Prestige Maintenance USA

BENEFITS ENROLLMENT GUIDE

MANAGEMENT & CORPORATE EMPLOYEES

POLICY YEAR

October 1, 2025 – September 30, 2026

LONE STAR BENEFITS

TABLE OF CONTENTS

BENEFITS PROGRAM OVERVIEW

WHO is Eligible

If you are a full-time employee who works a minimum of 30 hours per week, you are eligible to participate in the benefits program. You may also elect coverage for your eligible dependents. Eligible dependents are defined as:

- your legal spouse;
- eligible children up to age 26 (children are defined as your natural children, stepchildren, legally adopted children and children under your legal guardianship);
- physically or mentally disabled children of any age who are incapable of self-support.

Dependents must enroll in the same plan as the employee.

WHEN to Enroll

Eligible employees may review and change their benefit elections during the annual Open Enrollment period. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, or you experience a family status event. Please refer to the following page for examples of "Qualified Events".

Full-time employees who work a minimum of 30 hours per week and are at least 18 years of age are eligible to participate in the benefits program, with an effective date of 1st of the month following 30 days from your date of hire. Please review and complete enrollment before the end of the month prior to your benefits taking effect.

HOW to Enroll

1) Utilize this guide to make benefit elections during the Open Enrollment period.

2) Use this QR code to schedule a phone call with a benefits counselor to make your elections (in English or Spanish).
   You may also go through this link to schedule your call:
   https://BeneBlocEnrollment.as.me/Prestige

All Employees: Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you incur a Qualifying Event.

HOW to Make Changes

If you experience any of the events listed below, you must notify Human Resources within 30 days of the event to make the necessary adjustments. Changes reported after the 30-day window will not be accepted. Members will have to wait until the next Open Enrollment period to make any changes. Qualified Events include:

- Marriage
- Divorce or legal separation
- Birth of a child
- Adoption of a child or placement for adoption
- Gain or loss of legal custody of a child
- Dependent child turns 26 years old
- Death of a dependent
- Medicare eligibility
- Dependent becomes disabled
- Termination of spouse's employment
- Spouse loses healthcare benefits
- Loss or gain of another group coverage
- Employment termination
- Death of the person upon whom you or your dependents depend for coverage
- Change in employment status (i.e. part-time, full-time) of the employee

WHAT documents are required

Supporting documentation might be required to process a Qualifying Event Change. Examples of acceptable forms or documents include, but not limited to:

- Marriage certificate
- Divorce decree
- Birth certificate
- Legal adoption paperwork
- Death certificate
- Certificate of creditable coverage
- Documents indicating loss or gain of another group coverage
- Copy of insurance ID card

It is your responsibility to notify Human Resources of any family status change within 30 days of the qualifying event.

Say hello to Curative.

Health insurance you'll love to use.

The Curative promise: It's easy.

- Easy costs
- Easy to get care
- Easy to navigate

Let's get some (minor) details covered.

If they are under **18,** your dependents will also qualify for the **$0 copay and $0 deductible** with your completion of the Baseline Visit.

Note: Only one subscriber or spouse has to complete a Baseline for your minor dependent to qualify.

Members **18 or older** will need to complete their own Baseline Visit to qualify. They can make an appointment through the member portal.

Don't forget your Baseline!

By completing your Baseline Visit within 120 days of your plan effective date, you'll also keep your $0 copays and $0 deductible for in-network care and preferred prescriptions. For more info on the Baseline, go to **curative.com/baseline.**

Members can sign up for their visit through the member portal at **health.curative.com**

Our Baseline Visit is Vital.

We help you reach the healthiest version of you.

At Curative, we're committed to helping our members get the most out of their health plan from day one. Curative members are invited to participate in a Baseline Visit to help take the guesswork out of their health. By completing a visit in the first 120 days, members continue with $0 out-of-pocket costs for in-network care and preferred prescriptions.

Important things to know:

- The Baseline Visit is 100% cost-free
- Results and conversations are completely confidential
- Results will not impact cost the cost of your health insurance premiums
- Visits are typically between 45 min-1 hour
- Doesn't replace your annual physical exam

CURATIVE MEDICAL PLAN SUMMARIES					
Plan Type/Name	**EPO PLAN** (Exclusive Provider Organization)		**PPO Plan** (Preferred Provider Organization)		
Network	**First Health / EPO**		**First Health / PPO**		
Network Website	www.curative.com		www.curative.com		
Plan Type/Name **Covered Benefits**	**Yes Baseline Visit** **In-Network**	**No Baseline Visit** **In-Network**	**Yes Baseline Visit** **In-Network**	**No Baseline Visit** **In-Network**	**No Baseline Visit** **Out-Network**
Calendar Year Deductible					
Individual	$0	$5,000	$0	$5,000	$10,000
Family (Employee + 2 or more dependents)	$0	$10,000	$0	$10,000	$20,000
Calendar Year Out-of-Pocket Maximums*					
Individual	$0	$7,500	$0	$7,500	$15,000
Family (Employee + 2 or more dependents)	$0	$15,000	$0	$15,000	$30,000
Professional Services					
Physician Office Visit	$0	$25	$0	$25	$50
Specialist Office Visit	$0	$50	$0	$50	$100
Urgent Care	$0	20%**	$0	20%**	50%**
Virtual Visit	$0	$50	$0	$50	$100
Diagnostic Lab	$0	20%**	$0	20%**	50%**
Diagnostic X-Ray Services	$0	20%**	$0	20%**	50%**
Imaging (CT, PET Scans, MRI)	$0	20%**	$0	20%**	50%**
Hospital Services					
Inpatient	$0	20%**	$0	20%**	50%**
Outpatient Surgery	$0	20%**	$0	20%**	50%**
Emergency Room	$0	20%**	$0	20%**	20%**
Prescriptions					
Preferred Generic	$0	$50**	$0	$50**	50%**
Preferred Brand	$0	$50**	$0	$50**	50%**
Preferred Specialty	$0	$50**	$0	$50**	50%**
Non-Preferred Generic	$50/$250	$100**	$50/$250	$100**	50%**
Non-Preferred Brand	$50/$250	$100**	$50/$250	$100**	50%**
Non-Preferred Specialty	$50/$250	25%**	$50/$250	25%**	50%**

Chiropractic Care included under PPO Plan only

** Out-of-Pocket Maximums include all applicable deductibles, co-pays, and coinsurance paid by the member.*
*** Deductible must be met before coinsurance/copay will apply.*
**** Plus all applicable deductibles and coinsurance paid by the member.*

MEDICAL PAYROLL DEDUCTIONS		
Rates are based on 24 pay periods per year and reflect employer contributions.		
TIER ELECTION	**EPO**	**PPO**
Employee Only	**$180.85**	**$206.13**
Employee + Spouse	**$578.62**	**$659.49**
Employee + Children	**$506.31**	**$577.08**
Employee + Family	**$904.15**	**$1,030.53**

Please refer to the carrier's summaries and certificates for further details.

PRINCIPAL DENTAL PLAN SUMMARIES		
Network Name	**Principal Plan**	**Principal Plan**
Network Website	www.principal.com	www.principal.com
Plan Type / Name	**PPO / Low**	**PPO / High**
Annual Maximum	$1,000	$5,000
Annual Deductible (Individual/Family)	$50 / $150	$50 / $150
Out-of-Network Reimbursement	90% UCR	90% UCR
Preventive (Deductible Waived)	*Routiene Exams, Cleanings (2 per year), Topical Flouride, X-rays, Sealants, Space Maintainers*	*Routiene Exams, Cleanings (2 per year), Topical Flouride, X-rays, Sealants, Space Maintainers*
Coinsurance (Carrier Pays)	100%	100%
Basic (Deductible Applies)	*Fillings, Peridontal Maintenance, Emergency Exams*	*Fillings, Endodontics, Periodontics*
Coinsurance (Carrier Pays)	60%	80%
Major (Deductible Applies)	*Crowns, Bridges, Dentures, Inlays, Onlays, Repairs to Bridges & Dentures, Endodontics, Periodontics, General Anesthesia, Oral Surgery*	*Crowns, Bridges, Dentures, Inlays, Onlays, Repairs to Bridges & Dentures, Endodontics, Periodontics, General Anesthesia, Oral Surgery*
Coinsurance (Carrier Pays)	40%	50%
Orthodontia		
Lifetime Maximum	$1,000	$1,500
Coinsurance	50%	50%

DENTAL PAYROLL DEDUCTIONS		
Rates are based on 24 pay periods. Dental is voluntary and 100% employee responsibility.		
TIER ELECTION	**PPO / LOW**	**PPO / HIGH**
Employee Only	**$18.08**	**$29.32**
Employee + Spouse	**$34.27**	**$53.27**
Employee + Child(ren)	**$49.87**	**$75.05**
Employee + Family	**$69.87**	**$104.48**

PRINCIPAL VISION PLAN SUMMARY		
Network Name	**VSP Choice**	
Network Website	www.principal.com	
Plan Name	**PPO / Contributory**	
	In-Network	**Out-of-Network**
Eye Exam - Copay	$10	Plan pays up to: Up to $45
Lenses (Per Pair) - Copay		
Single	$10	Up to $30
Bifocal	$10	Up to $50
Trifocal	$10	Up to $65
Lens Options	30% Off	
UV Coating		N/A
Tint (Solid and Gradiant)		N/A
Standard Scratch-Resistance		N/A
Standard Polycarbonate		N/A
Standard Anti-Reflective		N/A
Frames	$130 Allowance + 20% discount off balance	Up to $70
Contact Lenses (in lieu of glasses)		
Conventional	$60 CoPay + $130 Allowance	Up to $105
Frequency		
Eye Exams	12 Months	
Lenses	12 Months	
Frames	24 Months	

VISION PAYROLL DEDUCTIONS	
Rates are based on 24 pay periods. Vision is voluntary and 100% employee responsibility.	
TIER ELECTION	**VSP**
Employee Only	**$3.57**
Employee + Spouse	**$7.14**
Employee + Child(ren)	**$7.66**
Employee + Family	**$12.04**

EMPLOYER PAID BENEFITS
These benefits are 100% employer paid and provided at no cost to you during your employment.

PRINCIPAL LIFE & AD&D PLAN SUMMARY	
Term Life & AD&D benefit per employee	$25,000
Age reduction schedule	Reduced to 65% at age 65. Reduced to 50% at age 70+

PRINCIPAL SHORT-TERM DISABILITY PLAN SUMMARY	
Benefit Percentage	70% of Gross Weekly
Maximum Weekly Benefit	$2,300
Benefit Waiting Period:	
Accident	14 days
Sickness	14 days
Benefit Duration	11 Weeks

PRINCIPAL LONG-TERM DISABILITY PLAN SUMMARY	
Benefit Percentage	60% of Gross Monthly
Maximum Monthly Benefit	$10,000
Elimination Period	90 Days
Own Occupation Period	36 Months
Survivor Benefit	3 Months
Pre-existing Condition ***(look-back period / treatment period)***	3/12

PRINCIPAL
VOLUNTARY LIFE & AD&D SUMMARY

These benefits are voluntary and 100% employee responsibility

EMPLOYEE BENEFIT*	
Maximum Amount of Coverage	$300,000
Minimum Amount of Coverage	$10,000
Guaranteed Issue Amount	$200,000
Rate per $1000 of Coverage:	
0-29	$0.086
30-34	$0.107
35-39	$0.135
40-44	$0.216
45-49	$0.309
50-54	$0.494
55-59	$0.798
60-64	$1.034
65-69	$1.586
70-74	$2.813
75-79	$2.813
80 & Over	$2.813
AD&D Rate	$0.028
SPOUSE BENEFIT*	
Maximum Amount of Coverage*	$250,000
Minimum Amount of Coverage	$5,000
Guaranteed Issue Amount	$30,000
Rate per $1000 of Coverage:	
0-29	$0.086
30-34	$0.107
35-39	$0.135
40-44	$0.216
45-49	$0.309
50-54	$0.494
55-59	$0.798
60-64	$1.034
65-69	$1.586
70-74	$2.813
75-79	$2.813
80 & Over	$2.813
AD&D Rate	$0.028
CHILD BENEFIT*	
Maximum Amount of Coverage*	$10,000
Minimum Amount of Coverage	$2k - $5k or $10k
Guaranteed Issue Amount	$2k - $5k or $10k
Monthly Rate	$0.40, $0.60, $0.80, $1.00 or $2.00
AD&D Rate	N/A

**The employee must be covered for Voluntary Life in order to insure dependents for voluntary life.*

THE HARTFORD ACCIDENT INSURANCE PLAN SUMMARY	
These benefits are 100% employee responsibility.	
Coverage	24 hour
Burn	up to $5k
Coma	$15k
Concussion	$300
Dental Injury	Crown: $600 / Extraction: $300
Dislocations	up to $10k
Eye Injury With Surgical Repair	$750
Fractures	up to $10k
Knee Cartilage Injury with Surgical Repair	$2K
Ruptured Disc with Surgical Repair	$2K
Tendon / Ligament / Rotator Cuff Injury with Surgical Repair	$1,500
Wellness Benefit (routine preventive care)	$50 (1 per person per cal. yr.)
TIER ELECTION	**RATE PER 24 PAY PERIODS**
Employee Only	**$4.67**
Employee + Spouse	**$7.37**
Employee + Child(ren)	**$7.94**
Employee + Family	**$12.44**

THE HARTFORD HOSPITAL INDEMNITY PLAN SUMMARY	
These benefits are 100% employee responsibility.	
Hospital Admission Benefit	$1K (1 per person per cal. yr.)
Daily Hospital Benefit	$100 (90 days per cal. yr.)
ICU Admission Benefit	$1k (1 per person per cal. yr.)
Daily Hospital ICU Benefit	$200 (30 days per cal. yr.)
Wellness Benefit (routine preventive care)	$50 (1 per person per cal. yr.)
TIER ELECTION	**RATE PER 24 PAY PERIODS**
Employee Only	**$7.68**
Employee + Spouse	**$19.00**
Employee + Child(ren)	**$12.51**
Employee + Family	**$24.73**

THE HARTFORD
CRITICAL ILLNESS PLAN SUMMARY

These benefits are 100% employee responsibility.

