA accounts each year. For 2024, the spending limit is \$3,200. 2025 limits have not been released yet. |
| Can I change my contributions throughout the year? | Yes, you can change your per-paycheck contributions at any time | No, unless you have a qualifying life event, you choose an annual election amount during open enrollment and that amount is taken out of each paycheck in equal increments throughout the year |

DENTAL | LINCOLN FINANCIAL

Keep Your Smile Healthy

Good dental care improves your overall health. The Lincoln Financial plan is designed to help you maintain a healthy smile through regular preventive dental care and to address any dental problems as soon as they occur. Because preventive care is so important, your dental plan covers your oral exam and cleanings twice a year in full.

With the dental plan, you can receive care from any dentist you choose. Your out-of-pocket costs will be less if you choose a Lincoln network dentist.

If you use a non-network provider, you will be responsible for any charges above the variable fee schedule and could be balance billed. The table below reflects patient responsibility to claims.

| | DENTAL LOW | DENTAL HIGH |
|--|--|--|
| SERVICES | IN-NETWORK | IN-NETWORK |
| Calendar Year Deductible | \$50 | \$50 |
| Calendar Year Maximum (per person) | \$1,000 | \$2,000 |
| Preventive Services (Oral exams, cleanings, x-rays) | 100% | 100% |
| Basic Services (Fillings, simple extractions) | 80% | 80% |
| Major Services (Bridges, dentures, root canal) | 50% | 50% |
| Orthodontia (Children under age 19; No Adult Coverage) | Not Covered | 50% \$2,000 lifetime maximum |
| Rollover Amount | \$250 (If Claim Threshold is \$1-\$500) | \$400 (If Claim Threshold is \$1-\$750) |
| DENTAL CONTRIBUTIONS (Per Bi-Weekly [24] Pay Period) | | |
| | DENTAL LOW | DENTAL HIGH |
| Employee Only | \$14.25 | \$26.73 |
| Employee + Spouse | \$26.86 | \$50.61 |
| Employee + Child(ren) | \$32.01 | \$67.52 |
| Family | \$44.61 | \$92.07 |



VISION | AMERITAS

See the Benefits of the Vision Plan

Our vision plan includes benefits for eye exams, eyeglasses, and contact lenses. You may visit a doctor within the VSP and EyeMed network and take advantage of higher benefits coverage or visit an out-of-network provider of your choice for a reduced benefit. You will pay less seeing an in-network provider compared to a non-network provider. In-network and out-of-network benefits are listed below.

| SERVICE | IN-NETWORK (VSP & EYEMED NETWORK) | OUT-OF-NETWORK (VSP & EYEMED NETWORK) | OUT-OF- NETWORK (VSP) | OUT-OF- NETWORK (EYEMED) |
|---|---|---|--------------------------|--------------------------------|
| Eye Exam – once every 12 months | \$10 copay | Up to \$45 | Up to \$45 | Up to \$35 |
| LENSES – ONCE EVERY 12 MONTHS | | | | |
| Single Vision Lenses | \$25 copay; covered in full | Up to \$30 | Up to \$30 | Up to \$25 |
| Lined Bifocal Lenses | \$25 copay; covered in full | Up to \$50 | Up to \$50 | Up to \$40 |
| Lined Trifocal Lenses | \$25 copay; covered in full | Up to \$65 | Up to \$65 | Up to \$55 |
| Lenticular Lenses | \$25 copay; covered in full | Up to \$100 | Up to \$100 | No benefit |
| Frames – once every 12 months | Up to \$180 allowance + 20% discount | Up to \$70 | Up to \$70 allowance | Up to \$90 |
| Contact Lenses: once every 12 months if you elect contacts instead of lenses/frames | Up to \$180 | Up to \$145 | Up to \$145 | Up to \$144 |
| VISION CONTRIBUTIONS (Per Bi-Weekly [24] Pay Period) | | | | |
| Employee Only | \$4.14 | | | |
| Employee + Spouse | \$8.02 | | | |
| Employee + Child(ren) | \$6.94 | | | |
| Family | \$10.82 | | | |

You have two plans to choose from. Both plans help you save money and maintain healthy eyes and sharper vision. Compare the networks, plan summaries and additional details to determine which plan better fits your needs.

