2026

Gestalt
COMMUNITY SCHOOLS

Employee Benefits Guide

Welcome!

Your Benefits. Your Future. Your Peace of Mind.

We are committed to providing competitive benefit programs that are flexible enough to meet your individual needs.

Our comprehensive benefits are carefully designed to give you the tools you need to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement.

Getting the most from your benefits is up to you. You know your family, your goals and your lifestyle best. This benefits guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family and be sure to act before the enrollment deadline.

Open Enrollment: Take Action!

- Dates: November 17- December 4, 2025
- Type: Passive
- Questions? Contact Jaleesa Oniovos at joniovos@gestaltcs.org

Ross & Yerger

Eligibility

Benefit Eligibility

You and your eligible family members may participate in the **2026** employee benefits program if you're a regular, full-time employee working a minimum of 30 hours per week.

New-Hire Eligibility

New hires can join the plan the first of the month following 30 days. Spouses and dependent children of the employee are also eligible to participate in our benefit plans, if you are a full-time employee.

Dependent Eligibility

You can enroll the following dependents in our group benefit plans:

- Your legal spouse
- Children up to age 26*
- A child under the age of 26 who is your natural child, stepchild, legally adopted child, or child for whom you have obtained legal guardianship
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

Reminder: Enrolled children lose coverage when they **turn 26**. You must inform HR **30 days** prior to your dependent reaching their 26th birthday

Ross & Yerger

Qualifying Life Event

Your benefit elections made during Open Enrollment will be effective **01/01/2026.** You may not make changes to your elections unless you experience a qualifying life event.

Common Qualifying Events:

- Change in the number of your dependents (through birth or adoption or if a child is no longer an eligible dependent)
- Change in spouse's employment status (resulting in a loss or gain of coverage)
- Change in legal marital status (marriage, divorce, or legal separation)
- Change in employment status from full-time to part-time or part-time to full-time, resulting in a gain or loss of eligibility
- Entitlement to Medicare or Medicaid
- A court order to provide health coverage for your eligible dependent (QMSCO)

Other Examples of Qualifying Life Events:

- Turning 26 and losing coverage through a parent's plan
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Important

If you need to make a change before the next Open Enrollment due to a change in status, you must:

- **Submit required documentation within 30 days of the qualifying life event**
- **Contact HR for assistance**
- **Log in to Employee Navigator to process the change**

Medical Plan Details

Your medical plan will be offered through UMR.

Elections you make during enrollment will be effective **01/01/2026** and remain in effect until **12/31/2026** unless you experience a Qualified Life Event.
You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lower out-of-pocket costs. In-network providers charge members reduced, contracted rates instead of their typical fees. Providers outside the plan's network set their own rates, so you may be responsible for the difference if a provider's fees are above the Reasonable and Customary (R&C) limits.

Register Online
Your connection to great healthcare is only a click away. Register for an online account at www.umr.com so you can access time-saving tools, tips for healthy living, view lab results, choose a doctor, manage your EOBs,and more!

Scan the QR code to download the UMR mobile app
With the UMR mobile app, you've got the tools you need to manage your healthcare all from your smartphone. The mobile app is available in the Apple and Google Play store.

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Medical Plan Details

Overview of your UMR Medical Plan

UMR A UnitedHealthcare Company	Silver Plan		Gold Plan		Platinum Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
PLAN FEATURES						
Annual Deductible: Individual	$3,500	$7,000	$1,500	$3,000	$500	$1,000
Annual Deductible: Family	$7,000	$14,000	$3,000	$6,000	$1,000	$2,000
Annual Out-of-Pocket: Individual	$8,500	$28,000	$5,850	$11,700	$2,500	$5,000
Annual Out-of-Pocket: Family	$17,000	$34,000	$11,700	$23,400	$5,000	$10,000
Coinsurance	20%	40%	20%	40%	20%	40%
YOUR COSTS FOR CARE						
Preventive Care	$0	Not Covered	$0	Not Covered	$0	Not Covered
Primary Care Physician (PCP)	$30 Copay	40% after deductible	$30 Copay	40% after deductible	$20 Copay	40% after deductible
Virtual Visits	$0	Not Covered	$0	Not Covered	$0	Not Covered
Specialist Visit	$50 Copay	40% after deductible	$50 Copay	40% after deductible	$50 Copay	40% after deductible
Urgent Care	$75 Copay	40% after deductible	$75 Copay	40% after deductible	$75 Copay	40% after deductible
Emergency Room	$350 Copay		$350 Copay		$350 Copay	
PHARMACY COSTS	**In Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Category 1 (generic)	$15.00	Not Covered	$10.00	Not Covered	$15.00	Not Covered
Category 2 (preferred)	$40.00	Not Covered	$35.00	Not Covered	$40.00	Not Covered
Category 3 (non-preferred)	$70.00	Not Covered	$60.00	Not Covered	$70.00	Not Covered

Medical Premiums

Coverage Level	Silver	Gold	Platinum
Employee	$0.00	$55.86	$92.36
Employee & Spouse	$99.51	$117.30	$213.85
Employee & Children	$95.37	$106.13	$169.18
Family	$152.06	$167.58	$273.32

Gestalt
COMMUNITY SCHOOLS

Gestalt Community Schools believes our team members should be able to embrace holistic wellness using Gestalt Community Schools Natural Health Program.

The program allows you to submit reimbursement for up to $600 annually, between January 1, 2026 to December 31, 2026, for the therapies listed below.

Gestalt Community Schools Natural Health Program

All natural health providers must have a Tax ID number and provide a receipt describing the procedure/service provided.

Submitted receipts must be dated between January 1, 2026 to December 31, 2026. Submit receipts to isbc@umr.com and hr@gestaltcs.org.

Questions?

If you have any questions, please contact human resources for clarification.

Ross & Yerger
INSURE THE FUTURE

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Approved Reimbursements

- Cryogenic Immersion
- Sauna Therapy
- Massages
- Homeopathy
- Float Therapy
- Tai Chi
- Reiki
- Meditation Therapy
- Biofeedback
- Hypnosis
- Electromagnetic Therapy

Cosmetic procedures will NOT be reimbursed under the Gestalt Community Schools Natural Health Program.