Maximum Amount of Coverage	$30,000
Minimum Amount of Coverage	$5,000
Guaranteed Issue Amount	$30,000
Spouse/Child Face Amount Reduction	100%/50% of Employee Face Amount
Pre-existing Condition	3/12
Heart Attack	100%
Stroke	100%
Major Organ Failure	100%
Cancer (invasive)	100%
Cancer (non-invasive/carcinoma in situ)	25%
Skin Cancer	$250
Coronary Artery Condition	25%
Wellness Benefit (routine preventive care)	$50 (1 per person per cal. yr.)

Monthly Rates:

Rate per $1000 of Coverage:	Employee	Spouse
0-24	$0.200	$0.200
25-29	$0.290	$0.290
30-34	$0.460	$0.460
35-39	$0.550	$0.550
40-44	$0.740	$0.650
45-49	$1.090	$1.000
50-54	$1.450	$1.350
55-59	$1.880	$1.780
60-64	$2.540	$2.450
65-69	$3.420	$3.330
70-74	$4.470	$4.380
75-79	$5.680	$5.580
80 & Over	$6.880	$6.780

HEALTH BOOST

This benefit package offers you wellness and peace of mind with no-cost virtual doctor visits, access to experienced lawyers, and discounts and flexibility to a national network of gyms!

Recuro Telehealth

Convenient care at the touch of a button, wherever you are, whenever you need it. **On-demand virtual visits** with board-certified doctors for treatment of common acute medical concerns typically available in less than 10 minutes. Ideal for allergies, sinus infections, ear problems, fever, nausea, pink eye, UTIs and more. You receive treatment plans and prescriptions, if medically necessary.

- 24/7 access to physicians when you or your immediate family needs care - day or night
- Multi-channel options for your virtual visit - live video and phone
- Diagnosis and treatment plan, based on your needs, and option to ask follow up questions at no charge
- Consults can be recorded and transcribed for access after your virtual visit

NB Fitness

Stay active for just $28 per month! NB Fitness provides you with extreme flexibility in membership choices, direct access to a national network of nearly 12,000 participating gym partners, and 9,000+ workout videos. You can switch gyms anytime, and you'll pay the monthly charges directly on the Active&Fit Direct website.

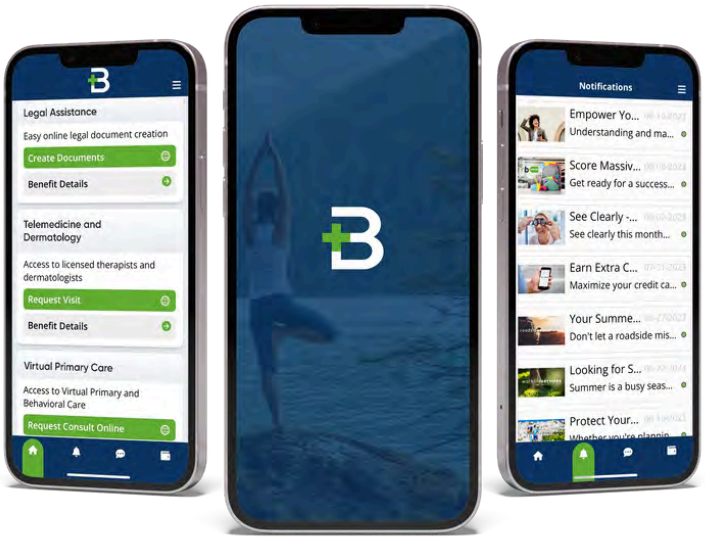
Legal Services

Have legal questions? Get legal answers from **experienced lawyers** at discounted rates. Attorneys help with traffic tickets, bankruptcy, divorce, and spousal and child support. Additional services are also available at no cost to you!

Prestige Maintenance USA®

$7.00
PER MONTH
includes member, spouse and dependents

SCAN FOR A BRIEF VIDEO ABOUT THIS PACKAGE!



ACCESS YOUR BENEFITS ON THE GO!

With the **My Benefits Work™** mobile app & portal

Download on the App Store

GET IT ON Google Play

DISCLOSURES

This program is NOT insurance coverage and does not meet the minimum creditable coverage requirements under the Affordable Care Act or Massachusetts M.G.L. c. 111M and 956 CMR 5.00. It contains a 30-day cancellation period, provides discounts only at the offices of contracted health care providers, and each member is obligated to pay the discounted medical charges in full at the point of service. The range of discounts for medical or ancillary services provided under the program will vary depending on the type of provider and medical or ancillary service received. Member shall receive a reimbursement of all periodic membership fees if membership is canceled within the first 30 days after the effective date. Discount Plan Organization: New Benefits, Ltd., Attn: Compliance Department, PO Box 803475, Dallas, TX 75380-3475, 800-800-7616. Website to obtain participating providers: MyBenefitsWork.com.

 Recuro Health does not guarantee that a physician will write a prescription, and physicians do not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Recuro Health affiliated physicians reserve the right to deny care for potential misuse of services. Medical services provided by physicians are subject to their professional judgment. Recuro Health operates subject to state regulation and some services may not be available in certain states.

NB Fitness Disclaimer: $28 per month plus applicable taxes for standard fitness centers. Costs for premium exercise studios exceed $28 per month and an enrollment fee will apply for each premium location selected, plus applicable taxes. Fees vary based on premium fitness studios selected. Add a spouse/domestic partner to a primary membership for additional monthly fees. Spouses/domestic partners must be 18 years or older. Fees may vary based on fitness center selection. The Active&Fit Direct™ program is provided by American Specialty Health Fitness, Inc., a subsidiary of ASH. Active&Fit Direct and the Active&Fit Direct logos are trademarks of ASH and used with permission herein. Other names or logos may be trademarks of their respective owners. Standard fitness center and premium studio participation varies by location and is subject to change. On-demand workout videos are subject to change. ASH reserves the right to modify any aspect of the Program (including, without limitation, the Enrollment Fee(s), the Monthly Fee(s), any future Annual Maintenance fees, and/or the Introductory Period) at any time per the terms and conditions. If we modify a fee or make a material change to the Program, we will provide you with no less than 30 days' notice prior to the effective date of the change. We may discontinue the Program at any time upon advance written notice.

Not available to residents in VT, WA, & UT.

IMPORTANT BENEFIT CONTACTS

BENEFIT	CARRIER	WEBSITE	PHONE	POLICY
Medical and Prescription Drug	Curative	www.curative.com	(855) 428-7284	Prestige Maintenance USA
Dental	Principal	www.principal.com	(800) 247-4695	TBD
Vision	Principal	www.principal.com	(800) 247-4695	TBD
Life/AD&D Voluntary Life/AD	Principal	www.principal.com	(800) 247-4695	TDB
Short-term Disability Long-term Disability	Principal	www.principal.com	(800) 247-4695	TDB
Accident Hospital Indemnity Critical Illness	The Hartford	www.thehartford.com	(888) 563-1124	TBD
Employee Assistance Program	Magellan Healthcare	member.magellanhealthcare.com	(800) 450-1327	-
Curative Virtual Urgent Care	Curative Telehealth	www.curative.com	(855) 428-7284	Prestige Maintenance USA
Curative Virtual Mental Health	Curative Telehealth	www.curative.com	(855) 428-7284	Prestige Maintenance USA
Telemedicine	Recuro Health	www.recurohealth.com	(855) 673-2876	BLOC001
LegalShield IDShield	LegalShield - Gloria Tisdale	www.shieldbenefits.com/prestigeusa	(214) 723-1559	154789
Account Executive	Jenn Medaris	jmedaris@LSBinc.com	(214) 619-0934	Lone Star Benefits, Inc.

PRODUCT	What Are These Benefits? *(INSURANCE OVERVIEW VIDEOS)**	Why Get These Benefits? *(Voluntary, LIGHT-HEARTED VIDEOS)**	Benefits in Action *(Voluntary)**
Accident	www.thehartford.com/learn/accident	www.thehartford.com/benefits/accident	www.thehartford.com/bia/accident
Critical Illness	www.thehartford.com/learn/criticalillness	www.thehartford.com/benefits/criticalillness	www.thehartford.com/bia/criticalillness
Hospital Indemnity	www.thehartford.com/learn/hospital	ww.thehartford.com/benefits/hospital	www.thehartford.com/bia/hospital

curative

Bending the **cost curve** and improving **employee wellbeing** with **member engagement**

Curative is removing barriers to care with affordability, engagement, and simplicity. When members actually use their benefits we **improve health outcomes** and lower costs.

Current health care isn't working for anyone

Rising deductibles and copays mean people are deferring care. Even a basic visit to a doctor can come with a lot of out-of-pocket expenses. Plus, the system is so complex and with nobody to help, getting the right care can be overwhelming. So we defer care as long as we possibly can, and prescriptions go unfilled because they're simply unaffordable.

Transparent, next-generation health care employees will love to use

We've created a simple plan that consumers love to use—that removes cost barriers like copays, deductibles and most prescription charges, while providing trusted support at every step— we will completely change the way members engage with their health. Getting every member the preventive care they need, encouraging healthy behaviors, putting medical advancements to work, and helping us all live longer, healthier lives — with lower long-term total costs of care for members and employers alike.

Curative Care Navigators

Care Navigators are at the core of our member-centric experience. Each Curative plan member is paired with a Care Navigator who will be their **first point of contact** to onboard with our plan, and support them through their entire journey as a member, providing resources and guidance on maximizing their **Curative benefits** to reach their health goals.

> Most people do not choose to seek the care that they need because of small barriers to access – not knowing the right questions to ask or lack of awareness of the resources available to them. I am easily accessible by phone, text, or email and the members can reach out to me directly at any time. It is my hope that I will build a relationship with the members during their **Baseline Visits** so that they feel comfortable enough to ask any questions that they may have about seeking care.
>
> **-Kyra N., Care Navigator**

Engagement from the start

In order to qualify for **$0 copays and deductibles** members must complete a Baseline Visit within the first 120 days of the plan effective date.