Search [vsp.com](https://www.vsp.com) and [eyemed.com](https://www.eyemed.com) to see which network includes your preferred providers or retail locations.

- VSP offers the nation's largest network of independent doctors. Retail locations include Costco, Walmart, Sam's Club, Visionworks, Pearle Vision
- EyeMed's network includes some of the most recognized names, including: LensCrafters, Pearle Vision, Target Optical



LIFE INSURANCE BENEFITS

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT | LINCOLN

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by ARC Health. The company provides basic life insurance of \$50,000 at no cost to you.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. ARC Health provides AD&D coverage of \$50,000 at no cost to you. This coverage is in addition to your company-paid life insurance described above.

VOLUNTARY LIFE AND AD&D | LINCOLN

You may purchase Life and AD&D insurance in addition to your company-provided coverage. You are guaranteed coverage without answering medical questions if you enroll when you are first eligible. Coverage is not effective until evidence of insurability is approved by Lincoln.

Voluntary Life & AD&D Summary

| Voluntary Life & AD&D Summary | | | |
|-----------------------------------|---|--|--|
| Eligibility Requirement | Employees working 30+ hours per week | | |
| Dependent Eligibility Requirement | Eligible spouse and dependent children under age 26. In order for spouse and/or child(ren) to be eligible for coverage, you must elect coverage for yourself. | | |
| When can you enroll? | When you are first eligible for benefits and during open enrollment every year. | | |
| Coverage Guidelines | Minimum | Guarantee Issue | Maximum |
| Employee | \$10,000 | 5x Annual Salary, up to \$150,000 | 5x Annual Salary up to \$500,000, in \$10,000 increments |
| Eligible Spouse | \$5,000 | 100% of Employee's benefit, up to \$50,000 | \$250,000 in \$5,000 increments |
| Eligible Child(ren) | \$10,000 | \$10,000 | \$10,000 |

Your Voluntary Life/AD&D cost is based on your age and amount elected. Please see Paylocity for your per-pay deduction.



VOLUNTARY DISABILITY BENEFITS

VOLUNTARY SHORT-TERM DISABILITY | LINCOLN

When trouble arises, Short-Term Disability insurance can provide employees with the peace of mind that a protected paycheck brings. Lincoln's Short-Term Disability plan provides income if you become disabled due to an injury or illness after satisfying the elimination period. Once enrolled in the plan, you can take advantage of the following benefits:

| Short-Term Disability Benefit | |
|-------------------------------|--|
| Benefit Percentage | 60% of Weekly Earnings |
| Maximum Weekly Benefit | \$1,500 |
| Elimination Period | 7 Days – the time to wait for benefits to begin after your disability occurs |
| Benefit Duration | 12 Weeks |

Please see Paylocity for your per-pay deduction.

VOLUNTARY LONG-TERM DISABILITY | LINCOLN

When employees choose this coverage, it will provide income replacement beginning after an elimination period of 90 calendar days of disability caused by the same or a related sickness or injury. The plan pays 60% of your pre-disability monthly salary, up to a maximum monthly benefit of \$10,000. Benefits may continue up to age 65 or your Social Security Normal Retirement Age (SSNRA), whichever is later.

| Long-Term Disability Benefit | |
|------------------------------|---|
| Benefit Percentage | 60% of Monthly Earnings |
| Maximum Weekly Benefit | \$10,000/month |
| Elimination Period | 90 Days – the time to wait for benefits to begin after your disability occurs |
| Benefit Duration | Social Security Normal Retirement Age |

Please see Paylocity for your per-pay deduction.



VOLUNTARY BENEFITS

VOLUNTARY ACCIDENT | LINCOLN

Accidental Injury insurance can provide you and your family with the additional financial protection you may need for expenses associated with an unexpected covered accident. While you can't predict life's unexpected events, you can plan for them by choosing benefits that can help protect your financial future. Regular expenses, big and small, can add up. Think about your ability to pay for those expenses if you or your family member were seriously injured in a covered accident. The plan pays benefits directly to you. What you do with the money is up to you.

