Health SOLUTIONS

Hope. Health. Together

EMPLOYEE BENEFITS GUIDE

MAKE THE MOST OF BENEFITS TO SUPPORT YOUR TOTAL WELL-BEING

2025-2026

Health Solutions Benefits

YOUR BENEFITS

YOUR HEALTH PLANS

ADDITIONAL BENEFITS

ADDITIONAL INFORMATION

At **Health Solutions**, we know our dedicated employees—YOU—are key to our overall success as an organization. We recognize that offering a quality, comprehensive benefit program is an important way to show you how valuable you are to the organization. We understand that navigating the world of employee benefits is challenging and no two employees are alike, which is why we offer this benefits guide to explain the multiple benefit options to improve your physical, financial and mental well-being.

About Us

Health Solutions is a comprehensive, non-profit community medical and behavioral health treatment provider with centers in Pueblo, Huerfano and Las Animas counties. Health Solutions is licensed by the State of Colorado and governed by a citizens' board of directors.

Our Mission

Our mission is to make available a comprehensive range of affordable and quality community-based medical and behavioral health services.

Health Solutions exists to assist those in need of healthcare services who require expert care to support recovery and to successfully achieve their healthcare goals.

We are committed to offering exceptional quality services that set the standard for healthcare in Colorado. This care is provided through service excellence, innovation, compassion and promotion of self-determination.

Our Services

- Diagnostic Evaluation
- Individual Therapy
- Couples Therapy
- Youth & Family Therapy
- Medications
- Recovery Treatment Services
- Emergency Crisis Services
- Acute Care
- Care Coordination
- School-based Therapy
- Early Childhood Services
- Ancillary Services

Management Team

Leadership With Heart

Health Solutions leaders work with a servant's heart knowing they are stewards to our local community and a life changing resource for those we serve.

With that powerful knowledge behind what they do, our Health Solutions leaders manage resources, people and the brand of our organization with gratitude and inspiration.

Developed as life-long learners our seasoned executives are well informed, strong decision makers, who are respected leaders in our community.

Our Values

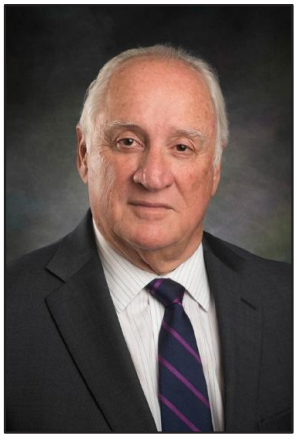
- We believe that individuals in need of our services are our highest priority. They are the reason why Health Solutions exists.
- We believe in the preservation of human dignity, self-respect and individual rights in a caring environment that results in enabling individuals to live, work and contribute in their chosen community.
- We believe in the person-centered approach to care in which the total healthcare needs of the individual are addressed. We encourage families to become involved in their loved one's treatment efforts.
- We believe our employees are our most valuable asset and we promote a healthy work environment, open communications, teamwork, trust, honesty, and ethical behavior which allows us to be accountable to each other, to the individuals we serve, and to our community.
- We believe that Health Solutions should be responsive to the healthcare needs of the communities it serves and direct its resources to meet those needs.
- We believe in being a good corporate citizen of the community, maintaining communications with the various publics we serve, and participating actively in community affairs, particularly those related to healthcare.

Strategic Objectives

- Be renowned for providing an exceptional patient experience that results in unabashed patient loyalty.
- Routinely meet patient expectations for our core business services while consistently exceeding expectations for the patient experience.
- Improve the health and/or quality of life of those we serve.
- Maintain financial sustainability by increasing market share, maximizing efficiencies, and expanding into profitable lines of business while improving the quality and diversity of care we provide.
- Consistently recognize demonstrated behaviors of staff members who engage in quality excellence, human kindness and financial efficacies.

HEALTH SOLUTIONS EXECUTIVE STAFF

Jason Chippeaux, MSW, LCSW
Chief Executive Officer



Rob Kepplinger, MA, LPC
Chief Facilities & Infrastructure Officer

Dana Brown, BS
Chief Technology Officer

Dani Smith
Chief Financial Officer

Heather Hankins, RN,
APN Chief Operations/
Chief Medical Officer

Eligibility

Eligibility

Full-time employees

Employees working 24 hours or more per week are eligible for all health benefits with no waiting period.

PRN employees

Employees working fewer than 24 hours per week may become eligible based on Affordable Care Act guidelines.

When coverage begins

- Immediate for employees hired on the first day of the month.
- The first day of the following month for employees whose date of hire is not on the first of the month.

When coverage ends.

If your employment with Health Solutions terminates (voluntarily or otherwise), your benefits will end on the last day of the month of your termination.

Adding a family member

Prior to electing benefits, employees should verify that Human Resources has proof of dependent status for any dependent who are being added. This is not required if your dependents have previously been covered through the **Health Solutions** insurance plan. The following can be used as proof:

- Marriage license for spouse
- Birth certificate, adoption, or placement documents for children
- Signed domestic partner affidavit

Covering your family members

Many of the plans offer coverage for your eligible family members, including:

- Your spouse, including your legally married same- or opposite-sex spouse, common law spouse, civil union partner, or same- or opposite-sex domestic partner
- Your dependent children, including your stepchildren, legally-adopted children, and children placed with you for adoption
  - Dependent children are eligible for medical, dental, and vision insurance up to the end of the month in which they turn age 26 (regardless of student or marital status)
  - Dependent children of any age may remain eligible if they are physically or mentally incapable of self-support.

Benefits Enrollment

New employees

As a new employee, you must enroll in benefits within 31 days of your date of hire. If you do not enroll within 31 days, you will need to wait until the next open enrollment period to enroll.

Current employees

Open enrollment is the only time during the year that you can change your benefits unless you experience a qualifying life event. During the open enrollment period, you can newly enroll in coverage or make changes to your current coverage.

If you wish to contribute pre-tax dollars to a flexible spending account in 2026, you must make a new election during the FSA open enrollment. FSA elections do not carry over from year to year.

At Health Solutions, open enrollment for benefits is typically held in October. The FSA open enrollment is held in November.

Any changes you make during benefits open enrollment become effective November 1. Elections made during FSA Open Enrollment become effective January 1.

Changing Your Benefits During the Year

As stated above, you cannot change your benefits during the year unless you experience a qualifying life event. The most common qualifying life events are:

- Marriage, legal separation, or divorce.
- Birth of a child (including adoption).
- Loss of other coverage (e.g., child turns 26 and loses coverage through parent's plan).

There are other, less common, life events that allow you to change your benefits. Please contact Human Resources for a complete list of qualifying life events.

If you experience a qualifying life event and wish to change your benefits, you must log into the Paycom portal within 30 days of the life event. You will be required to provide proof of your life event, such as a birth certificate or marriage license. You can only change benefits that were impacted by the life event (e.g., if you get married, you can add your new spouse to the medical plan, but you cannot change medical plans).