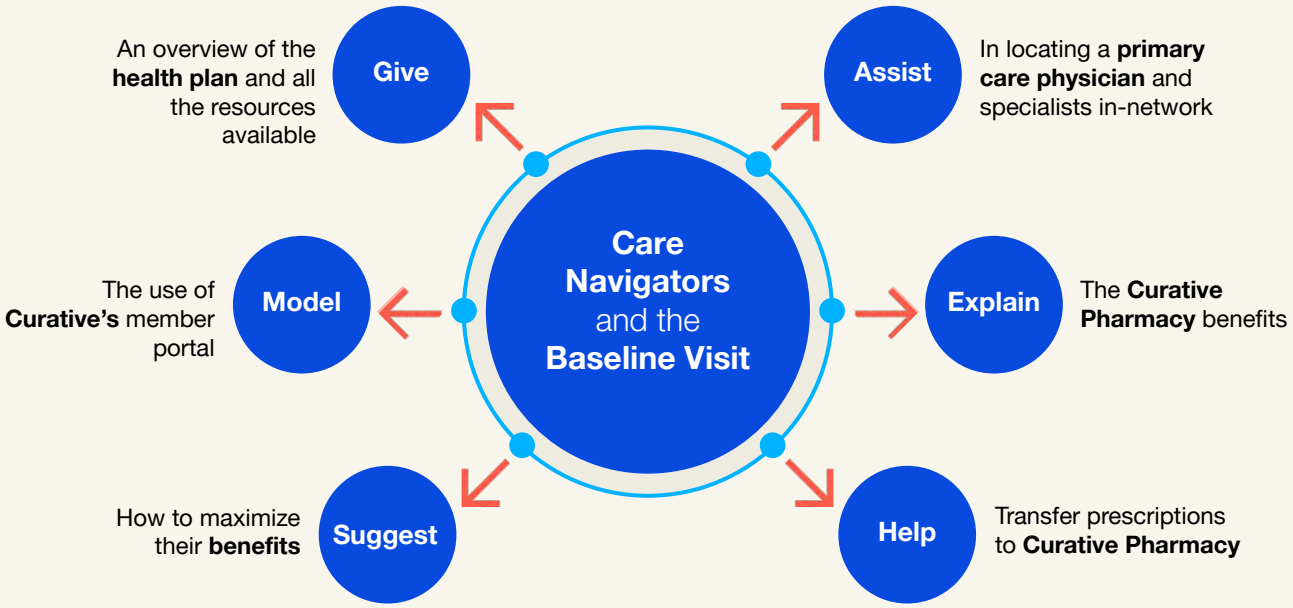
98% of health plan participants complete the Baseline Visit)

The **Baseline Visit**

A Baseline Visit is an **individualized virtual appointment** with a **Care Navigator** that focuses on the member's complete well-being and shares how to best utilize **Curative benefits** and resources.

Proactively starting the conversation around **health goals** and providing the tools to achieve them sets your employees up for **long-term success** and improved satisfaction.

Members also meet with a clinician who will review medical history, help the member with a care plan and, if appropriate, connect them to Curative **wellness management programs** for chronic or acute conditions related to: obesity, hypertension, diabetes, and maternal health. We also have a **robust case management** process to help with acute situations.



Continued member support so employees can focus on what matters

We've created a simple plan that consumers love to use—that removes cost barriers like copays, deductibles and most prescription charges, while providing trusted support at every step— we will completely change the way members engage with their health. Getting every member the preventive care they need, encouraging healthy behaviors, putting medical advancements to work, and helping us all live longer, healthier lives — with lower long-term total costs of care for members and employers alike.

Better health benefits benefit your business

Employers should offer plan options that focus on high-quality, comprehensive coverage that is cost-transparent, member-centric, and encouraged to use. When members are equipped and incentivized to prioritize their health, their health, wellbeing, and productivity improves.

curative cash card

Your Ticket to Hassle-free Care

We guarantee $0 copays and deductibles for any doctor in our search. There are two options to provide payment covered by Curative:

1) insurance billing using the Curative Member ID Card

2) self-pay using our unique Curative Cash Card.

Either way, you don't pay.

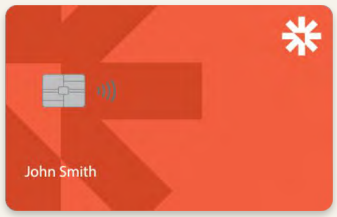
What will be approved?

It can be used for:

- Primary care and office visits
- Urgent care
- Behavioral health
- Many inpatient and outpatient hospital services, such as imaging, surgeries, or medical monitoring.

What will not be approved?

Prescriptions, certain lab services, non-covered benefits



Questions?

Call Member Services, available 24/7 at 855-428-7284

**To maintain $0 copays and deductibles, a Baseline Visit must be completed within the first 120 days of plan activation.*

Curative Cash Card Visa® Commercial Credit cards are issued by Celtic Bank. Additional Terms & Conditions can be found in your Member Portal Account at health.curative.com. BR240207-1

Here's how you can access your Curative Cash Card:

Step 1

Activate your Curative Cash Card by logging into the Member Portal at health.curative.com and selecting "Cash Card." Once activated, you'll instantly have access to your digital card.

A physical Cash Card will be delivered soon after your plan start date.

Note: Curative members must be 18 or older to access the card.

Step 2

Before attempting to use the Curative Cash Card, please try using your Curative Member ID Card first.

Step 3

If listed as Curative Cash Card only in the Provider Search, use your Curative Cash Card instead of your Member ID Card. Tell the front desk you will "pay cash!" and hand over your Curative Cash Card.

Backup: If a provider appears in our search but does not take your Member ID Card for any reason or tries to charge a copay, say you'll self-pay instead and hand over your Curative Cash Card.

curative

Curative Guide to $0 Care*

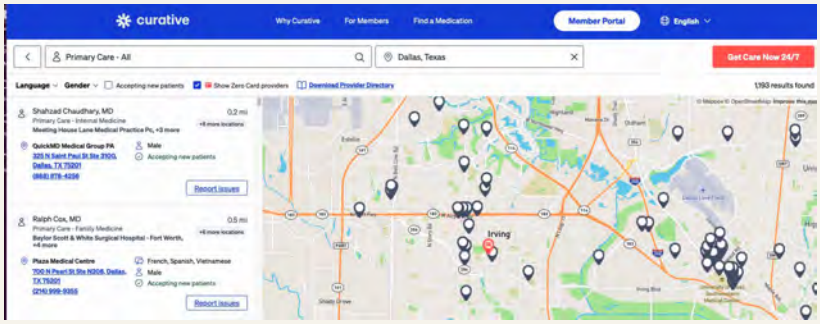
Two cards. One goal. Zero dollars.

We guarantee $0 copays and deductibles for covered services provided by any doctor in our search.* There are two options to provide payment covered by Curative: 1) insurance billing using the Curative Member ID Card and 2) self-pay using our unique **Curative Cash Card**.

Either way, you don't pay. Here is a quick and easy guide to $0 care.

Start here
Provider Search

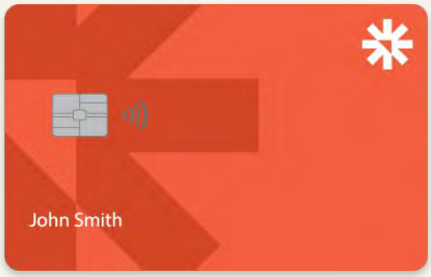
All clinicians shown at curative.com/providers have $0 out-of-pocket costs for covered services.



Option 1
Member ID Card

Use the Curative Member ID Card first if the provider shows in our search.

Option 2
Curative Cash Card



Use the Curative Cash Card for any provider that shows as Curative Cash Card. Tell the front desk you will **self-pay** and hand over your Curative Cash Card. Think of it as a payment card with no impact on credit. It can be used for office visits, urgent care, behavioral health, and certain services without hospital stays. It does not include medications, labs and non-covered benefits.

More $0 Providers: It's easy to nominate a provider for the Curative Cash Card. Fill out a quick form cur.tv/nominate or call Member Services 855-428-7284.

Backup: If a provider appears in our search but does not take your Member ID Card for any reason or tries to charge a copay, say you'll self-pay instead and hand over your Curative Cash Card.

Members must be 18 years and older to use the Curative Cash Card and complete their Baseline Visit in the first 120 days of their plan start date to maintain $0 out-of-pocket costs. Curative Cash Card Visa® Commercial Credit cards are issued by Celtic Bank. Additional Terms & Conditions can be found in your Member Portal Account at health.curative.com.

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Broker and Employer

Commonly Asked Questions

Why does Curative have two different cards?
Our dual-card system allows more provider choice and less friction with no out-of-pocket costs for members who complete a Baseline Visit within the first 120 days. Providers will either bill later through insurance or take cash pay at the point of service. Either way, members pay $0 copays, $0 deductibles and Curative foots the bill.

- **The Curative Member ID Card** is the traditional route – providers bill through claims and Curative pays those claims.
- **The Curative Cash Card** is on-the-spot payment – it allows members to see providers that don't take the Member ID Card for any reason. They may not take insurance at all, like many mental health providers, or they may not recognize Curative as contracted but do appear in the provider search. Some providers are designated as Cash Card only and you should show the Cash Card first.

Why do you guarantee your provider search?
Provider searches are known throughout the industry to be inaccurate and outdated, but we believe members shouldn't have to pay the price. If the provider is in the directory and it is for a covered service, we will cover it with one card or the other.

What if a member has a favorite doctor and doesn't see them in the provider search?
Members can easily nominate providers for the Curative Cash Card. All they need to do is fill out a quick form at cur.tv/nominate or call Member Services. Members will hear back within five business days, and, if approved, can see that provider immediately using the Cash Card. Curative will then consider adding that provider to the network, but that can take a much longer time.

What do providers think of Curative Cash Card?
Many providers accept self-pay as an option and appreciate the ease and ability to get paid on the spot instead of dealing with insurance billing. The self-pay price is set by the provider.

Who is eligible to use the Curative Cash Card?
In the first 120 days, Cash Card is available to all members 18 and over. For the remainder of the year, Cash Card is only available to members 18 and over who completed their Baseline. Cardholders can use it for themselves or their covered dependent.

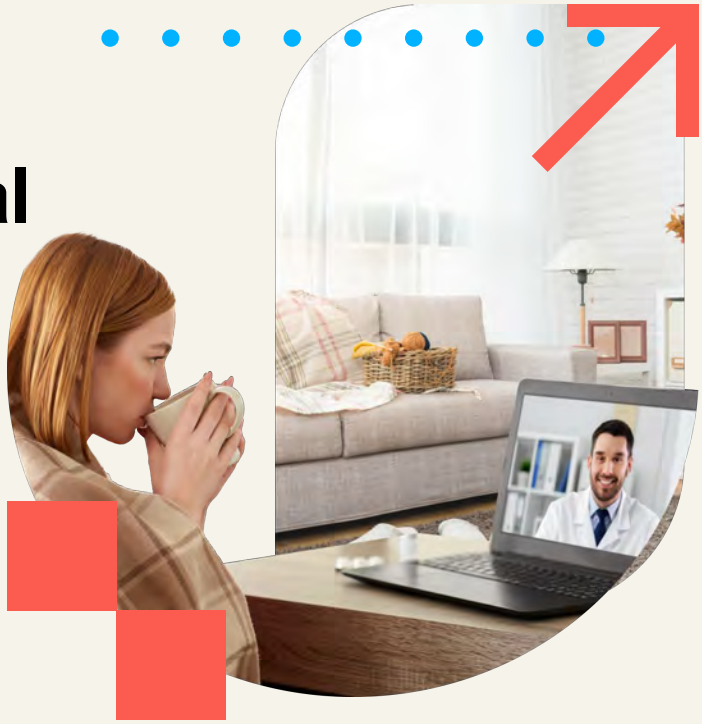
Are the cardholders responsible for any expenses? Does it impact credit?
Members will not owe anything as long as the provider is Cash Card approved, as marked in the provider search, and it is used for a covered service. Curative pays for all approved charges and member credit is not impacted.

What services does the Curative Cash Card cover? Does it include prescriptions or labs?
The Curative Cash Card covers office visits, urgent care, and services without hospital stays. The Curative Cash Card can also be used for behavioral health sessions where many clinicians don't accept insurance. Expenses for prescriptions, lab work, and non-covered plan benefits cannot be charged to the Curative Cash Card. Prior authorization requirements still apply.

*Members must complete Baseline in the first 120 days of plan start date to continue with $0 copays and deductibles.
The Member ID Card and Curative Cash Card can only be used for services outlined in the benefit booklet. Prior authorizations still apply. PPO Max can go out-of-network for $0 deductible but may receive a balance bill.

curative telehealth

Curative Telehealth: Fast, seamless virtual care



Get the care you need, anytime, anywhere.

Curative Telehealth provides 24/7 nationwide virtual care, connecting you with a licensed provider in less than 7 minutes. Whether by phone or video, get fast, hassle-free care—directly through your Curative Member Portal.

Fast, easy access
See a provider **in minutes,** anytime, from home, work, or on the go.

Seamless experience
Access directly through your Curative Member Portal without the hassle of extra apps or logins.

Nationwide coverage
Available **in all 50 states**, so you always have a consistent virtual care option.