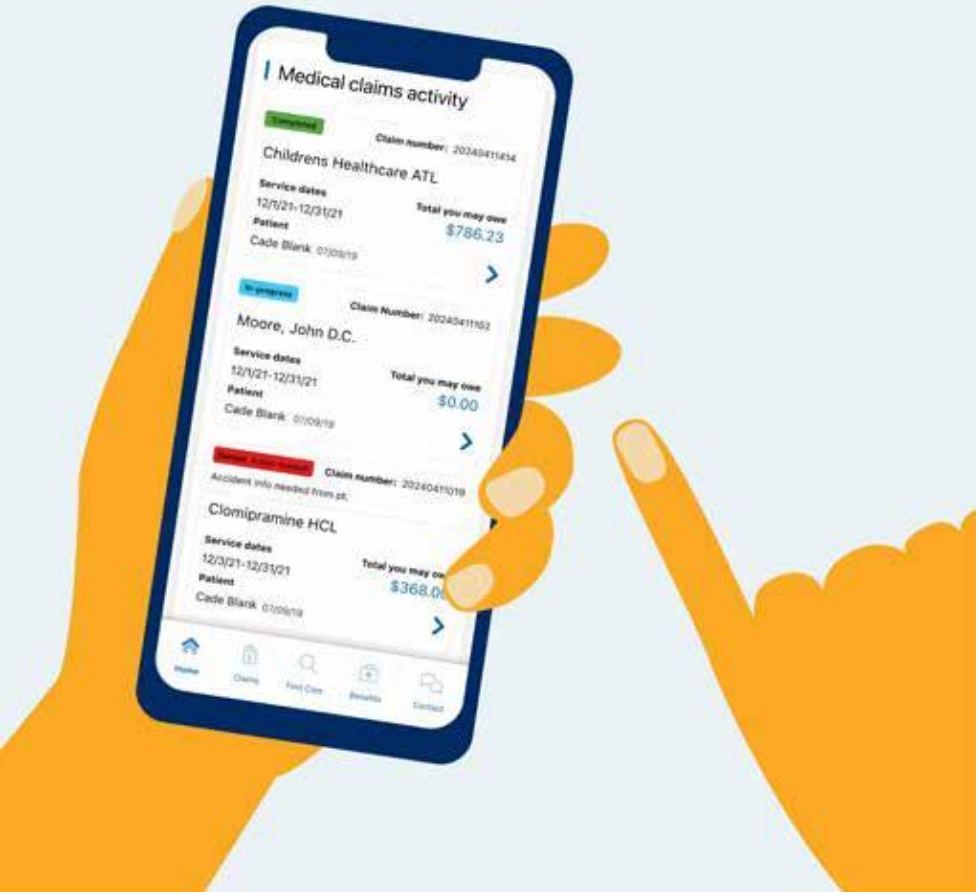
Welcome to a

smarter, simpler, faster

way to manage your health care benefits,

right from the palm of your hand.

UMR on the go!



The UMR app has a smart fresh look, simple navigation, and faster access to your health care benefits information. View your plan details on demand - anytime, anywhere.

With a single tap, you can:

- Access your digital ID card
- Look up in-network health care providers
- Find out if there's a co-pay for your upcoming appointment
- View your recent medical and dental claims
- Chat, call or message UMR's member support team

Download the UMR app today!

Simply scan the QR code or visit your app store to get started.

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Get all your answers **quick** and **easy** @ umr.com

Make umr.com your first stop

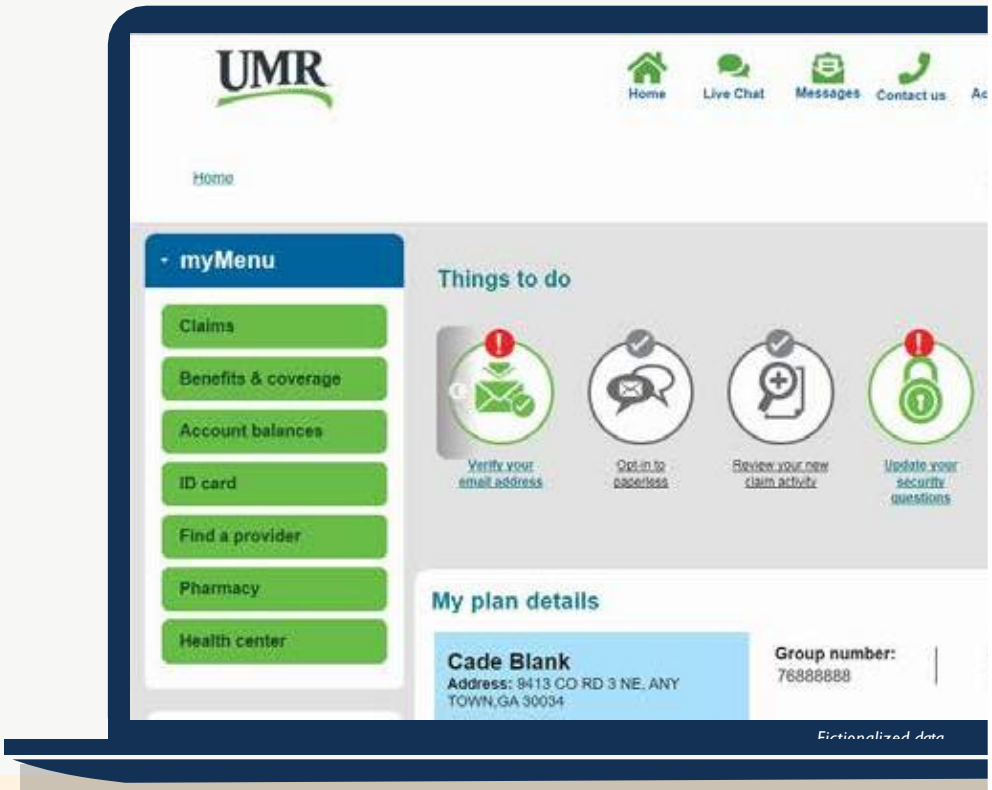
You want managing your health care to be fast and easy, right? You got it. At umr.com, you'll find everything you want to know – and need to do – as soon as you log in.

No hassles. No waiting. Just the answers you're looking for anytime, night or day!

