2027

BENEFITS GUIDE



Benefits for you and your family.

Learn more about all available benefits online at ***www.regbenefits.com***



ENROLLMENT

WHO'S ELIGIBLE

Team Members

You are eligible to participate in the Benefits Program if you are classified as a Regular Full-Time Team Member.

Dependents

When you enroll yourself in the Benefits Program, you may also cover your eligible dependents for medical, dental, vision, and supplemental life insurance coverage.

Eligible dependents include your:

- legal spouse
- children up to age 26
- unmarried child(ren) over age 26 fully dependent on you and incapable of self-support because of a total physical or mental disability
- Domestic partner (You and your partner must satisfy certain requirements. See the Benefits and Wellness Team for details.)



ENROLLMENT

- Beginning of Employment
- Life Event
- Open Enrollment 2 Weeks in November

Current Team Members — You may complete your Open Enrollment Elections by logging into the Dayforce Hub. You may add, drop or make changes to your benefits, or elect to participate in the Flexible Spending Account for the 2027 Plan Year. These choices become effective January 1, 2027. Take special note if any of the following statements are true:

- You want to be in a different plan than you had in 2026
- You want to drop out of a plan you had in 2026
- You want to elect the NEW HSA-Qualified plan offered in 2027
- You want to start covering an eligible dependent you didn't cover in 2026
- You want to stop covering an eligible dependent covered in 2027
- You want to enroll in a Health Care or Dependent Care Flexible Spending Account (FSA) for 2027 (you must re-enroll each year for FSAs)

New Hires and Newly Eligible Team Members
You have 30 days from your hire or eligibility date to complete your enrollment.

WHEN COVERAGE BEGINS

If you are an eligible team member, your coverage begins on the 1st of the month following your date of hire or eligibility date, provided you complete the enrollment process within 30 days of becoming eligible.



ENROLLMENT

CHANGING YOUR BENEFITS DURING THE YEAR

Your benefit elections remain in effect for the entire calendar year, unless you have an IRS-qualifying status change (proof will be required). All changes as a result of a qualifying life event must be made within 30 days of the qualifying event.

Eligible qualifying life events include the following:

- **Legal marital status –** any event that changes your legal marital status, including marriage, death of a spouse, divorce, legal separation or annulment.
- **Number of dependents –** any event that changes the number of your dependents, including birth, adoption, placement for adoption, divorce or death of a dependent or assuming primary support of the child of an unmarried dependent child.
- **Employment status –** any event in which employment begins or ends for an eligible dependent; the gain or loss of eligibility due to a change in full-time to part-time status or vice versa.
- **Dependent status** – any event which causes your married or unmarried dependent up to age 26 to satisfy or cease to satisfy eligibility requirements due to age, or similar circumstances under your plan.
- **Medicare eligible status** – you or your spouse become Medicare eligible.

If you have a qualifying life event during the plan year that allows for a change in benefit coverage, you can request a change in enrollment that is consistent with your change in status. To do so, contact Benefits and Wellness Team within 30 days of the event.

If at any time during the year your enrolled dependents no longer meet the eligibility requirements, please notify Human Resources to remove the individuals from coverage.

If at any time during the year your enrolled dependents no longer meet the eligibility requirements, please notify Benefits and Wellness Team to remove the individuals from coverage.





MEDICAL

Medical Contributions Per Pay Period		Wellness Tiers		
		1 credit (10%)	2 credit (20%)	3 credit (30%)
Wine PPO Plan				
Single	$76.75	$69.08	$61.40	$53.73
Family	$248.50	$223.65	$198.80	$173.95
Gold HSA Plan				
Single	$50.30	$45.27	$40.24	$35.21
Family	$178.75	$160.88	$143.00	$125.13

OUR MEDICAL PLANS

- Provide a wide range of health care services.
- Provide benefits for covered expenses after you pay a copayment or meet the applicable annual deductible.
- Offer network providers whose pre-negotiated rates will save you money.
- Allow you to use out-of-network providers, if you wish.

Learning as much as possible about the plans can help you make more informed choices regarding your needs and those of your covered dependents. Review the Benefits-at-a-glance chart. The chart will help you make an informed decision about the coverage that best meets your needs and those of your covered dependents.

YOUR OPTIONS FOR MEDICAL COVERAGE

Having access to high quality, affordable health care is a great concern for most people. We are pleased to offer team members and their families medical coverage through Medical Mutual. The company pays the majority of the cost of this coverage and offers two plan choices, Wine PPO, and Gold HSA.

All of our plans provide high quality, affordable medical care, including doctors' visits, preventive care, hospitalization and emergency care. Review the benefit summary comparison chart to learn as much as possible about the plans.

HOW THE PLANS WORK

Both plans are administered by Medical Mutual, utilizing the SuperMed Plus network. You have the freedom to choose where you receive care, with an expansive network of providers.

If you prefer to go out-of-network for medical care, you will be reimbursed at a lower benefit level. You may also have to file a claim for reimbursement.

Note: If a preferred provider refers you for covered services to another provider (such as a lab or specialist), make sure the provider you have been referred to is also a preferred provider. If the provider you use is not a preferred provider, your out-of pocket costs will be higher, even if you are referred by a preferred provider.

HOW TO SEARCH FOR A PROVIDER IN THE SUPERMED PLUS NETWORK

- Go to the Medical Mutual Provider Search Page Visit: https://www.medmutual.com
- Click "Find a Provider" located on the top right corner of the homepage. You will be prompted to log into your member portal for personalized results OR you may "Search without logging in".



