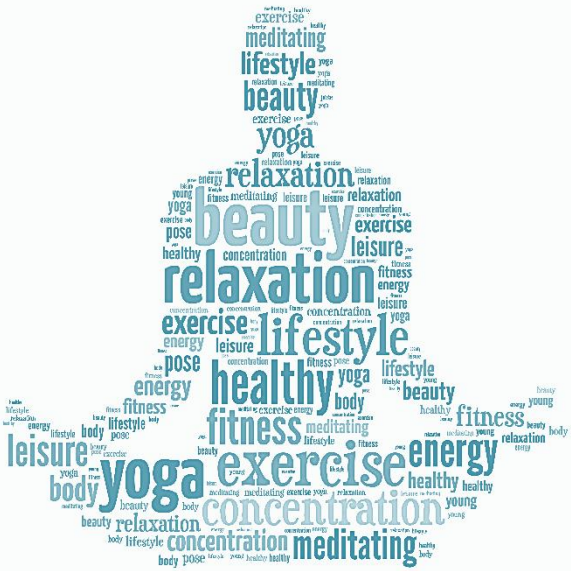
Caring for the WHOLE you…



Employee Benefits Guide

August 1, 2024 - July 31, 2025

Heluna Health

contents:

your *benefits* overview

WELCOME

Heluna Health
EMPOWERING POPULATION HEALTH INITIATIVES SINCE 1969

Welcome to the Heluna Health Employee Benefits Program!

As an employee of Heluna Health, you are a vital member of our team that is working across hundreds of initiatives to optimize the health of communities every day. You have been selected for your position because you not only have the skills needed to do the job, but also, we hope, are passionate about the mission of our organization.

Because we know how important you are to the organization as a whole, Heluna Health strives to keep our benefits and compensation plans comprehensive. Whether its medical, dental, vision or life insurance, we have handpicked a benefits package to do our very best to meet the needs of our diverse group of employees.

Heluna Health encourages everyone to proactively participate. We welcome feedback and suggestions at all levels of the organization. With everyone's help, we can continue to build healthy communities.

We are delighted that you have joined us, and we hope that you will have a successful and rewarding career with Heluna Health.

With Sincere Appreciation,

Blayne Cutler MD, PHD
President and CEO

INTRODUCTION & EMPLOYEE RESOURCES

FLEXIBLE SOLUTIONS FOR *your* BENEFITS NEEDS

We consider our employee benefits program to be one of our most important investments. Because we recognize the value our employees bring to our organization, we are committed to providing you with a complete benefits program as part of your total compensation.

This guide has been prepared to assist you in making informed decisions regarding your health insurance benefits and provide a brief overview of our overall employee benefits program.

Your Employee Support Center (ESC)

Supporting You With…

Benefits Inquiry
Claims Assistance
Eligibility
Materials/Forms Request
Plan Education
Provider Network Inquiries
Referral/Pre-authorization

Monday—Friday | 8am-4pm
855.670.2222
LosAngeles.ESC@ajg.com

Due to privacy regulations, our representatives will be required to obtain personal identifying information such as your full name, contact information, address, date of birth and in some cases SSN or Member ID#. **Please have this information ready.**

Some inquiries may require for you to provide HIPAA release in order for our advocates to work efficiently in resolving your issue with your provider or carrier.

GALLAGHER EMPLOYEE SUPPORT CENTER – YOUR ADVOCACY TEAM

Gallagher Employee Support Center (ESC) provides a dedicated team of specialized representatives ready to assist Heluna Health employees and dependents. Your ESC is available to you via a toll-free hotline Monday through Friday, 8a.m. to 4p.m. (PST) or via email inquiry.

The ESC team can support you as you utilize your employee health insurance benefits. The licensed representatives will work with both providers and the insurance companies on your behalf while protecting the privacy of your healthcare information.

SYNERGY ENROLLMENT – YOUR DECISION SUPPORT TEAM

Synergy's Enrollment Benefit Counselors are available Monday through Friday, 8am to 5pm (PST) to review your benefit options in greater detail, answer any benefits related questions, offer decision and enrollment support.

Scan the QR code to schedule your appointment and access Synergy's contact information

You can view detailed carriers' schedule of benefits for a more comprehensive outline, which can be located online through UKG:

- Login to UKG at **https://n21.ultipro.com**
- Click on "Myself"
- Click on "Benefits" then "Links"

ELIGIBILTY

EMPLOYEES

All full-time employees working at least 30 hours per week are eligible for group insurance benefits. Part-time employees working at least 20 hours per week may also be eligible for group insurance benefits if specifically provided by the funding source.

FAMILY MEMBERS

If you are an eligible employee, you may enroll the following dependents:

- Your spouse or domestic partner
- Your children up to age 26, including stepchildren, legally adopted children, children for whom you are the legal guardian, foster children, or children for whom you are legally responsible to provide health coverage under a Qualified Medical Child Support Order (QMCSO). Due to Affordable Care Act, your medical, dental, and vision plans cover dependents to age 26. However, for other plans, age limits may apply.
- Children are eligible for coverage regardless of their student status or whether they live with you.
- Children of children may not be covered unless they meet the plan's dependent eligibility rules.
- Disabled children over age 26 if unmarried, incapable of self-support, dependent on you for primary support and the disability occurred before the age of 26. Requirements for such coverage and documentation of disability depend on the insurance carrier. Please contact Benefits Department if you believe this applies to your family.

IF YOU COVER DEPENDENT(S)

You are required to complete and sign a **Dependent Attestation form**. If this step is not completed within 30 days of enrollment, your dependent coverage will be terminated from the medical, dental and vision plans. To meet health plan contract obligations, Heluna Health performs periodic reviews to verify family documentation (copy of marriage certificate, copy of certified birth certificate, copy of court order indicating legal guardianship or adoption, etc.) to verify eligibility.

Tax Implications of Domestic Partner Coverage:

If you cover your eligible registered domestic partner (or his or her children) under your Heluna Health sponsored benefits but your dependent(s) is not qualified as a tax dependent under Internal Revenue Code Section 152, be aware that in general, you must pay federal and state income and payroll taxes on the value of any benefit he or she receives under the plan. This value is called "imputed income."

Check with an accountant or tax attorney to determine whether your domestic partner qualifies as a tax dependent under Section 152 or is eligible for tax-favored health coverage.

things have changed...

Am I covered?

Examples of Qualifying Life Events:

Newly hired as full-time benefits-eligible

Change in work schedule for you or your spouse (part-time to full-time)

Change in employment for you, your spouse or dependent (i.e. your spouse loses their job and benefits)

Change in marital status

Change in dependents

Gaining other coverage through your spouse

Loss of other coverage for your dependent

Change in residence causing loss of coverage

Medicare or Medicaid entitlement for you, your spouse or dependent

Qualified Medical Child Support Order (OMCSO)

ENROLLMENT & CHANGES

BENEFITS AT A GLANCE

The following health and welfare benefit options are available for eligible employees:

Medical	Basic Life/AD&D & Supplemental Life/AD&D
Dental	Carve Out & Voluntary Short-Term Disability
Vision	Core & Buy-Up Long-Term Disability
Health Savings Accounts (HSA)	Voluntary Accident/Injury
Flexible Spending Accounts (FSAs)	Voluntary Critical Illness Identity
Employee Assistance Plan (EAP)	Theft & Cyber Security
403(b) Retirement	Voluntary Pet Insurance

WHEN COVERAGE BEGINS (NEWLY HIRED EMPLOYEES)

If eligible, your group insurance benefits will be effective the first day of the month after you complete your 30-day waiting period. Once you have completed your new hire waiting period, you have up to 31 days to enroll for benefits. If you do not enroll within that time period, you will be auto enrolled in the standard medical, dental and vision plans offered at zero cost to benefit eligible employees only.

MAKING CHANGES TO YOUR BENEFITS

Each year you have an opportunity to make changes without restrictions to your benefits and covered dependents during Open Enrollment. You must enroll by the Open Enrollment deadline for your benefits to be effective August 1st. All your elections will be locked in for the duration of the plan year (August 1st – July 31st).

CHANGING COVERAGE AFTER ENROLLMENT

You may change some of your elections during the year if you have a qualifying change in your status, provided the coverage change is consistent with your status change. You must notify and submit the appropriate forms to the Benefits Department within 30 days of experiencing a qualifying life event or you must wait until the next open enrollment period to make a change.

Providers may leave or join medical and dental plan networks at any time. If your provider leaves your plan's network during the year, this does NOT qualify as a change in status. As a result, you cannot change your medical or dental coverage.

UKG INSTRUCTIONS

INSTRUCTIONS ON HOW TO ENROLL IN YOUR NEW BENEFIT PLANS

Step 1: Login to UKG at **https://n21.ultipro.com**
Enter your **User Name** and **Password**. Click **Log In**. At the home page, click on **Myself** > **Life Events**
If you forgot your password, click "Forgot your password?" to reset it.
If you're locked out of UKG (UltiPro), email OnBoarding@helunahealth.org.

Step 2: Click on the link **I am a New Hire or Rehire** to go to the "About This Life Event" page to begin your enrollment process.

Step 3: **Note:** This Life Event is for existing employees who have had an employment status change that now makes them eligible for benefits.

Step 4: The **Life Event Effective Date** will automatically appear with your date of hire.

Step 5: Select a reason from the drop-down list by clicking on the drop-down arrow. To continue to the next page select **Next**.

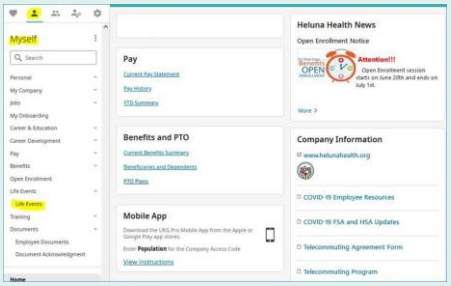
Step 6: Make sure your selections for each plan are correct. When done, click the **Next** button to go to the next plan. If you are NOT enrolling in a benefit plan, click **Decline**.

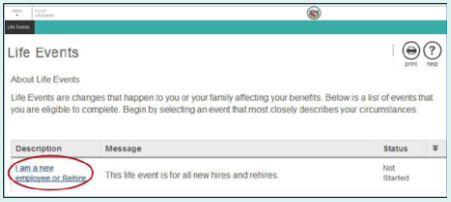
Note: If at any time during the enrollment process you realize you need to gather more information or finish at a later time, you can select **Draft** to save your progress.

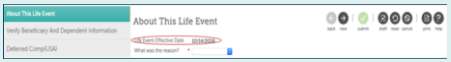
When you are satisfied with your benefit selections, make sure to click **Submit**. By submitting your elections the status will be Pending Approval, which means the benefits administrator must approve each plan selection.

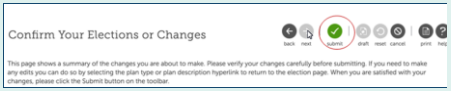
Congratulations! You've successfully completed your benefits enrollment in UKG!

Screenshot View:









Comprehensive Medical Coverage is an Important Part of Supporting Healthy Living

Heluna Health offers **five** medical plan options, all of which provide **preventive care services at no cost to you** to prevent healthcare problems before they arise. These are comprehensive medical plans to help you cover the costs when you are ill as well as to protect you from any catastrophic financial effects of a serious illness or injury.

You can choose from 3 HMO (Health Maintenance Organization) and 2 PPO (Preferred Provider Organization) plans. The medical plans are different in how they are designed. You decide which plan best meets your needs.

CA EMPLOYEES ONLY

UnitedHealthcare Harmony Ded. HMO + NSH (MERP)

Kaiser Ded. HMO + NSH (MERP)

UnitedHealthcare Alliance HMO UnitedHealthcare SignatureValue HMO

CA & NON-CA EMPLOYEES

UnitedHealthcare PPO

UnitedHealthcare HDHP/HSA PPO

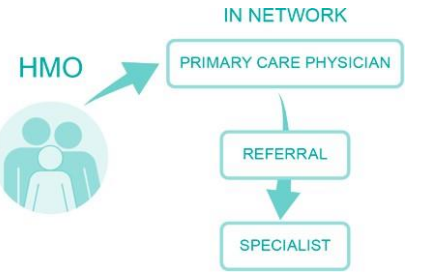
UnitedHealthcare AG-RO/PPO (Hawaii)

Transition of Care (TOC)

Transition of Care gives new UnitedHealthcare members the option to request extended coverage from their current, out-of-network health care professional at network rates for a limited time due to a specific medical condition until the safe transfer to a network health care professional can be arranged. You must apply for TOC no later than 30 days after the date your coverage begins. The TOC application can be located in UKG.

MEDICAL HMO OVERVIEW

HOW DO HMO PLANS WORK?



At the time of enrollment, you must select a primary care physician (PCP) and medical group. Your care is managed by the medical group and the assigned PCP. Your PCP will refer you to a specialist when it is needed and request pre-authorization for any medically necessary procedures. Most services are covered at 100% after you pay a copayment.

CAN I SELECT DIFFERENT PCPS FOR MYSELF AND MY DEPENDENTS?

Yes, you can select a different PCP for yourself and each of your dependents.

WHAT IF I NEED TO SEE A SPECIALIST?

When you want to see a specialist, like an orthopedic doctor or a cardiologist, you will need to visit your PCP first to get a referral. Your PCP will refer you to a specialist when it is needed and request pre-authorization for any medically necessary procedures.

WHEN CAN I CHANGE MY PCP OR MEDICAL GROUP?

You can change your PCP as often as you wish (even monthly); however, you must contact your plan carrier prior to the 15th of the month for a new provider to be assigned the 1st of the following month.

KAISER HMO PLAN

When enrolled in the Kaiser HMO plan, the physician, hospital, and pharmacy are contracted exclusively with Kaiser. Unlike a standard HMO plan which assigns you to a specific doctor and/or hospital, with Kaiser you are able to seek services with any Kaiser doctor and/or hospital at any time.

NONSTOP HEALTH (MERP)

Nonstop Health (NSH) is a program that allows Heluna Health to fund a significant portion of employees' healthcare out-of-pocket expenses (deductibles, copays, and coinsurance). This is coordinated through a Medical Expense Reimbursement Plan (MERP).

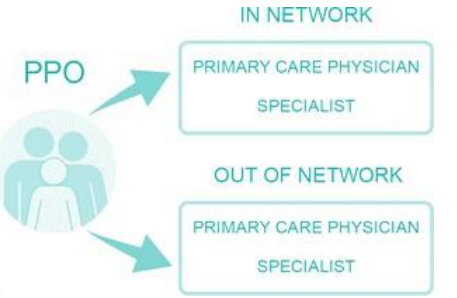
With Nonstop, you will receive two types of cards in the mail after you enroll: your Kaiser or UHC member ID card, and 2 Nonstop Visa cards. When accessing care with your Kaiser or UHC medical plan, you will use your Nonstop Visa card to help cover the cost of healthcare services. You may use your Nonstop Visa card at the time of service, and also if you receive a bill for in-network services. You cannot use the Nonstop Visa card for dental or vision payments.

Urgent Care centers are contracted with your assigned Medical Group. To locate the nearest contracted Urgent Care center, you must visit the assigned Medical Group's website instead of UHC's provider search site.

MEDICAL PPO OVERVIEW

HOW DO PPO PLANS WORK?

The PPO allows the member to self-refer to any provider. As a member, you can access care through an in-network (contracted) provider or through an out-of-network (non-contracted provider). You do not need to select a provider at the time of enrollment. However, you should always verify if your provider is contracted with UHC network prior to accessing care.



HIGH DEDUCTIBLE HEALTH PLAN (HDHP)/HEALTH SAVINGS ACCOUNT (HSA) PLAN

A HDHP plan is meant to give you more flexibility and control over your healthcare spending. It allows you to create a plan that meets your family's needs and comes with many of the same benefits as a traditional PPO plan. While your deductible will be higher, your premium will be lower. You can choose to contribute the difference in premium savings into a Health Savings Account. HSAs are like "medical" IRAs. It's a tax-deferred, private savings account designed to pay for certain current and future healthcare expenses with tax-free money. Because they are tax-advantaged and balances can accumulate over time, HSAs can also be used to accumulate savings.

WHAT IS THE DIFFERENCE BETWEEN IN-NETWORK VS OUT-OF-NETWORK PROVIDERS?

PPO plans offer a larger network of providers who have agreed to discount their fees for their services. You may choose to have your treatment provided by a PPO provider (in-network) and receive a higher level of benefit with a lower out-of-pocket cost to you. You may also choose to go outside the network; however, generally, benefits are reimbursed at a lower level and you may have higher out-of-pocket costs.

WHAT HAPPENS IF I RECEIVE CARE THROUGH OUT-OF-NETWORK PROVIDERS?

