

Benefits Summary

Hamra Enterprises

2027

HAMRA
ENTERPRISES



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Eligibility





2027 | Eligibility for Full-Time Employees

When Do Benefits Start?

The benefits plan year starts on January 1, 2027 and ends on December 31, 2027.

Eligibility Requirements

If you are a full-time employee (working 30 or more hours per week), you are eligible to enroll in the benefits described in this summary. Qualified dependents eligible for selected benefit coverage include:

- Your legal spouse
  - However, if your spouse is eligible for coverage through their employer, your spouse is not eligible to participate in the Hamra coverage.
- Your child(ren) up to age 26
- Your incapacitated child(ren) who are unmarried, incapable of self-support due to a mental or physical disability, and are federal tax dependents.

Eligibility for part-time employees is reviewed on the last day of the month of their first year anniversary of employment.

Please Note: If two employees of Hamra Enterprises and/or its affiliates are married and at least one employee is eligible for insurance coverage, they may be on one insurance plan, either Employee and Spouse, or Family.

New Hire Waiting Period

All benefit-eligible employees electing coverage will be effective 30 days from date of hire.

Qualifying Life Events

Outside of open enrollment you would need to have a qualifying event to add, drop, or make changes to your benefits. Employees are responsible for notifying Human Resources within 30 days of the qualifying life event to make a change to benefit elections. Qualifying event changes are effective on the date on which the event occurred.

Some examples of qualifying events are:

- Losing existing health coverage
- Losing eligibility for Medicare, Medicaid, or Children's Health Insurance Program (CHIP)
- Turning 26 and losing coverage through a parent's plan
- Getting married or divorced
- Having a baby or adopting a child
- Death in the family

Understanding Health Care Terms

To help you manage your health plan, see the following for definitions of common terms:

In-Network vs. Out-of-Network Coverage
An in-network provider is contracted with the health insurance company to provide services to plan members for specific pre-negotiated rates. An out-of-network provider is not contracted with the health insurance plan. The plan that you choose will dictate the type of coverage you have, and the rate you pay. Typically, if you visit a physician or other provider within the network, the amount you will be responsible for paying will be less than if you go to an out-of-network provider.

Calendar Year Deductible
This is the amount you have to pay in a calendar year before the plan begins to pay out. Note that not all services require you to meet the deductible. For example, there are plans that require you to pay up to the full deductible before Primary Care Physician, Specialist, or other office visits will be covered by insurance. Plans may have an individual and family deductible amounts. Copayments do not count towards meeting the deductible unless otherwise noted.

Preventive Care
Most health plans cover a series of preventive services, like screenings and shots, at no cost to you when administered by an in-network provider. These may include services like blood pressure screening, cholesterol screening, HIV screening, immunizations, counseling, and flu shots.

Copay
A copay is a fixed amount you pay for a health care service, usually when you receive the service. The amount can vary by the type of service. You may also have a copay when you get a prescription filled.

Coinsurance
Once you've met your deductible, you and your health plan share the cost of covered health care services. The coinsurance is your share of the costs, usually a percent of the cost of care. Your plan details show what portion of the cost you'll pay.

Out-of-Pocket Limit
This is the most you have to pay out your own pocket each year for covered services. This amount may include your deductible and your percentage of the costs, depending on your plan. There are plans that still have you pay a copay at the time of service.

Prescription Coverage
These are the amounts you pay for prescriptions used to treat illness. Prescriptions are divided into three tiers. The copay amount depends on the type of medication that you need. Note that some plans require you to meet the deductible before you can pay a copay for your prescription medication.

Premium
The premium is what you pay to have coverage under the plan. It's the money that comes out of your bi-weekly paycheck.

Insurance Benefits



Medical Insurance | Anthem

HDHP with HSA Plan

The plan is comprised of two components:
1. High Deductible Health Plan (HDHP)
2. Health Savings Account (HSA)

The HDHP is a high deductible health plan that provides health care benefits after the deductible has been met. All medical services, with the exception of preventive care, are paid for by you at 100%, less carrier discounts, prior to meeting your entire annual deductible. This includes routine office visits, procedures, lab work, prescription drugs, etc.

The HSA is a bank account paired with your HDHP allowing you to set aside money on a tax-free basis to pay your out-of-pocket qualified medical, dental, and vision expenses throughout the year or in the future. You own the money in your HSA account and it is yours to keep – even when you change plans or retire. The funds roll over from year to year to be used when you really need them.