MEDICAL

MEDICAL BENEFITS-AT-A-GLANCE – WINE PPO PLAN		
Type of Services	**In-Network You Pay**	**Out-of-Network* You Pay**
Deductible (per calendar year) (Individual / Family)	$500 / $1,000	$1,000 / $2,000
Coinsurance Limit (excludes deductible) (Individual / Family)	$1,000 / $2,000	$2,000 / $4,000
Out-of-pocket Maximum (includes deductible, coinsurance, and medical/Rx copays) Individual/Family (per calendar year)	$6,600 / $13,200	Unlimited
Coinsurance	20%	40%
Emergency Services		
Emergency – Emergency Room	$150 Copay	$150 Copay
Emergency Services – all other related charges	20%, after deductible	20%, after deductible
Non-Emergency – Emergency Room	20%, after deductible	$50 Copay, waived if admitted then 40%
Non-Emergency Services – all other related charges	20%, after deductible	40%, after deductible
Preventive Care		
Well Child Exams	Covered in full	50%, after deductible
Well Child Labs	Covered in full	40%, after deductible
Immunizations	Covered in full	50%, after deductible
Physical Exam	Covered in full	50%, after deductible
Routine Testing & Endoscopic Services* **Colon cancer screening, mammogram, Pap test, PSA test*	Covered in full	40%, after deductible
Mental Health Care, Drug Abuse/Alcoholism		
Inpatient Mental Health Care, Drug Abuse and Alcoholism Services Outpatient Mental Health Care, Drug Abuse and Alcoholism Services Biologically Based Mental Illness Services	Benefits paid are based on corresponding medical benefits	Benefits paid are based on corresponding medical benefits
Outpatient and Routine Services		
Medically Necessary Office Visits	$10 Copay	$20 Copay, then 40%
Outpatient Occupational, Physical and Chiropractic Visits	$10 Copay	$20 Copay, then 40%
Outpatient Speech Therapy Services	$10 Copay	$20 Copay, then 40%
Outpatient Allergy Testing and Treatments	20%, after deductible	50%, after deductible
Other Services		
Ambulance Services	$25 Copay	$25 Copay, then 40%
Home Health Care Services	20%, after deductible	50%, after deductible
Hospice Services	20%, after deductible	50%, after deductible
Immunizations	20%, after deductible	50%, after deductible
Organ Transplant Services	20%, after deductible	$250 copay per admission, then 50%

* Out-of-Network reimbursement is based on what the insurance carrier deems as reasonable & customary. You will be responsible for paying the difference between amount billed and reasonable & customary, in addition to the coinsurance levels above.



MEDICAL

MEDICAL BENEFITS-AT-A-GLANCE – GOLD HSA PLAN		
Type of Services	**In-Network You Pay**	**Out-of-Network* You Pay**
Deductible (per calendar year) (Individual / Family)	$3,500 / $7,000	$7,000 / $14,000
Coinsurance Limit (excludes deductible) (Individual / Family)	$0 / $0	$6,600 / $13,200
Out-of-pocket Maximum (includes deductible, coinsurance, and medical/Rx copays) Individual/Family (per calendar year)	$3,500 / $7,000	$13,600 / $27,200
Coinsurance	0%	50%
Emergency Services		
Emergency – Emergency Room	0%, after deductible	0%, after In-Network deductible
Emergency Services – all other related charges	0%, after deductible	0%, after In-Network deductible
Non-Emergency – Emergency Room	0%, after deductible	50%, after deductible
Non-Emergency Services – all other related charges	0%, after deductible	50%, after deductible
Preventive Care		
Well Child Exams	Covered in full	50%, after deductible
Well Child Labs	Covered in full	40%, after deductible
Immunizations	Covered in full	50%, after deductible
Physical Exam	Covered in full	50%, after deductible
Routine Testing & Endoscopic Services* **Colon cancer screening, mammogram, Pap test, PSA test*	Covered in full	40%, after deductible
Mental Health Care, Drug Abuse/Alcoholism		
Inpatient Mental Health Care, Drug Abuse and Alcoholism Services	Benefits paid are based on corresponding medical benefits	Benefits paid are based on corresponding medical benefits
Outpatient Mental Health Care, Drug Abuse and Alcoholism Services		
Biologically Based Mental Illness Services		
Outpatient and Routine Services		
Medically Necessary Office Visits	0%, after deductible	50%, after deductible
Outpatient Occupational, Physical and Chiropractic Visits	0%, after deductible	50%, after deductible
Outpatient Speech Therapy Services	0%, after deductible	50%, after deductible
Outpatient Allergy Testing and Treatments	0%, after deductible	50%, after deductible
Other Services		
Ambulance Services	0%, after deductible	50%, after deductible
Home Health Care Services	0%, after deductible	50%, after deductible
Hospice Services	0%, after deductible	50%, after deductible
Immunizations	0%, after deductible	50%, after deductible
Organ Transplant Services	0%, after deductible	50%, after deductible

Annual employer contributions to HSA Bank Account - $1,500 single / $3,000 Family

* Out-of-Network reimbursement is based on what the insurance carrier deems as reasonable & customary. You will be responsible for paying the difference between amount billed and reasonable & customary, in addition to the coinsurance levels above.



PRESCRIPTION DRUG

	Retail 30-day Supply	Mail-Order 90-day Supply
Wine PPO Plan – Copayments for Prescription Drugs		
Generic	$10	$20
Brand Name Formulary	$20	$40
Brand Name Non-Formulary	$40	$80
Gold HSA Plan - Subject to Medical Deductible		
Generic	0%, after deductible	0%, after deductible
Brand Name Formulary	0%, after deductible	0%, after deductible

PRESCRIPTION DRUGS

When you enroll in a medical plan, you automatically receive prescription drug coverage. If you have your prescription filled at a participating retail pharmacy, you may purchase up to a 30-day supply of covered drugs. At the participating pharmacy, you will need to present your ID card and make the required payment. You may obtain information on participating pharmacies by visiting the Express Scripts site. The plan also includes a home delivery order service through Express Scripts. If you are taking a medication for an extended period of time, you can purchase up to a 90-day supply of covered drugs through Express Scripts, which will be delivered directly to your home (or your local RiteAid pharmacy). By using the home delivery program, you are able to get a 90-day, rather than a 30-day, supply.

If your Prescription Order is for a Prescription Drug that is available through the Home Delivery Prescription Drug program and you choose not to use the Home Delivery Prescription Drug program, you will be required to pay two times the appropriate Prescription Drug copayment indicated when your Prescription Order is refilled beyond the second time within a 180- day period.

To use the home delivery program, ask your doctor to give you a new prescription for up to a 90-day supply of your regular medication, plus refills, if appropriate. You will receive forms for refills and future prescription orders each time you receive a prescription from the home delivery service. You can also re-order online at Express Scripts.



HEALTH SAVINGS ACCOUNT

WHAT IS AN HSA?