Log in now to:

- View **Things to do**, your personalized benefits to-do list
- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and your treatment options
- Access tools and trusted resources to help you live a healthier life

Note: *The images shown reflect available features within our desktop site. These features may or may not be available to all users, depending on your individual and/or company benefits.*



The **UMR app** is another way we're reimagining health care to work for you.

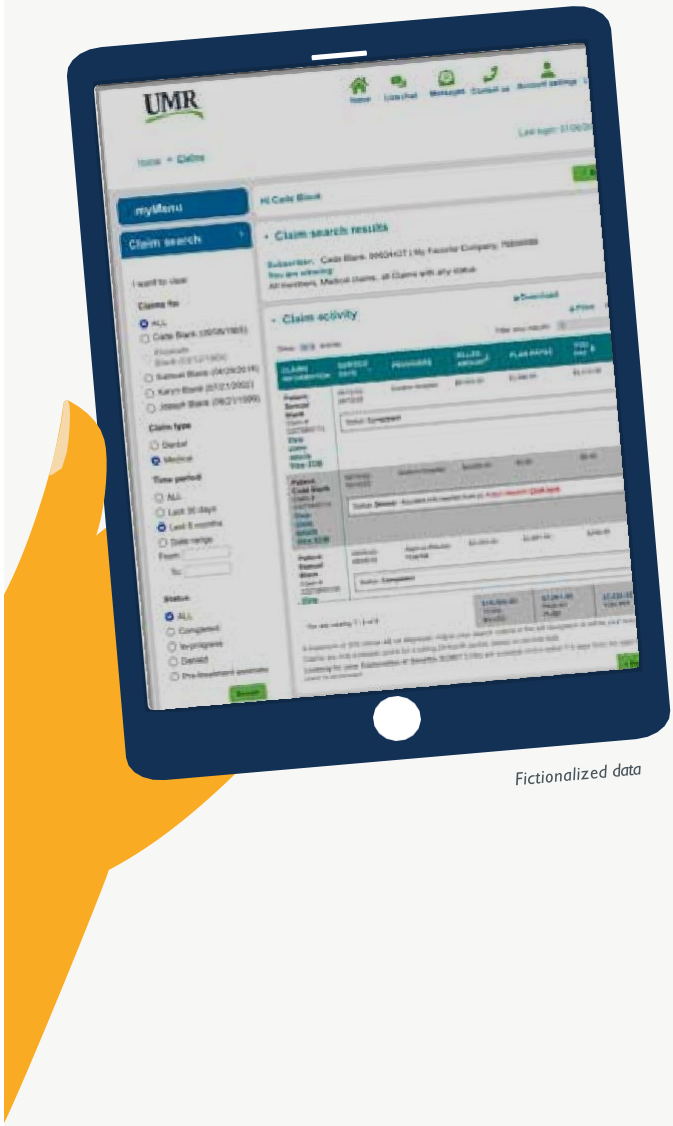
We have a smarter, simpler, faster way to manage your health care benefits, right from the palm of your hand.

With just a tap, you can:

- Access your digital ID card
- View your plan details on-demand – anytime, anywhere
- Find out if there is a co-pay for your upcoming appointment
- Chat, call or message UMR's member support team

Stay connected to your health care and download the UMR app today!

Simply scan the QR code to the left or visit your app store to get started.



Fictionalized data

You don't need a Ph.D. to understand your benefits

We've made it easy to find the top things people want to know. Choose **Benefits & coverage** from **myMenu** to find out:

- What health care services are covered?
- What's the cost difference between an in-network and out-of-network service?
- What's your deductible, and are you close to reaching it?
- Is there a co-payment for your office visit? If so, how much?

Buried in paperwork? A single click lets you track all your claims

Check in at your convenience to see if a claim has been processed and what you might owe. To get more details on a specific claim, click **view claim details** or **view EOB**. This will tell you the type of services provided, the amount billed and the amount paid, if any, and whether there's any action that needs to be taken before the claim can be processed.

You can choose to receive a secure e-mail any time you have a new EOB. If you're not ready to give up paper completely, you can print out copies from our claims center.

Don't be surprised by unexpected costs

- Know the price you'll pay ahead of time. Search treatments or procedures in the **Health cost estimator**.
- Get your in-network discount. Use **Find a provider** to look up doctors and facilities near you.

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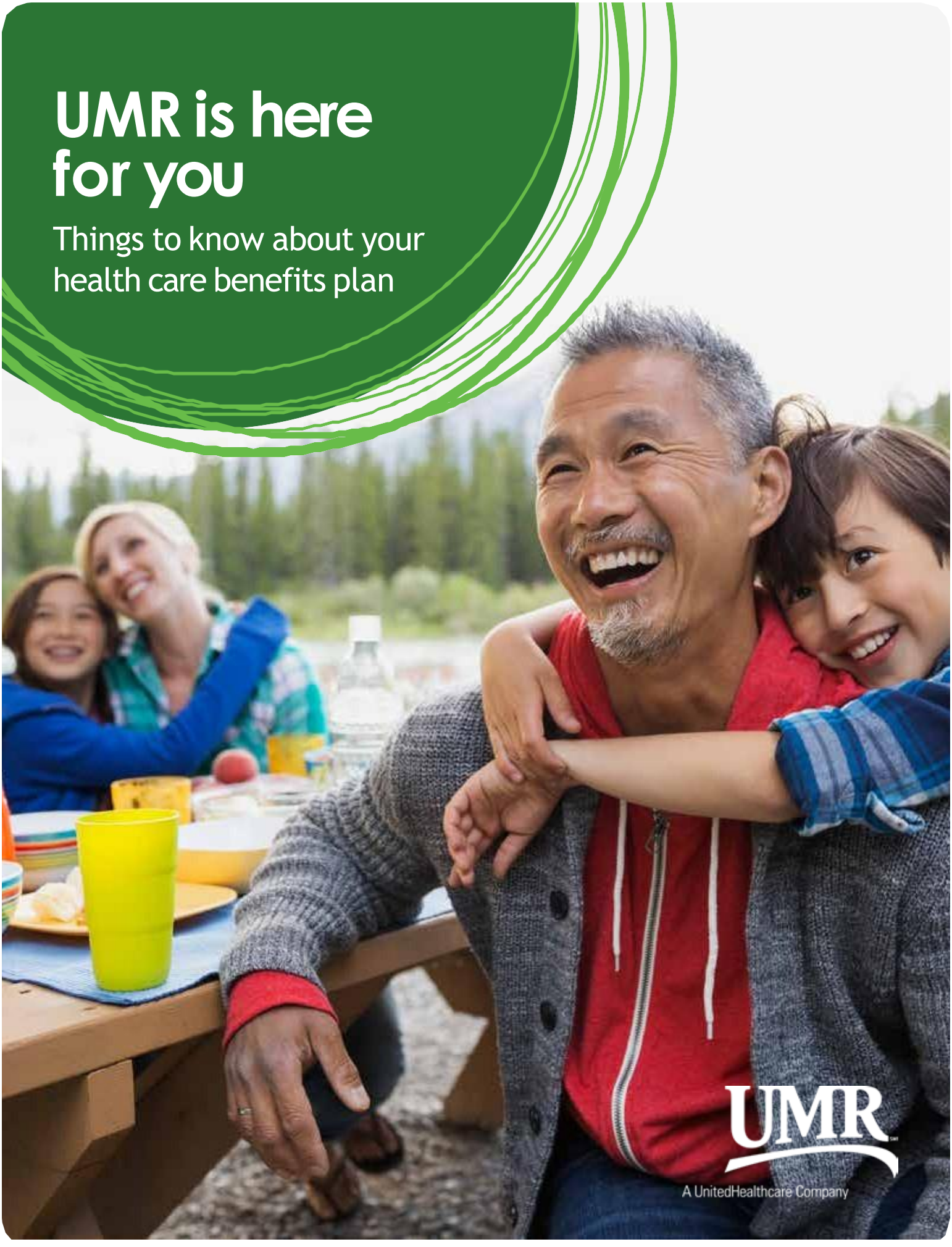
UMR is here for you