This benefit will pay a lump sum in the event of a covered accident. Examples include fractures, laceration, dislocation, ambulance transport, and more.

| VOLUNTARY ACCIDENT BENEFITS | | |
|-----------------------------|-----------|----------|
| | HIGH PLAN | LOW PLAN |
| Emergency Care | \$500 | \$300 |
| Urgent Care | \$425 | \$225 |
| Ground Ambulance | \$300 | \$300 |
| Air Ambulance | \$2,000 | \$1,500 |

| VOLUNTARY ACCIDENT RATES (Per Bi-Weekly [24] Pay Period) | | | | |
|--|----------|-------------------|-----------------------|---------|
| | Employee | Employee + Spouse | Employee + Child(ren) | Family |
| LOW PLAN | \$4.91 | \$7.76 | \$9.50 | \$12.88 |
| HIGH PLAN | \$6.74 | \$12.48 | \$11.42 | \$17.16 |



VOLUNTARY BENEFITS

CRITICAL ILLNESS | LINCOLN

ARC Health offers you the opportunity to purchase Critical Illness insurance on a voluntary basis to ease the financial impact of a major illness. If you or a covered family member is diagnosed due to an illness and meets the group policy and certificate requirements, you will receive a payment to use as you see fit. It can be used to help cover your health insurance deductibles, copays, incidental hospital charges (e.g. TV, phone, etc.) or for any purpose you choose. Critical Illness provides payments for illnesses such as:

Organ / Kidney Failure, Cancer, Heart Attack, Stroke, Benign Brain Tumor, Carcinoma In Situ, Arteriosclerosis

Benefit Amounts for Critical Illness:

- Employee: \$10,000 to \$30,000
- Spouse: \$10,000 to 100% of employee benefit amount up to \$30,000
- Child(ren): 25% of employee's benefit amount (i.e. if employee picks \$10,000 amount of coverage, then child is eligible for \$2,500)

Please see Paylocity for your per-pay deduction.

HOSPITAL INDEMNITY | LINCOLN

You don't want to be caught unprepared in a medical emergency and have to rely on your savings to cover the extra expenses you may face that your health plan may not cover such as deductibles, copays, and other out-of-pocket expenses. Hospital Indemnity provides payment directly to you if you experience hospital related services such as: hospital admission, or confinement.

| HOSPITALIZATION BENEFITS | | | | |
|---------------------------------------|-------------------------------------|-------------------|-------------------------------------|---------|
| | LOW PLAN | | HIGH PLAN | |
| Hospital Admission | \$1,000 per admission | | \$1,500 per admission | |
| Daily Hospital Confinement | \$330 per day | | \$425 per day | |
| Daily Hospital Intensive Care | \$330 per day | | \$425 per day | |
| Daily Newborn Nursery Care | \$75 per day, up to 2 days per year | | \$75 per day, up to 2 days per year | |
| Per Bi-Weekly [24] Pay Period Cost | EMPLOYEE | EMPLOYEE + SPOUSE | EMPLOYEE + CHILD(REN) | FAMILY |
| LOW PLAN | \$8.98 | \$19.74 | \$12.03 | \$24.06 |
| HIGH PLAN | \$12.99 | \$28.56 | \$17.14 | \$44.80 |

EMPLOYEE ASSISTANCE PROGRAM

Employee Connect through Lincoln Financial offers professional, confidential, services to help you and your loved ones improve your quality of life.

| In-person Guidance | Unlimited 24/7 assistance | Online resources |
|---|---|--|
| <p>Some matters are best resolved by meeting with a professional in person. With <i>EmployeeConnect</i>, you and your family get:</p> <ul style="list-style-type: none"> In-person help for short-term issues (up to five sessions¹ with a counselor per person, per issue, per year) In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings | <p>You and your family can access the following services anytime online, via the mobile app, or with a toll-free call:</p> <ul style="list-style-type: none"> Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning, and more Legal information and referrals for family law, estate planning, and consumer and civil law² Financial guidance on household budgeting and short- and long-term planning | <p><i>EmployeeConnect</i> offers a range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the <i>GuidanceNowSM</i> mobile app. You'll find:</p> <ul style="list-style-type: none"> Articles and tutorials Videos Interactive tools, including financial calculators, budgeting worksheets, and more |

***EmployeeConnect* counselors are experienced and credentialed.**

When you call the toll-free number, you'll talk to an experienced professional who will provide counseling, work-life advice, and referrals. All counselors hold master's degrees, with broad-based clinical skills, and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

You'll receive customized information for each work-life service you use.