Health Savings Accounts (HSA) are a tax-advantaged medical savings account available to those who enroll in the Consumer Driven Health Plan (CHDHP). The funds you invest are not subject to most taxes. The growth of the invested amount is not taxed and when the funds are distributed, no tax penalties are incurred when applied to qualifying expenses. The funds you contribute to your HSA are yours to keep and can be used not only for medical expenses, but for retirement expenses as well.

GREAT BENEFITS FOR YOU

Convenience: Paying for expenses from your HSA is as easy as using a debit card.

Choice: Pay for qualified expenses from your HSA or save your HSA money and pay out-of-pocket.

Control: You decide how the money is spent and you have the freedom to keep it if you change jobs or retire.

TRIPLE-TAX SAVINGS

Tax-Free Deposits: Even if you don't itemize deductions, you don't pay federal income tax on contributions.

Tax-Free Savings: You keep any money you don't spend and it grows tax-free. No use-it-or-lose-it.

Tax-Free Withdrawals: There's never tax on withdraws to pay for qualified expenses.

Contributions Limits	2027
Single	$4,500
Family	$9,000
Catch-up (55+)	$1,000

PLUS an annual contribution from ROCK Entertainment Group of $1,500 Single / $3,000 Family.

Examples of Qualified Medical Expenses

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limbs
- Braces
- Childbirth preparation classes (mother)
- Chiropractors
- Contact lenses
- Crutches
- Dental fees
- Dentures
- Diagnostic fees
- Doctor's fees
- Drug addiction recovery
- Dyslexia language training
- Eyeglasses and examination fees
- Hearing aid and batteries
- Home modifications for handicapped
- Insulin
- Laboratory fees
- Maternity expenses
- Nursing homes
- Optometrists
- Orthodontia
- Orthopedic shoes
- Oxygen/oxygen equipment
- Prescription drugs
- Psychiatric care
- Therapy treatments (prescribed)
- Transportation (for medical care)
- Vision correction surgery
- Vitamins (if prescribed)
- Wheelchairs
- X-rays

The above is a brief summary; refer to IRS Publication 502 for confirmation of eligible expenses



FAMILY FOCUSED

We've partnered with Carrot to provide inclusive hormonal health, fertility, and family-building benefits to full time Team Members — including funds to help pay for eligible care.

With the Carrot benefit, get support with:*

- Fertility health and wellness (e.g., hormone testing)
- Preservation (egg, embryo, or sperm freezing)
- Assisted reproduction, like IVF and IUI
- Adoption
- Donor assistance and gestational surrogacy

Through Carrot, you'll get:

- Access to funds to pay for eligible care and services
- Personalized advice from Carrot Experts to help you make the most of your benefit
- A Carrot Plan — customized next steps to help you move forward, at no cost to you
- Unlimited, free video chats with medical experts and specialists
- Help finding providers near you
- Exclusive partnerships and discounts
- Expert-produced educational resources — no more endless online searching
- Carrot Rx, powered by Alto, which offers up to 40% off and price matching on key fertility medications, 24/7 clinician support, and fast home delivery on all prescriptions



**Carrot services available may vary based on plan design, geography, and local rules and regulations.*

LEARN MORE

If you are interested, connect with a member of the People and Culture or reach out to Carrot directly for more information:

get-carrot.com/signup
1-888-828-2597 (24 hours a day, 7 days a week)



DENTAL

Dental Contributions Per Pay Period	
Single	$2.30
Family	$9.10

A comprehensive dental plan plays an important part in assuring your overall well-being. Our plan, provided through Medical Mutual's Superior Dental program, is a Preferred Provider Organization (PPO) that offers access to one of the most extensive provider networks in Ohio and nationwide. It also gives you a high level of benefits, whether you visit an in-network or out-of-network provider.

Through the PPO Plan, you have the flexibility to receive dental care from the dentist of your choice. However, using a network dentist that has prenegotiated rates will save you money.

MEDICAL MUTUAL PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

If you select a participating dentist from the Superior Dental Network, you will realize substantial savings, because network providers have agreed to accept a discounted fee schedule as payment in full, thereby reducing your out-of-pocket expenses. Using the network also provides reassurance about the level of care, since participating dentists have to meet certain standards to be included. In addition, using the network eliminates the hassle of filing claim forms. Conversely, non-participating dentists have not agreed to charge specific amounts and you will be responsible for any difference between the reasonable and customary amount and what the dentist actually charges. Out-of-network dentists will often bill you directly, requiring that you file a claim form to receive reimbursement from Medical Mutual.

PRECERTIFICATION REQUIREMENTS

Medical Mutual may require advance notice for certain more expensive services in order to receive full coverage. If you are unsure about coverage, contact Medical Mutual by calling the telephone number indicated on your ID card before you receive these services. You and your dentist should be clear about whether these services are approved under the plan before services are received.

To find a participating dentist, visit: www.medmutual.com or call Member Services at: 1-800-362-4700.





DENTAL

DENTAL BENEFITS-AT-A-GLANCE - Medical Mutual Dental PPO Plan		
	In-Network	**Out-of-Network**
Calendar year maximum per member (Class I, II, III expenses)	$1,500	$1,500
Calendar year deductible per member*	$50	$50
What the plan pays		
Benefits*	**In-Network**	**Out-of-Network**
Class I Services – Routine Preventive Services • Initial and periodic oral evaluations (two evaluations every 12 months) • Bitewing x-rays (two every 12 months) • Full mouth/panoramic x-rays (one every 36 months) • Diagnostic x-rays • Prophylaxis (two every 12 months) • Space maintainers (for eligible dependent children under age 16) • Topical fluoride applications (two every 12 months for eligible dependent children under age 14) • Emergency palliative treatments • Dental sealants** (one every 36 months for eligible dependent children under age 16)	0%, no deductible	0%, no deductible
Class II Services – Essential Services • Consultations/other evaluations • Amalgam or resin based composite fillings • Endodontic services • Periodontal services • Extractions • Impactions • Repairs, relines & adjustments of prosthetics • General anesthesia • IV sedation • Minor oral surgery	0%, after deductible	20%, after deductible
Class III Services – Complex Services • Inlays (1 every 5 years per tooth) • Onlays (1 every 5 years per tooth) • Crowns (1 every 5 years per tooth) • Fixed partial dentures (bridges) (1 every 5 years per unit) • Dentures*** (complete & partial) (1 every five years)	40%, after deductible	50%, after deductible
Class IV Services – Orthodontic Services • Lifetime Orthodontia Maximum	50% $1,500	50% $1,500

Benefit verification is required for any Course of Treatment exceeding $200 or involving major restorations.
* Deductible applies to Class II (Essential) & Class III (Complex) services only.
** Dental sealants are limited to eligible teeth free from decay or restorations on the occlusal surface.
*** Relining and rebasing is covered if done no less than six months after initial placement but not more than once in any 36 month period. One replacement of a temporary denture if a permanent denture is installed within 12 months of the installment of the temporary denture.