If you enroll in the HSA plan, Hamra Enterprises will contribute **$850 for Employee Only coverage, $1,300 for Employee + Spouse coverage, $1,500 for Employee + Child(ren) coverage or $1,800 for Family coverage** to your HSA to help pay for qualified medical expenses now and in the future.

PPO Plan

A PPO plan offers the freedom to receive care from any in- or out-of-network doctor, specialist or hospital without a referral. You have a deductible to meet and once the deductible is met, coinsurance (the cost share between you and the carrier) kicks in. The types of medical services that accumulate towards your deductible are inpatient hospital stays, outpatient surgeries, labs (blood work) and x-rays (MRIs, PET scans, CT scans, etc.). Generally, if you go to the doctor, see a specialist, utilize the ER or take a prescription drug, you'll pay a copay for those specific services. Copays do not count towards your deductible but they do accumulate towards your overall out-of-pocket maximum.

Medical Plans | Anthem

	HDHP 1		HDHP 2		PPO	
	Anthem Network	Out-of-Network	Anthem Network	Out-of-Network	Anthem Network	Out-of-Network
Deductible						
Individual	**$3,500**	$6,000	**$5,000**	$10,000	**$6,350**	$12,700
Family	**$7,000**	$12,000	**$10,000**	$20,000	**$12,700**	$25,400
Coinsurance						
	90%	70%	**90%**	70%	**70%**	50%
Out-of-Pocket Max						
Individual	**$4,500**	$12,000	**$6,000**	$20,000	**$8,000**	$14,700
Family	**$9,000**	$24,000	**$12,000**	$40,000	**$16,000**	$29,400
Physician Services						
Preventive Care	**100%**	70%	**100%**	70%	**100%**	70%
Physician Visit	**Deductible then 90%**	Deductible then 70%	**Deductible then 90%**	Deductible then 70%	**$50 copay**	Deductible then 50%
Specialist Visit	**Deductible then 90%**	Deductible then 70%	**Deductible then 90%**	Deductible then 70%	**$70 copay**	Deductible then 50%
Diagnostic Test	**Deductible then 90%**	Deductible then 70%	**Deductible then 90%**	Deductible then 70%	**Deductible then 70%**	Deductible then 50%
Imaging	**Deductible then 90%**	Deductible then 70%	**Deductible then 90%**	Deductible then 70%	**Deductible then 70%**	Deductible then 50%
Inpatient Hospital	**Deductible then 90%**	Deductible then 70%	**Deductible then 90%**	Deductible then 70%	**Deductible then 70%**	Deductible then 50%
Emergency Room	**Deductible then 90%**	Deductible then 90%	**Deductible then 90%**	Deductible then 90%	**$500 copay**	$500 copay
Urgent Care	**Deductible then 90%**	Deductible then 70%	**Deductible then 90%**	Deductible then 70%	**$75 copay**	Deductible then 50%
Pharmacy Generic/Preferred Brand/Non-Preferred Brand/Specialty						
Retail (30 Days)	**Deductible then 90%**	Not covered	**Deductible then 90%**	Not covered	**$100 deductible then copays $40/$80/$120/70%**	Not covered
Mail Order (90 Days)	**Deductible then 90%**	Not covered	**Deductible then 90%**	Not covered	**$100 deductible then copays $40/$80/$120/70%**	Not covered
Rates	**You Pay *(Bi-Weekly)***		**You Pay *(Bi-Weekly)***		**You Pay *(Bi-Weekly)***	
Employee Only	$146.56		$69.93		$56.00	
Employee + Spouse	$271.05		$154.53		$121.94	
Employee + Child(ren)	$269.19		$153.25		$120.06	
Family	$414.99		$236.10		$175.67	

Anthem



Your health plan now includes a yearly eye exam at no added cost

Regular eye exams provide a unique opportunity to find and detect serious health conditions like high blood pressure, heart disease, and diabetes, so we are including a comprehensive eye exam in your medical coverage. Discovering these conditions early on when they are easier to treat can help keep you healthier and lower your healthcare costs.

This eye exam is included at no extra cost through your medical plan.

Expanded benefits to cover your whole health

175,000 people were identified with a high-risk health condition through an Anthem vision claim in 2021.*

This eye exam is offered through Anthem's Blue View Vision network

- Dedicated vision providers with proven expertise
- More than 40,000 eye doctors to choose from
- 30,000+ locations nationwide, including independent optometrists and ophthalmologists, and vision retail stores

Details of your new benefit

Your new eye exam is all-inclusive with dilation and refraction. The benefit can be used once during each calendar or plan year. This plan also provides discounts on glasses and contacts at in-network eye care providers.