Using an out-of-network doctor, hospital, or other health care provider can significantly increase your out-of-pocket medical costs. That's because when a member sees an out-of-network provider, the member is responsible for the difference between what the provider charges and the amount UHC pays the provider. UHC uses established rates to pay for medical services for out-of-network doctors, hospitals, and other health care providers. However, out-of-network providers' actual charges are often much higher than UHC established rates, and they may charge members for the difference. This is called balance billing. When a member sees an in-network provider, they won't receive any additional charges from the provider.

EXAMPLE OF A MEMBER'S OFFICE VISIT WITH A SPECIALIST:

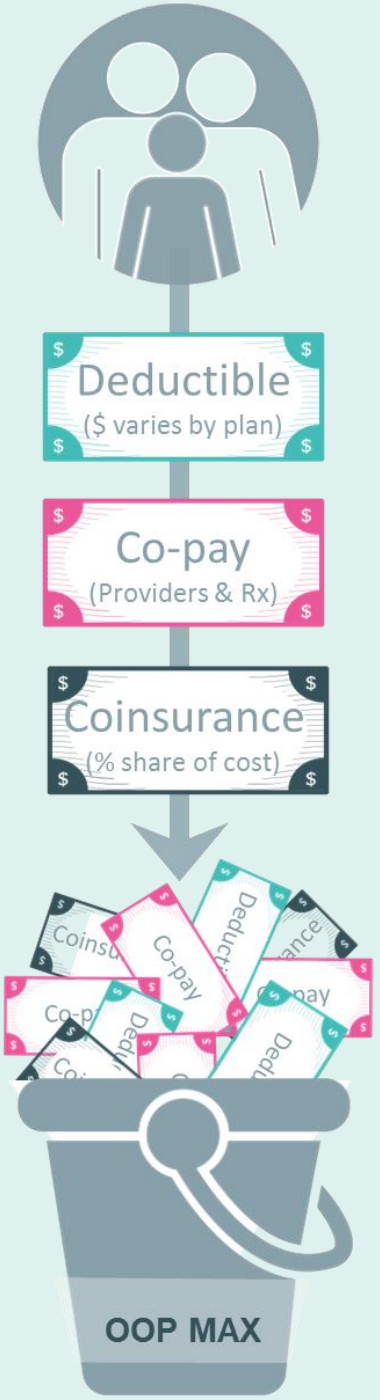
Cindy injured her knee and required a consultation with an orthopedic doctor. Cindy has a PPO plan, which gives her the option to seek services from a doctor in the **UHC** provider network, or one who does not participate in the network. The orthopedic doctor Cindy chose charges $450 for the consultation visit. If the doctor is in the **UHC** network, the plan would pay a negotiated rate for Cindy's visit. If the doctor is not in the network, the plan would pay the established rate for the out-of-network office visit. The chart shows how Cindy's out-of-pocket (OOP) costs will be lower if she chooses an in-network doctor.

	IN-NETWORK	OUT-OF-NETWORK
Provider's Actual Charge	$450	$450
UHC Pays	Provider Contracted Rate	Established Rate of $180
Balance Bill Amount (Cindy's OOP costs[1])	**$0**	**$270**

[1]All dollar amounts in this example and the table are hypothetical and for illustrative purposes only. Out-of-pocket (OOP) costs do not include deductible, copayment, or co-insurance.

MEMBER COVERAGE LIMIT

January 1st—December 31st



HEALTH CARE BASICS

WHAT IS A DEDUCTIBLE?

The amount you must pay each calendar year for covered health services **before** your health plan covers costs for medical or prescription expenses. The deductible can range from zero to several thousands of dollars. If you enroll in a health plan with an annual deductible, you will be responsible to pay for covered services until the deductible is satisfied. Some services such as preventive care are exempt from the plan deductible. The deductible resets every year on January 1st.

WHAT IS A COPAYMENT/COPAY?

A fixed dollar amount that you pay for a covered health service.

WHAT IS COINSURANCE?

After you meet your deductible, you pay coinsurance, which is your share of the costs of a covered health care service. Each health plan has it's own share of cost and it's identified in specified %.

WHAT IS OUT-OF-POCKET MAXIMUM (OOP MAX)?

The most you will pay for covered health services during the calendar year. All co-pay, deductible and coinsurance payments count toward the out-of-pocket maximum. Once you have met your out-of-pocket maximum, your insurance will pay 100% of covered health services.

WHAT IS AN EXPLANATION OF BENEFITS (EOB)?

An EOB is a statement from your health insurance plan describing what costs it will cover for medical care or products you have received. The EOB is generated when your provider submits a claim for the services you received. The insurance company sends you EOBs to help make clear:

- The cost of the care you received
- Any money you saved by visiting in-network providers
- Any out-of-pocket medical expenses you'll be responsible for

HEALTH CARE BASICS

KNOW WHERE TO GO FOR CARE, BEFORE YOU NEED IT

Knowing where to go if you get sick or hurt can save you time, money, and help you get the right care when you need it. Below are some common examples, which don't include all possible symptoms and conditions.

WHAT IS ROUTINE CARE?

Routine care is the regular care you get from your primary care physician or specialists. This type of care can include physical exams, health screenings, allergy diagnosis and treatment, pediatric checkups, immunizations and care for chronic conditions such as diabetes, heart disease, asthma, etc.

WHAT IS URGENT CARE?

Urgent care is for a condition that requires prompt medical attention, usually within 24 or 48 hours, but is not an emergency medical condition.

Examples include:

- Minor injuries and cuts
- Backaches and earaches
- Upper-respiratory symptoms
- Sore throats
- Frequent or severe coughs
- Frequent urination or a burning sensation when urinating
- Sprains
- Cuts and scrapes

WHAT IS EMERGENCY CARE?

The emergency room (ER) shouldn't be your first stop—unless there's a true emergency. **Go to the nearest emergency room or call 911 if you experience severe symptoms.**

Examples include:

- There is a lot of pain or bleeding
- You think a bone is broken
- You are experiencing severe shortness of breath
- Chest pain or pressure
- Severe stomach pain that comes on suddenly
- You think the problem might get a lot worse if you don't get help right away
- Decrease in or loss of consciousness
- There was no warning before your symptoms started

If you need help but it isn't an emergency, here are your options:

- **CALL YOUR DOCTOR.** He or she can help you decide whether you should go to an urgent care or come into the office.
- **GO TO AN URGENT CARE CENTER**. These centers are typically open late at night, on weekends and holidays. Keep in mind that each location has it's own hours of operation.
- **VISIT A DOCTOR USING TELEHEALTH ONLINE SERVICES.** Board-certified doctors are available 24/7 to see you via video using your computer or mobile device. Use Telehealth services for common health issues like the cold, a flu, allergies, pink eye, etc.

MEDICAL PREVENTIVE CARE

SCREENINGS	MALE	FEMALE	CHILD
Aortic aneurysm screening (men who have smoked)	•		
Behavioral counseling to promote a healthy diet	•	•	•
Blood pressure	•	•	•
Bone density test to screen for osteoporosis	•	•	
Breast cancer testing for BRCA 1 and BRCA 2 when certain criteria are met		•	
Breastfeeding: primary care intervention to promote breastfeeding support, supplies and counseling		•	
Cervical dysplasia screening			•
Cholesterol and lipid (fat) level	•	•	•
Colorectal cancer	•	•	
Contraceptive (birth control) counseling and FDA-approved contraceptive services provided by a doctor		•	
Counseling related to chemoprevention for women with a high risk of breast cancer		•	
Counseling related to genetic testing for women with a family history of ovarian or breast cancer		•	
Depression screening	•	•	•
Developmental and behavior screening			•
Eye chart test for vision	•	•	
Hearing screening			•
Height, weight and body mass index (BMI)			•
Hemoglobin (blood count)			•
Hepatitis C virus (HCV) for people at high risk for infection and a one-time screening for adults born between 1945 and 1965	•	•	
HPV screening		•	
Lead testing			•
Newborn screening			•
Obesity	•	•	•
Oral (dental health) assessment			•
Pelvic exam and Pap test, including screening for cervical cancer		•	
Pregnancy screenings: Includes, gestational diabetes, hepatitis B, asymptomatic bacteriuria, Rh incompatibility, syphilis, HIV and depression		•	
Prostate cancer	•		
Screening and counseling for STIs	•	•	•
Tobacco use: related screening and behavioral counseling	•	•	
Type 2 diabetes screening	•	•	•
Violence, interpersonal and domestic: related screening and counseling	•	•	•
Vision screening			•
Well-woman visits		•	
IMMUNIZATIONS			
Diphtheria, tetanus and pertussis (whooping cough)	•	•	•
Haemophilus influenza type b			•
Hepatitis A and Hepatitis B	•	•	•
Human papillomavirus (HPV)	•	•	•
Influenza	•	•	•
Measles, mumps and rubella	•	•	•
Meningococcal (meningitis)	•	•	•
Pneumococcal (pneumonia)	•	•	•
Polio			•
Rotavirus			•
Varicella (Chicken Pox)	•	•	•
Zoster (shingles)	•	•	•

UHC MEDICAL HMO

FOR CA MEMBERS ONLY

	UHC HARMONY DED. HMO + NSH (MERP) PLAN	
WHAT YOU PAY	**Base Plan**	**You Pay^ Using your Nonstop Health (NSH) Visa Card**
Nonstop Health (NSH) Medical Expense Reimbursement Plan (Individual/Family)	**$4,500/$9,000 NSH Visa Card (paid for by Heluna Health)**	
Calendar Year Deductible (Single)	$2,000	$0 with NSH Visa Card
Calendar Year Deductible (Family)	$4,000	$0 with NSH Visa Card
Calendar Year OOP Maximum (Single)	$5,000	$500
Calendar Year OOP Maximum (Family)	$10,000	$1,000
Preventive Services	No Charge	No Charge
Office Visits (Primary/Specialist/Telehealth)	$30 (PCP)/$60 (SPC)/$0 (TEL)[1]	**$0 Co-pay** with NSH Visa Card (Thereafter $30/$60 Co-insurance up to $500 OOP Max)
Lab & X-ray	20%[1]	$0 Co-pay with NSH Visa Card (Thereafter 20% Co-insurance up to $500 OOP Max)
Complex Radiology (includes CT, PET and MRI)	20%[1]	$0 Co-pay with NSH Visa Card (Thereafter 20% Co-insurance up to $500 OOP Max)
Inpatient Hospital Services (includes maternity)	20%[1]	$0 Co-pay with NSH Visa Card (Thereafter 20% Co-insurance up to $500 OOP Max)
Outpatient Surgery	20%[1]	$0 Co-pay with NSH Visa Card (Thereafter 20% Co-insurance up to $500 OOP Max)
Urgent Care	$30/visit[1] (within service area) 20%/visit[1] (out of service area)	$0 Co-pay with NSH Visa Card (Thereafter $30/20% Co-insurance up to $500 OOP Max)
Emergency Room	20%[1]	**$100 Co-pay**, then $0 cost with NSH Visa Card (Thereafter 20% Co-insurance up to $500 OOP Max)
Ambulance (Emergency only)	20%[1]	$0 Co-pay with NSH Visa Card (Thereafter 20% Co-insurance up to $500 OOP Max)
PRESCRIPTION DRUGS		
Prescription Deductible	$0 Rx Deductible	$0 Rx Deductible
Retail Rx (up to 30 day supply) Tier 1 Tier 2 Tier 3	 $10[1] $35[1] $60[1]	 $0 Co-pay with NSH Visa Card (Thereafter Rx Tier Co-pay $10//$35/$60 up to $500 OOP Max)

EMPLOYEE SEMI-MONTHLY CONTRIBUTIONS	
Employee	**$0.00**
Employee + Spouse	**$147.71**
Employee + Child(ren)	**$0.00**
Employee + Family	**$157.34**

The first $4,500 of in-network medical expenses for Employee Only ($9,000 for Family) is paid using your Nonstop Health (NSH) Visa Card. The member responsibility after this limit is shown in the You Pay column.

^These amounts apply after all your Nonstop Health (NSH) funds have been used.

[1]Calendar deductible must be satisfied first before any benefits are paid (unless specified otherwise).

Sign up as a member online to print ID cards, locate providers, and view benefits, claims and member resources.

myuhc.com

KAISER MEDICAL HMO

FOR CA MEMBERS ONLY

WHAT YOU PAY	Base Plan	You Pay^ Using your Nonstop Health (NSH) Visa Card
	KAISER DED. HMO + NSH (MERP) PLAN	
Nonstop Health (NSH) Medical Expense Reimbursement Plan (Individual/Family)	$5,500/$11,000 NSH Visa Card (paid for by Heluna Health)	
Calendar Year Deductible (Single)	$5,500	$0 with NSH Visa Card
Calendar Year Deductible (Family)	$11,000	$0 with NSH Visa Card
Calendar Year OOP Maximum (Single)	$7,000	$1,500
Calendar Year OOP Maximum (Family)	$14,000	$3,000
Preventive Services	No Charge	No Charge
Office Visits (Primary/Specialist/Telehealth)	$50 (PCP)/$50 (SPC)/$0 (TEL)[1]	**$0 Co-pay** with NSH Visa Card (Thereafter $50 Co-insurance up to $1,500 OOP Max)
Lab & X-ray	40%[1]	$0 Co-pay with NSH Visa Card (Thereafter 40% Co-insurance up to $1,500 OOP Max)
Complex Radiology (includes CT, PET and MRI)	40%[1]	$0 Co-pay with NSH Visa Card (Thereafter 40% Co-insurance up to $1,500 OOP Max)
Inpatient Hospital Services (includes maternity)	40%[1]	$0 Co-pay with NSH Visa Card (Thereafter 40% Co-insurance up to $1,500 OOP Max)
Outpatient Surgery	40%[1]	$0 Co-pay with NSH Visa Card (Thereafter 40% Co-insurance up to $1,500 OOP Max)
Urgent Care	$50/visit[1]	$0 Co-pay with NSH Visa Card (Thereafter $50 Co-insurance up to $1,500 OOP Max)
Emergency Room	40%[1]	**$100 Co-pay**, then $0 cost with NSH Visa Card (Thereafter 40% Co-insurance up to $1,500 OOP Max)
Ambulance (Emergency only)	40%[1]	$0 Co-pay with NSH Visa Card (Thereafter 40% Co-insurance up to $1,500 OOP Max)
PRESCRIPTION DRUGS		
Prescription Deductible	Combined with Medical Deductible	$0 Rx Deductible with NSH Visa Card
Retail Rx (up to 30 day supply)		
Tier 1	$15[1]	
Tier 2	40% up to $100[1]	$0 Co-pay with NSH Visa Card
Tier 3	40% up to $250[1]	(Thereafter Rx Tier Co-pay $15//40% up to $100/40% up to $250)

EMPLOYEE SEMI-MONTHLY CONTRIBUTIONS	
Employee	**$10.00**
Employee + Spouse	**$210.62**
Employee + Child(ren)	**$10.00**
Employee + Family	**$252.24**

The first $5,500 of in-network medical expenses for Employee Only ($11,000 for Family) is paid using your Nonstop Health (NSH) Visa Card. The member responsibility after this limit is shown in the You Pay column.

^These amounts apply after all of your Nonstop Health (NSH) funds have been used.

[1]Calendar deductible must be satisfied first before any benefits are paid (unless specified otherwise).

Sign up as a member online to print ID cards, locate providers, and view benefits, claims and member resources.

kp.org

CHIROPRACTIC & ACUPUNCTURE

TO FIND A LANDMARK-CONTRACTED PROVIDER:

1. Visit www.LHP-CA.com and select "Find a Provider"
   - Select your plan (Landmark Healthplan)
   - Enter the provider you're looking for, either acupuncturist or chiropractor
   - Enter your Zip code
   - Select search radius (i.e. How far are you willing to travel to see the provider?)
   - Hit "Enter"
2. Or call Landmark Customer Service at 1-800-298-4875
3. Let the provider know you are enrolled in Landmark Expanded benefits, and provide your name, date of birth, and group number (**NSHELUN*000**) so they can verify eligibility.
4. If the provider asks you for a copay, have them contact Landmark directly since you do not have a copay for these services. We recommend you clarify this with the provider before your appointment.

LANDMARK HEALTHPLAN: NSHELUN*000

Coverage Type	Benefits snapshot (in-network coverage)
Office visit	$0 copay
Maximum annual visits	30 visits per enrollee
X-ray services*	$75 annual maximum benefit
Emergency care**	$0 copay (same copay as office visit)
Durable Medical Equipment purchase or rental***	$50 annual maximum benefit
Acupuncture herbal therapies****	$5 copay per bottle/$500 annual max. benefit

*X-ray Services must be prescribed by a participating chiropractor
**Services provided by non-participating practitioners are covered for Emergency Services only
*** Durable Medical Equipment must be prescribed by a participating chiropractor
**** Herbal therapies must be prescribed by a participating acupuncturist

LANDMARK HEALTHPLAN OF CALIFORNIA

This plan is only available to employees enrolled in the UHC Harmony Ded. HMO + NSH or Kaiser Ded. HMO + NSH medical plans. Landmark Healthplan of California, Inc. (Landmark) provides you with a combined chiropractic and acupuncture benefit. **You must use Landmark-contracted providers to access this benefit.** You may not use your Nonstop Health (NSH) Visa card to pay for associated costs such as X-rays, durable medical equipment or herbal therapies unless they are covered by your medical plan.

