

Toyo COTTON CO.

your **benefits.**
your **well-being.**
your **choice.**

2027 OPEN ENROLLMENT
BENEFITS GUIDE

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benefits eligibility & dependent verification

WHO'S ELIGIBLE

- Employees working 30 or more hours per week
- Legal spouses
- Dependent children

DEPENDENT ELIGIBILITY

Your legal spouse and dependent children (up to age 26) may also be covered by:



DEPENDENT VERIFICATION

You may be asked to provide proof of dependent eligibility, including one or more of the following:

- Marriage certificate
- Birth certificate
- Affidavit of qualifying adult
- Adoption certificate
- Placement certificate
- Document of guardianship

NEW HIRES

- **When you enroll:** Within 30 days of your date of hire
- **When benefits take effect:** Most benefits are effective the first day of the month following your date of hire
- **If you miss the deadline:** Must wait for the next open enrollment period or until you experience a qualifying life event (See page 4.)

COBRA COVERAGE

When you or any of your dependents no longer meet the eligibility requirements, you may be eligible for continued coverage through the **Consolidated Omnibus Budget Reconciliation Act (COBRA)** of 1985.

Ready to Enroll?

Contact your local **Benefit Team** for enrollment instructions.

benefits changes & medicare

BENEFITS CHANGES DURING THE YEAR

The benefits you choose during open enrollment generally stay in place until the next open enrollment period unless you experience a qualifying life event. If you do, notify Human Resources within **60 days** to request the change, make your benefit elections, and provide required documentation, such as a marriage or birth certificate.

Types of Qualifying Life Events

Family Changes	Marriage, divorce, legal separation, birth, adoption, placement for adoption, or death of a dependent
Dependent Eligibility Changes	Child becoming newly eligible or no longer eligible
Other Coverage Changes	Change in spouse's employment or coverage, or loss of eligibility for other health coverage
Government Coverage Changes	Gaining or losing eligibility for Medicare, Medicaid, or a state Children's Health Insurance Program (CHIP), including eligibility for CHIP or Medicaid premium assistance
Marketplace Coverage	You, your spouse, or dependent child becoming eligible to enroll because of a Special Enrollment Period
Court Orders	Judgment, decree, or court order requiring you to add or remove coverage for a dependent child

Turning Age 65 and Becoming Medicare-eligible

- **Already getting Social Security?** Medicare enrollment information should arrive about three months before your 65th birthday.
- **Not getting Social Security?** You'll need to enroll in Medicare through Social Security.
- **Still working in a benefits-eligible position?** You may enroll in Medicare Part A (hospital), which is typically premium-free, or Part B (medical) and Part D (prescription) at your own cost.
- **Enrolling in Medicare?** Our medical plan and Medicare will coordinate coverage based on federal rules. If Medicare is primary, you may be required to enroll in Part B, so check with the medical plan.
- **HSAs and Medicare:** If you enroll in Medicare, you can no longer make Health Savings Account (HSA) contributions. You can still use the money already in your HSA to pay for eligible out-of-pocket expenses.

For more information, visit medicare.gov.

your benefits **glossary**

Coinsurance

Percentage of covered costs you pay after meeting your deductible

Example: If the plan pays 70%, you pay 30%.

Copay

Fixed amount you pay for certain healthcare services or prescriptions

Example: $30 for an office visit

Deductible

Amount you pay for covered care before the plan begins sharing the cost; deductibles may differ for individual and family coverage and for in-network and out-of-network care

Evidence of Insurability (EOI)

A health questionnaire you may need to complete before certain insurance coverage can be approved

Explanation of Benefits (EOB)

Statement showing how a claim was processed, including what the plan paid and what you may owe

Flexible Spending Account (FSA)

Account that lets you set aside pre-tax money for eligible healthcare or dependent care expenses

Guaranteed Issue

Coverage you can obtain without answering health questions or providing Evidence of Insurability (EOI)

Health Savings Account (HSA)

Tax-advantaged account you can use for eligible medical, dental, and vision expenses if you've enrolled in a high deductible health plan; money rolls over from year to year and stays with you if you change employers or plans; you and your employer may contribute up to IRS limits

Out-of-Pocket Maximum

The most you'll pay for covered expenses during the plan year; once you reach this limit, the plan pays 100% of the allowed amount for covered services

Prior Authorization/ Pre-Service Notification

Approval that may be required from your plan before you receive certain services for them to be covered

Qualifying Event

A life event—such as marriage, divorce, birth or adoption, or loss of other coverage—that may allow you to change your benefits outside of open enrollment