How to Enroll

Benefits enrollment is completed online through the **Paycom Self-Service Portal** website at **www.paycomonline.net.**

In order to complete your enrollment, you need:

- Dates of birth and social security numbers for yourself as well as any family members you are enrolling.
- Proof of eligibility for your spouse and dependent children (e.g., marriage license, birth certificate).

Need to Know Updates and Info

- Ask Charlie is your benefit advocacy team
- New carrier **Sun Life** for Basic Life, AD&D, Voluntary Life, Voluntary AD&D, Short-Term Disability (STD), Long-Term Disability (LTD), Accident Insurance, Hospital Indemnity, Critical Illness
- Consider what is new with you. Did you have a baby, get married, etc.?
- Online Enrollment dates:
  - **9/29/2025 – 10/13/2025**
- Open enrollment will be a **ACTIVE** for all lines except Medical, Dental, and Vision. These three benefits will rollover as is if no changes are made. FSA elections will need to be made each year.

Health SOLUTIONS
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Advocating for Your Benefits Support Needs

Discover How Charlie Can Help You Today!

Charlie's personalized benefits support provides a team of dedicated advocates to help you, and your covered family members, maximize your benefits, alleviating the overwhelming process of navigating the complex world of employee benefits.

A Line of Support at Your Fingertips

At Charlie, our team of licensed experts are available to answer benefit questions you may have, from:

+ Medical, Dental and Vision
+ Voluntary Benefits, Life & Disability
+ FSAs & EAPs
+ And more!

ASK Charlie

Let us help!

Ask Charlie Advocacy Center

M-F 8AM to 6PM CST

EMAIL: **healthsolutions.benefits@imacorp.com**

PHONE: **833.543.8695**

Our Benefits Experts

+ Explain the value and functionality of your benefits
+ Help locate in-network providers
+ Navigate your billing issues and assist in resolving insurance claims
+ Facilitate your pre-authorizations and support appeal options

...and other benefits-related concerns!

PROVIDED BY IMA

Cigna Medical – PPO Open Access Plus (Base Plan)

Health Solutions offers two medical insurance plans through Cigna. Please take the time to understand the features and differences of each plan so that you choose the coverage that is best for you and your family.

Both medical plans include in- and out-of-network benefits, which means you can choose any provider that you would like. However, you will pay less out of your pocket when you choose a **Cigna** provider. Locate a Cigna network provider at **www.mycigna.com.**

The table below summarizes the key features of the PPO Base plan. Please refer to the official pan documents for additional information on coverage and exclusions.

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible	$1,500 individual $3,000 family	$5,000 individual $10,000 family
Coinsurance	Plan pays 80%	Plan pays 60%
Out-of-Pocket Limit (Includes deductible and office copays)	$4,000 individual $8,000 family	$9,000 individual $18,000 family
Preventive Care	Plan pays 100%	Plan pays 60% after deductible
Office Visit	PCP: $35 copay Specialist: $50 copay	Plan pays 60% after deductible
MDLIVE Virtual Visits (In-Network ONLY)	PCP: $35 copay Specialist: $50 copay	Not Covered
Emergency Services	$300 copay per visit	
Diagnostics a) X-Ray and Lab Services b) MRI/nuclear medicine/high-tech	a) Plan pays 100% b) Plan pays 80% after deductible	a) and b) Plan pays 60% after deductible
Urgent Care	$50 copay per visit	Plan pays 60% after deductible
Inpatient Hospital	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient Hospital	Plan pay 80% after deductible	Plan pays 60% after deductible
Chiropractic Therapy (20 visits each per calendar year)	$50 copay per visit	Plan pays 60% after deductible
Prescription Drugs – 30-day supply Tier 1/Tier 2/Tier 3/Tier 4 Specialty	$15/$40/$70/20% up to $200	Not covered
Prescription Drugs – 90-day supply (retail and home delivery) ***excludes tier 4 Specialty***	2x Retail Copay	

Cigna Medical – PPO Open Access Plus (Buy Up Plan)

Health Solutions offers two medical insurance plans through Cigna. Please take the time to understand the features and differences of each plan so that you choose the coverage that is best for you and your family.

Both medical plans include in- and out-of-network benefits, which means you can choose any provider that you would like. However, you will pay less out of your pocket when you choose a **Cigna** provider. Locate a Cigna network provider at **www.mycigna.com**.

The table below summarizes the key features of the PPO Buy-Up plan. Please refer to the official pan documents for additional information on coverage and exclusions.

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible	$750 individual $1,500 family	$4,000 individual $8,000 family
Coinsurance	Plan pays 80%	Plan pays 60%
Out-of-Pocket Limit (Includes deductible and office copays)	$3,250 individual $6,500 family	$8,000 individual $16,000 family
Preventive Care	Plan pays 100%	Plan pays 60% after deductible
Office Visit	PCP: $25 copay Specialist: $40 copay	Plan pays 60% after deductible
MDLIVE Virtual Visits (In-Network ONLY)	PCP: $25 copay Specialist: $40 copay	Not Covered
Emergency Services	$300 copay per visit	
Diagnostics a) X-Ray and Lab Services b) MRI/nuclear medicine/high-tech	a) Plan pays 100% b) Plan pays 80% after deductible	a) and b) Plan pays 60% after deductible
Urgent Care	$40 copay per visit	Plan pays 60% after deductible
Inpatient Hospital	Plan pays 80% after deductible	$100 per visit, Plan pays 60% after deductible
Outpatient Hospital	Plan pays 80% after deductible	$100 per visit, Plan pays 60% after deductible
Chiropractic Therapy (20 visits each per calendar year)	$40 copay per visit	Plan pays 60% after deductible
Prescription Drugs – 30-day supply Tier 1/Tier 2/Tier 3/Tier 4 Specialty **Prescription Drugs – 90-day supply (retail and home delivery) *excludes tier 4 Specialty***	$15/$40/$70/20% up to $200 2x Retail Copay	Plan pays 50%

Member Choice Cigna 90

A pharmacy network designed to boost engagement and avoid surprises.

Member Choice Cigna 90 Now puts customers in control of where they fill their 30- and 90-day medications. Members can choose the pharmacy location and pharmacist care team that works best for them. With pharmacists playing an increasingly important role on the care team, there's opportunity to drive better patient adherence, clinical outcomes, satisfaction and overall health care savings.

A Team Based Approach

Having a pharmacist on your care team may drive better patient adherence, clinical outcomes and satisfaction. It's part of Cigna's Healthcare's whole-person, value-based care approach.

Anchor Option 1	Anchor Option 2
Walgreens	**CVS Pharmacy**
30-day supply: 55,000 pharmacies 90-day supply: 30,000 pharmacies	30-day supply: 55,000 pharmacies 90-day supply: 30,000 pharmacies
Voluntary or Exclusive 90-day supply benefit design available at one of the 30,000 pharmacies. **Network excludes CVS**	Voluntary or Exclusive 90-day supply benefit design available at one of the 30,000 pharmacies. **Network excludes Walgreens**

FAQ.