Take advantage of *EmployeeConnect*

For more information about the program, visit [GuidanceResources.com](https://www.guidanceresources.com), download the *GuidanceNow* mobile app, or call 888-628-4824.

GuidanceResources.com login credentials:

Username: LFGSupport

Password: LFGSupport1

GLOBAL ASSISTANCE PROGRAM | TRAVEL CONNECT

Get the support you need when you're far from home through Lincoln Financial.

Travel is a part of life — for business, fun, or any reason that has you packing your bags. When you leave home, feel confident knowing you're supported if you experience a medical emergency. *TravelConnect*® services are included with all life and AD&D insurance policies.*

With *TravelConnect*® services, you can access a range of travel, medical, and safety-related services when traveling more than 100 miles from home, whether for business or pleasure, including:

- Medical emergency help and transportation
- Emergency travel arrangements
- Medical, dental, and legal referrals
- ID recovery assistance
- Recovery of lost or stolen documents or luggage
- Language translation services

| Services you can count on during an emergency | Ongoing support when you're far from home |
|--|--|
| <p>You'll have dedicated support if you face an emergency when you're 100 or more miles from home. <i>TravelConnect</i> helps:</p> <ul style="list-style-type: none"> • Arrange travel if you're injured and need emergency evacuation to a medical facility • Manage travel for a companion and/or your dependent children, including transportation expenses and accommodations of a qualified escort • Plan and pay for a safe evacuation due to natural disaster or a political or security threat • Arrange transportation of a deceased traveler • Secure emergency pet return and/or boarding and vehicle return | <p>From planning the trip until you're home, <i>TravelConnect</i> services can assist you with:</p> <ul style="list-style-type: none"> • Medical records requests • Medication and vaccine delivery • Medical, dental, and pharmacy referrals • Corrective lenses and medical device replacement • Legal consultation • Recovering lost or stolen documents or luggage • ID recovery assistance • Language translation services • Destination information |

For a complete list of *TravelConnect*® services, visit myoncallportal.com and enter your Group ID: LFGTravel123

Scan the QR code to learn more about how *TravelConnect*® services can help.



VOLUNTARY BENEFITS

VOLUNTARY LEGAL | LEGAL SHIELD

Legal insurance helps you address everyday situations like dealing with traffic tickets, resolving warranty issues, or buying a home. Legal Shield offers top-performing legal insurance which features:

| Benefits | Description |
|---------------------------|--|
| Advice and Consultations | Telephone and office advise, review of simple documents and simple dispute resolution correspondence |
| Discounted Representation | Discounted hourly rates, contingency fees, bankruptcy, prenuptial agreement, real estate closing, traffic ticket |
| Financial Advisor | Consultations relating to investment strategies, debt matters, or any personal financing |
| Elder Law | Advice and consultations, simple wills, living wills, Power of Attorney and Healthcare |
| Mediation | Consultation services, counseling assistance, and discounted mediation services |
| Consumer Matters | Document preparation, consumer disputes, small claims court representation |
| Estate Planning | Simple wills, Healthcare Power of Attorney and Probate of Small Estate |
| Residential Matters | Refinancing of Primary Residence, foreclosure and tenant dispute |
| Family Matters | Separation, divorce, civil annulment, name change, guardianship/conservatorship, adoption and juvenile |

COST PER PAY

\$10.48

VOLUNTARY IDENTITY THEFT | ALL STATE

In today's world you can never be too safe, All State offers options to help protect you. Our society seems to be experiencing more and more scenarios that may put us at risk, so this is the best time to add protection that will help you relax a little easier at night. Should you become a victim of identity theft while enrolled in this product a dedicated team of specialists will work on your behalf to restore your identity.

EMPLOYEE COST PER PAY PERIOD

\$3.75

FAMILY COST PER PAY PERIOD

\$7.25

VOLUNTARY PET INSURANCE | ASPCA

You care about your pets and consider them members of your family. So whether your family includes kids with two feet or kids with four paws, or both, you know what responsibility looks like. Protect your pets using the unbeatable rates on pet insurance that ASPCA offers. To enroll in coverage please visit www.aspcapetinsurance.com/ArcHealth and use code **EB23ArcHealth** for quote.