Questions?

We're here to help!

Monday-Friday, 6am-5pm PT

877.626.6057

clientsupport@nonstophealth.com

NONSTOP IN ACTION

nonstop™

Employees enrolled in the UHC Harmony Ded. HMO or Kaiser Ded. HMO Medical plan will be enrolled with a Nonstop MERP.

YES
IN-NETWORK
facilities and doctors

YES
COVERED services
and prescriptions

NO
Vision

NO
Dental

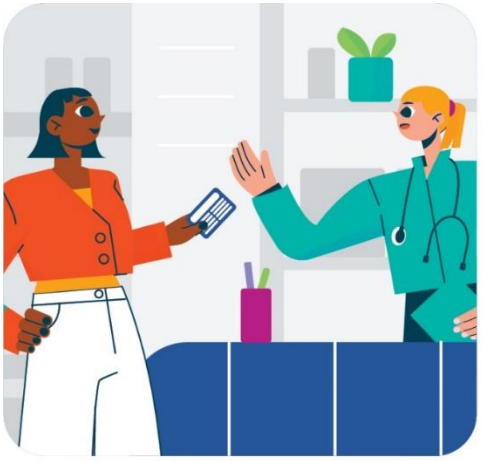
NO
Out-of-network

- Nonstop is only designed for in-network medical services and prescriptions approved by Kaiser and UnitedHealthcare. As such, you cannot use the Nonstop Visa card for dental or vision payments.
- You will be responsible for any un-approved charges on the card.

NONSTOP VISA CARD

You will receive two Nonstop Visa cards and they will both only be in your name. If you need additional cards, please call Nonstop at 1-877-626-6057. It is recommended that you DO NOT set up a PIN so you can use the card as a credit card versus a debit card.

HOW DO I USE NONSTOP HEALTH AT MY PROVIDER OR PHARMACY?



1 Present your **CARRIER CARD** to the front desk so they can apply service costs to your deductible and/or out-of-pocket maximum.

2 Pay for covered services and prescriptions with your **NONSTOP HEALTH VISA CARD**

3 If/when you receive a bill with a remaining balance, pay for those expenses with your **NONSTOP HEALTH VISA CARD**

(note: an Explanation of Benefits (EOB) is not a bill)

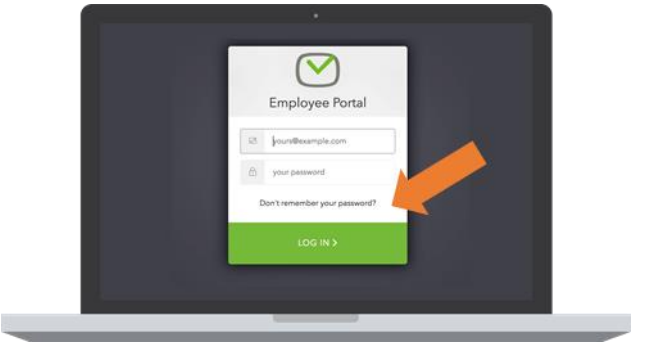
NONSTOP IN ACTION

Employees enrolled in the UHC Harmony Ded. HMO or Kaiser Ded. HMO Medical plan will be enrolled with a Nonstop MERP

NONSTOP EXCHANGE MEMBER PORTAL

Once you are enrolled with Nonstop, you will be able to access your plan information via the Nonstop Exchange member portal members.nonstophealth.com When you log into the system all your information will be available, allowing you to:

- View available card balances
- Navigate to the member help site through the HELP button
- File and view claims submissions



LOGGING INTO THE NONSTOP EXCHANGE PORTAL

Once you navigate to the Nonstop Exchange site https://members.prod.nonstophealth.com you will need to log in by entering your user name and password.

Your user name is your Heluna Health email address. When you log in for the first time, you will need to put in your Heluna Health email address and then click on “don’t remember your password?” This will allow you to set a private password for your account. Please see below for the steps to reset your password.

To reset your password:

1. Click on “don’t remember your password?”
2. You’ll receive an email with instructions on how to reset your password.
3. Click the link provided in the email and enter a password with a minimum of 8 characters, at least one number, one special character (i.e., ! # $), and one capital letter.
4. Once you have reset your password, you can log in with your username and password.

NONSTOP IN ACTION

Employees enrolled in the UHC Harmony Ded. HMO or Kaiser Ded. HMO Medical plan will be enrolled with a Nonstop MERP.

Meet two Heluna Health employees who each enroll in the UHC Harmony + NSH (MERP) or Kaiser + NSH (MERP) plan. Below is a quick overview of how they use their NSH Visa Card funds during the year. These funds are paid for 100% by Heluna Health to help cover out-of-pocket healthcare expenses during the calendar year.

Donna enrolls herself and her child in the UHC Harmony HMO + NSH (MERP) medical plan on. She sees a specialist regularly, who bills Donna full charge for each visit. Her child also has occasional urgent care visits for sports injuries. Sometimes Donna is charged at the time of her service, other times she receives a bill in the mail several weeks later. In either scenario, Donna pays for these charges using her NSH Visa card.

Donna's child requires a trip to the emergency room (ER), which Donna pays for $100 out of pocket. All other charges for the visit she pays for using her NSH Visa card. Donna also uses her own out of pockets dollars for dental & vision expenses that she and her child have during the year, since her NSH Visa card only applies to medical and pharmacy expenses covered by the health plan..

Suzy enrolls in the Kaiser HMO + NSH (MERP) medical plan. She had an office visit to discuss a health concern and receives a bill from the provider. Suzy pays this bill using her NSH Visa card. Her doctor orders additional tests, labs, x-rays, and complex radiology scans. Suzy continues to receive bills for these services and continues to pay them using her $5,500 NSH MERP funds. Her condition led to an inpatient hospital stay. She continues paying medical bills until she uses the remaining balance of her $5,500 NSH MERP funds.

Suzy still had a few outstanding bills that need to be paid. Since she no longer has NSH MERP funds to use, Suzy now had to pay using her own money to pay these bills. Once she reaches paying $1,500 out of her own pocket, any remaining medical expenses would be paid for by Kaiser 100%. These balances will reset on January 1, when she will have access to a new balance of $5,500 in NSH MERP dollars.

Scan the QR code to view the sample fee schedule of Kaiser services.

When deciding between UHC Harmony HMO + NSH (MERP) or Kaiser HMO + NSH (MERP), consider the net out-of-pocket amounts (member's calendar year responsibility after NSH Visa funds have been depleted). The UHC Harmony HMO + NSH plan has a $500 individual net out-of-pocket maximum, and Kaiser HMO + NSH plan has a $1,500 individual net out-of-pocket maximum. Consider electing Health Care FSA to cover medical, dental and vision out-of-pocket expenses.

NONSTOP IN ACTION

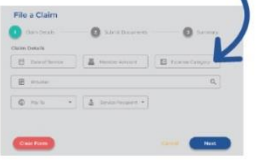
Employees enrolled in the UHC Harmony Ded. HMO or Kaiser Ded. HMO Medical plan will be enrolled with a Nonstop MERP.

While the Nonstop program is set up to help you pay for medical expenses, there may be times when you'll need to pay up front and be reimbursed later. Nonstop makes every effort to help you avoid these situations, but if needed, the claims submission process is quick and easy with reimbursement checks typically processed within 7 to 10 days of submission (assuming no processing delays).

HOW DO I SUBMIT A CLAIM TO NONSTOP?

1 **LOG IN TO THE NONSTOP EXCHANGE PORTAL** (members.nonstophealth.com)

2 **CLICK ON THE SUBMIT NEW CLAIM BUTTON** and fill in all of the required information.



3 **UPLOAD THE PROPER DOCUMENTATION.** For a provider visit, this is an Explanation of Benefits and provider bills. For prescriptions, upload the pharmacy paper bag receipt.*

4 **REVIEW YOUR CLAIM AND SUBMIT!** A ticket number will be provided that you can use as a reference when checking on the status of your claim.

5 Expect a **REIMBURSEMENT OR PROVIDER PAYMENT** to be mailed out after a 7–10 day processing period.**

* For a claim to be processed, the service date you enter on the first page must match the date stated on the uploaded documentation.
** During the peak claims season of December 1–April 1, it may take 14–20 days for Nonstop to process your claim.

Sign in on the Nonstop Exchange www.members.nonstophealth.com and click "New Claim"

Follow the steps on the portal to Submit Your Claim

NONSTOP IN ACTION

Employees enrolled in the UHC Harmony Ded. HMO or Kaiser Ded. HMO Medical plan will be enrolled with a Nonstop MERP.

NONSTOP VISA CARD SUBSTANTIATION POLICY

1. Nonstop will **REVIEW CHARGES** on a daily basis and **FLAG ANY THAT NEED TO BE SUBSTANTIATED.**
2. **NONSTOP WILL REACH OUT TO YOU THREE TIMES** (phone and/or email). Please do not ignore these messages!
3. Still no response? **WE MAY REACH OUT TO YOUR HR DEPARTMENT** to make sure we have the correct information and to see if they can help us contact you.
4. If we still do not hear from you after these five attempts, **WE WILL SUSPEND YOUR NONSTOP VISA CARD** and may refer you to a collections agency.

You may use the Nonstop Visa card for covered, in-network services and prescriptions, up to the allowed amount for your plan. The card may not be used for out-of-network or elective procedures or anything that UnitedHealthcare or Kaiser would not apply towards your in-network deductible and out-of-pocket tracking. In addition, the Nonstop Health program does not cover dental or vision costs so you cannot use your Nonstop Visa card to pay for these services.

Charges on your card may need to be substantiated to ensure they are in-network and covered. Substantiation simply means that we are confirming acceptable use of your Nonstop Visa card. **Nonstop reserves the right to ask you for documentation to confirm that the charges on the card were allowed and approved by UnitedHealthcare or Kaiser and counted towards your deductible and out-of-pocket tracking.** Documentation typically includes an Explanation of Benefits (EOB).

If charges on your Nonstop Visa card cannot be substantiated and/or have not been approved by UnitedHealthcare or Kaiser we may request that you repay the amount that does not qualify for the Nonstop Health program back into your employer's healthcare plan. If we do not receive documentation or repayment, your card may be suspended and you may be referred to a collections agency. However, before this happens we want to work directly with you to investigate the charge and determine what, if any, errors may have occurred.

NONSTOP IN ACTION

Employees enrolled in the UHC Harmony Ded. HMO or Kaiser Ded. HMO Medical plan will be enrolled with a Nonstop MERP.

The Nonstop customer support team is here to help with all of your needs, but some questions can be better answered by your insurance carrier. Below is a quick snapshot of when we recommend calling Nonstop and when to call your carrier.

CALL NONSTOP*:

- If your Nonstop Visa card has been declined
- If you have lost your Nonstop Visa card, it has been stolen, or you need additional cards
- For basic program questions
- For all claims questions such as:
    - Did Nonstop receive my claim?
    - Has my claim been processed?
    - How do I process a claim?
    - Why wasn't my claim processed?

General Phone: **1-877-626-6057**
clientsupport@nonstophealth.com

CALL KAISER OR UNITEDHEALTHCARE*:

- For a new insurance carrier card
- To determine if a specific surgery or test is covered by your insurance plan
- To determine if a medication is covered by your insurance plan
- To determine if a provider is in-network

Kaiser Customer Service: **800-464-4000**
www.kp.org

UnitedHealthcare Customer Service: **866-801-4409**
www.uhc.com

Unsure of who to call? Reach out to the Employee Support Center ESC for questions about any of your health plans!

Mon-Fri | 8am-4pm (PST)
Toll Free: **855.670.2222**
Local: **818.539.8804**
LosAngeles.ESC@ajg.com

** If you call Nonstop with questions meant for your insurance carrier, Nonstop will need to call the carrier to get that information; this could result in delays in getting you a response. As such we suggest you call the carrier directly for the above queries. In addition, HIPAA regulations can restrict Nonstop from obtaining information from the carrier on your behalf. While you can sign a HIPAA form allowing Nonstop to receive this information, it could take 2-4 weeks for processing on the carrier's end.*

UHC MEDICAL HMO

FOR CA MEMBERS ONLY

WHAT YOU PAY	UHC ALLIANCE (Sacramento County only) HMO PLAN IN NETWORK	WHAT YOU PAY	UHC SIGNATURE VALUE HMO PLAN IN NETWORK
Calendar Year Deductible (Single)	None	Calendar Year Deductible (Single)	None
Calendar Year Deductible (Family)	None	Calendar Year Deductible (Family)	None
Calendar Year OOP Maximum (Single)	$1,500	Calendar Year OOP Maximum (Single)	$1,500
Calendar Year OOP Maximum (Family)	$3,000	Calendar Year OOP Maximum (Family)	$3,000
Preventive Services	No Charge	Preventive Services	No Charge
Office Visits (Primary/Specialist/Telehealth)	$20 (PCP)/$35 (SPC)/$0 (TEL)	Office Visits (Primary/Specialist/Telehealth)	$25 (PCP)/$40 (SPC)/$0 (TEL)
Chiropractic/Acupuncture (20 visits combined)	$15/visit[1]	Chiropractic/Acupuncture (20 visits combined)	$15/visit[1]
Lab & X-ray	$20 (lab/X-ray)	Lab & X-ray	$20 (lab)//$25 (X-ray)
Complex Radiology (includes CT, PET and MRI)	$150/test	Complex Radiology (includes CT, PET and MRI)	$150/test
Inpatient Hospital Services (includes maternity)	$500/admission	Inpatient Hospital Services (includes maternity)	$500/admission
Outpatient Surgery	$125/procedure	Outpatient Surgery	$125/procedure
Urgent Care*	$20/visit (within service area) $50/visit (outside service area)	Urgent Care*	$25/visit (within service area) $50/visit (outside service area)
Emergency Room	$150/visit	Emergency Room	$150/visit
Ambulance (Emergency only)	$150/trip	Ambulance (Emergency only)	$150/trip
PRESCRIPTION DRUGS		PRESCRIPTION DRUGS	
Prescription Deductible	$0 Rx Deductible	Prescription Deductible	$0 Rx Deductible
Retail Rx (up to 30 day supply)		Retail Rx (up to 30 day supply)	
Tier 1	$10	Generic Rx	$10
Tier 2	$20	Brand Rx	$20
Tier 3	$40	Specialty Rx	$40
Mail Order Rx (up to 90 day supply) Tier 1/Tier 2/Tier 3	$25/$50/$100	Mail Order Rx (up to 90 day supply) Tier 1/Tier 2/Tier 3	$25/$50/$100

EMPLOYEE SEMI-MONTHLY CONTRIBUTIONS	UHC ALLIANCE HMO PLAN	UHC SIGNATUREVALUE HMO PLAN
Employee	**$0.00**	**$25.00**
Employee + Spouse	**$147.71**	**$271.48**
Employee + Child(ren)	**$0.00**	**$25.00**
Employee + Family	**$157.34**	**$271.48**

[1] Benefits include acupuncture and chiropractic services that are medically necessary services rendered by a participating provider. You may lookup contracted providers online or by calling OptumHealth Customer Service at (800) 428-6337, weekdays from 8am—5pm PST.