VISION

Vision Contributions Per Pay Period	
Single	$0.60
Family	$1.90

Our vision plan covers eye exams, eyeglasses and contact lenses. Services are provided through the extensive Medical Mutual/ EyeMed Vision Care network of optometrists, ophthalmologists, and other eye care professionals.

Receiving benefits from a network provider is as easy as making an appointment with the provider of your choice from the list of Medical Mutual/EyeMed Vision Care providers and giving them your membership information.

You also have the choice to use providers outside the network, but you'll pay more for their services, and you will be generally responsible for paying the entire service fee, and then requesting reimbursement of the scheduled allowance (shown in the chart below) from Medical Mutual/EyeMed Vision Care.

NETWORK OF PROVIDERS

To find a list of network providers, contact EyeMed Vision Care at 1-866-299-1358 or *www.eyemedvisioncare.com*.

VISION BENEFITS-AT-A-GLANCE

Plan Features	Frequency	In-Network Member Cost	Out-of-Network Member Reimbursement
Exam	12 Months	$10 Copay	$35 Allowance
Lenses • Single Vision • Bifocal • Trifocal	12 Months 12 Months 12 Months	$25 Copay $25 Copay $25 Copay	$25 Allowance $40 Allowance $60 Allowance
Additional discounts for lens options are available.			
Frames	24 Months	$0 Copay; $120 Allowance, 20% off balance over $120	$30 Allowance
Contact Lenses • Medically necessary • Elective	12 Months	Paid in full $135 Allowance, 15% off balance over $135	$200 Allowance $95 Allowance

Note: Once benefits are exhausted, they will reset at the beginning of next year.



FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) are voluntary accounts that allow you to use your before-tax pay for certain health care expenses and dependent care expenses as determined by IRS regulations. You can set up two separate accounts—one for eligible health care expenses and one for qualified dependent care expenses. These are two separate accounts for two separate purposes. The monies in one account can't be used to satisfy expenses in the other account. You can participate in either of these accounts or both — or none at all — depending on your needs. Medical Mutual My Spending Accounts is the claims administrator for the FSA Program.

For those enrolled in the HSA Plan option, you are eligible for the Limited Purpose FSA and Dependent Care FSA.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Contributions

You may contribute up to $3,500 per year as a before-tax contribution to your Health Care FSA.

Eligible Dependents

In general, an eligible dependent under the Health Care FSA is anyone you list as a dependent on your federal income tax return. This includes your immediate family members, a close relative or other person whose primary residence is your home and for whom you provide over 50% support

Limited Purpose FSA: Team members enrolled in the HSA plan who are looking to maximize their tax benefits can choose to elect to enroll in a Limited Purpose FSA for 2027 & use tax-free funds to pay for eligible dental & vision expenses.

ELIGIBLE HEALTH CARE EXPENSES

If you are enrolled on one of the PPO Plan options and choose to set-up a Health Care FSA, you can be reimbursed for eligible expenses that you or your dependents incur after your effective date during the calendar year in which you participate in the Plan.

Examples of eligible health care expenses, to the extent not covered by another plan, include:

- Copayments, deductibles and coinsurance not covered by medical or dental insurance
- Uninsured expenses, such as hearing aids, eyeglasses, contact lenses and certain eye surgeries
- Orthodontia
- Diabetic supplies
- Smoking cessation programs
- Fertility services

PAYING YOUR HEALTH CARE EXPENSES

There are two ways to pay for eligible expenses:

- **FSA Claim Form –** You pay your health care providers directly and then file a claim for reimbursement. Simply complete a health care FSA claim form and submit the form by mail or fax along with the receipts. The form is available by logging on to *www.MedMutual.com/member* or by calling Member Services at 1-800-525-9252.
- **Debit Card –** You can use this card to pay for eligible health care expenses at any health care provider or approved merchant. With the Debit Card, participants have instant access to the money in their FSA, which is automatically drawn from their account as purchases are made.



FLEXIBLE SPENDING ACCOUNTS

USING YOUR HEALTH CARE FSA DEBIT CARD

Per Internal Revenue Service (IRS) regulations, your Debit Card may only be used at health care providers who have a health care-related merchant category code (such as physicians, dentists, vision care offices, hospitals, and other medical care providers) or at grocery stores, discount stores and pharmacies who utilize an Inventory Information Approval System (IIAS). You may not use the Debit Card at any merchant, including pharmacies, that do not have a health care-related merchant category code unless that merchant or pharmacy utilizes an IIAS.

DEPENDENT CARE EXPENSES

For a complete list of eligible and ineligible health and dependent care expenses visit *www.IRS.gov* and review Publications 502 & 503. A list can also be obtained from your local IRS office.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Contributions

In the Dependent Care FSA, you may contribute up to $7,500 per year. The $7,500 annual maximum applies to all contributions made by you and your spouse to a dependent care account. If you are married and filing separately for federal income tax purposes, you may elect to contribute up to $3,750 per year.

Eligible Dependents

You can be reimbursed for day care expenses you have in a plan year, if the expenses are necessary to allow you and your spouse—if you're married— to work. These services may be provided inside or outside your home by babysitters, companions or eligible day care centers. Services may not, however, be provided by someone you claim as a dependent on your tax return.

Your day care expenses must be for:

- Your dependent under age 13 who lives with you for more than half the year and for whom you can claim an exemption
- A child under age 13 for whom you have custody if you are divorced or legally separated
- Your spouse who is physically or mentally incapable of self-care
- A dependent of any age, such as an elderly parent or other adult dependent, who meets all of the following criteria:
  - » Is physically or mentally incapable of caring for himself or herself,
  - » Receives over half of his or her support from you,
  - » Lives with you for more than half the year, and
  - » Is your sibling, step-sibling or any of their descendants; a parent or step-parent or any of their ancestors; an aunt, uncle, niece, or nephew; children or parents-in-law; or an unrelated individual who shares your residence as a member of the household.