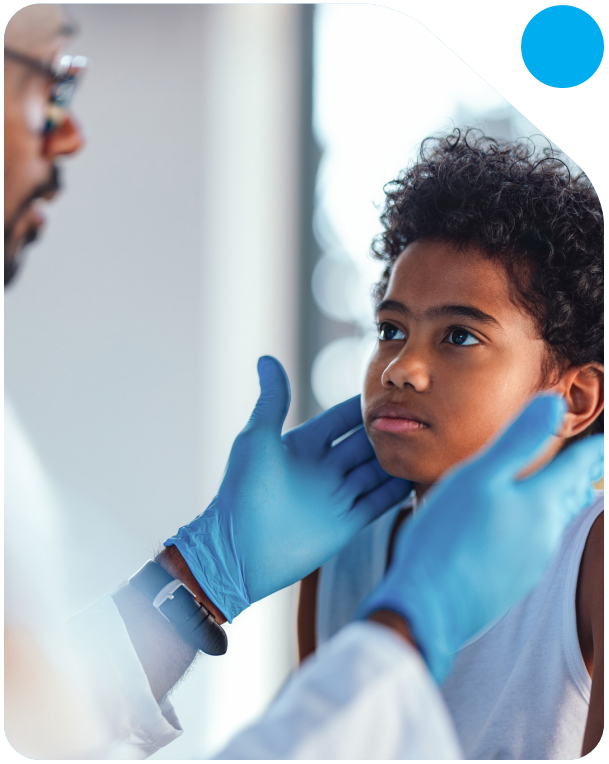
Usual, Customary, and Reasonable (UCR)

Typical cost of a healthcare service; used to determine how much the plan will pay for out-of-network care

your medical **coverage**

Medical coverage is one of the most valuable ways we help you stay healthy and feel secure. It means you can focus on your life and loved ones, knowing care is there when you need it. We offer four plans, so you can find the one that fits your needs and budget. All provide a **large provider network, prescription coverage,** and **free, in-network preventive care**.

	Traditional PPO	Choice HDHP	Advantage PPO	Value HDHP
At-A-Glance	Highest payroll deductions in exchange for lowest deductible	Lower payroll deductions in exchange for a higher deductible	Mid-range payroll deductions and deductible	Lowest payroll deductions in exchange for highest deductible
Paying for Care	Copays (set fees) for many services	Full cost until you reach deductible (amount where plan starts sharing costs)	Copays (set fees) for many services	Full cost until you reach deductible (amount where plan starts sharing costs)
Funding Accounts	Flexible Spending Account (FSA)	Health Savings Account (HSA)	Flexible Spending Account (FSA)	Health Savings Account (HSA)



Want the full details, including which providers are in-network? Visit the Benefits Hub, where you'll find everything you need in one place.

Anthem

anthem.com

866-798-7062

medical coverage: what you pay for care

	Traditional PPO	Choice HDHP	Advantage PPO	Value HDHP
In-Network Benefits				
Deductible Individual/Family	$1,000/$2,000	$1,750/$3,500	$2,500/$5,000	$3,000/$6,000
Coinsurance	15%	15%	25%	25%
Out-of-Pocket Maximum Individual/Family	$3,000/$6,000	$3,000/$6,000	$5,000/$10,000	$5,000/$10,000
Health Savings Account	N/A	Yes	N/A	Yes
Primary Care	$20 copay *(Deductible does not apply)*	Deductible, then 15%	$20 copay *(Deductible does not apply)*	Deductible, then 25%
Specialty Care	$35 copay *(Deductible does not apply)*		$35 copay *(Deductible does not apply)*	
Preventive Care Services	Covered in full			
LiveHealth Online (Virtual Primary Care and Preventive/Wellness Care)	$0			
Virtual Care Visit (Primary Care and Specialist)	$20 copay	$0	$20 copay	$0
Mental Health	$15 copay	Deductible, then 15%	$15 copay	Deductible, then 25%
Urgent Care	$20 copay		$20 copay	
Emergency Room	$200 copay		$200 copay	
X-rays*	$0 copay		$0 copay	
Labs*	$0 copay @ Labcorp/Quest	Deductible, then 15% @ Labcorp/Quest	$0 copay @ Labcorp/Quest	Deductible, then 25% @ Labcorp/Quest
Inpatient Hospital	Deductible, then 15%		Deductible, then 25%	
Outpatient Surgery—Hospital				
Prescription Drugs				
Pharmacy *(Up to 30-Day Supply)*	$10/$30/$60	Deductible, then 15%	$10/$30/$60	Deductible, then 25%
Specialty *(Up to 90-Day Supply)*	50% up to $120		50% up to $120	
Mail Order *(31-90-Day Supply)*	$20/$60/$90		$20/$60/$90	

Please note: When using hospital services, physician services may be covered separately and subject to deductible, coinsurance, or additional copays.