Sign up as a member online to print ID cards, locate providers, and view benefits, claims and member resources.

myuhc.com

UHC MEDICAL PPO

FOR CA & NON-CA MEMBERS

	UHC 1000/30/20% PPO PLAN		UHC HDHP/HSA PPO PLAN		UHC AG-RO PPO PLAN (Hawaii Employees)	
WHAT YOU PAY	**IN NETWORK[1]**	**OUT OF NETWORK[1]**	**IN NETWORK[1]**	**OUT OF NETWORK[1]**	**IN NETWORK[1]**	**OUT OF NETWORK[1]**
Calendar Year Deductible (Single)	$1,000	$2,000	$3,200	$5,400	$100	$100
Calendar Year Deductible (Family)	$3,000	$6,000	$6,400	$11,200	$300	$300
Calendar Year OOP Maximum (Single)	$4,000	$8,000	$4,000	$8,000	$2,500	$2,500
Calendar Year OOP Maximum (Family)	$8,000	$16,000	$8,000	$16,000	$7,500	$7,500
Preventive Services	No Charge	Not Covered[1]	No Charge	Not Covered[1]	No Charge	30%[1]
Office Visits (Primary/Specialist/ Telehealth)	$30(PCP/SPC)/ $0(TEL)	40%[1]	20%(PCP/SPC)/ $0(TEL)[1]	50%[1]	10%(PCP/SPC/TEL)	30%[1]
Acupuncture /Chiropractic (20 visits/24 visits)	$30/visit	Not Cov. (Acu) 40%[1] (Chiro)	20%[1]	Not Cov. (Acu) 50%[1] (Chiro)	Not Cov. (Acu) 10% (Chiro)	Not Covered
Lab & X-ray	20%	40%[1]	20%[1]	Not Cov. (Lab)	10%	30%[1]
Complex Radiology (includes CT, PET and MRI)	20%[1]	40%[1]	20%[1]	50%[1] (X-Ray) 50%[1]	10%	30%[1]
Inpatient Hospital Services (includes maternity)	20%[1]	40%[1]	20%[1]	50%[1]	10%	30%[1]
Outpatient Surgery	20%[1]	40%[1]	20%[1]	50%[1]	10%	30%[1]
Urgent Care*	$30/visit	40%[1]	20%[1]	50%[1]	10%[1]	30%[1]
Emergency Room	20%[1]		20%[1]		10%	
Ambulance (Emergency only)	20%[1]		20%[1]		10%[1]	
PRESCRIPTION DRUGS						
Prescription Deductible	$0 Rx Deductible		**Combined with Medical Deductible**		$0 Rx Deductible	
Retail Rx (up to 30 day supply)						
Tier 1	$15	$15	$15[1]	$15[1]	$10	$10
Tier 2	$40	$40	$40[1]	$40[1]	$30	$30
Tier 3	$60	$60	$60[1]	$60[1]	$50	$50
Mail Order Rx (up to 90 day supply) Tier 1/Tier 2/Tier 3	$37.50/$100/$150	Not Covered	$37.50/$100/$150[1]	Not Covered	$30/$90/$150	Not Covered

EMPLOYEE SEMI-MONTHLY CONTRIBUTIONS[2]	UHC PPO	UHC HDHP/HSA[2]	UHC Hawaii
Employee	**$90.00**	**$20.00**	**$20.00**
Employee + Spouse	**$386.40**	**$274.97**	**$284.91**
Employee + Child(ren)	**$90.00**	**$20.00**	**$20.00**
Employee + Family	**$386.40**	**$274.97**	**$284.91**

[1] The deductible applies to all in network and out of network services before coinsurance and co-pay coverage begins. Routine adult physical exam is not covered through out of network provider. Out of Network services are subject to limited daily benefit and balance billing. Members are responsible for the difference between provider charges and UHC's allowed charges/reimbursement amount. Precertification is required for certain services. Please refer to the Summary of Benefits or Evidence of Coverage for additional details.

[2] Heluna Health will contribute $66.68 per pay period, totaling $1,600.32 per plan year towards your Health Savings Account. The contributions will be pro-rated for new employees hired after August 1st.

Visit online to get details on PPO benefits, UHC local and national network, how to access covered care, how to obtain precertification for procedures, when you need to file a claim, how to submit claims, AND MORE!

myuhc.com

KEY FACTS ABOUT HSAs

If you enroll in the HDHP/HSA plan, you can choose to elect pre-tax payroll contributions into the HSA account administered by The Advantage Group or open a direct account with your bank.

HOW DO YOU MANAGE HSAs?

Since you are the account holder or HSA beneficiary, you manage your own account. You may choose when to use your HSA dollars for eligible expenses, such as deductibles and coinsurance.

WHEN CAN HSA DOLLARS BE USED?

HSA dollars can be used immediately following your account activation and once contributions have been made.

WHAT EXPENSES ARE ELIGIBLE FOR REIMBURSEMENT WITH HSAs?

HSA dollars may be used for qualified medical expenses incurred by the account holder and dependents. Please refer to Section 213(d) of the IRS Tax Code for details. For more information about eligible expenses, please refer to IRS Publication 502 available at **irs.gov/publications/p502/index.html**.

The Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") includes a provision that allows members to use HSA funds to pay for over-the-counter (OTC) medications and menstrual products without a prescription.
For a list of HSA approved expenses and a list of HSA eligible products, please visit IRS Qualified Medical Expenses - HSA Bank

HOW CAN YOU CONTRIBUTE TO AN HSA WHILE AT HELUNA HEALTH?

You can contribute to an HSA account through pre-tax payroll deductions. You may contribute as often as you like, provided that you do not exceed the annual contribution limits listed on the following page. You can make changes to your contribution amounts any time throughout the plan year by contacting your Benefits Administrator.

WHAT HAPPENS IF HSA FUNDS RUN OUT?

If your HSA dollars run out, you will be responsible for eligible medical expenses that fall within the coverage gap.

HOW DO YOU PAY YOUR PHYSICIAN OR NETWORK FOR SERVICES WITH HSA DOLLARS?

You may request that the network provider submit your claim to your health plan. Once the medical claim has been processed, out-of-pocket expenses will be billed to you (if any). At that time, you can use your HSA debit card to pay for any out-of-pocket expenses, or you can write a personal check and request reimbursement from your HSA at a later date.

WHAT HAPPENS TO HSA DOLLARS AT THE END OF THE YEAR?

The money remains in the account and any unused funds roll over from year to year to pay for health care costs in future years.

CAN HSA DOLLARS BE USED FOR NON-ELIGIBLE EXPENSES?

Money withdrawn from an HSA to reimburse for non-eligible medical expenses is considered taxable income and is subject to a 20 percent tax penalty, unless over age 65, disabled or the account holder dies.

HSA ELIGIBILITY GUIDELINES

To be eligible to make contributions to an HSA account, you must satisfy the following conditions.

		If "YES"	If "NO"
1	Can you be claimed as a dependent on another person's tax return?	Not Eligible	Proceed to #2
2	Are you enrolled in Medicare?	Not Eligible	Proceed to #3
3	Are you enrolled in a qualified high-deductible health plan (HDHP)/HSA compatible plan with a minimum annual deductible of at least $1,600 for single coverage and $3,200 for family coverage?	Proceed to #4	Not Eligible
4	Do you or family members covered under the HDHP have additional health coverage under another plan?	Proceed to #5	Proceed to #6
5	If you answered YES to question #4, is this other health plan coverage an HDHP/HSA compatible plan?	Proceed to #6	Not Eligible
6	Do you or family members covered under the HDHP currently participate in a tax-deferred health care Flexible Spending Account (FSA)?	Not Eligible	Eligible You may contribute any amount up to the 2024 Contribution Limits provided below.

Start. Stop. Change. You Decide.

Contributions into HSA accounts are flexible and can be adjusted from month-to-month. If elections are made through Heluna Health, all HSA contributions will be processed through pre-tax payroll contributions. Your HSA account is administered by The Advantage Group. You can also choose to open a direct account with your bank and make direct contributions (payroll deduction is not available in this case).

2024 Contribution Limits[1]:

Individual = $4,150 (2024) and $4,300 (2025)
Family = $8,300 (2024) and $8,550 (2025)
Catch-up[2]= $1,000

[1]The annual contribution limits are inclusive of any contributions deposited by Heluna Health or earned through UHC's Simply Engaged Program.

[2]Catch-up (age 55 or older) contributions can be made any time during the year in which the HSA participant turns 55.

UHC Rewards

GET IN ON UHC REWARDS

What's better than earning rewards for reaching goals and taking care of your health? Being able to choose how those rewards are earned and spent. **With UnitedHealthcare Rewards, you can earn up to $1,000/year.**
UHC Rewards is included in all UHC HMO, PPO, and HSA health plans at no additional cost.

CHOOSE REWARD ACTIVITIES THAT INSPIRE YOU

With UHC Rewards, a variety of actions lead to rewards — and new ways to earn will be added throughout the year. Some ways you can earn include:

- Getting a biometric screening
- Completing a health survey
- Tracking 14 days of sleep
- Going paperless

START EARNING TODAY

Download the **UnitedHealthcare® app** and then:

- Sign in or register
- Select the **Menu** tab and choose **UHC Rewards**
- Activate UHC Rewards and start earning

Getting started

Get in

UHC Rewards is available in the **UnitedHealthcare app** and on **myuhc.com** — a HealthSafe ID® is required to register

Get going

Complete reward activities — earn rewards for reaching daily goals and completing one-time reward activities

Get started

Download the UnitedHealthcare app and activate UHC Rewards

Get rewarded

Deposit directly into HSA or use toward a digital Visa® gift card

UHC MEDICAL PROVIDER SEARCH

UHC Plan Members

1. Visit www.myuhc.com and click to “Find a Provider”. A new window will open.
2. Select “Medical Directory” to locate doctors, hospitals, or labs. Select “Behavioral Health Directory” to locate mental and substance abuse providers and facilities.
3. On the next page click “Employer and Individual Plans”.
4. Scroll down to choose the network you want to search in:
   - **Harmony HMO**: choose “SignatureValue Plans”, select “California”, then “SignatureValue Harmony HMO”
   - **Alliance HMO**: choose “SignatureValue Plans”, select “California”, then “SignatureValue Alliance HMO”
   - **SignatureValue HMO**: choose “SignatureValue Plans”, “California”, then “SignatureValue HMO”
   - **PPO/HSA**: choose “Select Plus”
5. Enter your Zip Code, Address, City, or State.
6. If you already have a doctor in mind you can enter their name in the search box to verify if they are in network. If you are uncertain then click on “People”. Otherwise choose what type of doctor you would like to search for. If you are searching for a Primary Care Provider, click on “Primary Care”.
7. You will see a listing of doctors and facilities. You can refine your search results to show you providers accepting new patients, or who specialize in specific areas.

Remember: if you choose the HMO plan, make sure to check that any provider or facility you visit is both in-network with UHC and part of your Medical Group. Medical Group information will be displayed on the website. Provider contracts are always changing with the carriers. Please call your provider to ensure that they are still in-network before going to see them. Contact UHC before the 15th of the month to change your assigned Primary Care Doctor or Medical Group.

UHC Plan Networks

Looking for your Medication?

Visit https://www.uhc.com/member-resources/pharmacy-benefits/prescription-drug-lists and select “California Plans”, “Large Group - Access”, and then the “Tier 3 Formulary” link.

Getting Precertification

When receiving care through one of the PPO plans, you should always make sure the services requested by your provider are medically necessary and cost effective.

Some services—such as outpatient surgeries, scheduled hospitalizations, and complex lab and radiology procedures —require precertification.

This is an important step.
Failure to obtain precertification will result in a reduction of benefits.

New Members enrolling in one of UHC’s HMO plans, must enter the provider ID number in UKG for the PCP and/or Medical Group of choice to be assigned to you and your dependents. If you skip this step, UHC will auto assign a provider for you. You can always contact UHC’s member services department to change your provider and/or Medical Group assignment. Provider ID # begins with a “0”. Please do not reference the NPI number.

KAISER MEDICAL PROVIDER SEARCH

Kaiser HMO Plan Members

1. Visit **www.kp.org** and click on **MENU** then **DOCTORS & LOCATIONS**.
2. Choose the Search type you are looking for
3. Choose the Region you are searching in, and enter your zip code.
4. Once you press SEARCH you will get a listing of doctors. You can refine your search results after you get a listing.
5. **When you need chiropractic care, follow these simple steps:**
   - Find an ASH Plans Participating Provider near you
     - Online at www.ashlink.com/ash/kp or
     - Call 1-800-678-9133 weekdays from 5am to 6pm (PST)
   - Schedule an appointment
   - Pay for your office visit when you arrive for your appointment

Your benefits, Your choices, Your health!

Ready to make an appointment?

You can visit **kp.org/newmember** to see where you can get care.

At kp.org/newmember, you can browse Kaiser doctor profiles and search based on what's important to you—like location, languages spoken, or gender. You can also call Kaiser for help at **1-888-956-1616**, Monday through Friday, 7am to 7pm.

Reminder! You can switch doctors for any reason, at any time.

Providing you the information you need.

Scan the QR code to connect and learn about your Kaiser HMO plan.

MEDICAL RESOURCES

KAISER PERMANENTE®

United Healthcare

VIRTUAL VISITS

When you need care — anytime, day or night — virtual visits can be a convenient option. Talk with a doctor 24/7 about mild conditions such as flus, fevers, colds, sore throats, migraines, rashes, allergies, stomach aches, pink eye, and more.

MOBILE APP & MEMBER ID CARDS

Access the convenient features of the free mobile app offered by your insurance carrier. View details about your plan benefits, search for in-network providers, and view claim history. You can also view an electronic copy of your member ID card.

MEMBER DISCOUNTS & WELLNESS

Being healthy can be affordable, too. Take advantage of healthy discounts and extras included with your health plan to help you live better. Find discounts and perks on a variety of services including fitness and weight loss programs, eye care and hearing aids, health assessments, chiropractor and acupuncture visits, and more.

CARE WHILE TRAVELING

If you get hurt or sick while traveling, you are covered for emergency care anywhere in the world. If you have an emergency while traveling, call 911 or go to the nearest emergency facility. Examples of emergency conditions are shortness of breath, excessive bleeding and severe pain to body parts or organs. If you need routine care while outside of your service area, contact your insurance carrier prior to your travel plans.

*For these and more helpful resources from **Kaiser** please scan the QR code!*

*For these and more helpful resources from **UHC** please scan the QR code!*

DENTAL PLAN OPTIONS

DELTA DENTAL HMO PLAN OPTION

Dental HMO plan is designed to help you and your family maintain oral health and reduce your out-of-pocket costs. This type of insurance requires some type of prepayment from you. In exchange, you get dental care from a network of dental care providers. If you want to use a dentist outside the approved network, you must pay your entire dentist's bill yourself.

- You must choose a DHMO network general dentist. You won't be covered if you go to a dentist who's not in the DeltaCare DHMO network.
- If you do not select a DHMO dentist when you first enroll, Delta Dental will assign a dentist for you.
- Delta Dental's ID card will have the name of the DHMO dentist you are assigned to on the plan.

CAN I SELECT A DIFFERENT PCD FOR MYSELF AND MY DEPENDENTS?

Yes, you can select different Primary Care Dentist (PCD) and/or dental group for yourself and each of your dependents.

WHEN CAN I CHANGE MY PCD OR DENTAL GROUP?

You must seek all dental services with the dentist you are assigned to. You may change the dentist you are assigned to for any reason. You must contact Delta Dental prior to the 15th of the month for new provider to be assigned the 1st of the following month.

WHAT IF I NEED A SECOND OPINION?

You can request a second opinion from a different network general dentist by calling Delta Dental's customer service; they will help you make the necessary arrangements.

DELTA DENTAL PPO PLANS (HIGH AND LOW OPTIONS)

You may self-refer to any dentist, but you will have a higher benefit level and lower out-of-pocket costs if you visit a Delta Dental PPO network dentist.

- Savings are greater when you visit an In-Network provider because Delta Dental's contracted dentists have agreed to provide care at a negotiated rate.
- Out-of-Network benefit amounts are subject to the Delta Dental contracted fee schedule. You will be responsible for the difference between the plan payment and the dentist's usual charge.

TRANSITION OF CARE FOR ORTHODONTICS

Orthodontic transition allows patients who are under an orthodontist's care through another dental insurance plan to continue seeing the same orthodontist that was treating their case prior to becoming a member of Delta Dental Plan. In order to be considered for orthodontic transition, the subscriber needs to complete an Orthodontic Transition of Care Summary form (posted on UKG's portal) and send it to Delta Dental.

DeltaCare USA: a prepaid, fixed copayment plan with added benefits.

Over 400 procedures are covered by your HMO plan including tooth whitening.

- Copayments are all-inclusive:
- No lab fees or other hidden fees
- No additional charges for metals or porcelain

Treatment for pre-existing conditions (except work in progress), including missing or extracted teeth, is covered under your plan.

Out-of-area emergency care:

You and your eligible dependents have out-of-area coverage for dental emergencies when you are more than 35 miles from your primary care dentist.

Your out-of-area emergency benefit (typically limited to $100 per person) is for services to relieve pain until you can return to your primary care network dentist. Standard plan limitations, exclusions and copayments may apply.