Things to know about your health care benefits plan



We're happy to answer some questions about UMR

Who is UMR?

UMR is part of UnitedHealthcare, and we've been selected to help administer the health care benefits available to you and your family through your employer.

So UMR is my health insurance?

No. Not exactly. Your employer offers a self-funded health plan. Instead of buying health insurance, your employer pays the costs of any health care claims not paid by plan members like you.

What does UMR do?

We're what's called a third-party administrator, or TPA. Your employer hired us to handle many of the tasks associated with managing your health benefits. For example, UMR helps enroll new members when they sign up for benefits. We process claims for services from health care providers and make sure they are handled quickly and accurately. And we have medical professionals on staff that can help coordinate your care if you are in the hospital or are dealing with a serious health condition.

What if I have other questions or need help?

UMR has a team of benefits specialists available to answer questions about your health plan and help you find the care you need. For example, you can ask us whether certain services are covered by your plan, get help finding an in-network provider, or find out about how a recent medical claim was paid. Simply give us a call using the member services phone number listed on your ID card, or sign up at umr.com or on the **UMR app** to look up information about your benefits anytime.

How does our network work?

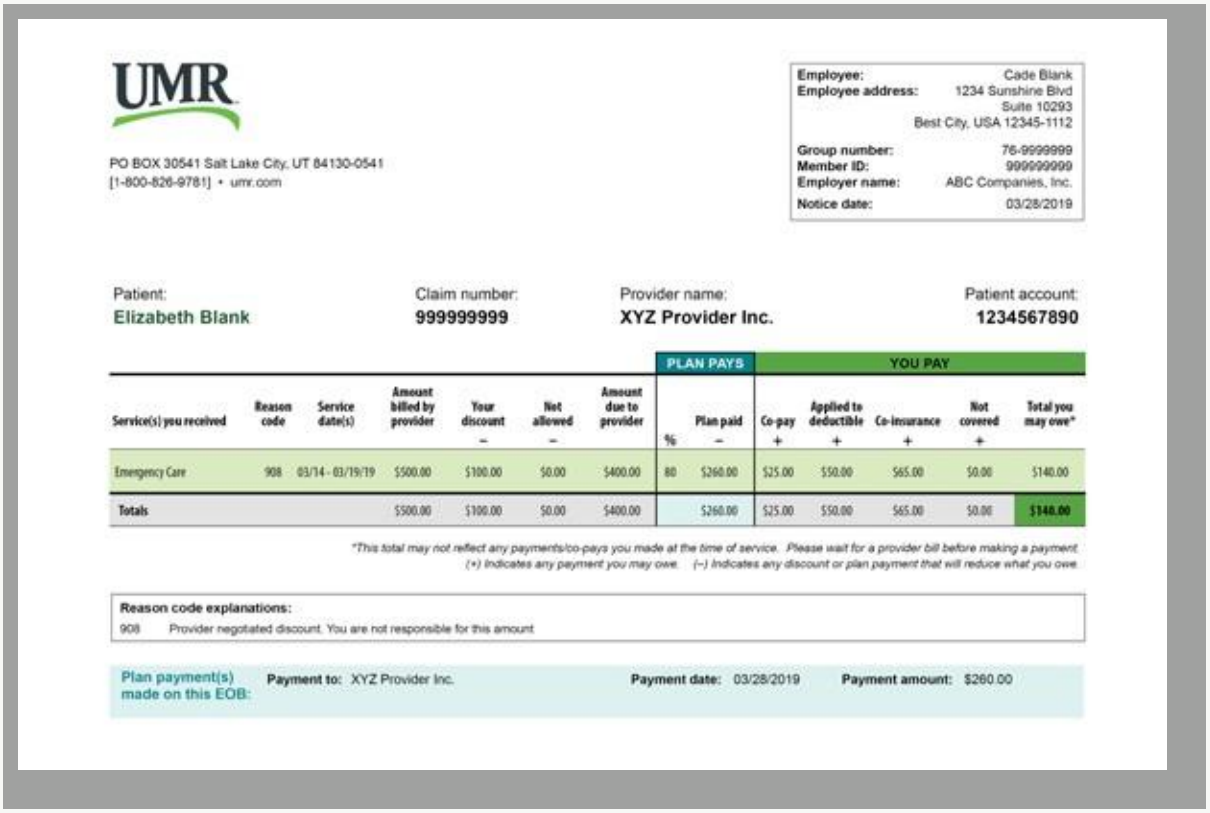
You may hear your health care network called a PPO, or preferred provider organization. This refers to a group of doctors, hospitals and other health professionals who have signed a contract agreeing to provide their services at reduced rates. This is your network discount, and you can save a lot of money by going to providers who are in-network vs. those outside the network.