1. **How are networks determined?** Network determined by anchor pharmacy. Walgreens will act as Health Solutions' anchor meaning that you will automatically be enrolled in the Walgreens anchor if you do not have pharmacy history with Cigna.
2. **How does it work?** Customers have access to more than 55,000 retail pharmacies - including Walgreens, grocery chains, local, and independent retail pharmacies.
   - **30-day network**: Access to more than 55,000 in-network regional and independent pharmacies.
   - **90-day network**: Access to more than 30,000 in-network regional and independent pharmacies.
3. **Can a customer change the assigned network?** After the plan effective date, customers can change their network chain one time per calendar year to CVS Pharmacy by calling Cigna Healthcare or by visiting MyCigna.com. Customers can also change their network chain upon certain events, such as relocation by calling Cigna Healthcare.
4. **Are network selections made at the subscriber level, or the individual level?** Every covered member in the household can choose the pharmacy network that works best for them.
5. **When can customers switch networks?** Customers have the option to change anchors once during the plan year and at other certain events, such as relocation.
6. **Are 90-day benefit designs available?** Yes, members can elect either a voluntary or exclusive benefit design for 90-day maintenance medications. This plan design feature determines whether filling the 90-day supply is required at one of the 30,000 pharmacies in the network.
   - **In-store and home delivery options**: Customers can fill 90-day maintenance medications at an in-network retail 90-day pharmacy, including Express Scripts Pharmacy.
   - **Opportunities for savings**: Moving to 90-day fills for maintenance medications can drive cost savings for customers and improved prescription adherence.

Health care that's there for you when and where you need it.

Head-to-toe virtual care from MDLIVE.

Virtual care is making access to high-quality healthcare more convenient and affordable – for you and every covered member of your family. That's why Cigna Healthcare℠ has partnered with MDLIVE® to offer a broad suite of convenient virtual care options – available by phone or video, and in English or Spanish

Primary Care[1]

Easy, fast appointments, referrals, prescriptions, lab work and diagnostic tests

- Preventive care and wellness screenings available at no additional cost to identify conditions early[2]
- Manage chronic conditions and establish a relationship with the same primary careprovider (PCP) through routine care.
- Receive orders for biometrics and blood work at local facilities[3]

Urgent Care

Available via E-Treatment, phone or video.[5]

- Convenient, affordable alternative to urgent care centers and the emergency room
- Care for many minor illnesses and injuries, such as infections, cold & flu, and sinus problems
- Includes pediatric care, allowing your child to be seen quickly and from the comfort of their home

Dermatology[4]

Fast, customized care for skin, hair, and nail conditions – no appointment required

- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Upload photos and describe symptoms for board-certified dermatologists to review
- Diagnosis and customized treatment plan, usually within 24 hours

Behavioral Care

Talk therapy and psychiatry from the privacy of home, with no waiting rooms

- Access to licensed therapists and board-certified psychiatrists
- Schedule an appointment that works for you andhave recurring sessions with the same provider
- Care for topics such as anxiety, stress, life changes, grief and depression

Prescriptions available through home delivery or at local pharmacies, if appropriate.

cigna healthcare

It's easy to connect to care.

Virtual care visits are convenient and easy, whether you choose on-demand care or to schedule an appointment. And you can select an appointment in English or Spanish.

1.

Access MDLIVE by logging into myCigna.com® or by using the **myCigna® App**.

2.

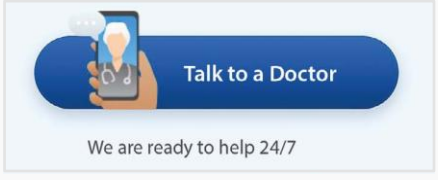
Find the "Talk to a Doctor" button on the homepage. You may have to scroll down.

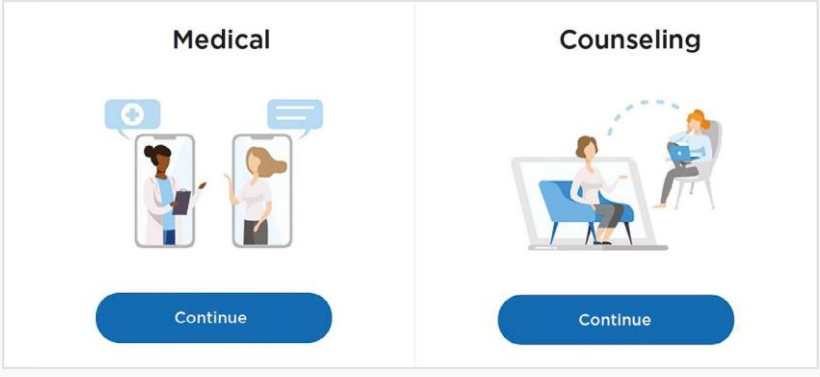
3.

Select the type of virtual care you need – Medical or Counseling. Estimated cost will be shown.[6]

4.

Schedule your appointment or start your visit today.





Visit myCigna.com or **call MDLIVE at 888.726.3171** when you need virtual care.

1. Virtual primary care through MDLIVE is only available for Cigna Healthcare medical members aged 18 and older.
2. Appointments are required. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.
5. E-Treatment care is available in U.S. states, except Kansas, Mississippi, New Mexico, West Virginia, and the District of Columbia.
6. Prices shown on myCigna are not a guarantee. Coverage falls under your plan terms and conditions.

Cigna Healthcare provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. In California: Services may be available on an in-person basis or via telehealth from the enrollee's primary care provider, treating specialist, or from another contracting individual health professional, contracting clinic, or contracting health facility consistent with California law. Enrollees that have coverage for out-of-network benefits may receive services either via telehealth or on an in-person basis using the enrollee's out-of-network benefits. Note: out-of-network benefits, if available, will generally include higher out-of-pocket financial responsibility and no balance-billing protections. Please refer to your benefit plan documents for specific information about your benefit plan and out-of-network benefits.

Cigna Healthcare products and services are provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company (Bloomfield, CT), Evernorth Care Solutions, Inc., Evernorth Behavioral Health, Inc., Express Scripts, Inc., or their affiliates. Policy forms: OK - HP-APP-1 et al., OR - HP-POL38 02-13, TN - HP-POL43/HC-CER1V1 et al. (CHLIC); GSA-COVER, et al. (CHC-TN).