Online or phone
Select **video or phone** visits based on your needs and comfort level.

Guided symptom intake
Answer a few quick questions to get connected with the right care provider.

Getting started with Curative Telehealth is easy

1. **Log in or call**
   Start a visit through your Curative member portal or by phone.
   health.curative.com/curative-telehealth
2. **Answer a few questions**
   Our system will match you with the right provider.
3. **See a provider fast**
   Get care via **video or phone,** with visits starting **in less than 7 minutes.**

For more info, go to curative.com/telehealth

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Get care when you need it with Curative

Find a provider near you

Use our network search tool to find your go-to care providers and pharmacies near you at curative.com/providers

Provider search tips

- Search using the provider, facility, or pharmacy name.
- Use filters to select a care type to get the most accurate results.
- Enable location services or add your location in the search box to populate providers or pharmacies near you.

Traveling? Simply enter your travel location to find in-network providers in that area (only within the U.S.)

- **When filtering**, be sure to select your language preference and check the box reading "Accepting new patients" when looking for a new provider.
- **When searching** for a primary care provider, note that providers may be found under "family medicine" or "internal medicine."

Don't see a retailer?

*If you are out-of-area for our preferred in-network pharmacies, go to the provider search tool at curative.com/providers or contact Member Services at 855-428-7284.

Free delivery from Curative Pharmacy — no more waiting in line. Overnight and same-day delivery options are available in select locations. Check your local pharmacy retailers for delivery options.

Questions?
Call Member Services at 855-428-7284

Meds made simple.

Transferring prescriptions? Follow these simple steps below or go to health.curative.com/pharmacy

Step 1

Get your Baseline Visit within 120 days of your plan's effective date to unlock $0 coverage for in-network care and preferred prescriptions.

Step 2

Visit an in-network provider who prescribes a preferred medication.

Step 3

Use the preferred in-network pharmacies.

Our in-network pharmacies include all locations across the United States and include: Curative, H-E-B, ACME, Albertsons, Amigos, Carrs, Haggen, Jewel-Osco, Market Street, MedCart, Pavillions, Randalls, Safeway, Sav-on, Tom Thumb, United, Vons, Publix, Brookshire Brothers.

For more information on what's covered, prescription transfers, and updates on Curative Pharmacy's Expansion, visit curative.com/pharmacy

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Let's check back in

Another year, another Baseline

Complete your annual Baseline to continue with $0 care!

If you completed your Baseline last year, enjoy $0 care and preferred prescriptions straight away!

If you missed last year's Baseline, you have a chance this time around to unlock your $0 perks.

Just remember to complete your Baseline **within 120 days of your plan renewal date** to keep or get these benefits.

As always, your Baseline is confidential and won't impact your premiums.

To schedule:

Log into your Curative account

You likely already have access to the member portal at health.curative.com. Log-in with your credentials or check and sign-up for your annual Baseline with the options below!

Part 1

Baseline Onboarding

Learn about your plan's benefits and resources, any updates and changes, find $0 providers, sign up for telehealth, check medication coverage, and get connected to programs to reach your health goals. There are two options for how to onboard:

Option 1: Self-Guided Onboarding
Complete your onboarding on your own by watching videos and completing important tasks. Your Care Navigator will follow up with you after to answer any questions.

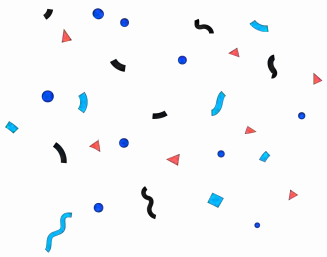
Option 2: Live Onboarding
Schedule a Zoom virtual meeting with your Care Navigator. They will explain how Curative works and what your health plan includes. Austin residents can also schedule in-person.

Part 2

Baseline Clinical Check-in

Schedule a Zoom virtual meeting with a Curative Clinician to discuss your medical history and any health questions. They'll help create a plan tailored to you. You can even get labs done before or after for a more complete picture of your health. Austin residents can also schedule in-person.

Clinical Check-ins can be scheduled after the Self-guided Onboarding or at the same appointment time as your Live Onboarding.



Done

Continue to enjoy $0 out-of-pocket costs!

Your Care Navigator will follow-up after the visit and you can always find their contact info on the member portal. For time-sensitive Curative benefit questions, you can call our **24/7 Member Services at 855-428-7284**.

Visit to learn more about the Baseline curative.com/baseline.

Watch to learn more about your Baseline Onboarding options. cur.tv/baseline-preview.

Who has to complete the annual Baseline Visit?

All our members must complete an annual Baseline Visit.
If you've joined us within the last 8 months before your renewal, don't worry – you won't have to go through the Baseline again right away. We've got your back until the next plan renewal.

If you're under 18 when your plan kicks in, you can hold off on the Baseline until the next plan year.

If you were moved to the high-deductible plan, you won't be shifted to the $0 out-of-pocket plan until after your renewal date and once your Baseline within the first 120 days of the renewal year is completed.

Members must complete a Baseline Visit within the first 120 days of the plan's start date to maintain $0 out-of-pocket costs for covered services with in-network providers and preferred prescriptions. See Summary Plan Description and Benefits Booklet for additional requirements for the Baseline Visit.

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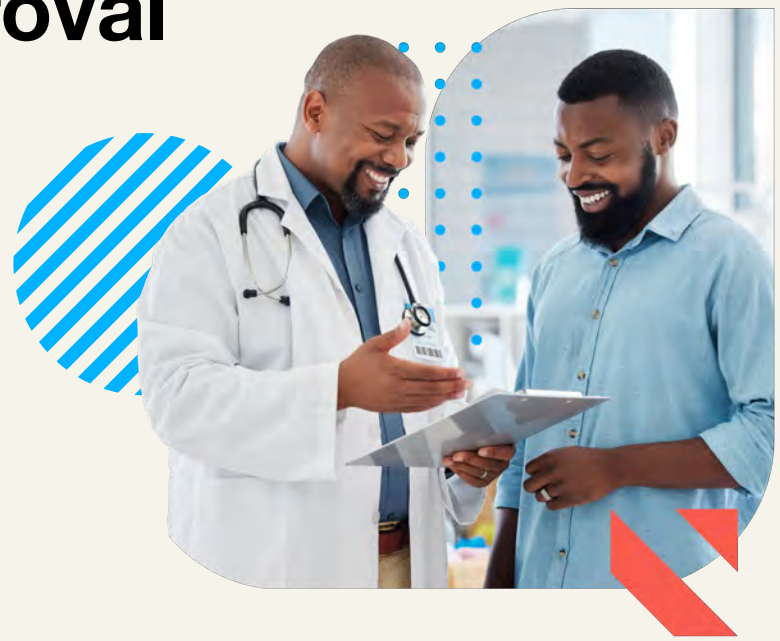
How to Get Approval for Medications

What's Prior Authorization



At Curative, we want to make sure you get access to the medications you need while keeping your safety and costs in check. That's why we have something called "prior authorization" for certain prescriptions.

Here's why we do this:

Better Care:
We want you to get the best care possible. Prior authorization lets our medical experts do an additional check if a medication is safe and based on what works best according to current medical guidelines.

Staying Safe:
Your safety is important. With prior authorization, we are additional eyes to your prescribing provider to make sure a treatment won't have serious side effects or interact negatively with other medications you may be taking.

Saving Money for Everyone:
By only paying for treatments that are really needed, we control healthcare costs, which keeps your insurance costs lower.

Different types of prescriptions:

The decision to prescribe brand-name drugs, generics, biosimilars, or specialty medications depends on several factors, including the medication's efficacy, the patient's specific health needs, and cost considerations.

- **Brand Name:** These medications are developed and patented by a pharmaceutical company and sold under a trademarked name. These drugs undergo extensive research, rigorous testing, and regulatory approval to ensure safety and effectiveness. Due to the investment in development and marketing, brand-name drugs are typically more expensive than generic equivalents.
- **Generic:** These are affordable versions of brand-name drugs with the same ingredients and effects. They're cheaper because they don't involve the costs of developing and marketing a new drug.
- **Biosimilar:** Biosimilars are similar to brand-name biological drugs but are usually less expensive. They have the same composition and are as effective as the original drugs.
- **Specialty:** These are advanced medications for serious or rare conditions. They're often more expensive and come with extra services like special handling, patient support, and infusion.

Here's how Prior Authorization works

1A As a New Member

If you're continuing with the same doctor, please inform them that they must submit a new 'prior authorization request' to us for any planned treatments. If you have a new doctor, they'll also need to do this. Please contact your doctor as soon as possible to get this process started.

1B As a Current Member

When you see your doctor, they may recommend a new medication. When you go to fill the medication, your pharmacy will see if it's covered. If it's not covered, it would require prior authorization by your doctor. Alternatively, your doctor may look at the Curative Formulary (preferred drug list) ahead of time and submit the prior authorization.

2 Our Review

We have a team of medical experts who will look at the prescription your doctor suggests. They make sure it's safe, necessary, and the right choice.

3 Approval or Discussion

If everything looks good, we'll approve it, and you can go ahead with the treatment as planned.

4 Getting Your Medication

Once we give the green light, you can visit any pharmacy in our network to get your medication. Just show them your insurance card, and they'll take care of the rest.

5 Ongoing Support

We're always here for you. If you ever have questions about your treatment, prescriptions, or anything else, don't hesitate to reach out to our friendly customer support team.

6 Feedback and Help Us Improve

Your experience matters to us. If you have any thoughts or suggestions about how we can make the process even better, please share them with us. Your feedback helps us improve our services.

Common Reasons for Denials

- **Formulary Restrictions:** A medication is not on the formulary or drug list, but a covered alternative may be suggested.
- **Medical Necessity Assessment:** We want to make sure you receive the most effective and cost-efficient treatments. If we believe an equally effective, less costly alternative is available, we may deny the prescription based on medical necessity.
- **Pre-requisite steps (aka Step Therapy Requirements:** You may be required to first try less expensive or preferred medications.
- **Quantity or Dosage Limits:** We may limit the quantity or dosage of medication per prescription or within a specific timeframe. If your prescription exceeds these limits, it may be denied.
- **Patient Eligibility Criteria:** Some medications have specific eligibility criteria. If you don't meet these criteria, your prescription may be denied.
- **Pharmacy Choice:** If you visit pharmacies that are not in our network without prior approval, your prescription may not be covered.
- **Documentation Accuracy:** Completeness and accuracy of information on prescription forms, medical records, or prior authorization requests are crucial. Errors can lead to denials.

Remember, we're here to assist you if your prescription is denied. You can work with your healthcare provider to address the reasons for denial, explore alternative medications, or file an appeal with us to reconsider the coverage decision.

How to file an appeal

Your provider will be notified of a denial of services via mail and/or fax. The notification will include a description of the procedure for filing an Appeal. It will include a notice to the Participant of the Participant's right to appeal an adverse determination to an IRO and of the procedures to obtain that review, including a copy of the form prescribed by the Texas Department of Insurance. An Appeal may take up to 30 days to review.

We know it might seem like an extra step, but it's all about making sure you get great care without breaking the bank. If you ever have questions or need help with prior authorization, our friendly Member Services team and your Care Navigator are here for you.

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A Simple Guide to Prior Authorizations

At Curative, we are dedicated to ensuring you receive the best, safest, and most cost-effective healthcare. Through prior authorization, our medical experts evaluate treatments for safety and effectiveness, supporting your well-being while controlling costs. By utilizing our trusted network, ensuring continuity of care, and preventing unnecessary claims, we strive to provide comprehensive and organized healthcare for our valued members.

When it's required:

- **Medical Necessity**
- **Benefits Restrictions**
- **Hospital-based Services**
- **Elective Procedures**
- **Therapy Services**

This list is not exhaustive. For more information call member services.

Uninterrupted care

Prior authorization helps us plan your care so you get the right support and we don't miss anything. During your transition to our health plan, preserving continuity of care is vital for a seamless healthcare experience.

Pregnancy: If you are 24 weeks or beyond, you cannot be required to use in-network providers. In cases of high risk, this period might be less than 24 weeks, but it will be subject to review.

Life-Threatening Illness (e.g., Oncology): If you are undergoing treatment for a life-threatening illness, our plan ensures that you won't be required to change providers for a set period, allowing you to utilize out-of-network services without disruption.