CONTACTS

| Benefit Type | Company | Group/Policy # | Website | Phone Number |
|-----------------------|------------------|---|---------------------------------------|--------------|
| Medical | Anthem | L15888 | Anthem.com | 844-995-1727 |
| Medical | Kaiser | 236505 – CA 47325 – CO 10774 – GA 34403 – Mid Atlantic | Kp.org | 303-338-3800 |
| Medical | Premera | 4026166 | Premera.com | 888-850-8526 |
| Dental | Lincoln | Group: 09-LF1855 Policy: 00001D045105 | Lfg.com | 800-487-1485 |
| Vision | Ameritas | 010-63110 | Ameritas.com | 800-487-5533 |
| Short-Term Disability | Lincoln | Group: 09-LF1855 Policy: GD3-890-LF1855-01 | Lfg.com | 800-487-1485 |
| Long-Term Disability | Lincoln | Group: 09-LF1855 Policy: GF3-890-LF1855-01 | Lfg.com | 800-487-1485 |
| Life AD&D | Lincoln | Group: 09-LF1855 Policy: SA2-890-LF1855-01 | Lfg.com | 800-487-1485 |
| Voluntary Life AD&D | Lincoln | Group: 09-LF1855 Policy: SA2-890-LF1855-01 | Lfg.com | 800-487-1485 |
| Accident | Lincoln | Group: 09-LF1855 Policy: ACC-0001707064 | Lfg.com | 800-487-1485 |
| Critical Illness | Lincoln | Group: 09-LF1855 Policy: CI-0001707062 | Lfg.com | 800-487-1485 |
| Hospital Indemnity | Lincoln | Group: 09-LF1855 Policy: HI-0001707063 | Lfg.com | 800-487-1485 |
| Pet | ASPCA | ARC Health | aspcapetinsurance.com | 877-343-5314 |
| Legal | Legal Shield | 303775 | legalshield.com | 877-391-3092 |
| ID Theft | Allstate | 9679 | Allstate.com | 800-789-2720 |
| Benefit Questions | Oswald Companies | | Email: mybenefits@oswaldcompanies.com | 216-206-6798 |

RETIRING?

Approaching retirement age is an exciting milestone, but it often comes with important questions about your health benefits:

- What are my options before I turn 65?
- What changes once I'm eligible for Medicare?
- Should I retire or keep working?
- What will Medicare cost me?
- What happens to coverage for my spouse and dependents?
- Who can guide me through all of this?

These are just a few of the common questions we hear, and you don't have to navigate them alone. The **UROne Benefits Individual & Medicare Services Team** is here to support you every step of the way. From understanding your options to enrolling in the right coverage, they'll make your Medicare transition smooth and stress-free.

Next Step: Call **1-888-705-6758** to speak with a UROne advisor today.

Anthem / Kaiser / Premera

ARE YOU, OR A FAMILY MEMBER, MEDICARE ELIGIBLE (OR ABOUT TO BECOME MEDICARE ELIGIBLE)? IF SO, PLEASE READ AND KEEP FOR YOUR RECORDS!

Notice of Creditable Coverage

Your prescription drug coverage provided under ARC Health is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as “creditable coverage”.

Why This is Important

This information is to help you decide whether or not you want to join a Medicare drug plan. It is important for those eligible for both Medicare and a group health plan to look ahead and weigh the costs, benefits, and participation terms of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

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. ARC Health has determined that the prescription drug coverage offered by the Anthem / Kaiser / Premera 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 May You Join A Medicare Drug Plan?

Eligible individuals may join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable 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 current ARC Health coverage may or may not be affected as well as dependent coverage. Additional guidance is available at <https://www.cms.gov/medicare/prescription-drug-coverage/creditablecoverage?redirect=/creditablecoverage/> which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

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 ARC Health 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 ARC Health changes. You also may request a copy of this notice at any time.

Contact--Position/Office: Human Resources

Address: 5005 Rockside Road Suite #950, Independence, OH 44131

Phone Number: 800-339-3903

For More Information Regarding 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:

1. Visit www.medicare.gov
2. 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
3. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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).