For more information, refer to your health plan benefit information or contact your human resources department. Or visit **anthem.com** or download the Sydney℠ Health mobile app for benefit information when and where you need it.

* Anthem internal data, 2022.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2020-2022.

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Virtual Visits | Anthem

Health Care Designed For Your Busy Life

In the rush of everyday life, it's easy to put off important health care until there's a problem. The Virtual First approach to care offers a way to fit the care you need into your schedule, rather than building your schedule around in-person visits.

The Virtual First Experience

Through the award-winning Sydney[SM] Health app, you have access to convenient virtual care options, from routine wellness care to chronic-condition management. You have 24/7 access to health care professionals through chat or a video visit, with shorter wait times than in-person urgent care. The doctors and other health care professionals who take care of you online are from a high-quality, carefully curated network. They can order prescriptions, approve refills, check your health, make a plan for your care, and follow up on previous virtual care, all through your mobile device at little or no additional cost. Shared medical records allow providers to access a fuller view of your health, and make it easy to share with the health care professionals you see in person, as well.

Virtual Care

With virtual wellness, condition management, and urgent care visits, you don't need to miss a beat. Core services include preventive care, lab work, new prescriptions and refills, specialist referrals, care management, and treatment of more than 300 common conditions.

Sydney App (Decision Support and Cost-Comparison Tools)

When you need a health care procedure, the Sydney Health app provides access to cost-comparison resources on more than 700 different procedures, along with guidance to direct you to higher-quality, lower-cost care that suits your needs.

PPO Plan Covers:

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care and medical services for urgent/acute care	$0 copay per visit medical deductible does not apply
Mental Health & Substance Use Disorder Services	$0 copay per visit medical deductible does not apply
Specialist Care	$70 copay per visit medical deductible does not apply

HDHP Plan Covers:

Visits with Virtual Care-Only Providers	Cost through our mobile app and website
Primary Care and medical services for urgent/acute care	$0 copay per visit medical deductible does not apply
Mental Health & Substance Use Disorder Services	$0 copay per visit medical deductible does not apply
Specialist Care	$70 copay per visit medical deductible does not apply



Download the Sydney Health app.

Scan this code with the camera on your smartphone to access Sydney Health.

Anthem

Health Savings Account (HSA) | Fidelity

You're eligible for a health savings account if:

- You are covered by a qualified high deductible health plan (HDHP)
- You are not covered by any other medical coverage that is not considered a qualified HDHP
- You are not enrolled in Medicare (Part A included)
- You are not claimed as a dependent on someone's tax return
- You are not enrolled in a Medical Flexible Spending Account (your own or your spouse's)

Advantages to having an HSA

- There's a triple tax savings benefit as contributions are not taxed going into the account, while they sit there earning interest or when they're taken out for a qualified medical expense.
- Unused funds roll over each year with no maximum on how much you can save and accumulate over time
- The account is portable so you never have to worry about losing the money in the account should you change between plans, retire or even seek employment elsewhere
- Your HSA can be viewed as a second means of savings for your retirement
- You control your health care spending and choose when to use your HSA dollars or when to save them
- You become a more informed participant in your health care and health care spending

Steps to using your HSA

- Go to the doctor and present your carrier ID
- Your doctor submits your medical services to the carrier to be discounted
- Your carrier adjusts the pricing to reflect the network discounted amount for your services
- The carrier generates an Explanation of Benefits (EOB) and sends it to you
- By now you've received an invoice from your doctor - make sure the EOB and invoice match
- Pay your doctor directly with pre-tax dollars from your HSA or post-tax dollars from your pocket if funds are not available

Using your HSA on qualified expenses

You can use the money in your HSA to pay for qualified medical, dental and vision expenses permitted under federal tax law.

2027 HSA Contributions

Tier	Company Contribution	Maximum Employee Contribution	Total Contribution Limit
Employee	$850	$3,650	$4,500
Employee + Spouse	$1,300	$7,700	$9,000
Employee + Child(ren)	$1,500	$7,500	$9,000
Family	$1,800	$7,200	$9,000
Catch-Up (Age 55+)	$1,000		

The tax-preferred status of your HSA contributions depends on a number of factors. Residents of California and New Jersey are taxed on HSA contributions at the state level. State tax laws can change periodically, so you should consult with a tax advisor to confirm the tax treatment of HSA contributions in your state.

Care Navigation | Quantum Health

Whatever it takes! Quantum Health are problem-solving, frustration-fighting people on a mission to make your health care simpler. Think of Quantum Health Care Coordinators as your personal team of nurses, benefits experts and claims specialists who will do all they can to support your unique health care needs. Each time you contact them, you'll talk to a real person who understands your benefits and knows how to navigate the health care system.