DISABILITY

An illness or injury that keeps you out of work for a long period of time can be financially devastating for you and your family. Our Long-Term Disability plan is designed to help protect your financial security by providing replacement income if you are ever disabled due to a non-work related injury or illness. When you are disabled, your medical insurance generally covers most of your medical expenses, such as doctor visits, physical therapy and prescription drugs. Disability benefits can help you cover your day-to-day living expenses. This program is insured through MedMutual Life Insurance Company and is provided at no cost.

LONG-TERM DISABILITY (LTD)

LTD benefits replace a percentage of your pre-disability earnings, which include your base salary plus bonuses and commissions but excludes overtime and other extra compensation. Benefits begin after an elimination period of 90 days is completed. The LTD benefit is 66 2/3% of the first $22,500 of your monthly pre-disability earnings, with a maximum benefit of $15,000.

If you have a pre-existing condition that occurred within 90 days of becoming covered by the policy, you must have been continuously insured by the policy for 12 months at the time of disability for the policy to cover that pre-existing condition.

Benefits will continue for two years. If you are unable to perform the duties of your own occupation for up to two years, but can do other work for which you are reasonably trained and educated, benefit payments will cease after that two-year period. If you are unable to work in any occupation, you will need to provide additional medical support for benefits to continue.

Your disability benefit coordinates with other sources of disability income you or your dependents receive, including Social Security and Workers' Compensation.

If you become disabled on or after age 61, benefits are based on a reduced benefit duration schedule.

Refer to your plan booklet for details such as benefit durations, pre-existing condition limitations and other terms of coverage, or contact Benefits and Wellness Team.

TAX-FREE OPTION

Normally, if you were to become disabled, your LTD monthly benefits would be taxable income to you, just as your regular salary is. However, these benefits can be distributed to you tax free, if you pay tax now on the monthly premium that the company pays. We refer to this as the Gross-Up Option. If you do not elect to pay tax now on the monthly premium and you become disabled, you would receive the same monthly benefit amount, but you would be required to pay federal income tax on those benefit payments.





TERM LIFE/AD&D

LIFE/ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Your life and accident insurance benefits are some of the most valuable benefits available to you. They are often referred to as "survivor" benefits because they provide financial security to your loved ones if you die or are severely injured in an accident. Because this kind of protection is so important, we provide, at no cost to you, basic Life/Accidental Death and Dismemberment (AD&D) coverage equal to 2.5 times your annual earnings, up to a maximum of $260,000. Annual earnings include bonuses and commissions. You also have the opportunity to purchase additional Life and AD&D coverage for yourself and your eligible dependents through our Supplemental Life program.

HOW BENEFITS ARE PAID

You should ensure that you have beneficiary designations on file with Benefits and Wellness Team. In the event of the death of your covered spouse or child(ren), benefit payments are made to you. In the event of your death, unless you choose a different beneficiary, benefit payments are made in the order listed below:

- Your spouse
- Your children (including legally adopted children but excluding step-children)
- Your parents
- Your brothers and sisters
- Your estate

DESIGNATING YOUR BENEFICIARY

You may change your beneficiary at any time during the year. You may access your current beneficiary form or request a new beneficiary form in People and Culture.

AGE REDUCTIONS

If you become 70 or older, your Basic Life and AD&D insurance will reduce by:

Age	Amount
70 through 74	35% of original amount
75 or over	50% of original amount

YOU HAVE THE FOLLOWING CHOICES FOR SUPPLEMENTAL LIFE:

Team Member Coverage
You can choose additional coverage in multiples of $10,000, from $10,000 to $500,000.

Guaranteed Issue
Can get up to $100,000 in coverage without providing Evidence of Insurability.

Spouse Coverage
You can choose spouse coverage in multiples of $5,000, from $5,000 to $250,000 (up to a maximum of 50% of your coverage amount).

Guaranteed Issue
Up to $25,000 in coverage without providing Evidence of Insurability.

Child(ren) Coverage
You can choose coverages for dependent child(ren) of $5,000 or $10,000 (up to a maximum of 50% of your coverage amount).

EVIDENCE OF INSURABILITY

You are guaranteed the ability to enroll for up to $100,000, of supplemental life coverage, regardless of your health, when you are first eligible to join the plan. If you apply for more than that amount or do not enroll when you are first eligible, you will be required to provide evidence of good health before the additional coverage becomes effective.

Your spouse will be required to provide evidence of good health if requesting more than $25,000 of coverage.



TEAM MEMBER ASSISTANCE PROGRAM

Our Team Member Assistance Program, offered through TotalCare EAP (a division of ESI), is a confidential counseling and referral service available to you, your dependents, and all members of your household. EAP is available to you at no cost to provide assistance and guidance whenever life events interfere with health and wellness or your ability to excel at work or at home.



PROGRAM HIGHLIGHTS

Through the EAP, you and your family have access to trained counselors who can address issues such as stress, depression, parenting, divorce, alcohol abuse, drug abuse, work place issues, family matters, work/ life balance, financial issues, marital problems, child and elder care, and legal problems.

Services are available to you and your household members for assistance with these and many other matters:

- Depression
- Stress and anxiety
- Marital or life partner problems
- Family concerns
- Child and parenting issues
- Grief and loss issues
- Referrals and discounts
- Local resources for information and assistance
- Tips for productive work and healthy families
- Eldercare support
- Financial Wellness

HOW TO ACCESS TOTALCARE EAP

To access the EAP, call 1-800-252-4555 or visit *www.theEAP.com* and create a username and password



TEAM MEMBER PAID BENEFITS

Team Members have the option to elect employee paid Accident, Critical Illness and Hospital Indemnity policies through Lincoln Financial.

ACCIDENT

When you, your spouse or child has a covered accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs. While health plans may cover direct costs associated with the accident, you can use the accident benefits to help cover related expenses like income, childcare, deductibles or copays…or any way you see fit.

Injury	Cash Payment
Hospital Admission	$1,000 / $2,000 ICU
Hospital Confinement	$200 per day / $400 per day ICU
Fracture	Schedule up to $3,000
Ambulance	Ground: $425 / Air $1,750
Emergency Room	$250
Dislocations	Schedule up to $3,000
Concussion	$300
Major Diagnostic Exam (X-ray, MRI)	Diagnostic Exam: $400; X-ray: $225
Wellness Benefit	$50

Get paid for having your preventive care! Under the Accident plan, you can submit a claim for a $50 reimbursement just for having your routine care!