DENTAL HMO

FOR CA MEMBERS ONLY

	DELTA DENTAL HMO
HMO DENTAL PLAN BENEFITS[1]	**HMO NETWORK**
PLAN MAXIMUMS	
Calendar Year Deductible	No Deductible
Calendar Year Maximum Benefit	No Limit
PREVENTIVE PROCEDURES	
Office Visits	$5
D1110/D1120 Cleaning Adult/Child	$0
D0210 – D0330 X-rays & Imaging	$0
RESTORATIVE PROCEDURES	
D2391 White Filling (posterior)	$55
D3330 Molar Endodontics (root canal)	$250
D4261 Periodontal Osseous Surgery (gum disease)	$225
D4342 Periodontal Scaling & Root Planning (gum disease)	$20
MAJOR PROCEDURES	
D5110 – D5120 Complete Denture (maxillary or mandibular)	$145
D5211 – D5212 Partial Denture (maxillary or mandibular)	$120
D6240 Pontic (porcelain fused to a high noble metal)	$240*
D6750 Crown (porcelain fused to a high noble metal)	$240*
D7220 Surgery to remove impacted tooth (soft tissue)	$50
ORTHODONTIA	
Comprehensive Orthodontic Treatment (child—up to age 19)	$1,700
Comprehensive Orthodontic Treatment (adult)	$1,900

EMPLOYEE SEMI-MONTHLY CONTRIBUTIONS	DELTA DENTAL HMO
Employee	$0.00
Employee + Spouse	$3.17
Employee + Child(ren)	$0.00
Employee + Family	$4.78

[1]Please refer to UKG to access the Delta Dental HMO Patient Charge Schedule for a complete description of the dental plan benefits.
*No additional fees for porcelain or noble metal enhancements

DENTAL PPO

FOR CA & NON-CA MEMBERS

	DELTA DENTAL LOW DPPO			DELTA DENTAL HIGH DPPO	
DENTAL PPO PLAN BENEFITS	**DELTA PPO[1]**	**DELTA PREMIER[1]**	**OUT OF NETWORK[2]**	**IN NETWORK + DELTA PREMIER[1]**	**OUT OF NETWORK[3]**
PLAN MAXIMUMS					
Calendar Year Deductible (Single)	$25	$100	$100	$25	$25
Calendar Year Deductible (Family)	$75	$300	$300	$75	$75
Calendar Year Maximum Benefit	$1,500 per person			$1,500 per person	
PREVENTIVE & DIAGNOSTIC CARE					
Oral Examinations, Bitewing or Full Mouth X-rays, Cleanings and Sealants	0% deductible waived	0% deductible waived	0% deductible waived	0% deductible waived	0% deductible waived
BASIC RESTORATIVE PROCEDURES					
Fillings, Endodontics (root canal therapy), Periodontics, Simple Oral Surgery and Simple Extractions	20%	50%	50%	20%	20%
MAJOR RESTORATIVE CARE					
Crowns, Inlays, Onlays and Cast Restorations	50%	60%	60%	50%	50%
Implant Services	20%	50%	50%	20%	20%
ORTHODONTIA					
Orthodontia Lifetime Maximum (Adult and Child)	Not Covered			$1,500 per person	
Orthodontia Benefit (Adult and Child)	Not Covered			50%	50%

EMPLOYEE SEMI-MONTHLY CONTRIBUTIONS	DELTA DENTAL LOW PPO	DELTA DENTAL HIGH PPO
Employee	**$22.66**	**$30.89**
Employee + Spouse	**$43.24**	**$59.19**
Employee + Child(ren)	**$25.94**	**$52.62**
Employee + Family	**$50.99**	**$91.30**

[1]Reimbursement based on Delta Dental's Fee Schedule. Members are not subject to balance billing.
[2]Reimbursement based on Delta Dental's Maximum Allowable Charges. Members may be subject to balance billing.
[3]Reimbursement based on Delta Dental's Program Allowance. Members may be subject to balance billing.

Sign up as a member online to print ID cards, locate providers, view benefits or claims and access cost estimator tool.

www.deltadentalins.com

DELTA DENTAL PLANS

Choosing the right dental plan can be challenging. Everyone's needs are different, and each dental plan works differently. Use this tool to help compare HMO and PPO dental plans.

Lower premium

Limited to DHMO dentists

Only specialists referred by your DHMO dentist

No maximum. As long as you can pay the copays the plan continues to cover you

Higher premium

Can see any dentist—in or out of network

Can see any specialist—in or out of network

$1500 maximum for the PPO Low, and PPO High. Once maximum is met, the plan will turn off for the remainder of the calendar year.

It is highly recommended that you request a treatment plan prior to any non-routine procedures and submit the treatment plan for predetermination of benefits.
Predetermination of benefits will give you a clear understanding of all your anticipated costs (deductible, coinsurance and reaching maximum benefit limit).

If you would like assistance with obtaining predetermination of benefits, please contact the Employee Support Center at **855.670.2222** or by email at **LosAngeles.ESC@ajg.com**

CHOOSING THE RIGHT DPPO

When you need dental care, choosing an in-network dentist is always a good idea. That's because network dentists have agreed to offer reduced fees and abide by Delta Dental policies—and have met industry standards for care, safety and cleanliness. Each PPO plan offers access to one or more of Delta Dental's dentist networks.

Delta Dental's Networks: What's the Difference?

DELTA DENTAL PPO™

Provides access to more than 112,000 dentists in 278,000+ locations nationwide.

Reduced Fees
Delta Dental PPO dentists are always considered contracted providers and offer the deepest discounts on dental procedures.

Stretch Your Maximum Dollars
Since fees are usually the lowest, your annual maximum dollars would go further.

Balance Billing
Your dentist can't charge you above his or her accepted fees. You will not receive a bill for the difference in balance due.

DELTA DENTAL PREMIER

More than 156,000 participating dentists in 342,000+ locations nationwide.

Reduced Fees
Premier dentists have agreed to reduced fees; however, these fees are higher than Delta Dental PPO provider fees.

Stretch Your Maximum Dollars
Your maximum dollars may go further than with a non-Delta Dental dentist, but not as far as with a PPO dentist

Balance Billing
High Plan: Your dentist can't charge you above his or her accepted fees.

Low Plan: You may be subject to some balance billing.

Save on Your Dental Bills!
Compare Your Options



Member Name	Joe	Sue	Ben
Procedure	Tooth Filling	Tooth Filling	Tooth Filling
Network Used	PPO In Network (Fee Schedule)	Delta Premier	Out of Network
Coinsurance	20%	20%	20%
Provider Fee	$125	$125	$125
Fee Schedule/MAC	$100	$110	$100
Delta Dental Pays (Low/High)	$80	$88	$80
Member Pays (Low/High)	$20	$37 (Low Plan)/$22 (High Plan)	$45
Provider Write-off (Low/High)	$25	$0 (Low Plan)/$15 (High Plan)	$0

The above chart is for illustrative purposes. Actual fees and discounts will vary by dentist and area.

Where's my Delta Dental ID Card?

If you've been looking for your dental plan ID card, we have good news for you: You don't need one!

Just tell your dental office the Delta Dental company through which you receive benefits and provide your name, your date of birth, your enrollee ID number (or social security number) and the name of your employer.

Want an ID card anyway?

Go to **deltadentalins.com**, log in to Online Services, then click on **Print ID card.**

You can also pull it up on your smartphone by downloading the **Delta Dental app** (by the Delta Dental Plans Association) from the App Store or Google Play.

Download on the App Store | GET IT ON Google Play

BrushSmart to Transform Your Oral Health!

BrushSmart is a new oral wellness program, exclusively for **Delta Dental HMO and PPO** plan enrollees, that offers personalized solutions, oral care and discounts on the products that help you improve your dental care routine.

Sign up today to get special discounts on Phillips Sonicare products. To get started:

- Go to **brushsmart.org**
- Fill out the sign-up section
- Check the user agreement box, then click the **Join BrushSmart** button.
- That's it! You'll receive your coupon code and a confirmation email.

DELTA DENTAL PROVIDER SEARCH

Use the below steps to find HMO and PPO In Network dentists, specialists and orthodontists

1. Go to **www.deltadentalins.com/find-a-dentist**
2. Under "**Find a Dentist**" on the right hand side of the screen, enter your Address, Zip Code, City, or State
3. **For the HMO Plan**: From the "Select Network" drop down menu select "**DELTACARE USA**"

   For the PPO Plan: From the "Select Network" drop down menu select "**DELTA DENTAL PPO**" or "**DELTA DENTAL PREMIER**"
4. Click "**Search**" to generate a list of contracted providers. Click "**Refine search"** to filter by categories such as specialty, network and language.

REMINDER For best results, please sign up on **www.deltadentalins.com** or download the **Delta Dental Mobile App** to access member specific provider search results and other information.

VISION PLAN

EYEMED VISION

EyeMed's Vision plan is a PPO plan that offers both in-network and out-of-network benefits. With EyeMed's Vision plan, you have access to independent providers as well as convenient retail stores like LensCrafters®, Target Optical®, and most PearleVision® locations. You also can order glasses and contacts online through Glasses.com (**glasses.com**), ContactsDirect (**ContactsDirect.com**).

When you use one of the providers in EyeMed's extensive network, you receive a higher level of coverage and you are only required to pay a copayment at the time of service. With an out-of-network provider, you must pay the bill in full and file a claim for reimbursement of covered benefits up to the allowance reimbursement schedule.

WHAT'S AN ALLOWANCE?

An allowance is a set amount of money the plan covers toward the purchase of eyeglass frames or other items. Here's a simple-to-follow example. If your plan includes a frame allowance for $120 and you select frames that cost $150, you'll owe $30 for frames at the time of purchase. As an EyeMed member, you may also receive an additional 20% off the remaining balance at participating providers – so your final cost for the frame could be as low as $24.

WHAT ARE THE DIFFERENT "MATERIALS"?

Vision materials refer to frames, lenses or contact lenses offered at a provider location. Materials may come with certain limitations and exclusions regulated by your policy or by the materials manufacturer.

WHAT'S A PLAN FREQUENCY AND HOW DOES IT WORK?

The vision plan has specified frequency for each covered benefit period. If your plan frequency reads "**Once every 12 months**" on your benefit summary, then benefits will refresh 12 months after the last date of service. For example: if a member used their benefit on March 17, 2024 then benefits will refresh on that day the following year, March 17, 2024.
If your plan frequency reads "**Once every 24 months**" on your benefit summary, then benefits will refresh 24 months after the last date of service. For example: If a member used their benefit on March 17, 2024 then benefits will refresh on that day 24 months later, March 17, 2025.

WHAT IS A PLUS PROVIDER?

Certain in-network providers offer an extra level of savings built right into your vision care — like a $0 exam copay and enhanced frame allowance. Providers with the  are PLUS Providers. Look for this symbol when choosing a provider.

Introducing Eye360…

Eye3601 provides enhanced benefits when members visit a PLUS Provider—a select group of providers in the EyeMed network. Eye360 focuses on health, simplicity and savings. Best of all, the perks are built into the vision plan. That means no promo codes or paperwork required.

Seeing Savings

With Eye360, members receive $0 copay eye exams and an additional $50 frame allowance at PLUS Providers—on top of the base plan's benefits. And when combined with other offers and discounts, it adds up to truly eye-opening savings.

Vision Care Is Healthcare

An annual eye exam not only helps uncover vision correction needs, it can sometimes be the first to detect signs of serious health conditions, such as diabetes, high blood pressure, high cholesterol and eye diseases like glaucoma and cataracts. With Eye360, $0 annual eye exams help encourage employees to be proactive with their holistic healthcare.

Find nearby PLUS Providers on our Provider Locator

Just look for the PLUS

EYEMED VISION

	WHAT YOU PAY	
VISION PLAN BENEFITS	**IN NETWORK**	**OUT OF NETWORK**
EXAMS (every 12 months)		
Vision Exam	$10 Exam Co-pay **$0 Plus Providers**	Up to $40 Reimbursement
LENSES (EVERY 12 MONTHS)		
Single Bifocal Trifocal	$25 Material Co-pay	Reimbursement up to: $30 $50 $70
FRAMES (every 24 months)		
Frames	$120 allowance/**$170 allowance (Plus Providers)**, then 20% off amount over frame allowance	Up to $84 Reimbursement
CONTACTS[1] (IN LIEU OF GLASSES) (every 12 months)		
Medically Necessary[2]	Covered in Full	Up to $300 Reimbursement
Elective	$120 allowance[3], then 15% off remaining balance	Up to $84 Reimbursement

EMPLOYEE SEMI-MONTHLY CONTRIBUTIONS	EYEMED VISION
Employee	**$0.00**
Employee + Spouse	**$1.19**
Employee + Child(ren)	**$0.00**
Employee + Family	**$2.38**

If you utilize Out of Network services, you may be required to make a full payment and submit a claim form for reimbursement.

[1]Contact lens allowance can only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases made during the same benefit period, nor can any unused amount be carried over to the following benefit period.

[2]Non-elective contact lenses are provided for reasons that are not cosmetic in nature and have a maximum benefit per benefit period. Non-elective contact lenses are covered when the following conditions have been identified or diagnosed:

Extreme Visual Acuity or other functional problems that cannot be corrected by spectacle lenses; or

Keratoconus: Unusual cone-shaped thinning of the cornea of the eye which usually occurs before the age of 20 years; or

High Ametropia: Unusually high levels of near sightedness, far sightedness, or

Anisometropia: When one eye requires a much different prescription than the other eye.

[3]Elective Conventional Lenses get additional 15% discount off any remaining balance. There is no additional discount on Elective Disposable Lenses.

EYEMED VISION PROVIDER SEARCH

1. Go to **www.eyemed.com**
2. Click “**Find an eye doctor**” at the top, right corner of the screen.
3. Under “**Network**” select “**Access**” from the drop-down menu
4. You may search by location, or search for a specific doctor by name. You may also search for online providers or Lasik specialists.
5. A list of localized providers will be generated for you to choose from.

Download the EyeMed Mobile app today!

With the **EyeMed** app, you can manage your benefits anytime and anywhere you go.

Just search for **EyeMed** and download the app, On the app you can find a doctor, get your ID card, estimate your costs, view your medical records, manage prescriptions, and more.

What expenses will you incur during the plan year?

Deductibles, coinsurance or copayments	$_____
Dental Care (exams, fillings, crowns)	$_____
Vision (exams, contacts, frames)	$_____
Hearing Care (exams, hearing aids and batteries)	$_____
Infertility treatment	$_____
Insulin and diabetic supplies	$_____
Prescription drugs (e. g. generic, brand, formulary, injectables)	$_____
Total pre-tax contributions to Healthcare Flexible Spending Accounts:	$_____

Contact The Advantage Group representative
By phone: (877) 506-1660
Email: support@enrollwithtag.com

THE ADVANTAGE GROUP

WHAT IS FSA

Flexible Spending Accounts (FSAs) are a great way to save on income taxes while you budget for healthcare and dependent care expenses. Your contributions to the FSAs are made with pre-tax dollars, meaning you pay no federal or Social Security taxes on that money and, depending on your state, you may not have to pay state taxes either (CA included). This leaves a smaller amount of your income subject to taxes. And when you pay less in income taxes, your take-home pay increases!

Your Options

- **HEALTH CARE FSA (HC FSA)**
  not available if enrolled in the UHC HSA medical plan
- **Limited Purpose FSA (LP FSA)**
  available if enrolled in the UHC HSA medical plan
- **Dependent Care FSA (DC FSA)**

How FSA(s) Work

ESTIMATE YOUR NEEDS

Estimate your out-of-pocket healthcare and/or dependent care expenses for the year.

ELECT YOUR CONTRIBUTION AMOUNT:

HC FSA/LP FSA: up to $3,200/year

DC FSA: up to $5,000 per year
Your total annual election will be deducted from each paycheck on a pre-tax basis

USE/MANAGE YOUR FSA

HC FSA/LP FSA: use your preloaded FSA debit card to pay for health care expenses or pay out-of-pocket and submit receipt online for reimbursement

DC FSA: limited to out-of-pocket expense claim reimbursement only

FSA Key Deadlines

Enroll and elect 2024 contribution amount	2024 eligible expenses must be incurred	HC FSA/LP FSA provide up to $640 carryover option to rollover unused contributions to next year.	Last day to submit eligible HC FSA, LP FSA, or DC FSA expenses incurred in 2024 for reimbursement
During annual Open Enrollment or within 30 days of hire date	HC FSA: 7/31/2025 LP FSA: 7/31/2025 DC FSA: 10/15/2025	Carryover balance will be available after 10/31/2025	10/31/2025

FSA AT A GLANCE

How Does FSA Work?