How it works:

1. When your healthcare provider recommends a service or treatment that requires prior authorization, they will submit a request to us.
2. Our team of medical experts will review the request based on (1) benefits coverage and (2) established guidelines and medical necessity.
3. If approved, you can proceed with the recommended treatment knowing that it meets evidence-based care protocols for quality and cost-effectiveness.
4. In cases where a request is denied, we will provide an explanation, and you and your provider can explore alternative options.

Common reasons for denial include:

- Lack of Medical Necessity
- Not a covered benefit
- In the Experimental/Investigational phase

How to Appeal

Request appeal by calling Member Services or email medicalmanagement@curative.com. A doctor needs to provide supporting documentation. Once we receive an appeal, we will respond with an Appeal Authorization Letter.

If you have any questions or need assistance withthe prior authorization process please contact Member Services at 855-428-7284.

Group benefits

Help handling life's ups and downs

Principal®

Life can be unpredictable. And it's not always easy. So it's a big deal to know there's help available when you need it. That's what the employee assistance program (EAP), provided by Magellan Healthcare, is all about.

With an EAP, you and your family have access to **free, confidential** resources to help handle life's everyday—and not so everyday—challenges.

You might use your EAP to help: manage stress, handle relationship issues, balance work and life, work through grief, cope with anxiety, and more. Plus, your EAP gives you access to discounts on major brands and everyday needs.

Services for you and your family

Your EAP offers these services to help you and your family deal with the big and little things.

In-person or virtual counseling

One valuable way to work through personal or work issues is by talking with a professional. You and your family can meet with a licensed, EAP professional in person, via text message, or by live chat, video, or phone sessions. Three counseling sessions per year are included.

Legal, financial, and identity theft services

You and your family have access to these services:

- **Legal services.** Receive a free 60-minute consultation to help deal with issues such as car accidents or family law.
- **Financial wellness.** Receive three free 30-minute consultations. This may include help with budget planning, debt consolidation, or retirement planning.
- **Identity theft resources.** Receive a free 60-minute consultation to help restore your identity if stolen.

Work-life web services

You and your family can access webinars, live talks, and articles on topics such as child and elder care, education, parenting, and more.

Help when and where you need it—day or night

Life's challenges don't always happen during regular business hours. That's why you and your family have 24/7 access to your EAP.

800-450-1327
International: 800-662-4504
TTY: 711

Member.MagellanHealthcare.com
When you create an account, enter **Principal Core** as the program name.

WE ALL NEED HELP SOMETIMES. WITH **211**, HELP IS THERE WHEN YOU NEED IT.

The Hartford is proud to partner with your employer to support you with our products and services. We also know situations may arise when you find yourself needing services other than those we provide.

A service of United Way, 211 is available in all U.S. states by simply dialing 2-1-1 or visiting 211.org. 211 connects millions of people just like you to experts who provide compassionate help every day. Some of the top reasons people seek help from 211 are for **financial** or **legal assistance**, or for **help feeding their families**.

Just keep the attached card in your wallet, or store a photo on your phone, because you never know when you may need support. And since 211 is available 24 hours a day, 7 days a week, 365 days a year, providing you with resources in your own community, you're sure to find the help you need.

THE HARTFORD
INSURANCE

Please cut here, fold in half and keep in your wallet.

THERE'S HELP WHEN YOU NEED IT

Dial 211 or visit 211.org
for help with hundreds of issues including:

- Crisis
- Emergencies & Disasters
- Food
- Health
- Housing
- Utilities
- Jobs & Employment
- Reentry
- Veterans
- Mental Health
- Financial
- Childcare
- And more

211 is a vital service that helps millions of people every year. Almost 95% of the United States has 211 coverage.

Keep this card or share it with someone who needs it.

THE HARTFORD | UNITED FOR ALICE®

The Hartford is committed to supporting the working population and those facing financial hardship, providing awareness, education and resources while highlighting the importance of life and disability insurance within a sound financial plan.

ABILITY ASSIST® COUNSELING SERVICES

For employees covered under The Hartford's Disability insurance, Critical Illness insurance or Leave Management Services.

GETTING SUPPORT SHOULD BE EASY.

Life presents complex challenges. If the unexpected happens, you want to know that you and your family have simple solutions to help you cope with the stress and life changes that may result. That's why the Hartford's Ability Assist Counseling Services, offered by ComPsych®,[1] can play such an important role. Our straightforward approach takes the complexity out of benefits when life throws you a curve.

COMPASSIONATE SOLUTIONS FOR COMMON CHALLENGES.

From the everyday issues like job pressures, relationships, retirement planning or personal impact of grief, loss, or a disability, Ability Assist can be your resource for professional support.

You and your family, including spouse and dependents, can access Ability Assist, at any time, as long as you are covered under The Hartford's **Disability insurance, Critical Illness insurance or Leave Management Services**.

ABILITY ASSIST COUNSELING SERVICES	
Emotional or Work-Life Counseling	Helps address stress, relationship or other personal issues you or your family members may face. It's staffed by GuidanceExperts℠ – highly trained master's and doctoral level clinicians – who listen to concerns and quickly make referrals to in-person counseling or other valuable resources. Situations may include: • Job pressures. • Relationship/marital conflicts. • Stress, anxiety and depression. • Work/school disagreements. • Substance abuse. • Child and elder care referral services.
Financial Information and Resources	Provides support for the complicated financial decisions you or your family members may face. Speak by phone with a Certified Public Accountant and Certified Financial Planner ™ Professionals on a wide range of financial issues. Topics may include: • Managing a budget. • Retirement. • Getting out of debt. • Tax questions. • Saving for college.

continued

THE HARTFORD

ABILITY ASSIST COUNSELING SERVICES *con't.*

Legal Support and Resources	Offers assistance if legal uncertainties arise. Talk to an attorney by phone about the issues that are important to you or your family members. If you require representation, you'll be referred to a qualified attorney in your area with a 25% reduction in customary legal fees thereafter. Topics may include: • Debt and bankruptcy. • Guardianship. • Buying a home. • Power of attorney. • Divorce.
Health Champion℠	A service that supports you through all aspects of your health care issues by helping to ensure that you're fully supported with employee assistance programs and/or work-life services. HealthChampion is staffed by both administrative and clinical experts who understand the nuances of any given health care concern. Situations may include: • One-on-one review of your health concerns • Preparation for upcoming doctor's visits/lab work/tests/surgeries • Answers regarding diagnosis and treatment options • Coordination with appropriate health care plan provider(s) • An easy-to-understand explanation of your benefits–what's covered and what's not • Cost estimation for covered/non-covered treatment • Guidance on claims and billing issues • Fee/payment plan negotiation

A CASE IN POINT.[3]

"The initial counselor I spoke with was so comforting and easy to communicate with. She put me right at ease and empowered me to follow through with the program. She was wonderful."

– Hartford Customer, Ability Assist User

SERVICE FEATURES.

The service includes up to three face-to-face emotional or work-life counseling sessions per occurrence per year. This means you and your family members won't have to share visits. Each individual can get counseling help for his/her own unique needs. Legal and financial counseling are also available by telephone during business hours. HealthChampion℠ offers unlimited access to services.[2]

GETTING IN TOUCH IS EASY.

On the phone: Just one simple call.
For access over the phone, simply call toll-free **1-800-96-HELPS (1-800-964-3577)**.

Online: The point is simplicity.
You'll also have 24/7 access to GuidanceResources® Online (offered by ComPsych).[1] This resource provides trusted information, resources, referrals and answers to everyday questions right from your desktop or the privacy of your home. It includes:

- Chat sessions with professional moderators.
- Access to hundreds of personal health topics and resources for child care, elder care, attorneys or financial planners.

Visit **WWW.GUIDANCERESOURCES.COM** to create your own personal username and password. If you're a first-time user, you'll be asked to provide the following information on the profile page:

1. In the **Company/Organization** field, use: **HLF902**
2. Then, create your own confidential user name and password.
3. Finally, in the Company Name field at the bottom of personalization page, use: **ABILI**

Prepare. Protect. Prevail.®

Visit us at **THEHARTFORD.COM/EMPLOYEEBENEFITS**

THE HARTFORD

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Home Office is Hartford, CT.

[1] Ability Assist®, The GuidanceResources® Program, and HealthChampion℠ services are offered through The Hartford by ComPsych®. ComPsych is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services provided by ComPsych. ComPsych and GuidanceResources are registered trademarks and HealthChampion is a service mark of ComPsych Corporation.

[2] HealthChampion℠ specialists are only available during business hours. Inquiries outside of this time frame can either request a call-back the next day or schedule an appointment.

[3] This case illustration is fictitious and for illustrative purposes only.

4264 06/15 Printed in U.S.A.

FILE A HEALTH SCREENING CLAIM WITH CONFIDENCE

Healthy lifestyles are rewarded under Accident (AI), Critical Illness (CI) and Hospital Indemnity (HI) insurance coverage.

If your employer offers any of this insurance coverage and a health screening benefit is included, you and your dependents are eligible to receive a benefit for health screenings while insured and filing a claim.[2]

If you have more than one type of coverage – for example AI, CI, and/or HI – one health screening would be eligible for each coverage that includes this feature.

THE HARTFORD MAKES IT EASY TO FILE A CLAIM. JUST FOLLOW THESE STEPS:

STEP 1

Review the list on the back of this page to determine if your health screening may be eligible for the benefit.

STEP 2

Prepare to file your claim.[1] You'll need the following information:

- Name, address and the group policy number;
- Name of the health screening or test performed and the date completed; and
- Details of where the health screening was received and physician contact information (if applicable).

STEP 3 – OVER THE PHONE

- File your claim by calling **866-547-4205**.
- Phones are open Monday through Friday, 8:00am – 6:00pm EST.

STEP 3 – ONLINE

- Visit the Supplemental Insurance Claims Portal at **TheHartford.com/benefits/myclaim**.
- Register for access if you have not done so already. (Please note: We must have current eligibility from your benefits administrator for you and any dependents to be eligible to register on the portal.)
- Log in to the portal.
- Click on "Complete Your Claim Form Online" under the Quick Links section.
- Follow the prompts to complete and submit a Health Screening Benefit claim.

NEXT STEPS

- Once the claim has been approved, the standard turnaround time for benefits to be paid is between 3-10 business days.[3]
- Standard mail times will apply (if applicable).

TO FILE YOUR HEALTH SCREENING CLAIM:

CALL THIS NUMBER:

866-547-4205
Monday through Friday,
8:00am – 6:00pm EST

VISIT US ONLINE:

TheHartford.com/benefits/myclaim
(Submit a claim online or download your health screening benefit form here.)

YOU'LL NEED TO PROVIDE:

- Name, address and the group policy number.
- Name of the health screening or test performed[3] and the date completed.
- Details of where the health screening was received and physician contact info (if applicable).

MAIL OR FAX THE DOCUMENTATION TO:

THE HARTFORD
SUPPLEMENTAL INSURANCE
BENEFIT DEPARTMENT

P.O. Box 99906
Grapevine, TX 76099
Fax Number: 469-417-1952

(Snap a photo with a mobile device to capture information above.)

ELIGIBLE HEALTH SCREENINGS[4]

- Bone Marrow Testing
- CA15-e (cancer antigen 15-3 blood test for breast cancer)
- CA125 (cancer antigen 125 blood test for ovarian cancer)
- CEA (carcinoembryonic antigen blood test for colon cancer)
- Chest X-Ray
- Colonoscopy
- COVID-19 testing when performed by an appropriately licensed medical professional
- Flexible Sigmoidoscopy
- Hemoccult Stool Analysis
- Mammography (including breast ultrasound)
- Pap Smear (including ThinPrep Pap Test)
- PSA (prostate specific antigen blood test for prostate cancer)
  Serum Protein Electrophoresis
- Biopsy for Skin Cancer
- Blood Test for Triglycerides
- HPV (Human Papillomavirus) Vaccination
- Lipid Panel (total cholesterol count)
- Doppler Screening for Carotids
- Doppler Screening for Peripheral Vascular Disease
- Thermography
- Echocardiogram
- Ultrasound Screening of the Abdominal Aorta for Abdominal Aortic Aneurysms
- EKG
- Stress Test on Bike or Treadmill
- Fasting Blood Glucose Test
- Serum Cholesterol to determine level of HDL & LDL

Coverage availability varies by state. Not all tests are available in all states.

For additional information, call **866-547-4205** Monday through Friday, **8:00am – 6:00pm** EST.

THE HARTFORD

Business Insurance
Employee Benefits
Auto
Home

[1] Claims must be submitted within 12 months of screening date.