Flexible Spending Account

Health Solutions offers two flexible spending account (FSA) options through **EBC Flex**. The money that you put into an FSA is collected from your paycheck before taxes are withheld, which means you don't pay taxes on those dollars. **A few very important rules apply to FSAs. Please read this page carefully before you make your FSA elections!**

IMPORTANT INFORMATION REGARDING YOUR FSA ACCOUNTS

- FSA elections must be made every year during the FSA open enrollment. Your current year election WILL NOT carry over to next year.
- You will be issued a prepaid debit card from **EBC Flex** with the balance of your election. This Smart Card can be used to pay for out-of-pocket eligible health care FSA expenses and can verify eligibility of purchases at many locations on the spot.
- All manual requests for reimbursement must be submitted to **EBC Flex** by December 31.
- A full list of eligible expenses is available at **www.ebcflex.com**

Health Care FSA

Health care FSA dollars can be used to pay for eligible out-of-pocket expenses such as deductibles, copays, and other health-related expenses that are not reimbursed by the medical, dental, or vision plans.

- Over-the-counter (OTC) medications require a prescription in order to be reimbursed.
- You may contribute up to the IRS maximum for your health care FSA for the January 1 plan year. The entire amount you elect is available to you on January 1 (or if you are a new hire, on date benefits become effective).
- Some reimbursement examples include:
- Medical copays and coinsurance
- Prescription copays and coinsurance
- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services and acupuncture
- Mental health care

Dependent Care FSA

- Dependent care FSA dollars can be used to pay for eligible dependent care expenses that allow you and your spouse to work or attend school full time.
- Eligible expenses include day care, preschool, summer camp, before- and after-school care, and elder care.
- Funds can be used for care for your:
  - Children under 13 years of age;
  - Child over 13, spouse, and/or elderly parent who lives with you and is unable to care for themselves
- You may contribute up to **$7,500** to the dependent care FSA if you are married and file a joint return or if you file a single or head of household return. If you are married and file separate returns, you can each elect $3,750.
- Dependent care contributions are deposited each pay period. You can only be reimbursed for amounts up to what is currently in your account.

Dental Insurance

Health Solutions offers dental insurance through **Cigna.** Be sure to use CIGNA Dental PPO Network providers in order to receive your best benefit and avoid out-of-pocket expense. Providers can be located at www.mycigna.com.

The table below summarizes the key features of the dental plans. The coinsurance amounts listed reflect the amount you pay for services. Please refer to the official plan documents for additional information on coverage and exclusions.

Do I need to see a dentist?

A visit to the dentist is about more than just a teeth cleaning. By looking in your mouth, your dentist can tell a lot about your overall health. In fact, he or she may be able to identify early signs of disease, such as diabetes, heart disease, kidney disease, and even some forms of cancer, before you even notice symptoms.

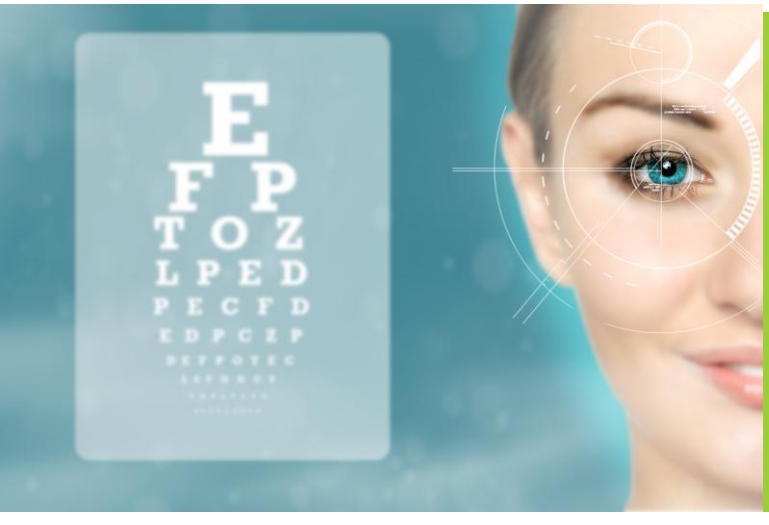
PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Individual Deductible	$50	
Family Deductible	$100	
Annual Maximum	$2,000 per calendar year for each member enrolled in the plan	
Preventive Service	Paid 100%, deductible waived	Paid 100%, deductible waived
Basic Services	Paid 80% after deductible	Paid 80% after deductible
Major Services	Paid 50% after deductible	Paid 50% after deductible
Adult & Child Orthodontia	50%, no deductible	50%, no deductible
Adult & Child Orthodontia Lifetime Max	$1,500	$1,500

Vision Insurance

Health Solutions offers a vision insurance plan through **Ameritas**. This plan allows you to choose any eye care provider. However, you will maximize the plan benefits when you choose a network provider through the Ameritas VSP network. Locate an **Ameritas** network provider at **www.ameritas.com**.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Exam Copay	$10 copay	Reimbursed up to $45
Materials Copay	$25 copay	Reimbursement schedule based on lens type
Contact Lenses a) Medically Necessary b) Elective	a) $25 copay b) Up to $130 allowance	a) Reimbursed up to $210 b) Reimbursed up to $105
Frame Retail Allowance	Up to $130 per frequency	Up to $70 per frequency
Lens Benefit, Single	$25 copay	Reimbursed up to $30
Lens Benefit, Bifocals	$25 copay	Reimbursed up to $50
Lens Benefit, Trifocals	$25 copay	Reimbursed up to $65
Frequency of Services	Exams, Lenses and Contacts – every 12 months Frames – every 24 months	
Laser Vision Correction	15% Discount off regular price or 5% off promotional price	No discount available



Do I need an annual eye exam if I have perfect vision?

Your eyes are your windows to the world. They are also your eye doctor's windows into your body. Just by looking in your eyes, a doctor can find warning signs of serious diseases and conditions like high blood pressure, high cholesterol, thyroid diseases, and certain types of cancer. In fact, eye doctors are frequently the first to detect signs of abnormal health conditions.

Life and Accidental Death and Dismemberment Insurance

Life and accidental death and dismemberment (AD&D) insurance provides financial protection for those who depend on you for financial support. Upon your death, your designated beneficiary will receive the life benefit. If you die as the result of an accident, you beneficiary will receive both the life and AD&D benefits. The carrier for basic, voluntary life and AD&D insurance is **Sun Life**.

Basic Life and AD&D Insurance

All eligible employees (full-time employees regularly working at least 24 hours per week) will receive 1x their annual salary up to $150,000 in Life and AD&D coverage. Employees are asked to designate a beneficiary at the time of enrollment. Health Solutions pays 100% of this premium.

If you are eligible for $50,000 or more in basic life insurance, you are required to pay income tax on the value of the coverage in excess of $50,000.

Designate a Beneficiary

In the event of your death Sun Life would pay your Life and/or AD&D policy to your beneficiaries. Designate your beneficiary for your Basic Life and AD&D insurance, as well as any Voluntary Life insurance.

You may change this designation at any time. You are automatically the beneficiary on your Spouse and/or Child Life policy.