HEALTH CARE FSA AND/OR LIMITED PURPOSE FSA	DEPENDENT CARE FSA
Purpose	
HC FSA allows you to use pre-tax dollars to help pay for out-of-pocket costs for healthcare (medical, dental, vision) expenses such as deductibles, copays, and other share of costs. If enrolled in Health Savings Account (HSA), LP FSA allows you to use pre-tax dollars to help pay for out-of-pocket costs for dental and vision expenses such as deductibles, copays, and other share of costs. This plan is limited to dental & vision expenses only.	DC FSA Allows you to use pre-tax dollars to reimburse yourself for eligible dependents' day care needs. Under certain circumstances, the account may be used to help pay for the care of elderly dependents or a disabled spouse or dependent. Your dependent care expenses must be for qualified individuals, including: • Your dependent child under the age of 13 who lives with you for more than half the year. • Your spouse or other tax dependent who is physically or mentally incapable of self-care and lives with you for more than half the year.
How Much You Can Contribute	
You may elect to contribute a whole-dollar amount between $100 and $3,200 per participant for the full plan year through payroll deductions. You cannot change your election mid-year unless you have a Qualifying Life Event.	You may elect to contribute a whole-dollar amount between $100 and $5,000 per year, per household ($2,500 if you are married and file separate tax returns) through payroll deductions. You cannot change your election unless you have a Qualifying Life Event.
When Are the Funds Available	
Your entire annual contribution election is available for reimbursement on August 1st, even if you have not contributed the full amount to your account.	Your funds become available as your contributions are made through payroll deductions. If you file a Dependent Care reimbursement claim that is more than the amount you currently have accumulated in your FSA, you will be reimbursed only up to the amount you've contributed to date. You will be reimbursed for the rest of the claim as the funds get added into your account each pay period.
Reimbursement Process	
You can use the FSA debit card to pay for any approved expenses or submit a claim for reimbursement. You'll be reimbursed up to the full amount you elected to contribute for the year, minus any paid claims. You cannot transfer funds between the FSA accounts. Be sure to keep your receipts in case your account is audited.	Once you have paid for expenses that qualify for reimbursement from the DC FSA, you will need to submit a claim. You'll be reimbursed up to the amount currently in your account. Dependent Care providers must be able to provide their Tax ID or SSN on the invoice presented. They cannot be a relative living in the same household or dependent children under the age of 19.
"Use It or Lose It" Rule	
Your HC FSA and LP FSA offer **Carryover** option. Up to $640 of any remaining balance as of October 31, 2025 can be rolled over for use in 2025/2026 plan year. **HAVE LEFTOVER FUNDS?** Visit **www.FSAstore.com** to purchase FSA eligible items by the end of the plan year.	Any remaining balance as of October 31, 2025 is forfeited per Internal Revenue Code, meaning those funds may not be paid back to you in cash or carried over for use in future plan years.

How Do I Create An Online Account?

All active participants have access to their online account features at:
http://enrollwithtag.wealthcareportal.com
Here you can easily access all of your account's activities, including viewing up-to-date account balance information, pending claims status, claims history, and submit for claims reimbursement from your personal account page.

Follow these simple instructions to create your account (new users):
Log on to: **http://enrollwithtag.wealthcareportal.com** and select **REGISTRATION.** Follow the prompts and enter your information. Select **NEXT** and create your **USERNAME AND PASSWORD**. Your login is now established and you will be directed to your personal account page where you can view up to date account information and access a variety of additional account features.

How Do I Submit Claims and Request Reimbursements Online?

You can pay out of pocket and request reimbursement through your online account. Your reimbursement can be paid to you as a check or direct deposit.

Follow these simple instructions to submit your claims:
Login to http://enrollwithtag.wealthcareportal.com and select **CLAIMS & PAYMENTS** from the drop-down menu, then click on **SUBMIT A CLAIM**. Review the 3 steps and click **NEXT**. Enter your receipt information and then click **ADD**. Please note: you can enter one expense at a time and you will be able to track each expense separately. After all expenses are entered, click **NEXT**. Follow the Upload instructions to upload your receipt(s) and click **NEXT**. Once Receipt is uploaded correctly, it will be referenced below **UPLOADED RECEIPT FILES FOR THIS CLAIM**. Please click on **SUBMIT RECEIPT FOR THIS CLAIM** to complete the process.

For more assistance please contact TAG participant support: **(877) 507-1660 or support@enrollwithtag.com**

GET THE TAG BENEFIT CENTER MOBILE APP TODAY!

FSA: WHAT IS AND ISN'T ELIGIBLE

What qualifies for FSA?

HEALTH CARE FSA

- Deductibles/coinsurance/copays
- Contact lenses/eyeglasses/LASIK
- Dental treatments/orthodontia
- Hearing exams & hearing aids
- Chiropractic/Acupuncture care
- Durable medical equipment (DME)
- Prescription drugs
- Over-the-counter medications (OTC) and qualified OTC first aid type items
- Other qualified medical expenses
- For a more extensive list of qualified medical and dependent care expenses, visit the IRS website at: **www.irs.gov/pub/irs-pdf/p502.pdf**

DEPENDENT CARE FSA

- After school program for child(ren)
- Au Pair for child(ren)
- Nursery School/Preschool
- Before or after school programs for child(ren)
- Adult daycare center
- Transportation to and from eligible care (provided by your care provider)
- Summer day camp for child(ren)
- Babysitting for child(ren) (Work-related, in your home or someone else's home)
- For a more extensive list of qualified medical and dependent care expenses, visit the IRS website at **www.irs.gov/pub/irs-pdf/p503.pdf**

What can't I use my FSA for?

- Cosmetic expenses
- Insurance premiums
- Nutritional supplements
- Weight loss programs
- Personal use items
- Medication from other countries

- Activity fees
- Educational, learning, or study skills services for child(ren)
- Kindergarten/School tuition
- Field trips for child(ren)
- Custodial elder care (not work-related, for other purpose)
- Meals, food or snacks for child(ren)
- Sleep-away camp for child(ren)
- Babysitting for child(ren) (not work-related

COMMUTER SPENDING ACCOUNT (CSA)

WHAT IS A COMMUTER SPENDING ACCOUNT (CSA)?

All Heluna Health employees are eligible to participate in the Commuter Spending Account, which includes Transit and/or Parking accounts.

Commuter Spending Account (CSA) enables you to pay for certain job-related transit and/or parking expenses on a tax-free basis through pre-tax (exempt from Federal, State and Social Security/FICA taxes) payroll deductions. CSA(s) are not tied to a benefit year, so the funds will remain in your account until exhausted (time limits for incurred claims apply). Election changes are not limited by a plan year and can be updated or stopped as your needs change.

When you enroll in a CSA, you determine the amount of qualifying commuter expenses you will have each month during the course of your plan year. This amount will be deducted from each paycheck and placed in your CSA. As you incur eligible costs, you can submit a claim form and documentation of your costs to The Advantage Group. TAG will reimburse you with available funds from your CSA account up to the allowed maximum amount.

	EXAMPLE OF SAVINGS PER MONTH		
	Without CSA (TAG)	With CSA (TAG)	Savings[1]
Mass-Transportation	$315	$210	$105
Parking	$315	$210	$105
Total	**$630**	**$420**	**$210**

[1]*The tax savings represented above are for illustration purposes only and vary among participants.*

HOW MUCH CAN I GET BACK DURING A PERIOD OF COVERAGE?

You can receive up to the IRS maximum monthly limit for transit and/or parking expenses.
The maximum monthly pre-tax allowances in 2024 are:

- Qualified Commuter/Transit Expense: $315.00/month
- Qualified Parking Expense: $315.00/month
- Any incurred claims must be submitted within 6 months
- IRS guideline requires all Transportation expenses to be paid with debit card. Parking expenses can be paid with debit card or submitted for reimbursement.

WHAT ARE QUALIFIED COMMUTER EXPENSES?

Commuter highway vehicle - A commuter highway vehicle is any highway vehicle that seats at least 6 adults, not including the driver. In addition, you must reasonably expect that at least 80% of the vehicle mileage will be for transportation between your home and work place with qualified passengers occupying at least one-half the vehicle's seats (not including the driver).

Transit pass - A transit pass is any pass, token, fare-card, voucher, or similar item entitling a person to ride one of the following 1) On mass transit, or 2) In a vehicle that seats at least 6 adults (not including the driver) if a person in the business of transporting individuals for pay or hire operates it. Mass transit may be publicly or privately operated and includes bus, light rail, regional rail, trolley, subway, ferry, etc.

Qualified parking - Qualified parking is parking provided to employees on or near your business premises. It includes parking on or near the location from which you commute to work using mass transit, commuter highway vehicles, or carpools. It does not include parking at or near your home.

BASIC LIFE INSURANCE

100% employer paid

This benefit is paid by Heluna Health. There is no cost to the employee!

All benefit eligible employees with Heluna Health are provided with employer paid Life and Accidental Death & Dismemberment (AD&D) coverage. All eligible employees are automatically enrolled in Life and AD&D plans.

ELIGIBILITY	BENEFIT AMOUNT
All benefit eligible employees	$50,000

Accidental Death and Dismemberment (AD&D)

100% of the Basic Life Benefit

Provides specified benefits for a covered accidental bodily injury that directly causes dismemberment In the event of death that occurs from a covered accident, both Life and AD&D benefits would be payable each in the amount of the basic life insurance

Benefits After Age 65

Your life benefits will reduce after age 70 and terminate at retirement.
The reduction schedule is as follows:

Age 65 – no change

Age 70 – reduced by 50%

Reminder! Please update your Life Insurance beneficiary information on UKG during Open Enrollment. You may make changes to your beneficiary assignment throughout the year.

NEW YORK LIFE

SUPPLEMENTAL LIFE INSURANCE

100% employee paid

This benefit is voluntary, paid by employees through after-tax payroll deductions

Because you may need additional coverage, Heluna Health offers you an opportunity to purchase extra life insurance at competitive group rates. The Supplemental Life and Accidental Death & Dismemberment (AD&D) insurance is available for employees, their spouses, and/or child(ren). You do not need to enroll in medical, dental, or vision plans to be eligible to enroll in this plan.

SUPPLEMENTAL EMPLOYEE LIFE/AD&D

Employees may purchase additional coverage in $10,000 increments, not to exceed 5 times annual salary or $300,000, whichever is less.

- New Hire Guaranteed Issue amount of $300,000
- Employee coverage will continue while actively employed (regardless of age)
- During Annual Open Enrollment, employees can increase existing coverage by up to $20,000 not to exceed Guaranteed Issue amount.

SUPPLEMENTAL SPOUSE LIFE/AD&D

You may purchase additional coverage for your spouse in $5,000 increments, not to exceed 100% of employee coverage or $150,000, whichever is less

- New Hire Guaranteed Issue amount of $60,000
- Spouse coverage will terminate when employee attains age 70
- Spouse coverage may only be elected if the employee is enrolled
- During Annual Open Enrollment, employees can increase existing coverage by up to $10,000 not to exceed the Guaranteed Issue amount.

SUPPLEMENTAL CHILD(REN) LIFE ONLY

You may purchase additional coverage for your child(ren) in the following amounts:

- Birth to 6 months: $500; 6 months to age 26 = $10,000
- Child coverage may only be elected if the employee is enrolled

Should you choose to elect coverage outside of your initial eligibility period, you or your spouse will need to complete the Evidence of Insurability (EOI) Form for medical underwriting purposes.

How much Insurance Can I Buy?

You can customize coverage to fit your family's needs. Your salary determines the maximum coverage amount available to you.

Who is eligible for this coverage?

You must be actively working (performing all normal duties of your job) at least 20 hours per week. Your dependent(s) must be performing normal activities and not be confined (at home or in a hospital/care facility).

Can I take this insurance with me if I change jobs or leave?

In the event this insurance ends due to a change in your employment/membership status with Heluna Health, you and your insured spouse may have the right to continue the policies under the Portability or Conversion provision, subject to certain conditions.

Late Entrants

If enrolling during open enrollment period and you ***did not elect coverage*** for yourself or your dependents when you were first eligible or were previously denied coverage through New York Life, any coverage amount is subject to New York Life's approval. You will be required to submit Evidence of Insurability (EOI) form.

Annual Guaranteed Increase

During annual enrollment periods, if you have not been previously denied and have elected at least one increment of coverage, you may select to increase your current coverage amount up to **$20,000 and $10,000** for your spouse without providing EOI form to New York Life.

NEW YORK LIFE

SUPPLEMENTAL LIFE INSURANCE RATES

EMPLOYEE SEMI-MONTHLY PREMIUMS

Attained Age	Employee Amounts of Insurance									
	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
<25	$0.28	$0.56	$0.84	$1.12	$1.40	$1.68	$1.96	$2.24	$2.52	$2.80
25 - 29	$0.28	$0.56	$0.84	$1.12	$1.40	$1.68	$1.96	$2.24	$2.52	$2.80
30 - 34	$0.38	$0.76	$1.14	$1.52	$1.90	$2.28	$2.66	$3.04	$3.42	$3.80
35 - 39	$0.48	$0.96	$1.44	$1.92	$2.40	$2.88	$3.36	$3.84	$4.32	$4.80
40 - 44	$0.58	$1.16	$1.74	$2.32	$2.90	$3.48	$4.06	$4.64	$5.22	$5.80
45 - 49	$0.83	$1.66	$2.49	$3.32	$4.15	$4.98	$5.81	$6.64	$7.47	$8.30
50 - 54	$1.23	$2.46	$3.69	$4.92	$6.15	$7.38	$8.61	$9.84	$11.07	$12.30
55 - 59	$2.08	$4.16	$6.24	$8.32	$10.40	$12.48	$14.56	$16.64	$18.72	$20.80
60 - 64	$2.88	$5.76	$8.64	$11.52	$14.40	$17.28	$20.16	$23.04	$25.92	$28.80
65 - 69	$5.38	$10.76	$16.14	$21.52	$26.90	$32.28	$37.66	$43.04	$48.42	$53.80
70 - 74	$8.63	$17.26	$25.89	$34.52	$43.15	$51.78	$60.41	$69.04	$77.67	$86.30
75+	$8.63	$17.26	$25.89	$34.52	$43.15	$51.78	$60.41	$69.04	$77.67	$86.30

Attained Age	Employee Amounts of Insurance									
	$110,000	$120,000	$130,000	$140,000	$150,000	$160,000	$170,000	$180,000	$190,000	$200,000
<25	$3.08	$3.36	$3.64	$3.92	$4.20	$4.48	$4.76	$5.04	$5.32	$5.60
25 - 29	$3.08	$3.36	$3.64	$3.92	$4.20	$4.48	$4.76	$5.04	$5.32	$5.60
30 - 34	$4.18	$4.56	$4.94	$5.32	$5.70	$6.08	$6.46	$6.84	$7.22	$7.60
35 - 39	$5.28	$5.76	$6.24	$6.72	$7.20	$7.68	$8.16	$8.64	$9.12	$9.60
40 - 44	$6.38	$6.96	$7.54	$8.12	$8.70	$9.28	$9.86	$10.44	$11.02	$11.60
45 - 49	$9.13	$9.96	$10.79	$11.62	$12.45	$13.28	$14.11	$14.94	$15.77	$16.60
50 - 54	$13.53	$14.76	$15.99	$17.22	$18.45	$19.68	$20.91	$22.14	$23.37	$24.60
55 - 59	$22.88	$24.96	$27.04	$29.12	$31.20	$33.28	$35.36	$37.44	$39.52	$41.60
60 - 64	$31.68	$34.56	$37.44	$40.32	$43.20	$46.08	$48.96	$51.84	$54.72	$57.60
65 - 69	$59.18	$64.56	$69.94	$75.32	$80.70	$86.08	$91.46	$96.84	$102.22	$107.60
70 - 74	$94.93	$103.56	$112.19	$120.82	$129.45	$138.08	$146.71	$155.34	$163.97	$172.60
75+	$94.93	$103.56	$112.19	$120.82	$129.45	$138.08	$146.71	$155.34	$163.97	$172.60

Attained Age	Employee Amounts of Insurance									
	$210,000	$220,000	$230,000	$240,000	$250,000	$260,000	$270,000	$280,000	$290,000	$300,000
<25	$5.88	$6.16	$6.44	$6.72	$7.00	$7.28	$7.56	$7.84	$8.12	$8.40
25 - 29	$5.88	$6.16	$6.44	$6.72	$7.00	$7.28	$7.56	$7.84	$8.12	$8.40
30 - 34	$7.98	$8.36	$8.74	$9.12	$9.50	$9.88	$10.26	$10.64	$11.02	$11.40
35 - 39	$10.08	$10.56	$11.04	$11.52	$12.00	$12.48	$12.96	$13.44	$13.92	$14.40
40 - 44	$12.18	$12.76	$13.34	$13.92	$14.50	$15.08	$15.66	$16.24	$16.82	$17.40
45 - 49	$17.43	$18.26	$19.09	$19.92	$20.75	$21.58	$22.41	$23.24	$24.07	$24.90
50 - 54	$25.83	$27.06	$28.29	$29.52	$30.75	$31.98	$33.21	$34.44	$35.67	$36.90
55 - 59	$43.68	$45.76	$47.84	$49.92	$52.00	$54.08	$56.16	$58.24	$60.32	$62.40
60 - 64	$60.48	$63.36	$66.24	$69.12	$72.00	$74.88	$77.76	$80.64	$83.52	$86.40
65 - 69	$112.98	$118.36	$123.74	$129.12	$134.50	$139.88	$145.26	$150.64	$156.02	$161.40
70 - 74	$181.23	$189.86	$198.49	$207.12	$215.75	$224.38	$233.01	$241.64	$250.27	$258.90
75+	$181.23	$189.86	$198.49	$207.12	$215.75	$224.38	$233.01	$241.64	$250.27	$258.90