*Services at freestanding facility

medical plan payroll deductions

BI-WEEKLY PREMIUM RATES

		Premium Rate by Plan/Tier			
		Traditional PPO	Choice HDHP	Advantage PPO	Value HDHP
Non-Exempt (Hourly)	Employee Only	$59.62	$22.31	$33.46	$11.92
	Employee & Spouse	$124.23	$54.62	$66.92	$28.08
	Employee & Child(ren)	$86.92	$38.46	$55.77	$16.92
	Family	$148.85	$76.92	$101.54	$40.38
Exempt (Salaried)	Employee Only	$64.62	$27.31	$38.46	$11.92
	Employee & Spouse	$129.23	$59.62	$71.92	$38.08
	Employee & Child(ren)	$91.92	$43.46	$60.77	$26.92
	Family	$153.85	$81.92	$106.54	$50.38

WELLNESS CREDIT PREMIUM RATES

		Wellness Participation		Premium Rate by Plan/Tier			
		Employee	Spouse	Traditional PPO	Choice HDHP	Advantage PPO	Value HDHP
Non-Exempt (Hourly)	Employee Only	✓		$29.62	$7.31	$13.46	$1.92
	Employee & Spouse	✓		$94.23	$39.62	$46.92	$18.08
	Employee & Spouse		✓	$104.23	$44.61	$51.92	$23.08
	Employee & Spouse	✓	✓	$74.23	$29.61	$31.92	$13.08
	Employee & Child(ren)	✓		$56.92	$23.46	$35.77	$6.92
	Family	✓		$118.85	$61.92	$81.54	$30.38
	Family		✓	$128.85	$66.92	$86.54	$35.39
	Family	✓	✓	$98.85	$51.92	$66.54	$25.38
Exempt (Salaried)	Employee Only	✓		$34.62	$12.31	$18.46	$1.92
	Employee & Spouse	✓		$99.23	$44.62	$51.92	$28.08
	Employee & Spouse		✓	$109.23	$49.61	$56.92	$33.08
	Employee & Spouse	✓	✓	$79.23	$34.61	$36.92	$23.08
	Employee & Child(ren)	✓		$61.92	$28.46	$40.77	$16.92
	Family	✓		$123.85	$66.92	$86.54	$40.38
	Family		✓	$133.85	$71.92	$91.54	$45.39
	Family	✓	✓	$103.85	$56.92	$71.54	$35.38

anthem health programs & resources

Your Anthem medical coverage comes with extra programs that make caring for your health easier and more convenient.

LIVEHEALTH ONLINE

Get care without leaving home. LiveHealth Online connects you with providers by phone or video for advice, treatment, and prescriptions.

Visit: livehealthonline.com
Questions? 888-548-3432

24/7 NURSELINE

Have a health question that isn't an emergency? Talk to a nurse anytime, day or night.

Call: 800-700-9184

WEIGHT MANAGEMENT CENTER

Get helpful resources and support to navigate your weight challenges and reach your goals.

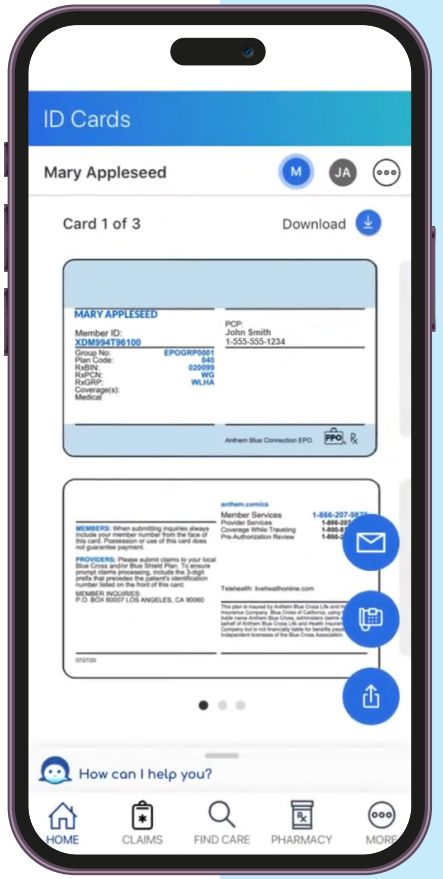
TOBACCO CESSATION CENTER

Find motivation, activities, and expert advice to help you quit tobacco for good.