The name of your network is listed on your UMR member ID card, along with the member services phone number to call with any questions. Make sure your health care providers have a copy of your current ID card on file so that your claims will be submitted and processed correctly.

Will I receive mail from UMR?

Only if you want to! If you create an account on umr.com or on the **UMR app**, you'll have the choice to continue to receive information by mail, or you can sign up to go paperless and get email alerts when you have new items to review online. Types of notifications UMR may send you include letters asking you to provide information about yourself or a recent claim, opportunities to work with clinical experts in managing your health, or explanation of benefits (EOB) statements for care received by you or a covered dependent.

Understanding your EOB



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PO BOX 30541 Salt Lake City, UT 84130-0541
[1-800-826-9781] • umr.com

Employee: Cade Blank
Employee address: 1234 Sunshine Blvd
Suite 10293
Best City, USA 12345-1112
Group number: 76-9999999
Member ID: 999999999
Employer name: ABC Companies, Inc.
Notice date: 03/28/2019

Patient: Elizabeth Blank
Claim number: 999999999
Provider name: XYZ Provider Inc.
Patient account: 1234567890

								PLAN PAYS		YOU PAY				
Service(s) you received	Reason code	Service date(s)	Amount billed by provider	Your discount −	Not allowed −	Amount due to provider	%	Plan paid −	Co-pay +	Applied to deductible +	Co-insurance +	Not covered +	Total you may owe*
Emergency Care	908	03/14 - 03/19/19	$500.00	$100.00	$0.00	$400.00	80	$260.00	$25.00	$50.00	$65.00	$0.00	$140.00
Totals			$500.00	$100.00	$0.00	$400.00		$260.00	$25.00	$50.00	$65.00	$0.00	$140.00

*This total may not reflect any payments/co-pays you made at the time of service. Please wait for a provider bill before making a payment. (+) Indicates any payment you may owe. (–) Indicates any discount or plan payment that will reduce what you owe.

Reason code explanations:
908 Provider negotiated discount. You are not responsible for this amount

Plan payment(s) made on this EOB: Payment to: XYZ Provider Inc. Payment date: 03/28/2019 Payment amount: $260.00

Plan members receive an explanation of benefits (EOB) statement for most health claims submitted by your health care providers.

An EOB is not a bill. It simply tells you everything you might want to know about how a recent medical service was covered by your benefits plan. You'll receive a bill from your provider for any amount you may owe.

Remember to review your EOBs for important details about your claims, including:

- Who received the medical service
- The name of the health care provider
- The type(s) of care provided
- How much your provider billed
- Your network discount
- The amount paid by your employer-sponsored plan
- The amount you may owe, including co-pays, deductibles and out-of-pocket amounts

Your EOB will also give you a breakdown of how much you and/or your family have applied toward your annual deductibles and out-of-pocket amounts.

You will not receive an EOB for claims where your responsibility is zero or only a co-payment. You can review your zero balance or co-payment claims on **umr.com**, on the **UMR app** or by calling UMR.

Get all your answers quick and easy

When you register for UMR's online services at umr.com or on the **UMR app**, you'll be able to find the information you need when you need it – anytime, anywhere! Log in anytime to:

- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and your treatment options
- Access tools and trusted resources to help you live a healthier life

And with the **UMR app**, you can have anytime access to your digital ID card on the go.

Fictionalized data

Note: *The images shown reflect available features within our desktop site. These features may or may not be available to all users, depending on your individual and/or company benefits.*

Download the UMR app!

Scan the code or visit your app store to download our app today.

How to contact UMR

Go to umr.com

Stay connected to the services and resources provided through your benefit plan by registering at umr.com. All your information is password-protected, and you can send us questions using the site's **Contact Us** email feature.

Download the UMR app

The **UMR app** is another way to get answers to your benefits questions quickly and easily. You can chat or message UMR's member support team 24/7.

Call us toll-free

Our UMR team is ready to help you. Simply call the phone number for member services listed on your benefits ID card.

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Dental Plan Details

Overview of your SunLife Dental Plan

Dental insurance helps you maintain a healthy smile by covering the cost of preventive services such as checkups, cleanings, and X-rays. Routine dental care not only supports your overall health but also helps protect you and your family from the high costs of dental disease or surgery.

Your plan includes coverage for preventive, basic, and major services, with 100% coverage for preventive care. Eligible employees and dependents can enroll in dental benefits administered by SunLife.

	Basic Plan		Enhanced Plan		Pre-Paid Plan	
PLAN FEATURES	**In Network**	**Out of Network**	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Annual Max Per Person	$1,000		$2,000		Copay Schedule	Not Covered
Preventive Care Routine Cleanings, Exams (twice a year)	100%		100%		Varies	Not Covered
Basic Services: Fillings, Routine Extractions	20%		20%		Varies	Not Covered
Major Services: Crowns, Dentures, Bridges	50%		60%		Varies	Not Covered
Orthodontia Adults and Children	N/A		N/A		Not Covered	Not Covered

*Out-of-network allowances are based on usual, customary, and reasonable charges (UCR).

Dental Premiums			
Coverage Level	Basic	Enhanced	Prepaid
Employee	$11.72	$19.48	$7.13
Employee & Spouse	$23.86	$39.43	$11.61
Employee & Child(ren)	$30.82	$45.95	$15.76
Family	$41.46	$73.08	$18.49

Sun Life Financial

Call: 1-800-247-6875
To locate a dentist visit:
https://www.sunlife.com/findadentist

Vision Plan

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Your vision insurance is provided by Guardian and entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

Vision Plan	In Network	Out of Network
Eye Exam (Once Every 12 Months)	$10 copay	Reimbursed up to $52
Lenses (Once Every 12 Months)		
Single Vision -	$25 copay	Reimbursed up to $55
Bifocal -	$25 copay	Reimbursed up to $75
Trifocal -	$25 copay	Reimbursed up to $95
Lenticular -	$25 copay	Reimbursed up to $125
Frames (Once Every 24 Months)	Up to $130 allowance + 20% off any amount above allowance	Reimbursed up to $57
Contact Lenses* (Once Every 12 Months)		
Medically Necessary -	Covered after $25 Copay	Reimbursed up to $210
Elective -	$130 allowance	Reimbursed up to $105

*In lieu of glasses

Vision Premiums	
Coverage Level	Per Pay Period
Employee	$4.99
Employee & Spouse	$9.72
Employee & Child(ren)	$10.55
Family	$16.58

Sun Life Financial

Group Life

Employer-Paid Protection for You and Your Family

Key Benefits

- Cost to you: $0
- Employer-paid coverage
- Benefit: 2x your basic Annual Earnings, up to a maximum of $50,000.
- AD&D coverage included

Reminder: Keep your beneficiary information up to date by checking it each year.