Reasons to Call Quantum Health

- Answers to claims, billing and benefits questions
- Contact providers to coordinate your treatment
- Review your care options
- Find in-network providers
- Replace ID cards
- Verify coverage and get prior approval if needed

Your Quantum Health Care Coordinators are the experts who know all about your benefits. We're here to help you understand, access, and answer questions about your benefits.

- Confused by spending accounts? They can explain.
- Need help understanding your dental and vision coverage? They understand.
- Looking for the right benefit for your situation? They can help.
- Forgot which benefits you signed up for during Open Enrollment? They know.
- Can't figure out who to contact about a specific benefit? Call them.

Contact your Care Coordinator by one of the three ways to connect:

- Call (866) 790-4406
- Visit Hamra.Quantum-Health.com
- Download the mobile app by scanning the QR code

Mail Order Pharmacy Program | Rx 'n Go

What is Rx 'n Go?

- $0 copay prescriptions shipped directly to you
- Mail order pharmacy program that supplies medications to you and eligible dependents
- Doctors can phone, fax, or Escribe the prescription to the pharmacy (Transition Pharmacy, PA)

Sign up in 3 easy steps in under 5 minutes

1



Check that your medication is covered at **rxngo.com/medications**

Employer: Hamra

2

Register an online profile by scanning the QR code below, visiting **rxngo.com**, or by calling **(888) 697-9646**

3



Have your doctor submit the prescription to the Rx 'n Go pharmacy, **Transition Pharmacy (PA)**:
- **Phone:** (888) 697-9646
- **Fax:** (888) 697-0646
- **Escribe:** Transition Pharmacy (PA)
- **NPI #:** 1336325265

Questions?
Generics: *888-697-9646*
rxngo@transitionrx.com

Questions?
Beyond: *833-390-1043*
support@rxngobeyond.com

THERAPEUTIC CATEGORIES COVERED

- Diabetes
- Hypertension
- Cholesterol
- Emotional Health
- Psoriasis
- Cardiac
- Thyroid
- And more!

After registering, your medication(s) will arrive in the mail in 14 business days. It's that easy!

(1) If you would like Rx 'n Go to transfer an existing prescription with refills, please include that detail in the checkout cart on the self-service portal.

(2) Branded medications must have a 1st fill of 30 days through insurance before using the Rx 'n Go Beyond.

Rx 'n Go
Care. Delivered.

Dental Insurance | Guardian

Dental Preferred Provider Organization (DPPO)
This dental plan allows the flexibility to select any dentist in-network or out-of-network, but if you stay within the Dental Guard Preferred network, you'll pay less.

Dental coverage focuses on preventive and diagnostic procedures in an effort to avoid more expensive services associated with dental disease and surgery. The type of service or procedure received determines the amount the carrier will cover for each visit. Each type of service fits into a class of services according to complexity and cost.

	Dental PPO	
	In-Network	Out-of-Network
Network	Dental Guard Preferred	
Individual Deductible (Family = 3x)	$50	$50
Preventive Coinsurance	100%	100%
Basic Coinsurance	80%	80%
Major Coinsurance	50%	50%
Annual Maximum	$2,000	$2,000
Orthodontia Coinsurance	50%	50%
Orthodontia Lifetime Maximum	$2,000	$2,000
Rates	**You Pay *(Bi-Weekly)***	
Employee	$4.54	
Employee + Spouse	$11.34	
Employee + Child(ren)	$9.07	
Family	$15.87	

Vision Insurance | VSP

Vision insurance helps offset the cost of routine eye exams and helps pay for vision correction eyewear like eyeglasses and contacts by an eye-care provider.

You're eligible for an eye exam and lenses or contact lenses every 12 months, and frames every 24 months. Out-of-network providers will provide an allowance towards your vision services.

	Frequency	In-Network	Out-of-Network
Network Name	**VSP Choice**		
Eye Exam	Every 12 months	$10 copay	$45 allowance
Lenses	Every 12 months*	$25 copay	Allowance varies
Frames	Every 24 months*	$175 allowance + 20% discount above allowance	$70 max allowance
Elective Contacts	Every 12 months**	$175 allowance	$105 max allowance

*Vision benefit frequencies are based on the date of service within the policy year
**You cannot get contacts and glasses in the same calendar year

Rates	You Pay *(Bi-Weekly)*
Employee	$2.43
Employee + Spouse	$4.86
Employee + Child(ren)	$5.20
Family	$8.31

VSP has a series of perks to be aware of for being an enrolled member on the plan:

Extra $20 to Spend - Maximize your benefits with an extra $20 to spend*, on top of your allowance, on any frame from a wide selection of featured frame brands. Simply select a featured frame brand in any VSP doctor's office and the $20 will automatically be applied to your purchase.