SYDNEY HEALTH APP

The Sydney Health app puts your benefits and health tools in one place, right on your phone. You can:

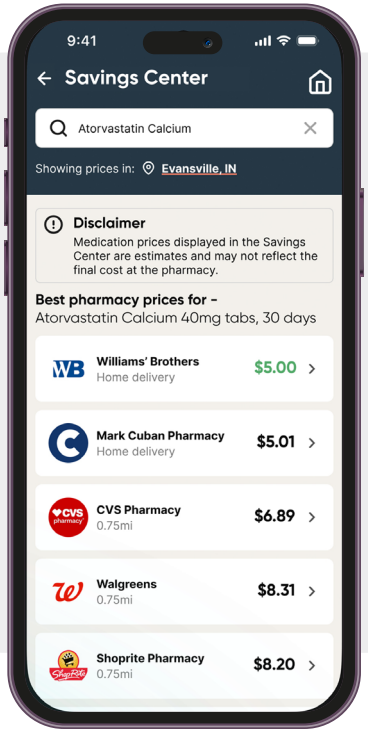
- **Find a provider:** Search for doctors, specialists, urgent care, or hospitals.
- **View your ID card:** Show, email, or fax your card straight from your phone.
- **Estimate your costs:** Compare providers based on price and quality.
- **Access your health record:** View and share it with your providers anytime.
- **Track your goals:** Follow your health goals, fitness, and rewards.
- **Chat live:** Connect in real time with Anthem Health Guides and nurses.



your prescription **coverage**

Prescriptions are a large part of how many people care for their health. Our pharmacy partner, True Rx, takes a whole-person approach to pharmacy care, supporting your overall health while helping you save.

- **Step Therapy:** Sometimes there's a lower-cost medication that works just as well. With step therapy, you'll try that option first before a higher-cost medication is approved.
- **Prior Authorization:** Some medications—like brand-name, high-cost, or high-dose prescriptions—need approval from True Rx first.



TRUE RX+ APP

True Rx+ is more than just a pharmacy app. It's your personalized digital pharmacy experience designed to help you stay informed, save money, and get support when you need it the most.

- View your insurance card and plan details
- See your active prescriptions, deductible, and out-of-pocket status
- Compare medication prices at local pharmacies
- Set refill reminders
- Track prior authorizations in real time
- Chat with a live True Rx Health Strategist

trueRx HEALTH STRATEGISTS

member.myplantruerx.com

866-921-4047

HOME DELIVERY: PRESCRIPTIONS MADE EASY

- **From app to door:** Manage prescriptions online or in the app and have them shipped right to your door.
- **More supply, less cost:** Get a 90-day supply of your maintenance medications and pay less than three separate 30-day refills.
- **Less legwork:** True Rx contacts your doctor for new 90-day prescriptions, and pharmacists are available 24/7 to answer your questions.
- **No-cost shipping:** Shipping is always free.

Ready to start?

True Rx partners with WB Rx Express to deliver your prescriptions.

1. Go to wbrxexpress.com and click "Become a New Patient."
2. Complete the online form and click the red Submit button.
3. Verify your account and medications when WB Rx Express contacts you, typically within two business days.

health savings accounts

ELIGIBLE WITH THE CHOICE AND VALUE PLANS

A Health Savings Account, or HSA, lets you set aside pre-tax dollars to pay for eligible healthcare expenses. If you enroll in either the Choice or Value medical plan, you are eligible for an HSA, and we will also add money to it—starting with a **seed contribution** in January, followed by **additional contributions each pay period** if you contribute, too.

- **Getting started:** Go to infinconsumer.lh1ondemand.com and decide how much to contribute, up to the IRS limits. Be sure to meet minimum contribution amounts to receive the company's full contribution amount.
- **Now or later:** Pay for eligible medical, dental, vision, and prescription drug expenses now or let your balance grow for the future.
- **Non-eligible expenses?** You may owe income tax and a penalty if you use your HSA for non-eligible expenses. See IRS Publication 969 at irs.gov/publications for details.

	IRS Contribution Limit	2027 Employer Contribution	Amount You Can Contribute
Employee Only	$4,500	**Total potential contribution:** $850 **Seed contribution:*** $250 **Additional contributions:**** $600	$3,650
Employee + Dependent(s)	$9,000	**Total potential contribution:** $1,700 **Seed contribution:*** $500 **Additional contributions:**** $1,200	$7,300
55+ Catch-Up	$1,000	N/A	$1,000

* Seed contribution will be made in January.

** Additional contributions will be made in equal installments and you must meet the minimum employee contribution requirement to receive the full company contribution.