Sun Life Financial

What This Means for You

You're covered automatically at no cost. This benefit protects your loved ones if the unexpected happens.

Life insurance provides peace of mind, knowing your family will have financial support to cover everyday expenses, debts, or future needs if something unexpected happens.

Voluntary Life

Sun Life Financial®

Employee Life Insurance

You may purchase additional life insurance at group rates:

- Available in increments of $10,000 up to
- $500,000, not to exceed 5 times your Basic Annual Earnings.
- You pay the full cost of this plan and the amount deducted depends on the age of the employee and the amount of coverage elected
- If you do not elect this coverage when first becoming eligible or an election over $200,000 is made, you are subject to medical underwriting by the carrier

Spouse Life Insurance

You may purchase additional dependent life insurance:

- Spousal and child cover is only available in addition to voluntary employee cover
- Spousal life is available in increments of $5,000 up to a max of $250,000 or 100% of the employee amount
- Spousal life can be elected up to $50,000 without medical underwriting as a new hire

Child Life Insurance

- Child life is available in increments of $2,000 up to $10,000 not to exceed 100% of your coverage amount.
- Children are not subject to medical underwriting
- The cost remains the same regardless of the number of children you have

Guaranteed Issue & Evidence of Insurability

- At first eligibility: may elect up to the GI amount without EOI
- Over GI: EOI required before coverage is effective
- Waived coverage or later increases: EOI required

Reminder: Keep your beneficiary information up to date by checking it each year.

Disability Coverage

Short-Term Disability (STD) Plan

The STD plan provides full-time employees with income replacement in the amount of **66.67%** of their earnings while disabled and unable to work due to a non-occupational illness or injury, including pregnancy. This coverage is **employee-paid (voluntary)** and the benefit payment is based on your exemption or union status.

	Choice 1	Choice 2
Benefit Percentage	66.67%	66.67%
Minimum Weekly Benefit	$10	$10
Maximum Weekly Benefit	$1,800	$1,8000
Benefit Duration	26 Weeks	24 Weeks
Injury & Sickness	Injury: 1 Day Sickness: 8 Days	Injury: 15 days Sickness: 15 days

Long-Term Disability (LTD) Plan

The LTD plan provides income protection if you are unable to work for an extended period due to a qualifying disability. If you are enrolled in this plan and remain disabled for 26 weeks or more, you may be eligible to receive up to 60% of your covered monthly earnings, up to a maximum amount based on your exemption status. This coverage is **employee-paid (voluntary).** Benefits continue until you recover or reach your Social Security normal retirement age (SSNRA), whichever comes first.

Benefit Percentage	60%
Minimum Benefit	$100
Maximum Benefit	$5000
Elimination Period	180 Days
Maximum Benefit Duration	Social Security Normal Retirement Age

Filing a Long-Term Disability Claim
In order to receive benefits, you must report your disability claim to SunLife if you will be out of work for at least 180 days from the date of your disability.
You can contact SunLife by phone or website.
Contact info can be found on contact list page of this booklet.

Voluntary Benefits

Hospital Indemnity Insurance

Hospital Indemnity insurance is a plan designed to pay for the costs of a hospital admission that may not be covered by other insurance. The plan covers employees who are admitted to a hospital or ICU for a covered sickness or injury. Even if your Medical insurance covers most of your hospitalization, you can still receive payments from your Hospital Indemnity insurance plan to cover extra expenses while you recover.

How does Hospital Indemnity Insurance work?

You pay monthly premiums for your Hospital Indemnity insurance plan. If you are admitted to the hospital for an injury or illness, your Hospital Indemnity plan makes cash payments to you. And

with the payments going directly to you, you can use these emergency funds to pay for costs not covered by your Medical insurance, Medical insurance deductibles, copays and coinsurance, child care expenses while you are in the hospital or cost-of- living expenses as you recover.

Covered Expenses Include:

- Hospital admission
- Hospital confinement
- Hospital intensive care
- Surgical care
- Diagnostic and imaging
- Transportation and lodging

Critical Illness Insurance

While Medical insurance is vital, it doesn't cover everything. If you suffer from a serious illness, such as cancer, stroke or a heart attack, Medical insurance may not provide the coverage you need. Critical Illness insurance will ease the financial strain and help you focus on your recovery.

How Will a Critical Illness Claim Get Paid?

After purchasing Critical Illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a

medical provider. The payment you receive can be used for many things including:

- Childcare costs
- Medical and living expenses
- Travel expenses for you and your family
- Lost wages from missed time at work

Covered Expenses Include:

- Heart attack
- Multiple Sclerosis
- Stroke
- Alzheimer's Disease
- Parkinson's Disease
- Major Organ Failure
- Invasive Cancer (covered at 100%)
- Non-Invasive Cancer (covered at 25%)

Voluntary Benefits

Accident Insurance

Accident insurance pays out a lump sum if you become injured because of an accident — even if the injuries you incur do not keep you out of work. While health insurance companies pay your provider or facility, Accident insurance pays you directly.

How Does Accident Insurance Work?

Accident insurance policies can provide you with a lump sum paid directly to you that will help pay

for a wide range of situations, including initial care, surgery, transportation and lodging and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit
- Coverage is available for you, your spouse and eligible dependent children
- You do not need to answer medical questions or have a physical exam to get basic coverage
- Accident insurance covers injuries that happen off the job — unlike workers' compensation, which only covers on-the-job injuries
- Benefit payments are not reduced by any other insurance you may have with other companies

Covered expenses typically include:

- Emergency room visits
- Hospital stays
- Fractures and dislocations
- Medical exams
- Physical therapy
- Transportation and lodging

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Flexible spending accounts: A benefit that saves you money!