Evidence of Insurability

If you purchase Life and AD&D insurance for yourself or your spouse and/or children when you are first eligible to enroll, you may purchase up to the guarantee issue amounts without completing a statement of health (evidence of insurability). If you do not enroll when first eligible and choose to enroll during a future open enrollment period, you will be required to submit evidence of insurability for any amount of coverage. Coverage will not take effect until approved by **Sun Life**

Voluntary Life Insurance

Employees may purchase additional life insurance for themselves and dependents. Employee benefits will be available in increments of **$10,000** up to **$500,000** or 5 times your annual salary (whichever is less), Guarantee Issue of **$150,000*.** Spouse benefits will be available in increments of **$5,000** up to **$250,000** (not to exceed 50 % of the employee benefit amount), Guarantee Issue of **$50,000*.** Child benefits will be available in values of **$5,000** or **$10,000** per child. Rates are age-based, and employees pay 100% of the premium.

Voluntary AD&D Insurance

Employees may purchase additional AD&D insurance for themselves and dependents. Employee benefits will be available in increments of $10,000 up to $500,000 or 5 times your annual salary (whichever is less).

Spouse benefits will be available in increments of $5,000 up to $250,000 (not to exceed 50 % of the employee benefit amount), Child benefits are available up to $10,000. Monthly cost is $.026 per $1,000 of coverage. Employees pay 100% of the premium.

*Evidence of Insurability (EOI) needed for amounts over the guarantee issue amounts. Also known as medical underwriting.

Benefits from Sun Life

Hospital stays, major illness diagnosis and unexpected accident treatment can be very expensive, even with medical insurance. These plans are designed to help you pay your medical bills and protect your finances. Benefits are paid directly as cash payments to you, regardless of any other coverage, to use however you see fit. All plans can be taken with you if you leave the company for any reason. These benefits are all voluntary. Premiums are paid 100% by you.

Accident Insurance

- $1,000 initial hospital benefit, $200 daily hospital benefit.
- Up to $4,000 for fractures or dislocations.
- Up to $40,000 for accidental death.
- Up To $200 for ER treatment, X-rays and physician treatment plus many more benefits.
- This plan includes a $50 wellness benefit that your can collect on you and your covered dependents each calendar year.

Critical Illness Insurance

Critical illness insurance is a policy that provides a lump-sum, cash benefit if you are diagnosed with a covered illness (e.g., heart attack, stroke, cancer). These diagnoses can cause significant financial burden, especially if you are unable work while receiving treatment. You can use the money you receive however you would like, including to help you pay your mortgage, pay your deductible, seek experimental treatment, or for any other expenses.

- You can elect a $10,000, up to $40,000, benefit, in increments of $10,000 on yourself that will pay if you are diagnosed with a covered illness.
- Covered Spouse: get a $5,000, up to $40,000, benefit in increments of $5,000, if you elect coverage for yourself, not to exceed 100% of your coverage amount.
- Covered Child: get a $5,000, up to $20,000, benefit in increments of $5,000, if you elect coverage for yourself, not to exceed 50% of your coverage amount.
- This product is a Guarantee Issue for all who sign up during initial enrollment, so no health questions to qualify.
- Covered illnesses include heart attack, stroke, invasive cancer, major organ transplant, benign brain tumor and complete loss of hearing, sight or speech plus many more.

Hospital Indemnity Plan

- A few days in the hospital can hit your out-of-pocket max on your medical plan.
- Two plan options: Low and High
- This plan is Guarantee Issue during initial enrollment, so no health questions to qualify.
- It pays a $1,000 or $2,000 initial hospital benefit for any sickness or injury related stay in the hospital.
- It also pays $150 or $250 for each day thereafter that you are still in the hospital.
- This plan includes a $50 wellness benefit that your can collect on you and your covered spouse each calendar year.

Short-Term Disability Income Protection

Most of us insure our home, car, etc., but neglect to insure our most important asset — our ability to earn income. This plan pays you a specific dollar amount when you are sick or injured and cannot work and provides income when you need it most. (Pregnancies are covered after nine months).

- Benefits start on the 15th day for a sickness or injury and can pay for a maximum 11-week benefit period.
- Replaces 60% of your salary to a max of $3,500.

Long-Term Disability Insurance

Health Solutions offers benefits-eligible employees Long Term Disability insurance through **Sun Life**. If you are unable to work (perform your job) for a continuous 90-day period due to illness or injury, your Long-Term Disability (LTD) benefit will take effect. LTD benefits are subject to pre-existing condition limits, and benefit duration is shortened if the disability begins after age 60. Heath Solutions offers this benefit to you at no cost.

Benefits Begin	After 90 days of disability
Maximum Benefit Payable to Employee	Up to $7,500 per month
Percentage of Income Replaced	60% of salary
Benefits End	When no longer disabled or at Social Security Normal Retirement Age

If you experience an injury that keeps you from working, be sure to contact HR to begin your paperwork as soon as you are able.

Employee Assistance Program

Profile EAP is available to you and your household family members with an employee assistance program (EAP) at no cost to you. The EAP is a valuable resource that can help you identify and resolve many workplace, family, social, economic, and mental health issues.

For all employees of Health Solutions — Full-Time, Part-Time and PRN

Talk to a counselor about:	Connect to local resources for:	Get tips for staying healthy:
• Improving relationships • Managing life changes • Improving esteem and confidence • Achieving work-life harmony	• Childcare needs • Caring for an elder • School success • Legal resources	• Sleep practices • Eating well • Finding a gym

EAP Benefits

- Completely confidential. Health Solutions does not receive any information about who contacts the EAP.
- Available 24/7/365.
- Includes eight in-person therapy sessions.
- Online resources.
- Unlimited phone consultations.

Call or go online for help with:

- Depression
- Conflict resolution
- Drug or alcohol abuse
- Marital or family difficulties
- Legal concerns
- Help finding child and elder care
- Wills and estate planning
- Financial counseling

EXAMPLE:

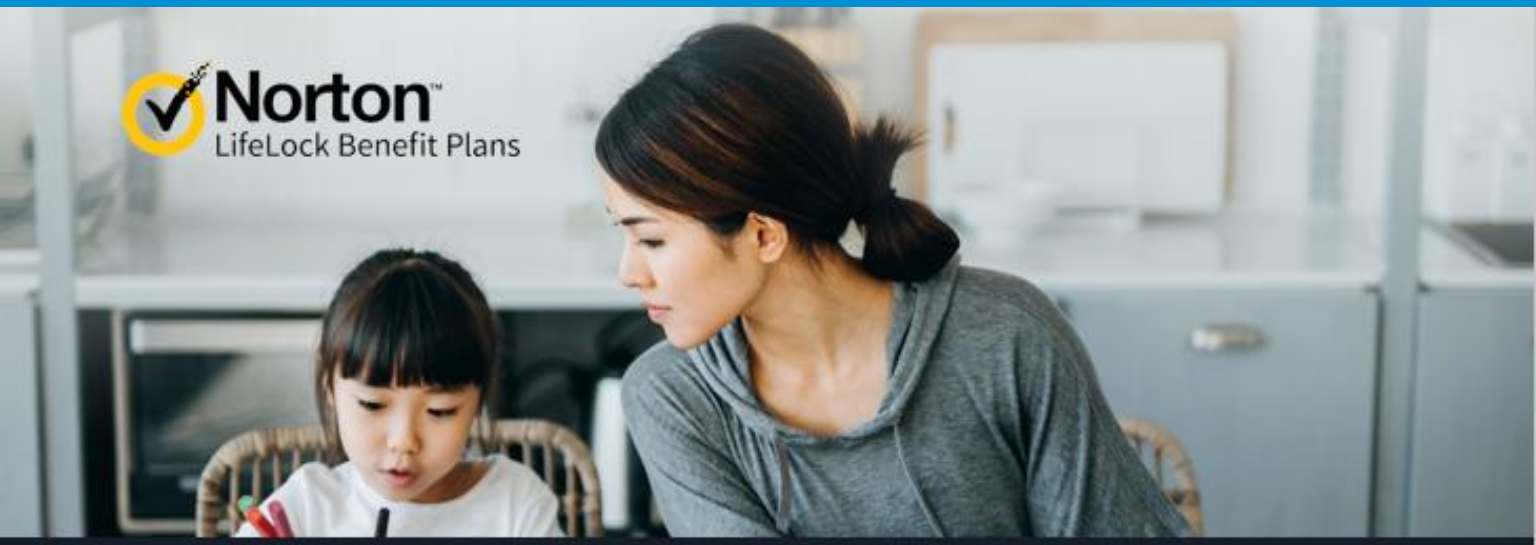
Jim has recently been struggling to balance his responsibilities at work with his responsibilities at home. At times, he struggles to find childcare and finds that this impacts his performance on the job.

Jim contacted the EAP to talk through these struggles, and they were also able to provide trusted childcare resources that he now uses regularly!

Call: 719-634-1825 (800-645-6571)
Website: www.profileeap.org (Company Code: SPHCS)

EAP resources are available for free to you and your household family members up to age 26.

ID Theft Protection



Opt-in to Cyber Safety

Health Solutions

No one intends to be unsafe online. Help protect your identity and devices with Norton LifeLock Benefit Plans. Let us help empower you and your family to live your digital lives safely.

Device Security

Anti-virus software and multi-layered, advanced security helps protect devices against existing and emerging threats, including malware and ransomware.

Online Privacy

Norton Secure VPN protects devices and helps keep online activity and browsing history private. Privacy Monitor scans common public people-search websites to help you opt-out. And SafeCam alerts you and blocks attempts to access your webcam.[1]

Screen modified for demonstration purposes. Features may differ depending on plan.

Identity

We monitor for fraudulent use of personal information, and send alerts when a potential threat is detected.[†]

Home & Family

Take action to monitor your child's online activity with easy-to-use tools to set screen time limits, block unsuitable sites, and monitor search terms and activity history.

Norton™
LifeLock Benefit Plans

	Benefit Premier
Identity	
LifeLock Identity Alert™ System†	
• Identity Verification Monitoring†,**	
• Telecom & Cable Applications for New Service	
• Payday - Online Lending Alerts†	
• Credit Alerts & Social Security Alerts†	
Dark Web Monitoring**	
Home Title Monitoring	
USPS Address Change Verification	
Stolen Wallet Protection	
Social Media Monitoring*	
Data Breach Notifications	
Bank & Credit Card Activity Alerts†,**	
Checking & Savings Account Application Alerts†,**	
Bank Account Takeover Alerts†,**	
401k & Investment Account Activity Alerts†,**	
Prior Identity Theft Remediation∂ This feature is separate from our Million Dollar Protection™ Package and does not provide coverage for lawyers and experts, reimbursement of stolen funds or compensation for personal expenses for events occurring during the 12 months prior to enrollment. See disclaimer for details.	
U.S.-based Identity Restoration Specialists	
24/7 Live Member Support	
Million Dollar Protection™ Package†††	*Up to $1 Million each*
• Stolen Funds Reimbursement	
• Personal Expense Compensation	
• Coverage for Lawyers and Experts	
Credit Application Alerts[2],**	*One-Bureau[1]*
Credit Monitoring[1],**	*Three-Bureau[1]*
Annual Credit Reports & Credit Scores[1],** The credit scores provided are VantageScore 3.0 credit scores based on data from Equifax, Experian and TransUnion respectively. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.	***On Demand –*** *Three-Bureau[1]*
• Identity Lock [1,5]	
Monthly Credit Score Tracking[1],** The credit score provided is a VantageScore 3.0 credit score based on Equifax data. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness.	*One-Bureau[1]*
Credit, Bank & Utility Account Freezes**	
Device Security	
Secures PCs, Mac & mobile devices**	*Up to 5 devices (Family gets 10 devices)*
Online Threat Protection**	
Password Manager**	
Smart Firewall**	
Cloud Backup[3],**	*50 GB*
Home & Family	
Parental Control[4],**	
Online Privacy	
Norton Secure VPN**	
Privacy Monitor	
SafeCam[3],**	

Benefit Plan - Monthly Rates

Benefit Premier

Employee Only (18+ Years Old)--employee benefit paid by Health Solutions

Employee + Family—can be purchased by employee for $5.30 bi-weekly

Rates

Cigna - Bi-weekly Employee Medical Cost

Cigna PPO Base Plan	Tobacco Use Bi-weekly	Non-Tobacco Use Bi-weekly
Employee Only	$109.03	$83.44
Employee + Spouse	$218.58	$167.39
Employee + Child(ren)	$249.81	$190.94
Employee + Family	$272.84	$208.86
Cigna PPO Buy Up Plan	**Tobacco Use Bi-weekly**	**Non-Tobacco Use Bi-weekly**
Employee Only	$126.95	$101.36
Employee + Spouse	$253.39	$202.20
Employee + Child(ren)	$290.25	$231.38
Employee + Family	$316.87	$252.88

Cigna - Bi-weekly Employee Dental Cost

Cigna PPO Plan	
Employee Only	$4.77
Employee + Spouse	$9.72
Employee + Child(ren)	$10.81
Employee + Family	$12.05

Ameritas - Bi-weekly Employee Vision Cost

Ameritas Vision	
Employee Only	$3.62
Employee + Spouse	$6.57
Employee + Child(ren)	$6.63
Employee + Family	$10.15

Rates

Sun Life - Employee Monthly Voluntary Life and AD&D Cost

MONTHLY RATES PER $1,000 (Unless otherwise stated)	UNISEX RATES (Rates are based on employee age for spouse)	UNISEX SMOKER RATES (Rates are based on employee age for spouse)
Under age 20	$0.06	$0.06
20-24	$0.06	$0.06
25-29	$0.06	$0.06
30-34	$0.08	$0.08
35-39	$0.11	$0.11
40-44	$0.16	$0.16
45-49	$0.27	$0.27
50-54	$0.44	$0.44
55-59	$0.69	$0.69
60-64	$0.92	$0.92
65-69	$1.48	$1.48
70 and over	$2.61	$2.61
Child Life	Units of $5,000 or $10,000 per child $0.146 per $1,000	
AD&D	$0.026 per $1,000 of coverage	

Sun Life Plans - Bi-weekly

Accident	
Employee Only	$3.15
Employee + Spouse	$5.09
Employee + Child(ren)	$6.11
Employee + Family	$8.05

Hospital Indemnity	Base Plan	Buy Up Plan
Employee Only	$5.74	$10.51
Employee + Spouse	$12.09	$22.24
Employee + Child(ren)	$9.54	$17.46
Employee + Family	$15.90	$29.20

Disability	**Age-banded rates based on monthly benefit amount. See HR for rate table.**
Critical Illness	**Age-banded rates based on plan election and tobacco usage. See HR for rate table.**

Additional Information

Resources and Contact Information

Do you have a question about your benefits?