Don't Leave Money on the Table

To receive the company HSA contributions after the seed contribution, contribute at least:

- **Employee-only:** $10 per paycheck
- **Employee + dependent(s):** $20 per paycheck

A Note for New Hires

If you're hired mid-year, you'll receive the seed contribution when you become eligible and enroll. The remaining employer contribution will be prorated, provided you meet the minimum contribution requirement.

isolved

infinconsumer.lh1ondemand.com

866-370-3040

Reminder: You will need to re-register for an account on the new platform. See our open enrollment newsletter for instructions.

your dental **coverage**

A healthy smile is a big part of your overall well-being, and good dental care helps you stay on top of it. That's why, for 2027, you can choose from **two dental plan options**, so you can pick the coverage that fits your needs.

	Enhanced	Core
Annual Deductible Single/Family	$50/$150	
Maximum Benefit Limits		
Annual Limit	$2,500	$1,500
Lifetime Limit: Orthodontics (Child Only)	$2,500	Not covered
Services		
Preventive Services Cleanings, Fluoride Treatment for Children, Space Maintainers, Topical Sealants	All in-network care is covered at 100%, no deductible	
Basic Services Restorative, Endodontics, Periodontics, Fillings, Oral Surgery	80%	50%
Major Services Crowns, Bridges, Dentures, Implants	60%	50%
Orthodontics (Child Only)	50%	Not covered

Out-of-Network Costs

Out-of-network providers mean the plan covers less, so you pay more. They can also bill you for the difference between their charge and what the plan pays, leading to surprise costs.

BI-WEEKLY PREMIUM RATES

	Enhanced	Core
Employee Only	$6.80	$2.00
Employee & Spouse	$15.57	$5.00
Employee & Child(ren)	$14.13	$5.00
Family	$21.92	$7.50



Anthem

anthem.com

866-798-7062

your vision **coverage**

Clear vision helps you feel your best every day, and our vision plan just got even better. Now you can get **new frames every year**, plus we've added the **Plus Network** with providers who offer additional perks and discounts. You can also see in-network providers through retail outlets like LensCrafters and Target.

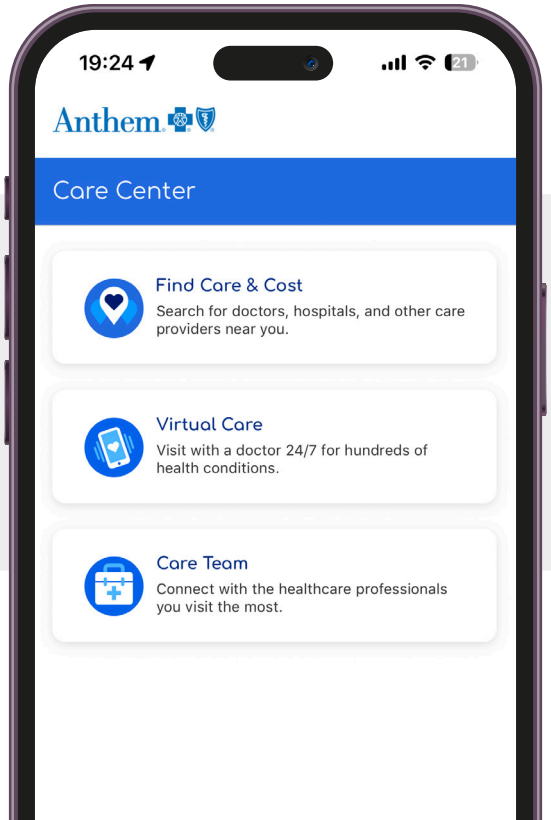
	Plus Network Provider	Network Provider
Exam Once Per Calendar Year	$0 copay	$15 copay
Frames Once Per Calendar Year	$200 allowance, then 20% of balance	$150 allowance, then 20% of balance
Lenses Once Per Calendar Year	$30 copay	$30 copay
Contact Lenses (Medically Necessary) Once Per Calendar Year in Lieu of Eyeglasses	$55 copay—fitting/evaluation $150 allowance	

BI-WEEKLY PREMIUM RATES

	Enhanced
Employee Only	$1.37
Employee & Spouse	$2.94
Employee & Child(ren)	$2.54
Family	$4.16

How to Find a Plus Provider

- Sign in through anthem.com or the Sydney Health app.
- Select **Find Care** or **Find a Doctor**.
- Choose **Vision** and select your Blue View Vision plan/network.
- Search by ZIP code, city, provider name, or retailer.
- Open the listing to confirm network.



Anthem

anthem.com
866-798-7062

life support

We care about your well-being, at home and at work, and offer two benefits—all at no cost to you—that help you manage life's demands.

EMPLOYEE ASSISTANCE PROGRAM

Our Employee Assistance Program (EAP) provides confidential support, counseling, and resources to help you with life's challenges. These services are available to you and your family, at no cost to you.