TruHearing - As a VSP member, savings on digital hearing aids and replacement batteries for you and your extended family through TruHearing* are available

**Check your benefits to see if this offer applies*

Basic Life/AD&D Insurance | Mutual of Omaha

Life insurance provides a financial benefit to your designated beneficiaries if you pass away, helping to cover expenses like funeral costs and living expenses. Accidental Death & Dismemberment (AD&D) insurance pays benefits if you die or lose a limb or sight due to an accident. Benefits may reduce as you age. See your plan documents for more detail. This benefit is 100% company-paid.

This benefit is available only to employees enrolled in Medical coverage.

Basic Life / Accidental Death & Dismemberment
$20,000 per employee - Life $20,000 per employee - AD&D

Voluntary Life/AD&D Insurance | Mutual of Omaha

Voluntary life/AD&D allows you to purchase additional life and AD&D coverage for yourself and your dependents. Your age and the amount of insurance you elect determine the premium you'll pay. Costs will increase as you age, and benefits may be reduced. See your plan documents for more detail and to determine if Evidence of Insurability applies.

Annual Benefit Amount Increase

If you enroll in at least the minimum amount of coverage during your initial enrollment, you have the ability to enroll for additional coverage at your next enrollment by up to $10,000, provided the total amount of insurance does not exceed your maximum benefit amount. This feature allows you to secure additional life insurance protection in the event your needs change (ex. you get married or have a child). Amounts over the Guaranteed Issue will require evidence of Insurability (proof of good health).

	Employee	Spouse	Children
Coverage Increments	$10,000	$5,000	$1,000
Maximum Benefit Amount	$200,000	$50,000	$10,000
Guaranteed Issue Amount (New Hires Only)	$200,000	$50,000	$10,000

Disability Insurance | Mutual of Omaha

Voluntary Short-Term Disability
If you become ill or suffer a non-work-related injury that prevents you from working, short-term disability insurance provides income replacement.

Voluntary Long-Term Disability
Long-term disability insurance is a type of income protection that is designed to cover serious injuries and illnesses that keep you out of work for an extended amount of time.

Disability Coverage	Voluntary Short-Term Class 1	Voluntary Short-Term Class 2
Waiting Period	Begins on the 15th day of continuous injury or illness	Begins on the 29th day of continuous injury or illness
Benefit Amount	60% of weekly earnings	60% of weekly earnings
Maximum Benefits	Up to $1,000 per week	Up to $1,000 per week
Length of Payment Period	11 weeks	9 weeks
Premium Contribution	Employee-Paid	Employee-Paid
Disability Coverage	**Voluntary Long-Term Class 1**	**Voluntary Long-Term Class 2**
Waiting Period	Begins on the 90th day of continuous injury or illness	Begins on the 90th day of continuous injury or illness
Benefit Amount	60% of weekly earnings	60% of weekly earnings
Maximum Benefits	Up to $2,500 per month	Up to $5,000 per month
Length of Payment Period	5 years	5 years
Premium Contribution	Employee-Paid	Employee-Paid

Accident Coverage | Mutual of Omaha

Voluntary Accident Insurance

Accident Insurance coverage provides you with payment for a covered accident. It also pays if you undergo testing, medical services, or treatment for any one of the covered events as defined in your group certificate. This includes hospitalization resulting from an accident and accidental dismemberment. Payments are made directly to you as you see fit. They can be used to help pay for medical plan deductibles and copays (if applicable), out-of-network treatments, your family's everyday living expenses or whatever else you need while recuperating from an accident.

Plan details:

- $50 reimbursement for completing a health screening throughout the year.
- Employees pay 100% of the insurance premium and all policies are portable.
- Benefits available for Employee, Spouse and/or Child(ren). You must be enrolled in employee coverage in order to cover a spouse and/or child(ren).

Benefit Type	Benefit Amount You're Paid
Injuries	
Burns	Amount Varies
Dislocations	Amount Varies
Fractures	Amount Varies
Medical Services and Treatments	
Emergency Room	$300
Diagnostic Exam	$100
Ambulance	$300 by ground; $1,500 by air
Hospital Coverage (Accident)	
Standard Hospital Admission	$1,500
ICU Admission	$1,500
Hospital Confinement	$300 per day
ICU Confinement	$600 per day

Critical Illness | Mutual of Omaha

Voluntary Critical Illness Insurance

A serious health event can come with serious costs. Critical Illness Protection helps with treatment costs when you need it most, so you can focus less on your wallet and more on getting better. Critical illness insurance can help safeguard your finances by providing you with a lump-sum payment when your family needs it most. The payment you receive is yours to spend as you see fit, in addition to any other insurance you may have. If you meet the policy requirements, Critical Illness insurance will provide you with a lump-sum payment upon diagnosis of many conditions. See your plan highlight sheet for specific coverage details.