Did you know there's a way to pay your health care expenses and save money at the same time? By enrolling in the flexible spending account (FSA) plan offered by your employer, you can set aside pretax dollars to pay for health care expenses not covered by your other employee benefit plans. That means more money for you and your family!

How do you enroll in the FSA?

- Submit an election form to your employer at the beginning of each benefit plan year
- List the amount of money you want to contribute to your account
- Your deductions are taken in equal installments from your paycheck each pay period
- Since the deductions are taken before taxes, you will not pay taxes on the amount you set aside

Remember…

To maximize the advantages of an FSA, consider your health care expenses carefully.

(*Continued*)

Know your eligible & ineligible expenses

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If you have a health savings account (HSA) or flexible spending account (FSA), you can use pre-tax dollars to cover eligible expenses. To help better understand what is and isn't eligible, we've developed a list of both. For a more detailed list of eligible and ineligible expenses, log in to **umr.com**.

Final determination of coverage is made at the time a claim is received and processed. If a conflict exists between the information provided to you and the terms of the plan, the terms of the plan will control.

Eligible expenses

This list is not meant to be all inclusive.

Dental services/procedures
Dental services
Dental X-rays
Dentures
Exams/teeth cleaning
Extractions
Fillings
Gum treatment
Oral surgery
Orthodontia/braces

Lab exams/tests as part of medical care
Blood tests
X-rays
Cardiographs
Laboratory fees
Metabolism tests
Spinal fluid tests
Urine/stool analyses

Vision services
Eye examinations
Eyeglasses
Contact lenses
Laser eye surgeries
Artificial eyes
Prescription sunglasses
Radial keratotomy/LASIK

Medical treatments/procedures
Acupuncture
Alcoholism (Inpatient treatment)
Body scans
Breast reconstruction surgery following mastectomy
Cancer Screening
Drug addiction
Hearing exams
Hospital services
Infertility
In vitro fertilization
Mastectomy
Norplant insertion or removal
Organ Transplants (Including organ donor)
Physical exam (Not employment related)
Physical therapy
Reconstructive surgery (If medically necessary due to congenital defect or accident)
Speech therapy
Sterilization
Vaccinations/immunizations
Vasectomy and vasectomy reversal
Well baby care

Medical equipment supplies and services
Abdominal/back supports
Ambulance services
Arches/orthopedic shoes
Contraceptive, prescribed
Crutches
Guide dog (For visually/hearing impaired)
Hearing devices and batteries
Mastectomy related bra
Medic alert bracelet or necklace
Oxygen equipment
Prescribed medical and exercise equipment
Prosthesis
Splints/casts or support hose (If medically necessary)
Syringes
Transportation expenses (Mileage and parking)
Wheelchair
Weight loss drugs (To treat specific disease)

Medication
Insulin
Prescribed birth control & vitamins
Prescription drugs

Obstetric services
Lamaze class
Midwife expenses
OB/GYN exams
OB/GYN prepaid maternity fees (Reimbursable after date of birth)
Prenatal and postnatal Treatments

Practitioners
Allergist
Chiropractor
Christian Science
Dermatologist
Homeopath
Naturopath
Osteopath
Physician
Psychiatrist

(Continued)

Over-the-counter eligible expenses

Eligible products include over-the-counter (OTC) products that are for medical care and primarily for a medical purpose. They include products, such as OTC medicines or drugs with or without a prescription that diagnose, alleviate or treat existing or imminent injuries, illnesses or medical conditions, or used for the prevention of disease.

Allergy and sinus medications
- Antihistamines
- Asthma flow meters and nebulizers
- Asthma medicines/ treatments/medicine delivery devices
- Nasal spray and strips

Baby care
- Breast pumps
- Breastfeeding class
- Diaper rash ointment and creams
- Thermometers
- Pediatric electrolyte solutions

Cough, cold and flu medications
- Syrups
- Capsules
- Rubs
- Drops

Condoms and contraceptive devices

Diabetes care/accessories
- Blood test strips
- Glucose tester
- Glucose food
- Monitors and kits

Digestive aids
- Antacids
- Laxatives
- Lactose intolerance medications

Eyecare and vision
- Contact lens solution
- Eye drops
- Reading glasses
- Braille books and magazines

First aid products
- Antibiotics
- Analgesics and ointments
- Antiseptic sprays and washes
- Bug bites and anti-itch medications
- Bandages
- Gauze pads and elastic bandages
- Rubbing alcohol
- Wart removal products
- Supports and braces
- First aid kits
- Wound care products
- Tape and gloves

Foot care
- Cushions
- Pads
- Creams
- Anti-fungal medications

Hemorrhoid treatments and medications

Homeopathic medicines

Incontinence supplies

Lice and scabies treatments

Menstrual products and pain relief
- Tampons
- Pads
- Liners
- Cups
- Sponges
- Disposable or non-disposable underwear for menstruation, or other similar products

Nausea and motion sickness medications

Health monitors and medical equipment
- Blood pressure and heart rate monitors
- Breathalyzer
- Crutches
- Medical bracelets
- Cholesterol test and kits

Pain and fever reducers
- Aspirin
- Acetaminophen
- Ibuprofen
- Menstrual cycle and migraine medications
- Muscle and joint pain relief creams and balms
- Heating pads

Personal Protective Equipment (PPE) for COVID-19
- Hand sanitizer
- Anti-bacterial wipes
- Face masks

Pregnancy products
- Ovulation monitor
- Pregnancy testing kits
- Prenatal vitamins

Smoking cessation products
- Nicotine patches
- Gum and lozenges
- Inhalers

Toothache and teething pain relievers

Potentially eligible services

Expenses that could be considered dual purpose (having both medical and personal benefits) may need a medical practitioner's note explaining the diagnosis and treatment action that is needed for this specific medical condition. This list is not meant to be all inclusive.