HIPAA Notice of Privacy Practices

You are receiving this Privacy Notice because you are eligible to participate in an employer sponsored group health plans. The Health Plans are committed to protecting the confidentiality of any health information collected about an individual. This Notice describes how the Health Plan may use and disclose, “protected health information” (PHI). For information to be considered “PHI”, it must meet three conditions:

Information is created or received by a health care provider, health plan, employer, or health care clearinghouse; Information relates past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and the information either identifies the individual or provides a reasonable basis for believing that it can be used to identify the individual.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to an individual. Additionally, the Health Plan is required by law to:

Maintain the privacy of an individual’s “protected health information” (PHI) and provide you with the Privacy Notice of its legal duties and privacy practices with respect to an individual’s PHI and follow the terms of its Privacy Notice that is currently in effect.

Employees of the plan sponsor who administer and manage this Health Plan may use PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These individuals must comply with the same requirements that apply to the Health Plan to protect the confidentiality of PHI.



Uses and Disclosures of Protected Health Information (PHI)

The following categories describe the ways that the Health Plan may use and disclose protected health information. For each category of uses and disclosures, examples will be provided. Not every use or disclosure in a category will be listed. However, all the ways the Health Plan is permitted to use and disclose information will fall within one of these categories.

Treatment Purposes. The Health Plan may disclose PHI to a health care provider for the health care provider’s treatment purposes. For example, if an individual’s Primary Care Physician (PCP) or treating medical provider refers the individual to a specialist for treatment, the Health Plan can disclose the individual’s PHI to the specialist to whom they have been referred so (s)he can become familiar with the individual’s medical condition, prior diagnoses and treatment, and prognosis.

Payment Purposes. The Health Plan may use or disclose health information for payment purposes; such as, determining eligibility for plan benefits, obtaining premiums, facilitating payment for the treatment and services an individual receives from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans. Examples of payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a specific treatment is covered under the plan

Health Care Operations. The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and

improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

To a Business Associate of the Health Plan. The Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, provided a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so or provides services to the Health Plan such as legal, actuarial, accounting, consulting, or administrative services. Examples of Business Associates include the Health Plan's Third-Party Administrators (TPAs), Actuary, and Broker.

To the Health Plan Sponsor. The Health Plan may disclose PHI to the Plan Sponsor as long as the sponsor has amended its plan documents, provided a certification to the Health Plan, established certain safeguards and firewalls to limit the classes of employees who will have access to PHI, and to limit the use of PHI to plan purposes and not for non-permissible purposes, as required by the Privacy Rule. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Some examples may include: disclosure for claims appeals to the Plan's Benefits Committee, for case management purposes, or to perform plan administration functions.

The Health Plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "Summary Health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

Required by Law or Requested as Part of a Regulatory or Legal Proceeding. The Health Plan may use and disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, the Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

Public Health Activities or to Avert a Serious Threat to Health or Safety. The Health Plan may disclose PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Law Enforcement or Specific Government Functions. The Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with an individual's written authorization or that of their legal representative, and the individual may revoke such authorization as provided by section 164.508(b) (5) of the Privacy Rule. Any disclosures that were made when the individual's Authorization was in effect will not be retracted.

An Individual's Rights Regarding PHI

An individual has the following rights with respect to their PHI:

Right to Inspect and Copy PHI. An individual has the right to inspect and copy health information about them that may be used to make decisions about plan benefits. If they request a copy of the information, a reasonable fee to cover expenses associated with their request may be charged.

Right to Request Restrictions. An individual has the right to request restrictions on certain uses and disclosures of their PHI (although the Health Plan is not required to agree to a requested restriction).

Right to Receive Confidential Communications of PHI. An individual has the right to receive their PHI through a reasonable alternative means or at an alternative location if they believe the Health Plan's usual method of communicating PHI may endanger them.

Right to Request an Amendment. An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI but is required to provide the individual with a response in either case.

Right to Accounting of Disclosures. An individual has the right to receive a list or "accounting of disclosures" of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual's Authorization, or to the individual. An individual's request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12-month period.

Breach Notification. An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so, required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Optional if covered entity engages in underwriting **Genetic Information** An individual's genetic information will not be used for underwriting except for long term care plans.

Right to Paper Copy. An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

The Health Plan's Responsibilities Regarding an Individual's PHI

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI. The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to all actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice

The complaint will be investigated, and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

**Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201**

HIPAA Plan Special Enrollment Notice

If you are declining your enrollment under the Plan, or declining coverage for your spouse or one of your dependents, because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing toward such other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends, or after the period for which the employer ceased contributing toward such other coverage if such payment applied to your circumstances.