Plan details:

- $50 reimbursement for completing a health screening throughout the year.
- Employees pay 100% of the insurance premium and all policies are portable.
- Benefits available for Employee, Spouse and/or Child(ren). You must be enrolled in Employee coverage in order to cover Spouse and/or Child(ren).

Eligible Individual	Initial Benefit
Employee	$10,000 or $20,000
Spouse	100% of employee's benefit
Dependent (Children)	25% of employee's benefit

Covered Conditions	Initial Benefit
Full Benefit Cancer	100% of initial benefit
Partial Benefit Cancer	25% of initial benefit
Heart Attack	100% of initial benefit
Stroke	100% of initial benefit
Coronary Artery Bypass Graft	50% of initial benefit
Kidney Failure	100% of initial benefit
Major Organ Transplant Benefit	100% of initial benefit

Hospital Indemnity | Mutual of Omaha

How it Works: This policy pays a specified amount when an insured person is admitted to a hospital, and through a series of optional riders, can provide benefits for a range of other medical situations. There is no coinsurance, copays, waiting period, or deductibles.

Coverage is available to employees and their families. Employees pay 100% of the premium.

Benefit	Hospital	ICU
Admission (per accident/sickness)	$1,000	$2,000
Confinement (per day to a max of 30 days per calendar year)	$200	$400

Other Benefits



Employee Assistance Program | Mutual of Omaha

The EAP offers caring and professional assistance for a broad range of concerns including stress management, depression and anxiety, relationship or family conflicts, workplace conflicts, legal or financial difficulties, and drug or alcohol abuse. Services are confidential - neither your employer nor co-workers have knowledge of your request for help. EAP services are available 24 hours a day, seven days a week for you and your eligible dependents. There is no cost; the service is available whenever you need it.

Possible reasons to call can include:

- Stress and depression
- Life transitions
- Grief and loss
- Parenting and child care
- *And more!*

The EAP is there for when you need it. Need some more specialized face-to-face assistance? The EAP offers up to 6 face-to-face visits with trained counselors for each issue you may have. If you are not interested in face-to-face visits, please call (800) 316-2796 or visit www.mutualofomaha.com/eap.



Personalized Pain Care | Hinge Health

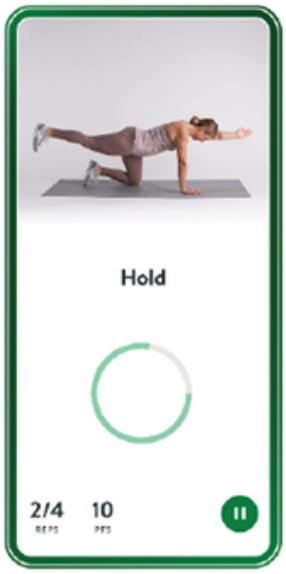
Hinge Health is available to all employees and their families enrolled in medical coverage.

Personalized pain care that gets you moving

Relieve joint and muscle pain with personalized exercise therapy at no cost to you. On average, participants reduce their pain by 68%.[1]

- **Virtual sessions anytime, anywhere**
- **Unlimited 1-on-1 health coaching**
- **Motion-tracking technology for instant form correction**

To learn more and apply, scan the QR code or visit
hinge.health/enroll-today
Questions? Call (855) 902-2777



Diabetes Management | Omada

Omada is a virtual care program for people who want to manage diabetes and improve their overall health and well-being.

The program is no cost to you and fully covered as part of your health benefits—all you must do is apply!