[2] Each person must complete an eligible health screening. Benefit payment is once per year, per covered person.

[3] Based on average claims turnaround time.

[4] This document explains the typical Health Screening Benefits covered, but in no way changes or affects the policy as actually issued. For a full list of benefits covered, please refer to your company's policy booklet.

Accident Form Series includes GBD-2000, GBD-2300, or state equivalent. Critical Illness Form Series includes GBD-2600, GBD-2700, or state equivalent. Hospital Indemnity Form Series includes GBD-2800, GBD-2900, or state equivalent.

7630 NS 04/20

LegalShield

National Plan Pricing

LegalShield

LegalShield.....$20.25/month

Who is covered:

- The participant (employee)
- Participant's spouse/domestic partner
- Dependent children up to the age of 26
- Parents*

*Parents, including step-parents, of the participant and participant's spouse/domestic partner are also eligible for advice, consultation and document review for covered personal legal matters and can receive the services available to them through the Elder Care Services of this Plan. Services include preparation of a Will and a Physicians/Medical Directive.

Rates are reflected for payroll deduction as the payment option and are guaranteed for four years with a contractual agreement.
For complete benefit definitions, please see Appendix.

LegalShield

National Plan Overview

New and enhanced coverage has been added for the 2024 plan year (shown in **purple**)

FAMILY	• Administrative Hearing • Adoption • Bullying Protection • Civil and Social Discrimination • Conservatorship • Domestic Violence Protection • **Elder Law Matter Coverage**	• **Gender Rights** • Guardianship • Immigration Assistance • Incompetency Defense • Juvenile Court Proceedings • Juvenile Defense • Paternity	• **Pet Protection** • Postnuptial/Domestic Partnership Agreements • Name Change • Prenuptial Agreements • **Reproductive Assistance** • School Hearings
HOME	• Boundary Title Disputes • Contractor Disputes • Deeds • Eviction and Tenant Issues • Foreclosure	• Home Equity Loans • Mortgages • Neighbor Disputes/Easements • Property Tax Assessments • Purchase/Sale of Home	• Real Estate Contracts/ Financial Disputes • Refinancing • Zoning Applications
FINANCIAL	• Affidavits • Bankruptcy • Civil Litigation • Consumer Credit Services • Consumer Protection • Contracts/Financial Disputes	• Debt Collection • GarnishmeHabeas Corpus • Identity Theft • IRS Audit Protection • Medicaid/Medicare Disputes • Personal Property Disputes	• Promissory Notes • Reposesession • Rental Agreements • Small Claims Assistance • Tax Audit Protection • Veterans Benefit Disputes
ESTATE PLANNING	• Codicils • Living Wills/Wills	• Living Trusts/ Special Needs Trusts • Physician's Directive	• Power of Attorney • **Probate**
AUTO	• Driver's License Restoration • Motor Vehicle Property Damage	• Moving Traffic Violations/ Traffic Tickets	• Property Damage Claims
GENERAL	• 24/7 Emergency Legal Access • 25% Preferred Member Discount	• Demand Letters/Phone Calls • Document Review • Legal Forms	• Mobile App • Office Consultation • Telephone Advice

IDShield

National Plan Pricing

IDShield

The employer must select either 1-Bureau or 3-Bureau monitoring. Only one option can be offered to employees.

1-Bureau Credit Monitoring

Individual $5.80/month

Family $10.70/month

3-Bureau Credit Monitoring

Individual $7.45/month

Family $14.05/month

Who is covered:

Individual Plan:	Family Plan:
The participant only	• The participant • Participant's spouse/domestic partner • Dependent parents • Dependent children under the age of 26

Dependent children ages 18-26 and dependent parents of the participant or participant's spouse/domestic partner are eligible for consultation and restoration services only. Monitoring services are not available for dependent parents and dependent children ages 18-26.

A dependent parent is defined as an adult parent that 1. Lives in the home of the participant/participant spouse, 2. Resides in a care facility or 3. The participant/participant's spouse has a durable power of attorney for the parent.

Rates are reflected for payroll deduction as the payment option and are guaranteed for four years with a contractual agreement. For complete benefit definitions, please see Appendix.

IDShield

National Plan Overview

FULL-SERVICE IDENTITY RESTORATION	• $3 Million Identity Fraud Protection Plan • 3B Credit Report Pre-and-Post Restoration	• Adult Dependent Parent Restoration • Full-Service Restoration by Licensed Private Investigators	• Pre-Existing Identity Theft Restoration • Unlimited Service Guarantee
MONITORED INFORMATION	• Bank Account Numbers • Credit/Debit/Retail Cards • Cryptocurrency Wallets • Date of Birth • Driver's License Number	• Gamertags • Investment Account Number • Mother's Maiden Name • National Provider Identifier Number	• Name • Passport Number • Social Security Number • Usernames • And More!
MONITORING AND DETECTION	• Child Monitoring *(Family Plan Only)* • Credit Monitoring* • Court and Criminal Record Monitoring • Deceased Family Monitoring • Financial Account Monitoring	• High Risk Application and Transaction Monitoring • Internet and Dark Web Monitoring • Local, State and Federal Database Monitoring • Online Chat Rooms and Social Feed Monitoring	• Payday Loan Monitoring • Public Record Monitoring • Telecom Monitoring • Sex Offender Monitoring • Sub-Prime Monitoring
ONLINE PRIVACY AND REPUTATION MANAGEMENT	• Anti-Malware Protection • Data Broker Site Management • Cyberbullying Protection • Mobile Security • Online Parental Controls	• Online Privacy Management • Password Manager • Reputation Management • Reputation Score	• Social Media Monitoring • VPN Proxy One
ALERTS	• Customizable Social Media Alerts • Hard Credit Inquiry Alerts	• Financial Transaction Alerts • Identity and Credit Threat Alerts	• Sex Offender Alerts
UNLIMITED CONSULTATION	• Assistance in Analyzing and Interpreting Credit Reports and Medical Data Reports	• Consultation on Common Trends and Scams • Credit Counseling and Education	• Identity Theft Consultation • Lost/Stolen Wallet Assistance
GENERAL	• 24/7 Emergency Assistance • Auto-Monitoring	• Direct Access to Licensed Private Investigators • Live Member Support	• Mobile App • Monthly Credit Score Tracker**

**Monthly credit score tracker is based on Experian data.

We'll help make sure your money works as hard as you do.

PNC WorkPlace Banking® lets you show your money who's boss.

With smart, easy-to-use tools that let you track and manage your money how and when you want, our bank-at-work program helps you take control today and plan wisely for down the road. And that's not all:

Work with a dedicated team

PNC WorkPlace Banking provides personalized information and guidance to help you select the products and services that are best for your needs.

Tap into free financial education and 1-to-1 appointments

Get insights and guidance to help you make smart money decisions at every stage of your financial journey.

Open a PNC mortgage and earn $300[1]

Offer is available with a qualifying PNC WorkPlace Banking checking account.

Explore more WorkPlace Banking offers that may be available to you[2]

Visit pnc.com/workplaceoffers

*Carrier fees for data usage may apply

Talk with me today

to schedule your financial wellness conversation.

Dianna Hagian
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214-871-4393
NMLS 935356

PNC BANK | BRILLIANTLY BORING SINCE 1865℠

Virtual Wallet®

Checking and savings in one smart, easy package

1 Spend

Your everyday checking account

2 Reserve

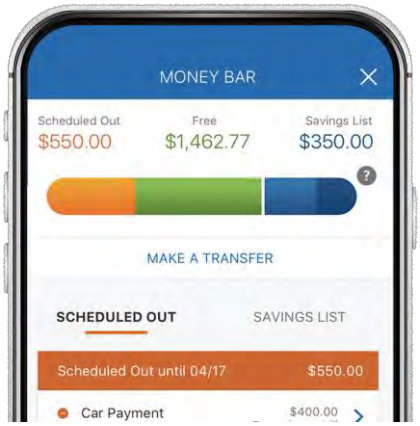
An additional checking account to set aside money for short-term planning

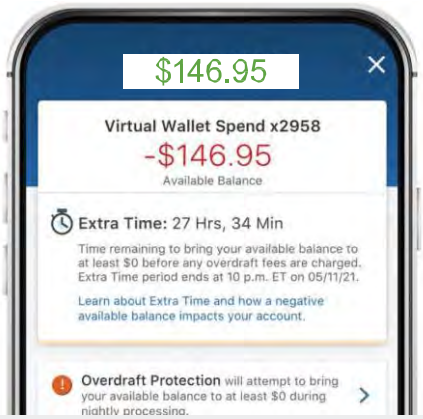
3 Growth

A savings account that can earn interest — ask about our rates

Innovative Online[3] and Mobile Banking[4] tools

- Money Bar and Calendar for scheduling and tracking spending
- Zelle® to send money to and receive money from people you know and trust — wherever they bank in the U.S.[5]
- Low Cash Mode® to help you avoid surprise overdraft fees[6]





1 To qualify for the $300 mortgage account reward, at the time of mortgage funding, the PNC WorkPlace Banking or PNC Military Banking customer must have an eligible PNC WorkPlace Banking or PNC Military Banking Virtual Wallet with Performance Select, Virtual Wallet with Performance Spend, Virtual Wallet Checking Pro, Performance Select Checking account or Performance Checking account.

The PNC WorkPlace Banking or PNC Military Banking checking account must remain open in order for you to receive the $300 reward, which will be credited to the eligible checking account within 90 days after conditions have been met and will be identified as "CREDITS MORTGAGE WKP MIL" on your monthly checking account statement.

Offer may be extended, modified, or discontinued at any time. The value of the reward may be reported on the appropriate Internal Revenue Service (IRS) forms, and may be considered taxable income to you. Please consult your tax adviser regarding your specific situation.

2 In order to be eligible for the WorkPlace Banking Program offers and rewards, you must apply for eligible PNC products either directly with a dedicated WorkPlace Banking Consultant or you must notify a PNC Branch Banker/PNC Customer Care Consultant that you are employed by a WorkPlace Banking company.

3 Online Banking is free to customers with an eligible account; however there may be a fee for certain optional services. We reserve the right to decline or revoke access to Online Banking or any of its services. All online banking services are subject to and conditional upon adherence to the terms and conditions of the PNC Online Banking Service Agreement.

4 PNC does not charge a fee for Mobile Banking, including PNC Alerts. However, third-party message and data rates may apply. Check with your wireless carrier for details.

5 Zelle® should only be used to send or receive money with people you know and trust. Before using Zelle® to send money, you should confirm the recipient's email address or U.S. mobile phone number. Neither PNC nor Zelle® offers purchase protection for payments made with Zelle® — for example, if you do not receive the item you paid for, or the item is not as described or as you expected, Zelle® is available to almost anyone with a bank account in the U.S. Transactions typically occur in minutes between enrolled users. If the recipient has not enrolled, the payment will expire after 14 calendar days. See the PNC Zelle Terms of Use for additional terms and conditions. Use of Zelle® is subject to and conditional upon adherence to the terms and conditions of the PNC Zelle® Terms of Use.

6 Low Cash Mode is only available on the Spend account of your Virtual Wallet product.

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PNC WorkPlace Banking is a registered mark of The PNC Financial Services Group, Inc.

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WKP PDF 0224-068-2416703

PNC BANK | BRILLIANTLY BORING SINCE 1865℠

1% RATE BUYDOWN CREDIT

We're giving back to employees, contractors, and family members across the U.S. in all 50 states to make homeownership more affordable.
The buyers will receive a 1% Buydown Credit when they close with Monty Felts on a primary residence, vacation home, or investment property.

SAMPLE PURCHASE: **$500,000 WITH $100,000 DOWN PAYMENT**

CURRENT RATE	PAYMENT	SAVINGS
6.49%	$2,526/MO	------
*5.49%	$2,269/MO	$257/MO

EXAMPLE OF SPECIAL OFFER WITH 1% RATE BUYDOWN

EXCLUSIVE BUYER ADVANTAGES

Pre Approval Promise
to the seller that we have a loan in place with a $2,500 guarantee.

Deposit Protection
up to $50,000.

Our On-Time Closing Guarantee
or we pay $500 per day to the seller.

$1% Rate Buydown Credit

MONTY FELTS
972-853-1110

APPLY HERE
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With Monty and his team, you'll experience home financing with a personal touch, making your dreams a reality and building generational wealth.

T-MOBILE WORK PERKS

we're going to be *fast friends*

Experience our 5G speeds.

$35/mo.

with AutoPay and any postpaid voice line.
Delivered via cellular network; speeds vary due to factors affecting cellular networks.