CRITICAL ILLNESS

No one is ever really prepared for a life-altering critical illness diagnosis. The whirlwind of appointments, tests, treatments & medications can add to your stress levels. Critical illness coverage helps provide financial support if you are diagnosed with a covered critical illness. The plan provides a lump sum benefit to help you bounce back when you suffer a major health event. The Critical Illness benefit pays cash, on top of any other medical, disability or supplemental plan.

- Coverage is available to all family members: up to 50% of the employee's face amount on both spouse & children
- Elect $10,000, $20,000 or $30,000 in coverage on yourself
- Guarantee Issue $30,000 (All coverage is guarantee issue - no medical questions asked)
- Includes an annual Wellness benefit that pays you $50 per person per year for many common preventive screenings
- Covered conditions include: Heart Attack, Stroke, Cancer & many more



TEAM MEMBER PAID BENEFITS

HOSPITAL INDEMNITY

Hospital Indemnity insurance can cover some of the cost associated with a hospital stay, letting you focus on your recovery. If you become seriously ill or injured it can be a little scary, as well as expensive. While medical insurance may cover the hospital bills, there can also be non-medical expenses such as transportation to medical treatment or additional child care, which could be considerable. The Hospital Indemnity plan will pay you a cash benefit that you decide how to use.

- Coverage is available to you, your spouse & children
- No pre-existing condition limitation
- Receive $1,000 per admission
- Receive $100 per day you're confined to the hospital ($200 per day for ICU)
- Includes a $50 Wellness benefit that pays you for having your Preventive Care

LEGAL SHIELD

LegalShield provides you and your family the legal protection you not only need but deserve. Affordable legal protection for $22.50 a month! LegalShield provides benefits for the following:

- Estate Planning
- Family
- Financial
- Auto
- Home

PET INSURANCE

Pet insurance reimburses you for vet bills when your pet is sick or injured, to help take the financial worry out of vet visits.

- Fast claims processing and payment
- Optional direct deposit and direct vet pay options
- Use any veterinarian in the U.S. – including specialty and emergency clinics
- Exclusive employee discount on a BestBenefit plan*
- Optional coverage for routine care
- Access to a 24/7 pet helpline powered by whiskerDocs





OTHER BENEFITS

VACATION

As a full-time team member, you are entitled to vacation based on your length of service, as noted below. Vacation is accrued on a fiscal year basis. You will begin accruing your vacation time on your first day of employment. All vacation requests must be approved by Team Leader in advance. Note: team members have unlimited accrual; however, you are only to be paid out based on number of years of service you have completed. Vacation must be approved by your team leader in advance.

	Annual Accrual	Payout Cap
1 – 4 Years of Service	Earns 3 weeks per year	Up to 3 weeks
5 – 9 Years of Service	Earns 4 weeks per year	Up to 4 weeks
10+ Years of Service	Earns 5 weeks per year	Up to 5 weeks

HOLIDAYS

You are entitled to the following paid holidays:

- New Year's Day
- Martin Luther King Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

PERSONAL SIGNIFICANCE DAY

Team Members will receive a total of 5 Personal Significance Days to use over the course of the fiscal year (July 1-June 30). These will not roll over or get paid out upon separation.

TEAM MEMBER MILESTONE TRIPS

Team Members reaching 15, 25, 35, 45 milestone years of service will be invited on a special trip. Team Members will be eligible every 10 years.

TEAM MEMBER SABBATICAL

Regular full time, non-union Team Members who reach 10 years of service will be eligible to apply for a 4-week paid sabbatical. The People and Culture team will inform Team Members who are eligible for a sabbatical by July 1 of each year. Sabbaticals must be taken between 7/1-9/30; exceptions may be made by the senior leader.

COMPLIMENTARY TICKETS

Full-time team members are eligible to request a limited number of tickets, for personal use, for Cavaliers, Monsters, and Cleveland Charge regular season home games, subject to availability and the Company's Ticket Policy.

PAID PARKING

You are eligible for parking access and hangtag that allows you to park at any time in the East Garage adjacent to Rocket Arena. You may park in any unmarked space throughout the garage or a space that is designated "Reserved Parking, Facility Employee" on Lower Level.

RETIREMENT BENEFITS

After one month of service, you are eligible to participate in the Cavaliers 401(k) Vanguard Plan, which allows pre-tax and/or post-tax retirement savings. Entry to the plan occurs the first pay after one month of service. Unless you formally choose otherwise, you are automatically enrolled in the plan with a 8% contribution, deposited to a pre-tax fund that corresponds to your expected year of retirement.

Beginning the first pay following six months of service, the Company will match 50% of the first 8% of compensation that you contribute. Vesting is immediate and a loan program is available after you have at least $2,000 in savings.

LEAVE OF ABSENCE

In certain situations, you may be eligible for a job protected leave under the Family and Medical Leave Act if you have worked at least one year and 1,250 hours over the 12 months preceding a leave. Contact Human Resources for further details.



MEDICARE

ARE YOU OR A PARENT ELIGIBLE FOR MEDICARE?

Medicare is the health insurance program run by the Federal Government. It is available to those 65 and older, those under 65 with certain disabilities, and those with end-stage renal disease.

Personalized service is now available to you and your family members so you can choose the right Medicare coverage for your individual situation. Call an UROne Medicare Enrollment Specialist at 1-800-722-7331 for answers to these and all your Medicare questions:

- When do I enroll in Medicare?
- How do I enroll in Medicare?
- What are the four parts of Medicare?
- What is the right type of Medicare coverage for me?



These services are provided by a knowledgeable and licensed specialist at no charge to you. They will:

- Identify the plans and companies that meet your personal needs.
- Look up the doctors and hospitals you use to make sure they are part of the plan provider list.
- Look up the prescription drugs you take to make sure they are covered.
- Review and explain the plan benefits and coverage.
- Provide Monthly Premium rates.
- Help you complete your enrollment application and in some cases take your application over the phone.
- Obtain your application approval from the insurance company.
- Provide you with a personal Welcome Kit and Document Envelope to retain all of your personal insurance information.