When you engage with Omada, you will receive:
· Support from a certified coach and specialist who offers personalized guidance about nutrition, exercise, and self-care.
· Access to online peer communities to share successes
· A welcome kit with smart devices to help monitor progress and show results; they are yours to keep*

- Two continuous glucose monitor sensors (CGMs)*
- Blood glucose meter
- Ongoing supply of test strips and lancets
- Smart scale

Claim your benefit at omadahealth.com/hamra
*See plan details for additional information

HERO Fund

The HERO Fund is funded by employees for employees. Hamra Enterprises matches employee donations dollar for dollar. The funds raised provide grants to Hamra employees for the following purposes:

Emergency Assistance Grants:
(When an unexpected, one-time emergency causes financial hardship)

- Emergency Travel
- Funeral Expenses
- Medical Out of Work
- Transitional Housing (In case of physical and sexual abuse)
- Total Loss of Home
- Relocation Assistance/Eviction Prevention
- Loss or Purchase of Medically Necessary Equipment
- Natural Disaster

Other Grant Assistance:

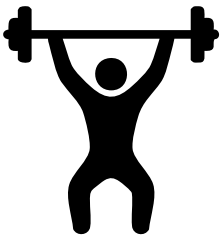
- Tuition Reimbursement (for employee and/or employee's dependent child)
- First-time Homebuyer Down Payment Assistance
- Debt Management Program (DMP) grants (towards monthly fees if you participate in GreenPath's DMP)

For more information or to contribute (and get cool swag) visit: hamraheroes.org or scan the QR code above.

Wellness Portal

Visit the Hamra Enterprises "Join Us" website to learn more about our Wellness Portal. We are proud to offer a wide array of health and wellness resources to our employees. From diabetes management to prevention education, Hamra Enterprises supports your goals and wants to focus on how well-being impacts you as a whole by helping you achieve your goals. This is available for all employees.

Visit: https://hamraenterprises.com/medical-benefits/ and click on the WELLNESS PORTAL BUTTON.



Benefits/Discounts | LifeMart through ADP

We've made it easy for you to access thousands of amazing discounts, cashback offers, discounted gift cards, and purchase additional voluntary benefits all in one place! Enjoy savings on travel, car buying, electronics and more! Enjoy free discounts, cashback and perks on thousands of brands you love in a variety of categories:

- Pet Insurance
- Travel
- Auto
- Electronics
- Magazines
- Home Services/Tax Prep
- Restaurants
- Health and Wellness
- Beauty and Spa
- Child Care
- Flowers and Gifts

Go to the ADP Portal, click on the rotating LifeMart banner or select Myself > Benefits > Employee Discounts > LifeMart

Questions? Email adpwfnhelpdesk@lifecare.com

**Please note that products purchased on LifeMart will be 100% paid for by the employee on a post-tax basis and billed directly to the employee using the payment option of their choice. These benefits are individual policies and written outside of Hamra Enterprises, meaning even if you leave the company these products are yours to keep.*



Save Money with Hamra's Medical Plans

Preventive/Wellness Exams Covered at 100%.
Preventive care is equal to one physical exam per year per enrolled member. Females get an annual well-woman exam covered at 100% in addition to their annual exam. No deductible expenses apply—the exam is completely no cost to you, provided it's coded as preventive.

Prescription Drugs
Ask your doctor if there's a generic version of the medication they're prescribing or you're already taking. Take advantage of the Generic Prescription Savings Programs at major retailers. Ask about free samples from your doctor and/or manufacturer rebates.

High Cost Scans, X-Rays & Tests
MRI, PET scans, CT scans, etc. are nearly 2/3 less costly at free-standing, in-network imaging centers than at hospitals. Finding an in-network, free-standing imaging center can save you a substantial amount of money.

Accessing Medical Care
The emergency room is a costly experience for issues that aren't true emergencies. There are alternatives that can offer you quick care at a much more affordable cost. The key is finding these alternatives today when you're happy and healthy. You can also utilize Quantum Health when deciding what care option suits your situation.

Doctor's office: for symptoms that aren't extreme, call and let them know your symptoms require immediate attention

Convenient Care Clinics: use when you don't have a primary doctor or can't get an appointment. Good for fever, sore throat, strep throat, coughs, congestion, sports physicals, UTIs, etc.

Urgent Care (UC): less costly than the ER; can treat sprains, strains, minor breaks, mild asthma, minor infections, rashes, small cuts, burns, etc.



Carrier Information

Quantum	
Website	Hamra.Quantum-Health.com
Phone Number	(866) 790-4406
Plans with Anthem	Medical PPO, HDHP 1, HDHP 2
Policy Number	TBD

VSP	
Website	www.vsp.com
Phone Number	(800) 877-7195
Plans with VSP	Vision
Network	VSP Choice Network
Policy Number	30093878

Guardian	
Website	www.guardianlife.com
Phone Number	(800) 542-7846
Plan	Dental
Network	Dental Guard Preferred

Fidelity	
Website	www.netbenefits.com
Phone Number	(800) 544-3716
Plans with Fidelity	Health Savings Account (HSA)