5-Year Price Guarantee *included*

Exclusions like taxes & fees apply.

Bundle our Home Internet with any voice plan, and get it starting at just $35/mo.

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Limited time; subject to change. Home Internet: With $15 monthly bill credit. Limited-time; subject to change. Qualifying credit, postpaid voice line, and Internet line required. Credits may take up to 2 bill cycles; credits will stop if you cancel any lines or change plans. Limit 2/account. May not be combined with some offers or discounts (e.g., Price Lock); see FAQs at T-Mobile.com/plans. **Rely General Terms: During congestion, customers on this plan may notice speeds lower than other customers and further reduction if using >1.2TB/mo., due to data prioritization.** Not available in all areas. $35 device connection charge due at sale. Plus taxes & fees for accounts currently paying for a T-Mobile wireless line with additional taxes & fees: Monthly Regulatory Programs & Telco Recovery Fees totaling up to $1.60 per line, and federal and local surcharges apply. Credit approval required. For use only with select T-Mobile Gateways for in-home use at location provided at activation; service restricted away from approved address. Return each device undamaged or pay up to $370. **Video** streaming resolution depends on available speeds. For best performance, leave video streaming applications at their default resolution setting. Not compatible with some live TV streaming services. **AutoPay Pricing** for lines 1–8 on account. AutoPay discount requires bank account or debit card, otherwise $5 more/line/mo. May not be reflected on first bill. **5-Year Price Guarantee** means that we won't change the price of fixed-wireless 5G internet data for at least 5 years while you are on an eligible plan. Taxes & fees, voluntary equipment or speed upgrades, future wireless generations, select limited-time promotions, per-use charges, third-party services, and network management practices aren't included. This guarantee starts when you activate or switch to an eligible plan and doesn't restart if you add a line or change plans after that. **Network Management:** Service may be **slowed, suspended, terminated, or restricted** for misuse, abnormal use, interference with our network or ability to provide quality service to other users. See T-Mobile.com/OpenInternet for details. **See Terms and Conditions (including arbitration provision)** at www.T-Mobile.com for additional information. T-Mobile, the T logo, Magenta and the magenta color are registered trademarks of Deutsche Telekom AG. © 2025 T-Mobile USA, Inc.

T-MOBILE FOR BUSINESS

Getting ready for activation.

What to know before you get started.

We look forward to having you join the T-Mobile family! So that the process of creating your account will go smoothly when you call us or visit a store, let's review the information you'll need handy:

- Full name
- Billing/shipping address
- Driver's license and expiration date
- Date of birth
- Social Security Number
- Phone number to best contact you
- Email address for paperless billing
- Credit card for ordering equipment, down payments, and sales tax
- Names of any Authorized User Contacts who will need access to your account

If you're trading in your old phone or other device, you'll need to know that device's IMEI number. The IMEI can be found on the About screen of your device's Settings or by dialing *#06#.

When you create your T-Mobile account, you'll be asked to select a 6–15 digit PIN passcode used to help verify your identity when you contact customer service.

T-Mobile will need to run a credit check to activate new customers. Make sure to unfreeze credit monitoring or credit checks beforehand.

T-MOBILE WORK PERKS

Be sure to mention your employer to take advantage of special savings through the T-Mobile Work Perks program.

T-MOBILE FOR BUSINESS

Finalizing your transition to T-Mobile.

What to do once your devices are activated.

Port your existing numbers.

Porting is the process by which you transfer your phone number from your old carrier to another.

Once your SIM card and/or new devices arrive, you are ready to port your existing numbers to your new devices. Until your numbers are ported, your device will have a temporary phone number.

You can complete porting one of two ways:

Call Customer Care at 1–877–789–3106

Visit a T-Mobile store T-Mobile.com/store-locator

Whether by phone or in store, you'll need the following information to port your existing phone number:

- **T-Mobile Order Number**
- **Account owner name**—this must match the **exact** spelling on your previous carrier's bill
- **Billing Account Number** from your previous carrier—usually located on your bill or service provider portal
- **Account PIN** from your previous carrier
- **The existing phone number(s)** you want to port

When porting numbers from AT&T or Verizon, you'll need to request a **Port-out PIN** to transfer your number.

- from AT&T—dial ***PORT** on the AT&T phone or call AT&T customer care
- from Verizon—dial **#PORT** on the Verizon mobile phone or call Verizon customer care

Resolve common porting issues.

Incorrect account information causing phone numbers not to transfer

- Engage your Program Manager expert or call 611 from your T-Mobile device. Customer Care will diagnose the issue, determine what was processed incorrectly, and resolve.

Ported phone numbers are mixed up

- Swap physical SIM cards into the correct devices.
- If the devices use eSIM, Customer Care can reassign the numbers to swap them to the proper devices.

Bringing over your phone from another carrier

- If you are bringing your own device to T-Mobile, you will need to ensure your device is unlocked with your previous carrier.
- If the device is unlocked, it will read "T-Mobile" at the top when a T-Mobile SIM card is put into the device.

Prepare your device trade-in.

Trade in your old device within 30 days from when your new device shipped, or you'll miss out on the trade-in value and promotional offer.

- Ensure your personal information is completely wiped off your trade-in device.
- If you're trading in an Apple device, deactivate Find My iPhone and iCloud.
- Trade-in devices need to be shipped in a T-Mobile-provided box or completed in a T-Mobile store.

More information on trade-in options is available at www.switch2t-mobile.com.

T-MOBILE FOR BUSINESS

T-MOBILE WORK PERKS

Your employees can save

on our new Experience plans and get up to $5K in value over 3 years with 2 lines

Req. 1 line on Experience More for Business or Experience Beyond for Business with Autopay and 15% discount on up to 5 lines. AutoPay discount requires eligible payment method.

- **We do the heavy lifting.** T-Mobile provides a customized mix of materials to explain these offers and savings.
- **Dedicated Account Managers** work with you to bring this exclusive benefit to your workplace
- With our **Family Freedom** plan, we'll reimburse your remaining device balance and early termination fees up to $800 per line.
  New device, qual'g credit, service & port-in req'd. Card typically takes 15 days
- Your Experience plan price? **Guaranteed for 5 years**
  Guarantee applies to monthly price for on-network talk, text, and 5G data. **Exclusions like taxes & fees apply.**
- **T-Life** is the all-in-one app designed to simplify your T-Mobile experience. Manage your account, shop the latest tech, and unlock exclusive perks.
- With **Try T-Mobile** you get our network free for 30 days before you switch. Keep your current phone, and wireless carrier.
  Eligible for users not already on the T-Mobile network; 1 trial per user. Compatible unlocked device req'd.
- **We are America's largest and fastest 5G network.**

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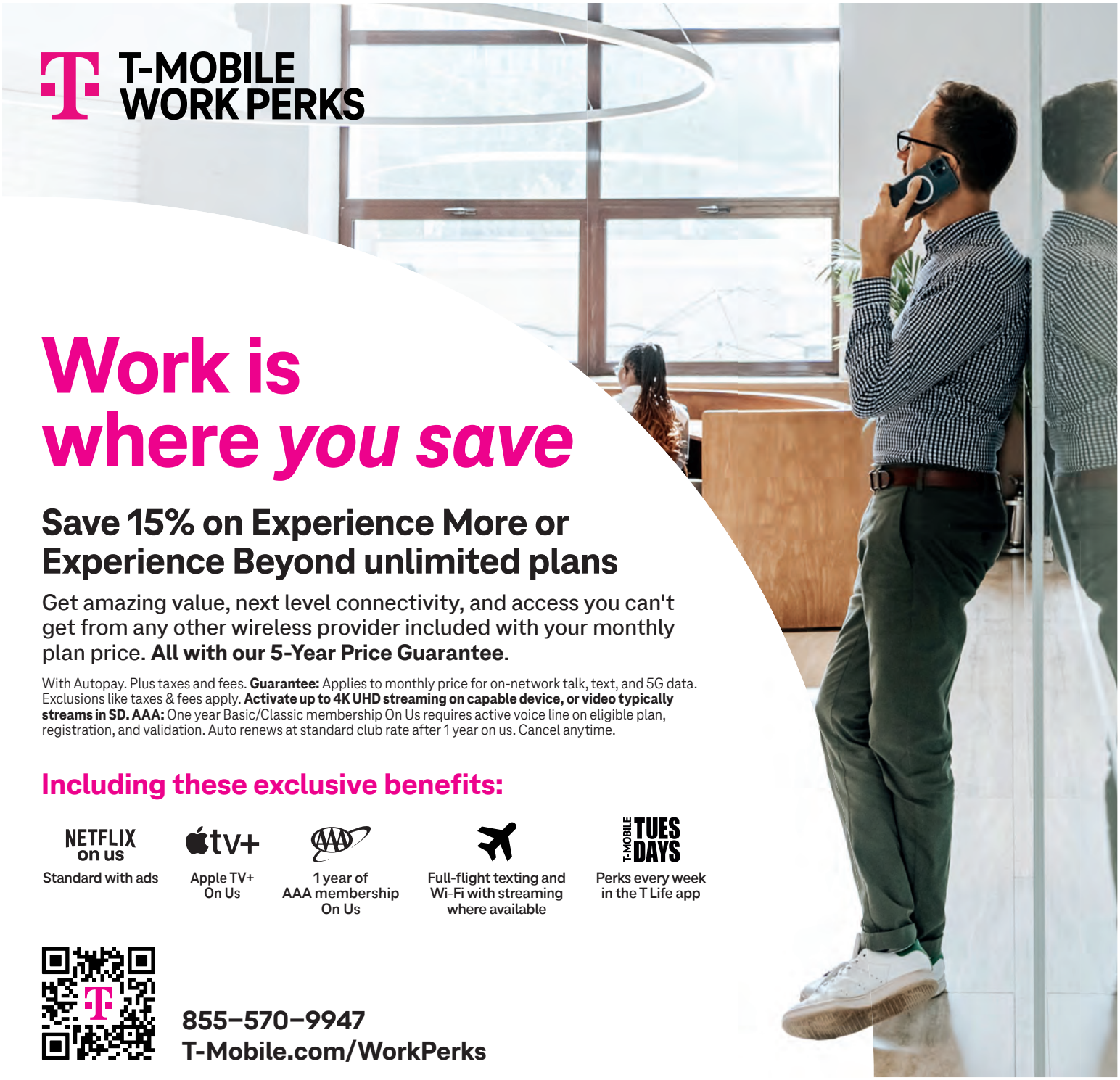
T-Mobile.com/WorkPerks