SUPPLEMENTAL LIFE INSURANCE RATES

DEPENDENT SEMI-MONTHLY PREMIUMS

Attained Age*	Spouse Amounts of Insurance**									
	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
<25	$0.14	$0.28	$0.41	$0.55	$0.69	$0.83	$0.96	$1.10	$1.24	$1.38
25 - 29	$0.14	$0.28	$0.41	$0.55	$0.69	$0.83	$0.96	$1.10	$1.24	$1.38
30 - 34	$0.19	$0.38	$0.56	$0.75	$0.94	$1.13	$1.31	$1.50	$1.69	$1.88
35 - 39	$0.24	$0.48	$0.71	$0.95	$1.19	$1.43	$1.66	$1.90	$2.14	$2.38
40 - 44	$0.29	$0.58	$0.86	$1.15	$1.44	$1.73	$2.01	$2.30	$2.59	$2.88
45 - 49	$0.41	$0.83	$1.24	$1.65	$2.06	$2.48	$2.89	$3.30	$3.71	$4.13
50 - 54	$0.61	$1.23	$1.84	$2.45	$3.06	$3.68	$4.29	$4.90	$5.51	$6.13
55 - 59	$1.04	$2.08	$3.11	$4.15	$5.19	$6.23	$7.26	$8.30	$9.34	$10.38
60 - 64	$1.44	$2.88	$4.31	$5.75	$7.19	$8.63	$10.06	$11.50	$12.94	$14.38
65 - 69	$2.69	$5.38	$8.06	$10.75	$13.44	$16.13	$18.81	$21.50	$24.19	$26.88

Attained Age*	Spouse Amounts of Insurance**									
	$55,000	$60,000	$65,000	$70,000	$75,000	$80,000	$85,000	$90,000	$95,000	$100,000
<25	$1.51	$1.65	$1.79	$1.93	$2.06	$2.20	$2.34	$2.48	$2.61	$2.75
25 - 29	$1.51	$1.65	$1.79	$1.93	$2.06	$2.20	$2.34	$2.48	$2.61	$2.75
30 - 34	$2.06	$2.25	$2.44	$2.63	$2.81	$3.00	$3.19	$3.38	$3.56	$3.75
35 - 39	$2.61	$2.85	$3.09	$3.33	$3.56	$3.80	$4.04	$4.28	$4.51	$4.75
40 - 44	$3.16	$3.45	$3.74	$4.03	$4.31	$4.60	$4.89	$5.18	$5.46	$5.75
45 - 49	$4.54	$4.95	$5.36	$5.78	$6.19	$6.60	$7.01	$7.43	$7.84	$8.25
50 - 54	$6.74	$7.35	$7.96	$8.58	$9.19	$9.80	$10.41	$11.03	$11.64	$12.25
55 - 59	$11.41	$12.45	$13.49	$14.53	$15.56	$16.60	$17.64	$18.68	$19.71	$20.75
60 - 64	$15.81	$17.25	$18.69	$20.13	$21.56	$23.00	$24.44	$25.88	$27.31	$28.75
65 - 69	$29.56	$32.25	$34.94	$37.63	$40.31	$43.00	$45.69	$48.38	$51.06	$53.75

Attained Age*	Spouse Amounts of Insurance**									
	$105,000	$110,000	$115,000	$120,000	$125,000	$130,000	$135,000	$140,000	$145,000	$150,000
<25	$2.89	$3.03	$3.16	$3.30	$3.44	$3.58	$3.71	$3.85	$3.99	$4.13
25 - 29	$2.89	$3.03	$3.16	$3.30	$3.44	$3.58	$3.71	$3.85	$3.99	$4.13
30 - 34	$3.94	$4.13	$4.31	$4.50	$4.69	$4.88	$5.06	$5.25	$5.44	$5.63
35 - 39	$4.99	$5.23	$5.46	$5.70	$5.94	$6.18	$6.41	$6.65	$6.89	$7.13
40 - 44	$6.04	$6.33	$6.61	$6.90	$7.19	$7.48	$7.76	$8.05	$8.34	$8.63
45 - 49	$8.66	$9.08	$9.49	$9.90	$10.31	$10.73	$11.14	$11.55	$11.96	$12.38
50 - 54	$12.86	$13.48	$14.09	$14.70	$15.31	$15.93	$16.54	$17.15	$17.76	$18.38
55 - 59	$21.79	$22.83	$23.86	$24.90	$25.94	$26.98	$28.01	$29.05	$30.09	$31.13
60 – 64	$30.19	$31.63	$33.06	$34.50	$35.94	$37.38	$38.81	$40.25	$41.69	$43.13
65 – 69	$56.44	$59.13	$61.81	$64.50	$67.19	$69.88	$72.56	$75.25	$77.94	$80.63

Dependent Child Age	Child Amounts of Insurance
	$10,000
Up to 26 years	$0.47

* Spouse coverage terminates at Employee Age 70.
** Spouse Rates are based on employee's age.

CARVE OUT SHORT TERM DISABILITY

FOR NON-CA MEMBERS

100% employer paid

This benefit is paid by Heluna Health. There is no cost to the employee!

Employees residing and working outside of California are provided with employer paid Basic Short Term Disability coverage for those unexpected situations (illness or injury) that may keep you from performing the daily responsibilities of your job. This benefit is exclusively offered to all benefits eligible Non-CA employees. California employees are insured through CA State Disability Insurance (SDI). Please note that this is a separate benefit from the Worker's Compensation coverage for work-related injuries.

SHORT TERM DISABILITY

You will need to satisfy a 7-day elimination period before short term disability benefits would begin. This elimination period can be satisfied with days of partial disability, total disability or a combination of both. If you are totally disabled beyond the elimination period due to a covered injury or sickness, you will be eligible to receive a weekly benefit up to 60% (non-integrated) of your basic weekly income, up to $1,540 per week.

The Maximum benefit duration is 25 weeks (26 weeks with elimination period).

WILL MY BENEFITS BE REDUCED BY OTHER SOURCES OF INCOME?

Yes, depending on the type of income you receive. Your benefit amount may be reduced by other sources of income such as retirement/government plans, paid family leave, salary continuance/sick leave, settlements on payments received and no -fault benefits.

NEW YORK LIFE

Refer to the New York Life plan documents for a complete description of this plan.

VOLUNTARY SHORT TERM DISABILITY

This benefit is voluntary, paid by employees through after-tax payroll deductions

Employees can elect Voluntary Short Term Disability coverage for those unexpected situations (illness or injury) that may keep you from performing the daily responsibilities of your job. The voluntary disability plan is available to help supplement your income in addition to CA SDI (CA employees) or employer paid Basic Short Term Disability coverage (Non-CA employees). Please note that this is a separate benefit from the Worker's Compensation coverage for work-related injuries.

SHORT TERM DISABILITY

You will need to satisfy a 7-day elimination period before short term disability benefits would begin. This elimination period can be satisfied with days of partial disability, total disability or a combination of both. If you are totally disabled beyond the elimination period due to a covered injury or sickness, you will be eligible to receive a weekly benefit equal to 20% (non-integrated) of your basic weekly income, up to $1,500 per week for both Class 1 and Class 2 employees.

The Maximum benefit duration is 25 weeks (26 weeks with elimination period)

PRE-EXISTING CONDITION

Your plan is subject to a pre-existing condition limitation. The pre-existing condition under this plan is 3/6 which means any condition that you receive medical attention, treatment or medication for in the 3 months prior to your effective date of coverage that results in a disability during the first 6 months of coverage, would not be covered.

WHAT'S COVERED?

This insurance may cover a variety of conditions and injuries. The following are New York Life's top reasons for short term disability claims: normal pregnancy, injuries, joint disorders, back disorders, digestive disorders, etc.

WILL MY BENEFITS BE REDUCED BY OTHER SOURCES OF INCOME?

No, your plan will not be reduced by any other sources of income.

WHY IS THIS COVERAGE SO VALUABLE?

The CA State Disability Insurance for California employees and Basic STD for Non-California employees only covers up to 60% of your pay. You can supplement your lost wages with this coverage and use the funds however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

NEW YORK LIFE

Refer to New York Life plan documents for a complete description of this plan.

CORE AND BUY-UP LONG TERM DISABILITY

The core benefit is paid by Heluna Health. There is no cost to the employee!

A disability doesn't always mean a serious handicap. It can be any illness or injury that prevents you from earning your salary. Consider what would happen if you couldn't work or pay your bills. How might this affect your savings and your lifestyle? Long Term Disability (LTD) insurance from New York Life can help provide the financial security you'll need if you experience a covered illness or injury that keeps you out of work for more than 6 months. Heluna Health provides all eligible employees with Core LTD coverage and the ability to elect Buy Up LTD. The Buy-Up LTD benefit is voluntary and paid by you through after tax payroll deductions. This supplemental benefit pays in addition to your employer paid Core LTD benefit and insures you from 50% (company provided) up to 60% of your basic monthly income.

YOUR CORE LONG TERM DISABILITY

You will need to satisfy a 180-day elimination period before long term disability benefits would begin. This elimination period can be satisfied with days of partial disability, total disability or a combination of both. If you are totally disabled beyond the elimination period due to a covered injury or sickness, you will be eligible to receive a monthly benefit equal to 50% of your basic monthly income, up to $3,000 per month. If needed, your benefits will be paid up to Social Security Normal Retirement Age.

This benefit is voluntary, paid by employees through after-tax payroll deductions

YOUR BUY UP LONG TERM DISABILITY BENEFITS

You need to satisfy a 180-day elimination (waiting) period before the Buy-Up disability benefits would begin. This elimination period can be satisfied with days of partial disability, total disability or a combination of both. If you are totally disabled beyond the elimination period due to a covered injury or sickness, you will be eligible to receive a monthly benefit equal to 60% of your basic monthly income, less your employer paid long term disability benefit and state disability payments, up to $6,000 a month. If needed, your benefits will be paid up to Social Security Normal Retirement Age.

Buy Up LTD Rate: $0.080/$100 covered payroll.

PRE-EXISTING CONDITION

Your plan is subject to a pre-existing condition limitation. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention, treatment or medication for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.

NEW YORK LIFE

Refer to New York Life plan documents for a complete description of this plan.

VOLUNTARY ACCIDENT & INJURY

100% employee paid

This benefit is voluntary, paid by employees through after-tax payroll deductions

BENEFIT TYPE[1]	HIGH PLAN (On/Off Job)/LOW PLAN (Off Job Only) MUTUAL OF OMAHA INSURANCE PAYS YOU
Express Benefit	$100
Fractures[2]	Up to $6,000
Dislocations[2]	Up to $9,000
Second and Third Degree Burns	Up to $15,000
Cuts/Lacerations	Up to $800
Dental	Up to $300
MEDICAL SERVICES & TREATMENT	
Ambulance	Up to $1,500
Emergency Care	$200
Physician Office Visit	$100
Physician Follow-Up (up to 6 per accident)	$75
Therapy Services (including physical therapy up to 6 per accident)	$25
Medical/Prosthetic Devices	Up to $750
Inpatient Surgery	Up to $1,500
HOSPITAL[3] COVERAGE (ACCIDENT)	
Admission	$1,000 per accident
Confinement	$200/day (non-ICU)/$400/ day (ICU)
WELLNESS BENEFIT	
Health Screening (Wellness) Benefit	$50 per insured member per calendar year
MEDICAL SERVICES & TREATMENT	

[1]Covered services/treatments must be the result of a covered accident as defined in the group policy/certificate.
[2]Chip fractures are paid at 25% of Fracture.
[3]Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities.
See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

The Health Screening Wellness Benefit makes sure you still get paid even if you don't have an accident!

These plans offer additional benefits such as Accidental Death, Dismemberment, Loss, Paralysis, Lodging, etc. Please refer to the Mutual of Omaha Plan Documents for a complete description of the plan benefits.

What Accident Worries

Statistically, fractures are the most common accident to occur, subsequently followed by lacerations, concussions, and dislocations. Based on the lifestyle you live you may be at higher risk for one of these accidents to occur.

Do you play a sport? Sports require you to engage in repetitive motions, which can overuse muscles and can lead to muscle fatigue. This causes more force on the bone and can lead to stress fractures.

Are you someone who's often in a hurry? Being rushed can result in a lack of focus that can lead to accidents like a fall down the stairs or even a vehicle collision. These accidents often result in an impact injury such as a violent blow to your head or body that can cause a laceration or a concussion.

With the increasing cost of medical care, a trip down the stairs or sports injury can hurt your bank account as much as your body. Accident insurance pays you directly based on your injury and treatment and you decide how to spend it.

This policy is portable

How to file a claim

Claims should be reported as soon as possible by one of the following methods:

Download and submit a claim form online at **https://www.mutualofomaha.com/support/forms**

Call 800-775-8805 to speak with one of the dedicated customer service representatives.

Fax documents to 402-997-1898

Email Accident claims to:
submitgrpacc@mutualofomaha.com

Mail documents to:
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001

Mutual of Omaha

What Life-Changing Event Worries You the Most?

What's a critical illness? Some common examples are heart attack, stroke and cancer.

Do any diseases run in your family? Cancer is one of the most common life-threatening illnesses that has overcome the United States. 1 out of every 2 men and 1 out of every 3 women will develop some sort of cancer in their lifetime.

How healthy is your lifestyle? Every 40 seconds an American will experience a heart attack. If you smoke, eat a poor diet, do not exercise, and/or drink alcohol heavily you are at risk for developing heart disease. Did you know over 30 million U.S. adults were diagnosed with heart disease as of 2018? By 2035, more than 45% of Americans are projected to have some form of cardiovascular disease.

Critical Illness coverage gives you the financial freedom to take care of what matters most, whatever that may be, during the most critical time of your life. This benefit could cover anything from medical expenses, travel expenses to seek the best care possible, time off work, or even your basic monthly costs that may be in a pinch. We understand that you know your life better than anyone else, so in critical times we give you the money so you can allocate it where you need it most!

! This policy is portable

How to file a claim

Claims should be reported as soon as possible by one of the following methods:

Download and submit a claim form online at **https://www.mutualofomaha.com/support/forms**

Call 800-775-8805 to speak with one of our dedicated customer service representatives.

Fax documents to 402-997-1898

Email Critical Illness claims to: **submitgrpci@mutualofomaha.com**

Mail documents to:
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001

MUTUAL of OMAHA

VOLUNTARY CRITICAL ILLNESS

100% employee paid

This benefit is voluntary, paid by employees through after-tax payroll deductions

COVERAGE GUIDELINES	MINIMUM[2]	MAXIMUM GUARANTEE ISSUE
Employee/Spouse	Increments of $10,000 Spouse coverage cannot exceed 100% of employee principal sum	$30,000
Child(ren)	50% of employee's principal sum, up to $10,000	$10,000
COVERED CONDITIONS[1]	**INITIAL BENEFIT**	**RECURRENCE BENEFIT**
Full Benefit Cancer	100% of Elected Amount	100% of Initial Benefit
Carcinoma in Situ	25% of Elected Amount	100% of Initial Benefit
Heart Attack	100% of Elected Amount	100% of Initial Benefit
Stroke	100% of Elected Amount	100% of Initial Benefit
Coronary Artery Bypass Graft	25% of Elected Amount	100% of Initial Benefit
Acute Respiratory Distress Syndrome (ARDS)	25% of Elected Amount	100% of initial Benefit
End-Stage Renal (Kidney) Failure	100% of Elected Amount	100% of initial Benefit
Major Organ Transplant/Placement on UNOS List	100% of Elected Amount	100% of Initial Benefit
Progressive Diseases: ALS, Advanced Alzheimer's Disease, Advanced Parkinson's Disease	100% of Elected Amount	Not Applicable
ADDITIONAL BENEFITS/LIMITATIONS		
Wellness Benefit	$50 per insured member per calendar year	
Pre-Existing Condition Limitation (12/12)	Any condition that you receive medical attention for in the 12 months prior to your effective date of coverage that results in a critical illness event during the first 12 months of coverage, would not be covered.	
Policy Benefit Maximum	The maximum payout amount is 400% of the Critical Illness principal sum amount for each insured person.	

[1]Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for specific information about these benefits and a list of additional conditions covered by this policy.

! The Wellness Benefit makes sure you still get paid even if you don't have a critical illness!