All Cigna members should create their MyCigna profile at www.mycigna.com.

Information on all plans can be obtained at the contact information below.

Benefit	Carrier & Phone	Website
Medical and Dental	**Cigna** 1-866-494-2111	www.cigna.com www.mycigna.com
Vision	**Ameritas** 1-800-877-7195	www.ameritas.com
Flexible Spending Accounts, Dependent Care Account	**Employee Benefits Corp (EBC)** 800-346-2126 Participantservices@ebcflex.com	www.ebcflex.com
Life and Disability	**Sun Life** 877-786-5433	www.Sun Life.ca/en/support/sign-in-help/my-sun-life/
Employee Assistance Program	**Profile EAP** 719-634-1825 (800-645-6571 toll free)	www.profileeap.org
Disability, Accident, Hospital Indemnity, Critical Illness	**Sun Life** 877-786-5433	www.Sun Life.ca/en/support/sign-in-help/my-sun-life/
Ask Charlie Benefits Advocacy Center	**Ask Charlie** (833) 543-8695	Healthsolutions.benefits@imacorp.com
Identity Theft Protection	**NortonLifeLock**	Direct enrollment: www.Norton.com/EBsetup

To obtain a copy of your benefit plan documents, contact Human Resources.

NOTICE: CMS PART D NOTICE OF CREDITABLE OR NON-CREDITABLE COVERAGE

When you or a family member becomes eligible for Part D (Medicare's prescription drug benefit), it is important to understand when to enroll in Part D. You can wait as long as you maintain "creditable" coverage (i.e., coverage which on average expects to pay at least as well as Part D expects to pay on average). But if you do not have creditable coverage, you need to enroll in Part D at the earliest opportunity to avoid future penalties.

Below are highlights to note:

- A continuous break in creditable coverage of 63 or more days will trigger a late enrollment penalty payable for life.
- The longer you go without creditable coverage, the higher the penalty. For the rest of your life, you would be charged an additional 1% of Part D base premium for each month you are late.
- When creditable coverage ends, a special enrollment period of two (2) months may be provided to enroll in Part D (but note that this is only available when normal coverage ends, not when retiree or COBRA coverage ends).
- The Part D annual open enrollment occurs each year from October 15th through December 7th for coverage to begin January 1st.

The information below indicates whether prescription drug coverage under our plan is creditable.

Creditable Coverage	Non-Creditable Coverage
PPO Base Plan **PPO Buy-Up Plan**	**None (all plans are creditable)**

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at https://www.shiphelp.org.

REMEMBER: If you have creditable coverage through our plan, keep this Notice as proof. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this Notice when you join to show you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

DATE:	11/1/2025
NAME OF ENTITY/SENDER:	Spanish Peaks dba Health Solutions
CONTACT--POSITION/OFFICE:	Human Resources
ADDRESS:	41 Montebello Road, Suite 202 Pueblo, CO 81001
PHONE NUMBER:	719-423-1234

NOTICE: SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance, 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 stopped contributing towards the other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, see the contact information at the end of these notices.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

NOTICE: HIPAA NOTICE OF PRIVACY PRACTICE

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. It also describes how your protected health information may be used or disclosed to carry out treatment, payment or healthcare operation or for any purposes that are permitted or required by law.

Your Rights	**You have the right to:** ❖ Get a copy of your health and claims records ❖ Correct your health and claims records ❖ Request confidential communication ❖ Ask us to limit the information we share ❖ Get a list of those with whom we've shared your information ❖ Choose someone to act for you ❖ File a complaint if you believe your privacy rights have been violated
Your Choices	**You have some choices in the way that we use and share information as we:** ❖ Answer coverage questions from your family and friends ❖ Provide disaster relief ❖ Market our services and sell your information
Our Uses and Disclosures	**We may use and share your information as we:** ❖ Help manage the health care treatment you receive ❖ Run our organization ❖ Pay for your health services ❖ Help with public health and safety issues ❖ Do research ❖ Comply with the law ❖ Respond to organ and tissue donation requests and work with a medical examiner or funeral director ❖ Address workers' compensation, law enforcement and other government requests ❖ Respond to lawsuits and legal action

Your Rights	**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.
Get a copy of health and claims records	❖ You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. ❖ We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	❖ You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. ❖ We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	❖ You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. ❖ We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	❖ You can ask us not to use or share certain health information for treatment, payment or our operations. ❖ We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	❖ You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with and why. ❖ We will include all the disclosures except for those about treatment, payment and health care operations and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	❖ You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	❖ If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. ❖ We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	❖ You can complain if you feel we have violated your rights by contacting us using the information on page 9. ❖ You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. ❖ We will not retaliate against you for filing a complaint.

Your Choices	**For certain health information, you can tell us your choices about what to share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right	❖ Share information with your family, close friends, or others involved in payment for your care

and choice to tell us to:	❖ Share information in a disaster relief situation *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	❖ Marketing purposes ❖ Sale of your information

Our Uses and Disclosures	**How do we typically use or share your health information.** We typically use or share your health information in the following ways.	
Help manage the health care treatment you receive	❖ We can use your health information and share it with professionals who are treating you.	***Example:*** *A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	❖ We can use and disclose your information to run our organization and contact you when necessary. ❖ **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.	***Example:*** *We use health information about you to develop better services for you.*
Pay for your health services	❖ We can use and disclose your health information as we pay for your health services.	***Example:*** *We share information about you with your dental plan to coordinate payment for your dental work.*
Administer your Plan	❖ We may disclose your health information to your health plan sponsor for plan administration.	***Example:*** *Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: Your Rights Under HIPAA | HHS.gov.

Help with public health and safety issues	We can share health information about you for certain situations such as: ❖ Preventing disease ❖ Helping with product recalls ❖ Reporting adverse reactions to medications ❖ Reporting suspected abuse, neglect or domestic partner violence ❖ Preventing or reducing a serious threat to anyone's health or safety
Do research	❖ We can use or share your information for health research

Comply with the law	❖ We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	❖ We can share health information about you with organ procurement organizations. ❖ We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	We can use or share health information about you: ❖ For workers' compensation claims ❖ For law enforcement purposes or with a law enforcement official ❖ With health oversight agencies for activities authorized by law ❖ For special government functions such as military, national security and presidential protective services
Respond to lawsuits and legal actions	❖ We can share health information about you in response to a court or administrative order or in response to a subpoena.