Rx 'n Go	
Website	rxngo.com
Phone Number	(888) 697-9646

Mutual of Omaha	
Website	www.mybenefits.mutualofomaha.com
Phone Number	(800) 228-7104
Plans with Mutual of Omaha	Basic Life & AD&D Voluntary Life & AD&D Short-Term Disability Long-Term Disability Accident Critical Illness Hospital Indemnity Employee Assistance Program (EAP)
Website for EAP	www.mutualofomaha.com/eap
Phone Number for EAP	(800) 316-2796
Policy Number	G000BNR4

Omada (Diabetes Health Program)	
Website	www.omadahealth.com/hamra

Personalized Pain Care	
Website	www.hingehealth.com
Phone Number	(855) 902-2777

Human Resources Contact Information	
Email Address	benefits@teamhamra.com



NOTE: This Benefits Summary provides a brief overview of your employer's benefit programs and is for informational purposes only. For exact terms, please review the employee handbook and the official carrier plan documents. If there is any conflict between this summary and those governing documents, the governing documents will control.

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Hamra Management Company, L.L.C.
Health and Welfare
Benefits Annual Notice Packet

For the 2027 Plan Year.

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights

Should you have any questions regarding the content of the notices, please contact us Maryjo Kiser or Human Resources.

Medicare Part D
Creditable Coverage Notice

Important Notice from Hamra Management Company, L.L.C.
About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan while enrolled in Hamra Management Company, L.L.C. coverage as an active employee, please note that your Hamra Management Company, L.L.C. coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Hamra Management Company, L.L.C. coverage as a former employee.

You may also choose to drop your Hamra Management Company, L.L.C. coverage. If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Hamra Management Company, L.L.C. 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 Hamra Management Company, L.L.C. 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 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).

Date: 1/1/2027
Name of Entity/Sender: Hamra Management Company, L.L.C.
Contact-Position/Office: Human Resources or Maryjo Kiser

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Hamra Management Company, L.L.C.group health 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).

In addition, if you have a new dependent as a result of 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.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact Human Resources or Maryjo Kiser.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Hamra Management Company, L.L.C. sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Hamra Management Company, L.L.C., the Plan, and your legal rights regarding your protected health information, including certain substance use disorder (SUD) records covered by 42 CFR part 2 (Part 2), held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;

(2) the provision of health care to you; or

(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully insured group health plans offered by Hamra Management Company, L.L.C., you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Hamra Management Company, L.L.C. HIPAA Privacy Officer or Human Resources:

Effective Date

This Notice, as revised, is effective January 1, 2027.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;

- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories. Note: Any protected information we may use or disclose under this Notice may be shared again by the person or organization who receives it. Once your protected health information is shared with others, it may no longer be protected.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud &

abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information, including SUD treatment records, to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

SUD treatment records received from programs subject to 42 CFR part 2, or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on your written consent, or a court order after notice and an opportunity to be heard is provided to you or the holder of the record, as provided in 42 CFR part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or

(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;

(2) treating such person as your personal representative could endanger you; or

(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of SUD Part 2 treatment records, psychotherapy notes, and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period Hamra Management Company, L.L.C. has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format

if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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, 2026. 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: 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+)	**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	ILLINOIS - 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 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	**IOWA – Medicaid and CHIP (Hawki)**
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	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	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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	**MAINE – 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	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	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA - Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084

	Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid	NEVADA – Medicaid
Website: http://accessnebraska.ne.gov/ Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	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)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 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. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a 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. If you would like more information on WHCRA benefits, contact your plan administrator.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending

provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Model General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Health Equity

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

APPENDIX

- ☐ Medicare Part D Cross-Reference
- ☐ HIPAA Privacy Notice of Availability
- ☐ Surprise Billing Notice – "Your Rights and Protections Against Surprise Medical Bills"

Medicare Part D
Cross-Reference

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 2 for more details.

HIPAA Notice of Availability of
Notice of Privacy Practices

The Hamra Management Company, L.L.C. (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Maryjo Kiser or Human Resources.

Your Rights and Protections
Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not 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" describes 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 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 the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles 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 believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). 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 Employment-Based 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 9.12%[1] 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 9.12% of the employee's household income.[1,2]

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.

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[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] 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.

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.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

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, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your 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.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
5. Employer address		6. Employer phone number
7. City	8. State	9. ZIP code
10. Who can we contact about employee health coverage at this job?		
11. Phone number (if different from above)	12. Email address	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:

  All employees. Eligible employees are:

  ☐

  ☐ Some employees. Eligible employees are:

- With respect to dependents:

  ☐ We do offer coverage. Eligible dependents are:

  ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)