Visit *https://oswaldsecure.formstack.com/forms/medicare* to securely complete a Medicare Personal Information Sheet. This will help our Medicare Enrollment Specialist better understand your needs and provide the best recommendations for your individual situation.

Why wait? Call 1-800-722-7331 today to get your questions answered.



CONTACT INFORMATION

Plan/Carrier	Website	Phone Number	Policy Number
Medical Benefits Medical Mutual of Ohio (Medical Mutual)	*medmutual.com*	Member Services: 1-800-362-4700	Group #334363-106 and 334363-111
Medical Mutual HSA	*MedMutual.com/member*	1-800-522-2037	
Dental Benefits Medical Mutual of Ohio (Medical Mutual)	*medmutual.com*	Member Services: 1-800-362-4700	Group #334363-109
Vision Benefits Medical Mutual of Ohio/EyeMed	*medmutual.com*	Member Services: 1-800-362-4700	Group #334363-110
Flexible Spending Accounts (FSA) Medical Mutual My Spending Accounts	*MedMutual.com/member*	Member Services: 1-800-525-9252	
Disability Benefits MedMutual Life Insurance Company	*medmutuallife.com*	1-866-925-2542	Group #334363
Life and Accidental Death and Dismemberment Insurance MedMutual Life Insurance Company	*medmutuallife.com*	1-866-925-2542	Group #334363
Team Member Assistance Program TotalCare EAP	*theeap.com*	1-800-252-4555	
Accident, Critical Illness, Hospital Indemnity Lincoln Financial	*lincolnfinancial.com*	1-800-423-2765	ID# 1150998

People and Culture Team		
Alberta Lee	216-420-2662	EVP, Chief People & Culture Officer
Heather Brockler	216-420-2214	VP, People & Culture
Megan Dean	216-420-2218	Director, Benefits & Wellness
Aysia Kemp	216-420-2554	Senior People and Culture Coordinator
Gavin Stephens	216-420-2279	Director, Talent & Engagement



NOTICES

Notice Regarding Wellness Program

If a Constituent Benefit Program listed is a voluntary wellness program available to all employees, it is intended to be administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, depending upon that program, it may include a voluntary health risk assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include blood tests or other diagnostic tests. Please note that this is voluntary, and you are not required to participate in these evaluations or examinations.

In certain wellness programs, employees who choose to participate in the wellness program will receive an incentive that is disclosed to you in the open enrollment information for the Constituent Benefit Program. Although you are not required to complete the assessments or participate in the biometric screening, only employees who do so will receive the incentive. Additional incentives up to the maximums permitted by law, may be available for employees who participate in certain health-related activities or those who achieve certain health outcomes. If so, these will be described in your program materials or otherwise communicated to you.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Plan Administrator listed in your Summary Plan Description. The information from any assessment and any results from your examinations or screenings will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Consistent with the disclosures in this Notice regarding the protection of your health and personally identifiable health information, any information gathered in the Constituent Benefit Program that is a wellness program, will be confidential. The wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, but it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Also, your health information will not be sold, exchanged, transferred, or otherwise disclosed (except as permitted or required by law) to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving any incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a wellness program nurse, or physician or other health coach staff for purposes of the wellness program. You may inquire about who specifically has access to your information in this regard.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Precautions deemed appropriate will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. Finally, you may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. Any questions should be directed to the Plan Administrator as listed in your Summary Plan Document.

ARE YOU, OR A FAMILY MEMBER, MEDICARE ELIGIBLE (OR ABOUT TO BECOME MEDICARE ELIGIBLE)? IF SO, PLEASE READ AND KEEP FOR YOUR RECORDS!

Notice of Creditable Coverage

Your prescription drug coverage provided under Cavaliers Holdings LLC's Health & Welfare Plan is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage".

Why This is Important

This information is to help you decide whether or not you want to join a Medicare drug plan. It is important for those eligible for both Medicare and a group health plan to look ahead and weigh the costs, benefits, and participation terms of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would reduce payment in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

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. Cavaliers Holdings LLC has determined that the prescription drug coverage offered by the Medical Mutual of Ohio plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When May You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current Cavaliers Holdings LLC coverage may or may not be affected as well as dependent coverage. Additional guidance is available at https://www.cms.gov/medicare/prescription-drug-coverage/creditablecoverage?redirect=/creditablecoverage/ which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Cavaliers Holdings LLC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the person listed below for further information NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Cavaliers Holdings LLC changes. You also may request a copy of this notice at any time.

Contact--Position/Office: Megan Dean - HR
Address: 1 Center Court, Cleveland, OH 44115
Phone Number: (216) 420-2000

For More Information Regarding Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

1. Visit www.medicare.gov
2. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
3. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

HIPAA Notice of Privacy Practices

You are receiving this Privacy Notice because you are eligible to participate in an employer sponsored group health plans. The Health Plans are committed to protecting the confidentiality of any health information collected about an individual. This Notice describes how the Health Plan may use and disclose, "protected health information" (PHI). For information to be considered "PHI", it must meet three conditions:

Information is created or received by a health care provider, health plan, employer, or health care clearinghouse; Information relates past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and the information either identifies the individual or provides a reasonable basis for believing that it can be used to identify the individual.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to an individual. Additionally, the Health Plan is required by law to:

Maintain the privacy of an individual's "protected health information" (PHI) and provide you with the Privacy Notice of its legal duties and privacy practices with respect to an individual's PHI and follow the terms of its Privacy Notice that is currently in effect.

Employees of the plan sponsor who administer and manage this Health Plan may use PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These individuals must comply with the same requirements that apply to the Health Plan to protect the confidentiality of PHI.

Dependent Coverage

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Effective first day of the Plan Year that began on or after September 23, 2010.

Lifetime Limitations

The lifetime limit on the dollar value of benefits under the Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the Plan Administrator.

Rescission

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud, or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review. See the Claims Procedure Section under the Plan for more information.

Uses and Disclosures of Protected Health Information (PHI)

The following categories describe the ways that the Health Plan may use and disclose protected health information. For each category of uses and disclosures, examples will be provided. Not every use or disclosure in a category will be listed. However, all the ways the Health Plan is permitted to use and disclose information will fall within one of these categories.