- **24/7 telephone consultations:** Talk with licensed mental health professionals anytime for guidance, information, support, and referrals.
- **Face-to-face and virtual counseling:** Get confidential support for personal and family concerns.
- **Personalized one-on-one coaching:** Connect with an experienced coach by email, text, or phone.
- **Mindfulness on the go:** Get weekly text messages with positive reminders, quick tips, and simple exercises.
- **Live and on-demand webinars:** Find expert advice and practical tips to help strengthen your mental and emotional well-being.
- **Here with all types of support:** Mental and emotional well-being, healthy lifestyle support, alcohol or substance use, relationship issues, legal concerns, adult dependent care, childcare needs

New for 2027: Headspace will become our new EAP provider. More information will be shared soon.

NEW: CARE.COM

Balancing work, family, and everything in between just got easier with our new care.com benefit. Use your free membership to:

- Find short-term or ongoing care
- Get discounts on child care, education, travel, fitness, and more
- Join expert-led sessions on parenting, senior care, mental health, money matters, and more

Care.com | care.com/yourbenefits

Anthem

anthemEAP.com
Code: Toyota Tsusho
800-865-1044

life insurance and AD&D

Sun Life

sunlife.com
800-247-6875

BASIC: COMPANY-PROVIDED

Basic life and accidental death & dismemberment (AD&D) insurance are provided to employees at no cost. This coverage offers built-in financial protection for you and your loved ones in the event of a death or serious accidental injury.

	Life and AD&D Coverage
Life Insurance	**Employee:** 2 x annual earnings up to a maximum of $300,000 **Spouse:** $5,000 **Child(ren):** $2,000*
Accidental Death and Dismemberment (AD&D)	**Employee:** 2 x annual earnings up to a maximum of $300,000 **Spouse:** $5,000 **Child(ren):** $2,000*
Benefit Reduction Schedule	None

*Live birth, but under 26 years

VOLUNTARY: AT YOUR COST

Want a little extra peace of mind for the people who count on you? Voluntary life insurance lets you add life insurance coverage for yourself, your spouse, and your dependent children—on top of basic life insurance we already provide.

- **Timing is everything:** The easiest time to sign up is when you first become eligible. Choose your coverage then, and no extra steps are required.
- **Small step for later:** If you decide to add coverage later, you'll need to provide Evidence of Insurability (EOI). This is a short health questionnaire that shares information about your current health.

	Voluntary Life Coverage		
	Employee	**Spouse**	**Dependent Child(ren)**
Increments	1, 2, 3, 4 or 5 x annual salary	Increments of $10,000	Less than 6 months of age: $1,000 6 months to age 26: Increments of $2,000
Guaranteed Issue Amounts (EOI not required)	$200,000	$30,000	$10,000
Maximum	$500,000	$150,000; not to exceed 100% of employee elected amount	$10,000
Benefit Reduction Schedule	None		N/A
	Voluntary AD&D Coverage		
Increments	1, 2, 3, 4 or 5 x annual salary	Increments of $10,000	Less than 6 months of age: $1,000 6 months to age 26: Increments of $2,000
Maximum	$500,000	$150,000; not to exceed 100% of employee elected amount	$10,000
Benefit Reduction Schedule	None		N/A

pet insurance

Your pets are part of the family. Our new pet insurance benefit helps you plan for both routine and unexpected care, so you can keep your furry companions happy and healthy.

YOU'LL RECEIVE

- Discounts of up to 30%
- Up to 90% reimbursement for injuries and illnesses
- Optional preventive care coverage
- 24/7 live vet chat
- Any licensed veterinarian in the U.S.

MetLife

Get a free quote

metlife.com/getpetquote

888-465-4490



general claim & benefit information

NEED HELP?

Customer Service Helpline:

Hylant Toyotsu is your one-stop resource for benefit questions, claims issues, and general support.

Call: (419) 255-1020
Hours: Monday–Friday, 8 a.m.–4:30 p.m. ET
Website: hylanttoyotsu.com

Have handy: Insurance or ID card number and any relevant documents, such as an explanation of benefits, bill, or denial letter



Benefit	Provider	Contact
Enrollment/Eligibility	TAI Benefits Team	877-977-9008 openenrollment@taiamerica.com
Medical	Anthem	866-798-7062 enrollmentanthem.com/toyotatsusho
Pharmacy	True Rx	866-921-4047 truerx.com
Non-critical Healthcare Assistance	24/7 Nurseline	800-700-9184
Employee Assistance Program	Anthem Company code: Toyota Tsusho	800-865-1044 anthemeap.com
Health Savings Account (HSA)	iSolved	866-370-3040 infinconsumer.lh1ondemand.com/Login.aspx
Dental	Anthem	866-798-7062 enrollmentanthem.com/toyotatsusho
Vision	Anthem	866-798-7062 enrollmentanthem.com/toyotatsusho
Life/AD&D	Sun Life	800-247-6875 sunlife.com
Pet Insurance	MetLife	888-465-4490 metlife.com/getpetquote