Limited time; subject to change. $35 device connection charge due at sale. **T-Mobile Perks:** Discount available for new and existing customers while on Experience More/Beyond plans ($90+/mo. plan w/Autopay) and applied to plan monthly recurring charge. Validate new line within 30 days of activation. Must be eligible employee, active & in good standing to receive discount. Reverification may be required. Discount may stop if you cancel any lines. Discount on up to 5 lines applied after any AutoPay discount. May not be combined with some offers and discounts. Not transferrable. Limit 1 T-Mobile Work Perks Corp node per acct. **Experience More/Experience Beyond General Terms:** Regulatory Programs & Telco Recovery Fees totaling up to $3.99 per line, and federal and local surcharges apply. See Broadband Facts at T-Mobile.com. Credit approval & deposit may be required. U.S. roaming and on-network data allotments differ: includes 200MB roaming. Unlimited talk & text features for direct communications between 2 people; others (e.g., conference & chat lines, etc.) may cost extra. Unlimited high-speed data in US only. Not available for hotspots and some other data-first devices. Capable device required for some features. Activation required to deliver video streams at speeds that provide up to Ultra HD video capability (max 4K); some content providers may not stream their services in UHD. May affect speed of video downloads; does not apply to video uploads. **AutoPay Pricing** for voice lines 1–8. AutoPay discount requires bank account or debit card, otherwise $5 more/line/mo. May not be reflected on first bill. **Up to $800:** New financed smartphone, qualifying credit, port-in from eligible postpaid carrier (AT&T, Verizon, Spectrum, Claro, Liberty, Xfinity, UScellular, or C Spire), and qualifying service required. Carrier's Early Termination Fee and remaining device balance, including lease purchase option, up to $800, paid via virtual prepaid Mastercard® (**no cash access & expires in 6 months**) typically within 15 days. Submit proof of balance & 90+ days in good standing w/ carrier within 30 days of port-in and be active and in good standing when processed. **We might ask for more information.** Up to 4 lines. One offer per subscriber. T-Mobile virtual prepaid Mastercard is rebate/reimbursement or exchange on new device, service, or port-in; for any tax implications, consult a tax advisor. No money has been paid by you for the card. Cards issued by Sunrise Banks N.A., Member FDIC, pursuant to a license from Mastercard International Incorporated. Mastercard is a registered trademark of Mastercard International Incorporated. Some limitations for virtual cards. Cards will not have cash access and can be used everywhere MasterCard debit cards are accepted. Use of this card constitutes acceptance of the terms and conditions stated in the Cardholder Agreement. **5 year guarantee** means we won't change the price of talk, text, and 5G smartphone data on our network for at least 5 years as long as you are on an Experience plan. Guarantee also applies to price for data on wearable/tablet/mobile internet lines added to your plan. Your guarantee starts when you activate or switch to an eligible plan and doesn't restart if you add a line or change plans after that. Taxes & fees, per-use charges, plan add-ons, third-party services, and network management practices aren't included. **Network Trial:** 5G device req'd to access 5G network. Data available for 3 monthly cycles for approximately 90 days. During congestion, customers on this plan using>50GB/mo. may notice reduced speeds until next monthly cycle due to data prioritization. Video typically streams on smartphone/tablet in SD quality. Tethering not available. Not for international use. Active non-T-Mobile service required; your carrier's terms also apply. You may need to upgrade when you switch to get full coverage. **Fastest** based on analysis by Ookla® of Speedtest Intelligence® data of national Speed Score results incorporating 5G download and upload speeds for 2H 2024. Ookla trademarks used under license and reprinted with permission. See 5G device, coverage, & access details at T-Mobile.com. **Coverage not available in some areas. Network Management:** Service may be **slowed, suspended, terminated, or restricted** for misuse, abnormal use, interference with our network or ability to provide quality service to other users, or significant roaming. On-device usage is prioritized over tethering usage, which may result in higher speeds for data used on device. See T-Mobile.com/OpenInternet for details. See **Terms and Conditions (including arbitration provision)** at www.T-Mobile.com for additional information. T-Mobile, the T logo, Magenta and the magenta color are registered trademarks of Deutsche Telekom AG.



T-MOBILE WORK PERKS

Work is where *you save*

Save 15% on Experience More or Experience Beyond unlimited plans

Get amazing value, next level connectivity, and access you can't get from any other wireless provider included with your monthly plan price. **All with our 5-Year Price Guarantee.**

With Autopay. Plus taxes and fees. **Guarantee:** Applies to monthly price for on-network talk, text, and 5G data. Exclusions like taxes & fees apply. **Activate up to 4K UHD streaming on capable device, or video typically streams in SD. AAA:** One year Basic/Classic membership On Us requires active voice line on eligible plan, registration, and validation. Auto renews at standard club rate after 1 year on us. Cancel anytime.

Including these exclusive benefits:

- NETFLIX on us — Standard with ads
- tv+ — Apple TV+ On Us
- 1 year of AAA membership On Us
- Full-flight texting and Wi-Fi with streaming where available
- T-MOBILE TUES DAYS — Perks every week in the T Life app

855–570–9947
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Limited time; subject to change. $35 device connection charge due at sale. **T-Mobile Perks:** Discount available for new and existing customers while on Experience More/Beyond plans ($90+/mo. plan w/Autopay) and applied to plan monthly recurring charge. Validate new line within 30 days of activation. Must be eligible employee, active & in good standing to receive discount. Reverifi cation may be required. Discount may stop if you cancel any lines. Discount on up to 5 lines applied after any AutoPay discount. May not be combined with some offers and discounts. Not transferrable. Limit 1 T-Mobile Work Perks Corp node per acct. **Experience More/Experience Beyond General Terms:** Regulatory Programs & Telco Recovery Fees totaling up to $3.99 per line, and federal and local surcharges apply. See Broadband Facts at T-Mobile.com. Credit approval & deposit may be required. U.S. roaming and on-network data allotments differ: includes 200MB roaming. Unlimited talk & text features for direct communications between 2 people; others (e.g., conference & chat lines, etc.) may cost extra. Unlimited high-speed data in US only. Not available for hotspots and some other data-fi rst devices. Capable device required for some features. Activation required to deliver video streams at speeds that provide up to Ultra HD video capability (max 4K); some content providers may not stream their services in UHD. May affect speed of video downloads; does not apply to video uploads. **Apple TV+:** Receive Apple TV+ (up to $9.99/mo. value) while you maintain 1 qualifying Experience More/Beyond line in good standing. Valid only for Apple TV+ in the United States. Complete registration with Apple in the Apple TV app; requires iTunes/Apple Media Services account. Terms and Apple Privacy Policy apply; see the applicable terms at https://www.apple.com/legal/internet-services/itunes/us/terms.html. Must be 13+. Only one offer per account; may take 1–2 bill cycles. Apple TV+ is a registered trademark of Apple Inc. Apple is not a sponsor of this promotion. **Netflix:**Receive Netfl ix Standard with ads while you maintain 1 qualifying Experience More/Beyond line in good standing. Netfl ix account, plan availability & compatible device required. Alternative discount toward different Netfl ix streaming plans may apply. Not redeemable or refundable for cash; cannot be exchanged for Netfl ix gift subscriptions. Cancel Netfl ix anytime. Netfl ix Terms of Use apply: www.netfl ix.com/termsofuse. 1 offer per T-Mobile account; for existing Netfl ix members it may take 1–2 bill cycles during which time you will continue to be charged separately for any existing Netfl ix account. If you link an existing Netfl ix account to this offer, terminating the qualifying line(s) will not automatically cancel your Netfl ix membership, and Netfl ix will automatically resume charging your existing payment method that they have on fi le. Like all plans, features may change or be discontinued at any time; see T-Mobile Terms and Conditions at T-Mobile.com for details. **Tethering:** 60GB high-speed data then unlimited on our network at max 3G speeds. Service may be terminated or restricted for excessive roaming. For customers using >50GB/mo., primary data usage must be on smartphone or tablet. Smartphone and tablet usage is prioritized over Mobile Hotspot Service (tethering) usage, which may result in higher speeds for data used on smartphones and tablets. **AutoPay Pricing** for voice lines 1–8. AutoPay discount requires bank account or debit card, otherwise $5 more/line/mo. May not be refl ected on fi rst bill. **AAA On Us:** Limited time; subject to change. Avail. for new and active AAA members and T-Mobile postpaid customers in good standing. Active voice line and AAA member validation required. Receive 1 year AAA Basic or Classic membership/renewal on us, or equivalent credit to be applied to membership/renewal of a membership type of higher value such as Plus or Premier memberships, when you register at Promotions.T-Mobile.com/AAA and enroll for a new AAA membership with auto-renewal and a valid credit card or provide your existing AAA member number. Offer not available for any membership types of lesser value than Basic or Classic. Existing AAA members must remain a T-Mobile customer in good standing through their registered AAA membership next renewal date in order for their renewal to be paid by T-Mobile. Limit 1 per AAA Member household and T-Mobile account. Membership automatically renews at up to $89/year after 1 year On Us unless cancelled. This offer may be changed or cancelled at any time. Void where prohibited. Nontransferable, not for resale, and not redeemable for cash. This offer and AAA membership is for personal use. May not be combinable with some offers, promotions or discounts. Other restrictions and taxes may apply. **Int'l Roaming:** Calls, including over Wi-Fi, are $.25/min. in 215+ countries and destinations (no charge for Wi-Fi calls to US, Mexico, and Canada). In Canada/Mexico, up to 15GB high-speed data then unlimited at up to 256kbps. In 215+ countries and destinations, up to 5GB high-speed data, then unlimited at up to 256 Kbps. Video typically streams at up to 2.5 Mbps (SD), where available. Not for extended international use; you must reside in the U.S. and primary usage must occur on our network. Device must register on our network before international use. Service may be terminated or restricted for excessive roaming. Coverage not available in some areas; we are not responsible for our partners' networks. **In-Flight Connection:** On select fl ights on select U.S.-based airlines; Wi-Fi Ca lling functionality, valid email address, & 1 prior Wi-Fi call w/ current SIM card req'd for messaging. Streaming where available. **5 year guarantee** means we won't change the price of talk, text, and 5G smartphone data on our network for at least 5 years as long as you are on an Experience plan. Guarantee also applies to price for data on wearable/tablet/mobile internet lines added to your plan. Your guarantee starts when you activate or switch to an eligible plan and doesn't restart if you add a line or change plans after that. Taxes & fees, per-use charges, plan add-ons, third-party services, and network management practices aren't included. **Coverage not available in some areas. Network Management:** Service may be **slowed, suspended, terminated, or restricted** for misuse, abnormal use, interference with our network or ability to provide quality service to other users, or signifi cant roaming. On-device usage is prioritized over tethering usage, which may result in higher speeds for data used on device. See T-Mobile.com/OpenInternet for details. See **Terms and Conditions (including arbitration provision)** at www.T-Mobile.com for additional information. T-Mobile, the T logo, Magenta and the magenta color are registered trademarks of Deutsche Telekom AG.

Hello Prestige Family,

We're thrilled to **relaunch a powerful employee benefit** that could help you **cut down your home electric bill** — thanks to our partnership with **Energy Utility Group!**

Energy Utility Group specializes in **outsourced energy management, procurement, consulting, and advising** — all designed to help you **reduce your energy costs** and keep more money in your pocket.

If you or your family **live in Texas**, you could qualify for **real savings** on your electricity. Here's how to get started:

3 Easy Steps to Explore Your Savings:

1. Click the link: https://prestigeusa.energyutilitygroup.com
2. Listen to the information presented
3. Follow the simple steps outlined in the process

Don't miss out on this opportunity to lower your energy costs and take advantage of this exclusive benefit!

Questions?

Send an email to **info@energyutilitygroup.com** and be sure to mention that you're a **Prestige Maintenance USA employee**.

Let's power up your savings — starting today!

IMPORTANT NOTICES & REMINDERS

The following notices contain important information about your employee benefits plan(s). Please read through all notices and contact Human Resources for more information.

SPECIAL ENROLLMENT NOTICE

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

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption

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

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

WOMEN'S HEALTH AND 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 this plan.

YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. If you elect one of our traditional health insurance plans that has office visit and prescription copays, the prescription drug coverage is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage 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. However, for anyone that elects a Health Savings Account plan, the prescription drug coverage is not considered Creditable Coverage. Because of this, if you do not enroll in Medicare Part D, when first eligible, you will pay a penalty when you try to enroll in Part D at a later date.

Medicaid or CHIP

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

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – 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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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

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.

OMB Control Number 1210-0137 (expires 1/31/2026)

Important COBRA Information

The following notices contain important information about your employee benefits plan(s). Please read through all notices and contact Human Resources for more information.

**** CONTINUATION COVERAGE RIGHTS UNDER COBRA ****

Introduction
You're getting this notice because you recently gained coverage under a group health 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;
- 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 Human Resource Department.

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, Medicaid, 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.

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.

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

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

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

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

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

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

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____

_____.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. mployer name	4. mployer dentification Number N	
5. mployer address	6. mployer phone number	
7. ity	8. State	9. code
10. ho can we contact about employee health coverage at this ob		
11. hone number if different from above	1 . mail address	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
  - ☐ We do not offer coverage.

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

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

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

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

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

☐ **Yes** ontinue
13a. f the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage _____ mm dd yyyy ontinue
☐ **No** ST and return this form to employee

14. Does the employer offer a health plan that meets the minimum value standard
☐ es o to uestion 15 ☐ No ST and return form to employee

15. For the lowest cost plan that meets the minimum value standard **offered only to the employee** don t include family plans f the employer has wellness programs, provide the premium that the employee would pay if he she received the ma imum discount for any tobacco cessation programs, and didn t receive any other discounts based on wellness programs.
a. ow much would the employee have to pay in premiums for this plan $_____
b. ow often ☐ eekly ☐ very weeks ☐ Twice a month ☐ Monthly ☐ uarterly ☐ early

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

16. hat change will the employer make for the new plan year _____
☐ mployer won t offer health coverage
☐ mployer will start offering health coverage to employees or change the premium for the lowest cost plan available only to the employee that meets the minimum value standard. remium should reflect the discount for wellness programs. See uestion 15.
a. ow much would the employee have to pay in premiums for this plan $_____
b. ow often ☐ eekly ☐ very weeks ☐ Twice a month ☐ Monthly ☐ uarterly ☐ early

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)