Treatment Purposes. The Health Plan may disclose PHI to a health care provider for the health care provider's treatment purposes. For example, if an individual's Primary Care Physician (PCP) or treating medical provider refers the individual to a specialist for treatment, the Health Plan can disclose the individual's PHI to the specialist to whom they have been referred so (s)he can become familiar with the individual's medical condition, prior diagnoses and treatment, and prognosis.

Payment Purposes. The Health Plan may use or disclose health information for payment purposes; such as, determining eligibility for plan benefits, obtaining premiums, facilitating payment for the treatment and services an individual receives from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans. Examples of payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a specific treatment is covered under the plan

Health Care Operations. The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

To a Business Associate of the Health Plan. The Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, provided a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so or provides services to the Health Plan such as legal, actuarial, accounting, consulting, or administrative services. Examples of Business Associates include the Health Plan's Third-Party Administrators (TPAs), Actuary, and Broker.

To the Health Plan Sponsor. The Health Plan may disclose PHI to the Plan Sponsor as long as the sponsor has amended its plan documents, provided a certification to the Health Plan, established certain safeguards and firewalls to limit the classes of employees who will have access to PHI, and to limit the use of PHI to plan purposes and not for non-permissible purposes, as required by the Privacy Rule. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Some examples may include: disclosure for claims appeals to the Plan's Benefits Committee, for case management purposes, or to perform plan administration functions.

The Health Plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "Summary Health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

Required by Law or Requested as Part of a Regulatory or Legal Proceeding. The Health Plan may use and disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, the Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

There are limits on the Plan's use and disclosure of PHI in regard to disclosures related to Reproductive Health Care. In regard to such requests, if a request may impact Reproductive Health Care, as defined in the Policy and the HIPAA Regulations, the Plan must obtain an Attestation to verify that the requested use or disclosure if not for a Prohibited Purpose, as defined by Regulations. Prohibited Purposes in this regard include the following; 1) to conduct criminal, civil or administrative investigation into any person for the mere fact of seeking, obtaining, providing or facilitating lawful reproductive healthcare; 2)to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, provoking , or facilitating lawful reproductive health care; and/or 3) to identify any person for purposes of items (1) and (2). Certain types of requests automatically require Attestation.

In Addition, when substance use disorder treatment related to PHI is requested, there are limits on permitted disclosures related to civil, criminal, administrative, or legislative proceedings against the individual, unless based on written consent, or a court order after notice an opportunity to be had is provided to the individual or the holder of the record. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before PHI can be used or disclosed.

Public Health Activities or to Avert a Serious Threat to Health or Safety. The Health Plan may disclose PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Law Enforcement or Specific Government Functions. The Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with an individual's written authorization or that of their legal representative, and the individual may revoke such authorization as provided by section 164.508(b) (5) of the Privacy Rule. Any disclosures that were made when the individual's Authorization was in effect will not be retracted.

An Individual's Rights Regarding PHI

An individual has the following rights with respect to their PHI:

Right to Inspect and Copy PHI. An individual has the right to inspect and copy health information about them that may be used to make decisions about plan benefits. If they request a copy of the information, a reasonable fee to cover expenses associated with their request may be charged.

Right to Request Restrictions). An individual has the right to request restrictions on certain uses and disclosures of their PHI (although the Health Plan is not required to agree to a requested restriction).

Right to Receive Confidential Communications of PHI). An individual has the right to receive their PHI through a reasonable alternative means or at an alternative location if they believe the Health Plan's usual method of communicating PHI may endanger them.

Right to Request an Amendment. An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI but is required to provide the individual with a response in either case.

Right to Accounting of Disclosures. An individual has the right to receive a list or "accounting of disclosures" of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual's Authorization, or to the individual. An individual's request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12-month period.

Breach Notification. An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so, required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Genetic Information If the covered entity under the Plan engages in underwriting an individual's genetic information will not be used for underwriting except for long term care plans.

Right to Paper Copy. An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

The Health Plan's Responsibilities Regarding an Individual's PHI

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI. The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to all actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice.

The complaint will be investigated, and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20210

HIPAA Plan Special Enrollment Notice

If you are declining your enrollment under the Plan, or declining coverage for your spouse or one of your dependents, because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing toward such other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends, or after the period for which the employer ceased contributing toward such other coverage if such payment applied to your circumstances.

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

To request special enrollment or obtain more information, please contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for further information.

Genetics Information Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Mental Health/Substance Use Disorder Parity

Effective for Plan Years on and after July 1, 2010, benefits under Plans that provide Mental Health Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Newborns and New Mothers Care Disclosure

This Plan generally does not, consistent with applicable Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, consistent with that same Federal law, this Plan generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, this Plan does not, in accordance with Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual and Regular Notice

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, notwithstanding anything herein to the contrary, the Plan provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for further information.

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272). If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: 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
ILLINOIS - Medicaid	**KANSAS – Medicaid**
Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: mhfs.boc.hipp@illinois.gov	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	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**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/buy-out-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/fam-is-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, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Employee Benefits Security Administration

www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services

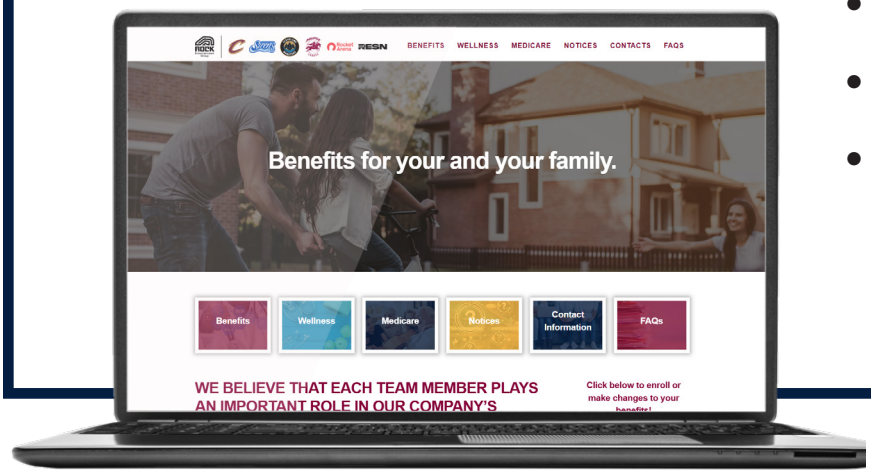
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565



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