PLAN NOTICES, DISCLOSURES & LEGAL DOCUMENTS

NOTE TO ALL EMPLOYEES

Certain Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance, please contact your **Plan Administrator** as follows:

Toyota Tsusho America, Inc.
Brooke Lampton, Total Rewards
700 Triport Road, Georgetown, KY 40324
1-877-977-9008

Group Health Plan: Toyota Tsusho America, Inc.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of a 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 marriage, birth, or placement for adoption. (Note pre-tax payments may not be made for retroactive coverage due to marriage.)

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

To request special enrollment or obtain more information, please contact your Plan Administrator (identified at the beginning of this section).

NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)

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. Refer to your benefit materials for specific deductibles and coinsurance that apply.

If you would like more information on WHCRA benefits, please call your Plan Administrator (identified at the beginning of this section).

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence.

This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

The dependent is suffering from a serious illness or injury.

The leave is medically necessary.

The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date of the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law became effective for plan years beginning on or after October 9, 2009.

NOTICE REGARDING PATIENT PROTECTION RIGHTS

Your Group Health Plan (identified at the beginning of this section) generally allows the designation of a primary care provider.

You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from your Group Health Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The healthcare professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology healthcare professionals, please contact the Plan Administrator (identified at the beginning of this section) or issuer.

HIPAA PRIVACY

The Plan complies with the privacy requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These requirements are described in a Notice of Privacy Practices that was previously given to you. A copy of this notice is available upon request to the Plan Administrator (identified at the beginning of this section).

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan.

However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.5% (indexed annually) of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.5% (indexed annually) of the employee's household income. (An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution - as well as your employee contribution to employment-based coverage - is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage.

Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer- sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting- medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your Plan Administrator (identified at the beginning of this section).



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 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 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 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, 2026. 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: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/
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.flmedicaidtplrecovery.com/flmedicaidtplrecovery.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

ILLINOIS | Medicaid

Illinois Medicaid Premium Assistance Information
Medicaid application website: https://abe.illinois.gov
HIPP Hotline Number: 217-524-8268
HIPP Email: mhfs.boc.hipp@illinois.gov

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: 1-800-403-0864
Member Services Phone: 1-800-457-4584

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: KIHIPP.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

Louisiana Medicaid Website:
https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

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/ofi/applications-forms
Phone: 1-800-977-6740
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: 1-800-694-308
Email: HHSHIPPProgram@mt.gov

NEBRASKA | Medicaid

Website: http://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	PENNSYLVANIA | Medicaid and CHIP	VERMONT | Medicaid
Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ 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)	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)	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
NEW YORK | Medicaid	**RHODE ISLAND | Medicaid and CHIP**	**VIRGINIA | Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	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
NORTH CAROLINA | Medicaid	**SOUTH CAROLINA | Medicaid**	**WASHINGTON | Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
NORTH DAKOTA | Medicaid	**SOUTH DAKOTA | Medicaid**	**WEST VIRGINIA | Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
OKLAHOMA | Medicaid and CHIP	**TEXAS | Medicaid**	**WISCONSIN | Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
OREGON | Medicaid	**UTAH | Medicaid and CHIP**	**WYOMING | Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	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/	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, 2026, 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. Dept. of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

MEDICARE PART D COVERAGE NOTICE – IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are or will become eligible for Medicare in the next 12 months.

- If you choose one of the following, **Advantage PPO, Choice HDHP, Traditional PPO, and Value HDHP** medical plan options, these plans are considered Creditable Coverage and will follow the creditable coverage description below.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to end-stage renal disease (ESRD)

You are responsible for providing this notice to your spouse, your domestic partner or any dependent who is or will become Medicare eligible in the next 12 months. If your spouse, your domestic partner, or any dependent resides at a different address then please contact us to provide that individual's address as soon as possible.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Group Health Plan (as identified at the beginning of this section) 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.

CREDITABLE COVERAGE

There are two important things you need to know about the Advantage PPO, Choice HDHP, Traditional PPO, and Value HDHP Medicare's prescription drug coverage if you choose one of the coverages considered Credible Coverage (see above):

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. The prescription drug coverage offered by the Group Health 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 15 through December 7. 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 current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health Plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 through the Group Health Plan 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 19 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 your Plan Administrator (identified at the beginning of this section). You will receive this notice each year and again if this coverage through your company 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 **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 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 U.S. Social Security on the web at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice showing the Advantage PPO, Choice HDHP, Traditional PPO, and Value HDHP Plans are considered Creditable Coverage. 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).