WORKSITE BENEFITS RATES

SEMI-MONTHLY PREMIUMS

SHORT TERM DISABILITY Step Rates per $10 of Volume (Semi-Monthly Premiums)	
Age	**Rate**
<25	$0.297
25-29	$0.725
30-34	$1.102
35-39	$0.704
40-44	$0.404
45-49	$0.356
50-54	$0.416
55-59	$0.491
60-64	$0.616
65+	$0.740

ACCIDENT & INJURY COVERAGE	HIGH PLAN (On/Off Job)	LOW PLAN (Off Job Only)
Tier	**Rate**	**Rate**
Employee	$10.59	$6.28
Employee + Spouse	$18.38	$10.36
Employee + Child(ren)	$19.77	$11.81
Employee + Family	$27.55	$15.89

CRITICAL ILLNESS: $10,000 BENEFIT			CRITICAL ILLNESS: $20,000 BENEFIT			CRITICAL ILLNESS: $30,000 BENEFIT		
Age	**Employee[1]**	**Spouse**	**Age**	**Employee[1]**	**Spouse**	**Age**	**Employee[1]**	**Spouse**
<25	$1.85	$1.85	<25	$3.70	$3.70	<25	$5.55	$5.55
25-29	$2.30	$2.30	25-29	$4.60	$4.60	25-29	$6.90	$6.90
30-34	$2.80	$2.80	30-34	$5.60	$5.60	30-34	$8.40	$8.40
35-39	$3.70	$3.70	35-39	$7.40	$7.40	35-39	$11.10	$11.10
40-44	$4.75	$4.75	40-44	$9.50	$9.50	40-44	$14.25	$14.25
45-49	$6.25	$6.25	45-49	$12.50	$12.50	45-49	$18.75	$18.75
50-54	$7.80	$7.80	50-54	$15.60	$15.60	50-54	$23.40	$23.40
55-59	$10.50	$10.50	55-59	$21.00	$21.00	55-59	$31.50	$31.50
60-64	$14.45	$14.45	60-64	$28.90	$28.90	60-64	$43.35	$43.35
65-69	$20.20	$20.20	65-69	$40.40	$40.40	65-69	$60.60	$60.60
70-74	$30.25	$30.25	70-74	$60.50	$60.50	70-74	$90.75	$90.75
75-79	$42.50	$42.50	75-79	$85.00	$85.00	75-79	$127.50	$127.50
80-84	$57.30	$57.30	80-84	$114.60	$114.60	80-84	$171.90	$171.90
85+	$57.30	$57.30	85+	$114.60	$114.60	85+	$171.90	$171.90

[1]Children (if enrolled) are automatically included with employee rate

IDENTITY THEFT AND CYBER SECURITY

100% employer paid

This benefit is paid by Heluna Health. There is no cost to the employee!

IDENTITY THEFT PROTECTION

Every employee's identity is unique. NortonLifeLock monitors for fraudulent use of their Social Security number, name, address and date of birth in applications for credit and services. You will get alerts when a potential threat is detected and it's backed by world-class service. Our dedicated specialists will work with you to resolve ID theft issues.

DEVICE SECURITY INCLUDING ANTIVIRUS

Devices, whether mobile or desktop, are a fact of every employee's connected life. It's a no-brainer that you should have real-time threat protection for those devices. Multi-layered, advanced security helps protect devices against existing and emerging malware threats, including ransomware, and helps protect private and financial information when employees go online.

HOME & FAMILY

Parents need to take an active role in how their child engages with the digital world. With Norton Family Parental Control, employees can take action to monitor their child's online activity and identify potential dangers before they become problems. This feature includes easy-to-use tools to set screen time limits, block unsuitable sites, and monitor search terms and activity history.

ONLINE PRIVACY

Online privacy is becoming harder to protect. That's why we have Norton Secure VPN to protect devices on vulnerable connections and help keep online activity and browsing history private. We also have Privacy Monitor that scans common public people-search websites to find employee personal information and help them opt-out. And SafeCam alerts users to attempts to access their webcam, and blocks those who are not authorized to access it.

SPECIALTY TRAINED AGENTS

Dedicated agents available to answer questions Monday through Friday, from 9am to 7pm EST.
Employee Benefits Member Support Line: 800-607-9174.
Urgent After-Hours Support Line: 800-543-3562

NortonLifeLock™

*For these and more helpful resources from **NortonLifeLock** please scan the QR code!*

VOLUNTARY PET INSURANCE

100% employee paid

This benefit is voluntary, paid by employees via direct bill (payroll contributions are not available).

ASPCA offers employees the ability to purchase discounted Pet Insurance. This benefit is voluntary and paid for 100% by eligible employees and paid directly to ASPCA.

WHAT DO THE PLANS COVER?

ASPCA plans provide nose-to-tail coverage for a wide range of injuries, illnesses, genetic conditions, and emergency care for dogs and cats. Coverage is provided with no claim limits and offers unlimited lifetime benefits with an annual deductible. Multiple discounts are applied at time of rate quote with actual dollar savings presented to the pet parent. The plan co-insurance can cover up to 90% of your veterinary bills.

HOW DOES THE BENEFIT SCHEDULE WORK?

Unlimited lifetime benefits are available with no caps on claims. There are some pre-existing conditions on the plans, and the plans do not cover routine care, office visits, or spay/neutering.

Refer to the ASPCA website for a complete description of this plan.

HOW TO ENROLL

Phone: call 877-343-5314 and tell the pet insurance specialist that you're an employee of Heluna Health.

Online: visit the link below to obtain personalized rates. The rates given will include your group discount.

Sign up for these plans any time during the year!
Visit: **www.aspcapetinsurance.com/HelunaHealth**
Save with your priority code: **EB23HelunaHealth**

EMPLOYEE ASSISTANCE PLAN (EAP)

This benefit is paid for 100% by your employer. There is no cost to you, the employee.
All members of your household can utilize the benefits of this program.

TELUS® Health

Understanding Your Employee Assistance Program (EAP)

Your Employee Assistance Program (EAP) provides you with immediate and confidential help for any work, health or life concern. We're available anytime and anywhere.

Your EAP is a confidential and voluntary support service that can help you take the first step toward change. Let us help you find the solutions to the challenges you face at any age and stage in life.

You and your immediate family members (as defined in your employee benefit plan) can access immediate and confidential support in a way that is most suited to your preferences, comfort level and lifestyle.

No Cost

There is no cost to you or your family to use your EAP. This benefit is provided to you by your employer. Your EAP can provide a series of session with a professional and if you need more specialized or longer-term support, our team of experts can suggest an appropriate specialist or service that is best suited to your needs. While fees for these additional services are your responsibility, they may be covered by your health plan.

Confidentiality

Your EAP is completely confidential within the limits of the law. No one, including your employer, will ever know that you have used the program unless you choose to tell them.

Your EAP Plan offers face-to-face visits with a counselor based on your specific issue and needs.

Let Us Help.
Access your Employee Assistance Program (EAP) 24/7
By Phone: 1-800-433-7916
By Web: https://login.lifeworks.com
Username: helunahealth
Password: lifeworks
Or on the **TELUS Care mobile app**

Download on the App Store | GET IT ON Google Play

Solutions for your work, health and life.

Achieve Wellbeing
- Stress
- Mental health concerns
- Grief and Loss
- Crisis Situations

Manage Relationships and Family
- Communication
- Separation/Divorce
- Parenting

Deal with Workplace Challenges
- Stress
- Performance
- Work-Life Balance

Tackle Addictions
- Alcohol
- Drugs
- Smoking Cessation
- Gambling

Find Child and Elder Care Resources
- Child Care
- Schooling
- Nursing/Retirement Homes

Get Legal Advice
- Family Law
- Separation/Divorce
- Custody

Receive Financial Guidance
- Debt Management
- Bankruptcy
- Retirement

CORPORATE DISCOUNTS

100% employer paid

This benefit is paid by Heluna Health. There is no cost to the employee!

Planning your next getaway? A fun day at an amusement park? Or simply a family fun night?

GREAT WORK PERKS IS HERE FOR YOU!

Great Work Perks makes saving possible for everyone, no matter what lifestyle you live, with savings on hotels, theme parks, electronics, financial wellness, movie tickets, rental cars, apparel, automotive, flowers & gifts, beauty & skincare, insurance, education, and more!!

WHAT IS GREAT WORK PERKS?

This cost-free benefit provides you access to thousands of exclusive travel and entertainment discounts, so you can make the most of your time away from work.

HOW DO I BECOME A MEMBER?

1. Visit **https://helunahealth.gwperks.com**
2. Click “Sign Up” at the top of the page
3. Enter your name, email, and password to create account and start saving!

GreatWorkPerks

Sign Up Today To Access Your Perks

Movie Buffs - Travel Bugs – Thrill Seekers – Entertainment Enthusiasts - Shopping Fanatics There’s something for everyone with savings on:

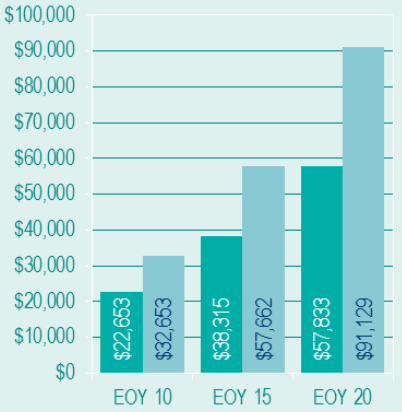
- Hotels
- Theme Parks
- Gym Memberships
- Movie Tickets
- Retail
- Food & Drinks
- Financial Wellness
- Automotive
- Insurance
- Rental Cars
- Education
- Electronics
- Flowers & Gifts
- & More!

Need help?

Call **888-295-7375** or email **help@greatworkperks.com**

Harness the Power of Tax Deferral

This is a hypothetical example. It is not indicative of any product or performance and does not reflect any expense associated with investing. It assumes $200 monthly contributions, 6% interest, and a 25% tax bracket. Taxes will be due upon distribution of the tax-deferred amount, and if shown, results will be lower. Actual investment results will fluctuate with market conditions so that the amount withdrawn may be worth more or less than the original amount invested.



[1] *The 2010 Retirement Confidence Survey: Confidence Stabilizing, But Preparations Continue to Erode.* Employee Benefit Research Institute, March 2010: 18.

403(b) RETIREMENT PLAN

Heluna Health offers a 403(b) tax-deferred retirement plan with a discretionary employer contribution of 6% that is contributed by Heluna Health semi-monthly for eligible employees. In order to receive the employer contribution, an employee must meet the eligibility and service condition requirements of the Plan. The employer contribution is *not deducted* from your salary and is in addition to your regular semi-monthly salary.

Upon hire, all eligible employees can immediately make their own contributions into the 403(b) and/or Roth 403(b) retirement account. Heluna Health is dedicated to help make planning for your future easier by automatically enrolling eligible employees in the 403(b) retirement plan. Therefore, upon eligibility, 6% of your pay will be automatically deducted from your paycheck pre-tax and invested in to your 403(b) retirement plan; unless you choose a different amount or decline to participate.

You may increase or decrease your own contributions (employee deferral) at any time by following the below steps:
Go to Empower Retirement's website https://participant.empower-retirement.com/participant/#/login > **Participant Login** > **Enter your Username** and **Password** > **My Account** > **Contributions**.

For general information or to process transactions, log into **www.retiresmart.com.** If you have not created a RetireSmart account, **call Empower RetireSmart Support at (866) 467-7756.**

For information regarding eligibility, please see the Summary Plan Description document by logging into UKG; click on **Myself** > **Benefits** > **Links.**

Contact Janice Maize at (562) 901-4382 or email at **janice.p.maize@morganstanley.com** for more information regarding financial planning or general questions about your 403(b) or Roth 403(b) plan.

EMPOWER RETIREMENT®

Need help?
To speak with a representative regarding your account, contact Empower at (866) 467-7756
- Monday – Friday between 5am – 7pm PST
- Saturdays 6am – 2:30pm PST

The New Health Insurance Marketplace

Notice of Medical Coverage Options

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 8.39% 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 8.39% of the employee’s household income.

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.

If you have questions, please visit the Health Insurance Marketplace website at www.healthcare.gov

The New Health Insurance Marketplace

When Can I Enroll in Health Insurance Coverage through the Marketplace? You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

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.

IMPORTANT EMPLOYEE NOTIFICATIONS

DISCLOSURE NOTICE This proposal (analyses, report, etc.) is an outline of the coverages proposed by the carrier(s) based upon the information provided by your company. It does not include all the terms, coverages, exclusions, limitations, and conditions of the actual contract language. See the policies and contracts for actual language. This proposal (analyses, report, etc.) is not a contract and offers no contractual obligation on behalf of Gallagher Benefit Services (GBS). Policy forms for your reference will be made available upon request.

MODEL GENERAL NOTICE OF COBRA CONTINUATION 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 (or aren't required to 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."

If the Plan provides retiree health coverage: Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
· Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer; or
· The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).The end of employment or reduction of hours of employment;

- Death of the employee;
- The employee is 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 [or enter longer period permitted under the terms of the Plan] after the qualifying event occurs. You must provide this notice to your employer/Human Resources.

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 period1 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.

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/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.

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.

1 https://www.medicare.gov/basics/get-started-with-medicare/sign-up/ready-to-sign-up-for-part-a-part-b

If you have 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/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.

GRANDFATHERED PLANS If your group health plan is grandfathered then the following will apply. This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform This website has a table summarizing which protections do and do not apply to grandfathered health plans.

PATIENT PROTECTIONS DISCLOSURE For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries:

- Your HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- For children, you may designate a pediatrician as the primary care provider.
- You do not need prior authorization from your health group or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Human Resources office.

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. If you would like more information on WHCRA benefits, please call your Plan Administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

HIPPA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights Your employer is committed to the privacy of your health information. The administrators of the health plan use strict privacy standards to protect your health information from unauthorized use or disclosure. The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources.

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 January 31, 2023. Contact your State for more information on eligibility. To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

To see if any other states have added a premium assistance program since July 31, 2023, 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

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	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 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx (https://www.pa.gov/) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

MEDICARE PART D MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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 prescription 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. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

What happens to your current coverage if you decide to join a Medicare prescription drug plan? If you decide to join a Medicare drug plan, your current employer coverage will be affected. For individuals who elect Part D coverage, coverage under the employer plan will end for the individual and all covered dependents. See pages 9–11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D. 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 your employer and do not join a Medicare prescription 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 your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer 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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA 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 prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

HIPAA SPECIAL ENROLLMENT RIGHTS

Notice of Your HIPAA Special Enrollment Rights Our records show that you are eligible to participate in the Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction). A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Human Resources.

Date:	August 1, 2024
Name of Entity/Sender:	Heluna Health
Email:	benefits@helunahealth.org
Phone	(562) 205-2433

Benefit Plan Contact Information

COVERAGE TYPE	CONTACT INFORMATION
Medical Kaiser Group #35113(N-CA)/122090(S-CA) UnitedHealthCare Group #367423 (Harmony)/ #367510 (Alliance)/#367420 (Full HMO)/ #928077 (PPO) Nonstop Health	Kaiser: (800) 464-4000 **www.kp.org** UnitedHealthcare: (866) 414-1959 **www.uhc.com** Nonstop Health: (877) 626-6057 **clientsupport@nonstophealth.com**
Chiropractic/Acupuncture	Landmark (877) 626-6056 **www.LHP-CA.com**
Dental Delta DHMO Group #79465 Delta DPPO Group#21343	Delta Dental DHMO: (800) 422-4234 DPPO: (888) 335-8227 **www.deltadentalins.com**
Vision EyeMed Group #1050370	EyeMed (866) 939-3633 **www.eyemed.com**
Flexible Spending Account (FSA)	The Advantage Group (877) 506-1660 **www.enrollwithtag.com**
NYL Life and AD&D (Basic/Supplemental), Group #FLX970389/OK971752 NYL Short Term Disability (Employer Paid/Voluntary), Group #VDT963548 NYL Long Term Disability (Core/Buy-Up), Group #FLK961166	New York Life (800) 225-5695 **www.newyorklife.com**
Mutual of Omaha Voluntary Accident/Injury Group #G000BWLK Mutual of Omaha Voluntary Critical Illness Group #G000BWLK	Mutual of Omaha (800) 775-6000 **www.mutualofomaha.com**
Employee Assistance Plan (EAP)	Telus Health (LifeWorks) (800) 433-7916 Username: **helunahealth** Password:**lifeworks** **www.login.lifeworks.com**
ID Theft and Cyber Security Group #E0013208	NortonLifeLock (800) 607-9174 **www.nortonlifelock.com**
Voluntary Pet Insurance	ASPCA (877) 343-5314 Discount Code: EB23HelunaHealth **www.aspcapetinsurance.com/HelunaHealth**
403(b) Retirement Benefits	Empower Retirement (855) 756-4738 **www.retiresmart.com**
Corporate Discounts	Great Work Perks (888) 295-7375 **www.helunahealth.gwperks.com**
Benefits Department	Heluna Health Phone: (562) 205-2433 Fax: (562) 222-7373 **benefits@helunahealth.org** **Benefits site: https://helunahealth.org/benefits/**
Employee Advocacy Team	***Gallagher Employee Support Center*** Toll free: 855.670.2222 / Local: 818.539.8804 Monday - Friday | 8am - 4pm **LosAngeles.ESC@ajg.com**
Employee Enrollment & Decision Support	***Synergy Enrollment & Benefits*** ***(858) 282-0660*** ***Monday - Friday | 8am - 5pm*** ***enrollment@synergyenrollment.com***