Our Responsibilities

- ❖ We are required by law to maintain the privacy and security of your protected health information.
- ❖ We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- ❖ We must follow the duties and privacy practices described in this notice and give you a copy of it.
- ❖ We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: Your Rights Under HIPAA | HHS.gov.

NOTICE: CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Continuation Coverage Available?

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

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

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

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 (for fully insured plans issued in California, coverage generally last for 36 months).

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

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

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact information at the end of these notices. 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.

NOTICE: WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Did you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information, see the contact information at the end of these notices.

NOTICE: 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 **(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 **(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 March 17, 2025. Contact your State for more information on eligibility.

ALABAMA – MEDICAID	COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)
WEBSITE: http://myalhipp.com/ **PHONE:** (855) 692-5447	**HEALTH FIRST COLORADO WEBSITE:** https://healthfirstcolorado.com/ **HEALTH FIRST COLORADO MEMBER CONTACT CENTER:** (800) 221-3943 / STATE RELAY 711 **CHP+:** https://hcpf.colorado.gov/child-health-plan-plus **CHP+ CUSTOMER SERVICE:** (800) 359-1991 / STATE RELAY 711 **HEALTH INSURANCE BUY-IN PROGRAM (HIBI):** https://www.mycohibi.com/ **HIBI CUSTOMER SERVICE:** (855) 692-6442
ALASKA – MEDICAID	**FLORIDA – MEDICAID**
THE AK HEALTH INSURANCE PREMIUM PAYMENT PROGRAM **WEBSITE:** http://myakhipp.com/ **PHONE:** (866) 251-4861 **EMAIL:** CustomerService@MyAKHIPP.com **MEDICAID ELIGIBILITY:** **WEBSITE:** https://health.alaska.gov/dpa/Pages/default.aspx	**WEBSITE:** https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html **PHONE:** (877) 357-3268

LOUISIANA – MEDICAID

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

MEDICAID HOTLINE: (888) 342-6207

LAHIPP PHONE: (855) 618-5488

MONTANA – MEDICAID

WEBSITE: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

PHONE: (800) 694-3084

EMAIL: HHSHIPPProgram@mt.gov

MAINE – MEDICAID

ENROLLMENT WEBSITE: https://www.mymaineconnection.gov/benefits/s/?language=en_US

PHONE: (800) 442-6003

TTY: Maine Relay 711

PRIVATE HEALTH INSURANCE PREMIUM WEBPAGE:

https://www.maine.gov/dhhs/ofi/applications-forms

PHONE: (800) 977-6740

TTY: Maine Relay 711

NEBRASKA – MEDICAID

WEBSITE: http://www.ACCESSNebraska.ne.gov

PHONE: (855) 632-7633

LINCOLN: (402) 473-7000

OMAHA: (402) 595-1178

NEVADA – MEDICAID

WEBSITE: https://dhcfp.nv.gov/

PHONE: (800) 992-0900

OREGON – MEDICAID

WEBSITE: http://healthcare.oregon.gov/Pages/index.aspx

PHONE: (800) 699-9075

NEW HAMPSHIRE – MEDICAID

WEBSITE: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program

PHONE: (603) 271-5218

TOLL FREE NUMBER FOR THE HIPP PROGRAM:

(800) 852-3345 Ext. 5218

EMAIL: DHHS.ThirdPartyLiabi@dhhs.nh.gov

PENNSYLVANIA – MEDICAID

WEBSITE:

https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html

PHONE: (800) 692-7462

CHIP WEBSITE: Children's Health Insurance Program (CHIP) (pa.gov)

PHONE: (800) 986-KIDS (5437)

NEW JERSEY – MEDICAID AND CHIP

MEDICAID WEBSITE: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

MEDICAID PHONE: (800) 356-1561

CHIP PREMIUM ASSISTANCE PHONE: (609) 631-2392

CHIP WEBSITE: http://www.njfamilycare.org/index.html

CHIP PHONE: (800) 701-0710 (TTY: 711)

RHODE ISLAND – MEDICAID AND CHIP

WEBSITE: http://www.eohhs.ri.gov/

PHONE: (855) 697-4347 or

(401) 462-0311 (Direct Rite Share Line)

NEW YORK – MEDICAID

WEBSITE: https://www.health.ny.gov/health_care/medicaid/

PHONE: (800) 541-2831

SOUTH CAROLINA – MEDICAID

WEBSITE: https://www.scdhhs.gov

PHONE: (888) 549-0820

NORTH CAROLINA – MEDICAID

WEBSITE: https://medicaid.ncdhhs.gov/

PHONE: (919) 855-4100

SOUTH DAKOTA - MEDICAID

WEBSITE: http://dss.sd.gov

PHONE: (888) 828-0059

NORTH DAKOTA – MEDICAID	TEXAS – MEDICAID
WEBSITE: https://www.hhs.nd.gov/healthcare **PHONE:** (844) 854-4825	**WEBSITE:** Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services **PHONE:** (800) 440-0493
OKLAHOMA – MEDICAID AND CHIP	**UTAH – MEDICAID AND CHIP**
WEBSITE: http://www.insureoklahoma.org **PHONE:** (888) 365-3742	**UTAH'S PREMIUM PARTNERSHIP FOR HEALTH INSURANCE (UPP)** **MEDICAID WEBSITE:** https://medicaid.utah.gov/upp/ **EMAIL:** upp@utah.gov **PHONE:** (888) 222-2542 **ADULT EXPANSION WEBSITE:** https://medicaid.utah.gov/expansion/ **UTAH MEDICAID BUYOUT PROGRAM WEBSITE:** https://medicaid.utah.gov/buyout-program/ **CHIP WEBSITE:** http://chip.utah.gov/
VERMONT– MEDICAID	**WEST VIRGINIA – MEDICAID AND CHIP**
WEBSITE: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access **PHONE:** (800) 250-8427	**WEBSITE:** https://dhhr.wv.gov/bms/ http://mywvhipp.com/ **MEDICAID PHONE:** (304) 558-1700 **CHIP TOLL-FREE PHONE:** (855) MyWVHIPP (699-8447)
VIRGINIA – MEDICAID AND CHIP	**WISCONSIN – MEDICAID AND CHIP**
WEBSITE: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs **MEDICAID & CHIP PHONE:** (800) 432-5924	**WEBSITE:** https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm **PHONE:** (800) 362-3002
WASHINGTON – MEDICAID	**WYOMING – MEDICAID**
WEBSITE: https://www.hca.wa.gov/ **PHONE:** (800) 562-3022	**WEBSITE:** https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ **PHONE:** (800) 251-1269

To see if any other States have added a premium assistance program since March 17, 2025, or for more information on *Special Enrollment Rights*, contact either:

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

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

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