In addition, if you have a new dependent, as a result of your marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, please contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for further information.

Genetics Information Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Mental Health/Substance Use Disorder Parity

Effective for Plan Years on and after July 1, 2010, benefits under Plans that provide Mental Health Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Newborns and New Mothers Care Disclosure

This Plan generally does not, consistent with applicable 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, consistent with that same Federal law, this Plan 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, this Plan does not, in accordance with 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).

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual and Regular Notice

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, notwithstanding anything herein to the contrary, the Plan provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for further information.

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 | ALASKA – Medicaid |
|---|---|
| Website: http://myalhipp.com/ Phone: 1-855-692-5447 | 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 | CALIFORNIA – Medicaid |
| Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447) | 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+) | FLORIDA – Medicaid |
| 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 | Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268 |
| GEORGIA – Medicaid | INDIANA – 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 | 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: 1-800-403-0864 Member Services Phone: 1-800-457-4584 |
| IOWA – Medicaid and CHIP (Hawki) | KANSAS – Medicaid |
| 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 | Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660 |

| KENTUCKY – Medicaid | LOUISIANA – Medicaid |
|---|--|
| <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</p> <p>Phone: 1-855-459-6328</p> <p>Email: KIHIPPPROGRAM@ky.gov</p> <p>KCHIP Website: https://kynect.ky.gov</p> <p>Phone: 1-877-524-4718</p> <p>Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p> | <p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp</p> <p>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p> |
| MAINE – Medicaid | MASSACHUSETTS – Medicaid and CHIP |
| <p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US</p> <p>Phone: 1-800-442-6003</p> <p>TTY: Maine relay 711</p> <p>Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms</p> <p>Phone: 1-800-977-6740 TTY: Maine relay 711</p> | <p>Website: https://www.mass.gov/masshealth/pa</p> <p>Phone: 1-800-862-4840</p> <p>TTY: 711</p> <p>Email: masspremassistance@accenture.com</p> |
| MINNESOTA – Medicaid | MISSOURI – Medicaid |
| <p>Website: https://mn.gov/dhs/health-care-coverage/</p> <p>Phone: 1-800-657-3672</p> | <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</p> <p>Phone: 573-751-2005</p> |
| MONTANA – Medicaid | NEBRASKA – Medicaid |
| <p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</p> <p>Phone: 1-800-694-3084</p> <p>Email: HSHIPPProgram@mt.gov</p> | <p>Website: http://www.ACCESSNebraska.ne.gov</p> <p>Phone: 1-855-632-7633</p> <p>Lincoln: 402-473-7000</p> <p>Omaha: 402-595-1178</p> |
| NEVADA – Medicaid | NEW HAMPSHIRE – Medicaid |
| <p>Medicaid Website: http://dhcfp.nv.gov</p> <p>Medicaid Phone: 1-800-992-0900</p> | <p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</p> <p>Phone: 603-271-5218</p> <p>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218</p> <p>Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov</p> |

| NEW JERSEY – Medicaid and CHIP | NEW YORK – Medicaid |
|---|--|
| <p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p> | <p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p> |
| NORTH CAROLINA – Medicaid | NORTH DAKOTA – Medicaid |
| <p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p> | <p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p> |
| OKLAHOMA – Medicaid and CHIP | OREGON – Medicaid and CHIP |
| <p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p> | <p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p> |
| PENNSYLVANIA – Medicaid and CHIP | RHODE ISLAND – Medicaid and CHIP |
| <p>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)</p> | <p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlts Share Line)</p> |
| SOUTH CAROLINA – Medicaid | SOUTH DAKOTA - Medicaid |
| <p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p> | <p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p> |
| TEXAS – Medicaid | UTAH – Medicaid and CHIP |
| <p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p> | <p>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/</p> |

| VERMONT– Medicaid | VIRGINIA – Medicaid and CHIP |
|---|--|
| Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924 |
| WASHINGTON – Medicaid | WEST VIRGINIA – Medicaid and CHIP |
| Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| WISCONSIN – Medicaid and CHIP | WYOMING – Medicaid |
| Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002 | 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