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of- pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in- network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post- stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost- sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may not ask you to give up your protections **not** to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of- network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, or for more information about your rights under Federal law, contact the Center for Medicare & Medicaid Services at **https://www.cms.gov/nosurprises/consumers**. The federal phone number for information and complaints is: 1-800-985-3059

In addition to federal law, you may have protections available to you through state law. If state law protection is available, contact information will be included on your Explanation of Benefits (EOB) for any applicable services.

WELLNESS PROGRAM PRIVACY NOTICE

Preventive Care Incentive

Your employer offers a voluntary wellness program available to all employees enrolled in the company-sponsored health plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program you will be invited to validate completion of your annual well-adult physical. You are not required to participate in the program or complete a medical exam. However, only employees who choose to participate may qualify for an incentive as outlined in the wellness program portion of your benefit guide.

Additional incentives may be available for employees who participate in certain health-related activities. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting **openenrollment@taiamerica.com**.

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all enrolled employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact **openenrollment@taiamerica.com** and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you considering your health status.

The information collected by the wellness program will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You are encouraged to share your results or concerns with your own doctor.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and your employer may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the Hylant data analytics partner to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. Notwithstanding these precautions, you should be aware that regardless of the safeguards in place, there is always a risk that your data could be used or disclosed other than as intended. If you are concerned about sharing your medical information through the wellness program, you can always undergo a screening directly with your physician, or you can forgo any exam entirely. It's important to balance the health benefits of regular healthcare screenings though against these privacy risks.

You may not be discriminated against in employment because of the medical information you provide as a participant in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your plan administrator.

NOTICE OF RESCISSION COVERAGE

Under Health Care Reform, your coverage may be rescinded (i.e., retroactively revoked) due to fraud or intentional misrepresentation regarding health benefits or due to failure to pay premiums. A 30-day advance notice will be provided before coverage can be rescinded.

SUMMARY OF BENEFITS & COVERAGE (SBC)

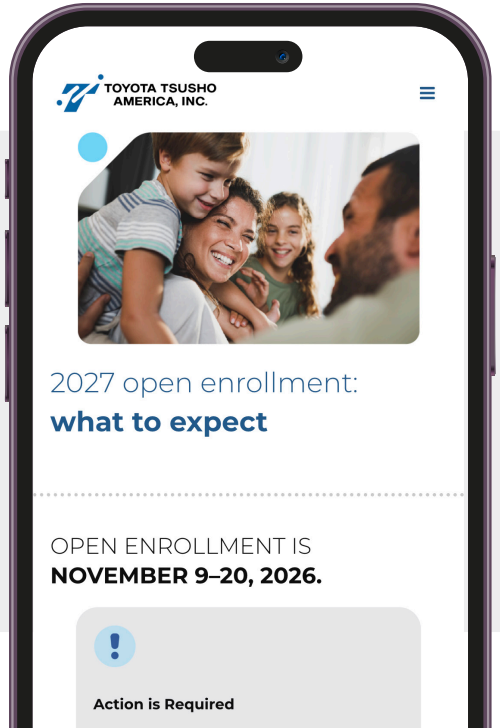
As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

The Summary of Benefits & Coverage (SBC) is a document intended to help people understand their health coverage and compare health plans when shopping for coverage. The federal government requires all healthcare insurers and group healthcare sponsors to provide this document to plan participants.

SBCs will be created for each medical plan offered. Group health plan sponsors must provide a copy of the SBC to each employee eligible for coverage under the plan. The SBC includes:

- A summary of the services not covered by the plan
- A glossary of terms commonly used in health insurance
- The copays and/or deductibles required by the plan, but not the premium
- Information about members' rights to continue coverage
- Information about members' appeal rights
- Examples of how the plan will pay for certain services

The SBCs are available electronically on carrier websites. A paper copy is also available, free of charge, by contacting your Plan Administrator (identified at the beginning of this section).



Explore Employee Benefit options in one centralized hub 24/7!

Scan the QR code to easily access benefit plan details and resources available to you and your family. The Benefits website combines everything you need to make an informed decision including Open Enrollment Information & Important Dates, Educational Video Resources, Direct Links to our Benefit Partners, as well as Important Plan Documents.

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your **benefits.**
your **well-being.**
your **choice.**

This Benefits guide is intended as a high level overview and is for informational purposes only. The plan documents, contribution schedules, insurance certificates, and policies will serve as the governing documents to determine plan eligibility, benefits, and payments. In the case of conflict between the information in this guide and the official plan documents, the plan documents will always govern.