- Acne preparations
- Counseling
- Hospital beds
- Infant formula
- Lead paint removal (If not capital expense and incurred for a child poisoned)
- Tuition fee at special school for disabled child
- Learning disability (Special school/teacher)
- Weight loss programs (as prescribed by your doctor)
- Wigs (hair loss due to disease)
- Weight loss drugs to treat a specific medical condition

Ineligible expenses

Expenses to promote general health are not eligible expenses unless prescribed by a physician for a specific medical ailment. This list is not meant to be all-inclusive.

- Babysitting and childcare
- Contact lens or eyeglass insurance
- Cosmetic surgery/procedures
- Dancing/exercise fitness programs
- Diaper service
- Electrolysis
- Hair loss medication
- Hair transplant
- Insurance premiums
- Marriage counseling
- Maternity clothes
- Personal care items
- Personal trainers or exercise equipment
- Vitamins or nutritional supplements
- Swimming lessons
- Teeth whitening/bleaching

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How does FSA work?

- To request reimbursement, you must complete the FSA claim form:
  - Claim forms are located on the UMR member website
  - Mail, upload or fax the document to the address/fax number provided on the form
- When submitting claims for health care, you must include either:
  - A written statement/bill(s) from providers of the service stating that the eligible medical expense(s) have been incurred and the amount of such expenses, or
  - An explanation of benefits (EOB) form from any primary medical and/or dental coverage indicating the amount(s) which you are obligated to pay

The general turn around time is 5-7 business days. A small percentage of claims will occasionally require further substantiation or clarification.

You will receive an EOB with each reimbursement, which provides a year-to-date summary of the status of your account.

What expenses will your FSA cover?

The health care spending account can be used for a variety of expenses that may not be covered by any other source, including the following examples:

- Health coverage deductibles and copayments
- Eye exams, glasses, contacts and corrective laser eye surgery
- Dental care, including braces
- Routine physicals, X-rays and lab fees
- Prescription medication copayments
- Over-the-counter supplies and medications that alleviate or treat injuries or sickness, such as antacids, cold medicines, pain relievers aspirin, menstrual supplies, nasal sprays, fungicides, etc.

Note: Your eligible expenses are listed in your plan document.

Here's an example of how you can reduce your taxes and increase your take-home pay by enrolling in a UMR flexible spending account.

Here's how it works...

You deposit	$1,000 in your FSA
You save	$200 in federal income tax*
You save	$76 in FICA taxes**
You take home	**$276 in yearly tax savings**

*Assumes federal income tax rate of 20%

**Includes Social Security tax rate of 6.2% and Medicare tax rate of 1.45%

(*Continued*)

The UMR FSA program is a benefit so valuable, you can't afford to pass it up!

Plan carefully

To maximize the advantages of participating in the FSA program, consider your health care expenses carefully and estimate your future expenses as closely as possible. (We've included a worksheet in this document to help you.) You can also visit our UMR member website and use the online FSA calculator to help you determine how much money to allocate for the upcoming year.

- All expenses reimbursed by the FSA must be health care services received during the plan year.
- Most plans allow members 120 days after the plan year ends to submit expenses for services received within the plan year. Funds not requested within those 120 days may be forfeited unless your plan allows a carryover or grace period.
- If your plan allows carryover, the funds will be rolled over to the new plan year. Please refer to your flex plan document to confirm your carryover amount.
- If your plan has a grace period, you may still incur claims for up to 75 days after the end of the plan year and be reimbursed from your prior year FSA. Plans with this feature typically allow members to submit expenses for a period of 45 days after the end of the grace period.*
- Once you've selected the amount to be deducted from your pay, you cannot change the amount during the year unless you have a qualified change in status that's permissible under your benefit plan and IRS regulations, such as a change in:
  - Marital status
  - Dependent status
  - Employment status

Determining your spending account expenses

Take time to plan your expected expenses during the coming year. It could save you money. This worksheet gives you a tool to determine how much to contribute to your FSA. Please refer to your plan document for details on your particular benefit plan.

* Not all plans have this feature. Please refer to your plan document for specifics on your plan.

(*Continued*)

Health Care Spending Account Worksheet

This account covers health-related expenses not paid by your medical or dental plans. Please refer to your benefit plan as you complete this worksheet. The following expense items may or may not be covered by your plan:

Expense	Cost estimate
Medical and dental care plan deductible(s)	$
Your share of medical and dental plan expenses above the deductible amount (copayments)	$
Amounts over the customary allowances	$
Medical, dental, vision and hearing care expenses not covered by the plan	$
Eye glasses and contacts	$
Hearing aids	$
Prescription medications	$
Over-the-counter medications and over-the-counter supplies, if allowed by the plan	$
Routine physical exams	$
Other health-related expenses, such as travel	$
Total estimated annual health care expenses	$
Total estimated annual health care expenses divided by the number of pay periods during the plan year	$ *(Per payday contribution)*

Health care FSA contribution amounts are limited due to Health Care Reform Law. Please refer to your plan document for the specific contribution limits allowed by your plan.

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Dependent care FSAs

A benefit for the entire family

Did you know there's a way to pay your dependent care expenses and save money at the same time? By enrolling in the dependent care flexible spending account (FSA) plan offered by your employer, you can set aside pretax dollars to pay for dependent care expenses not covered by your other employee benefit plans. That means more money for you and your family!

How to sign up

You can enroll in a dependent care FSA by filling out a form from your employer at the beginning of your plan year. You will list the total amount of money you want to put in that account.

The money will be taken out in equal amounts from each of your paychecks. It will then be used to pay you back for expenses that qualify according to your plan.

How it works

There are several ways to submit a dependent care claim for reimbursement depending on your plan's options.

You can find a claim form on our website, **umr.com**. You can mail or fax it to the address/fax number listed on the form. You can also download the form, electronically sign it and upload it to the member portal.

(Continued)

What you need to include

A written statement/bill from your service provider. It should state what eligible dependent care expenses you received and the cost.

OR

You can include a completed claim form signed by your dependent care provider in the section to confirm your information is accurate.

What is covered by a dependent care FSA?

Your dependent care FSA covers work-related expenses. You can set aside up to $7,500 a year (the limit per household) to cover expenses like:

- Day care for children under 13 by babysitters, day care centers, nursery schools/preschools (if the primary purpose is to care for the child rather than educate)
- In-home services by a full-time, live-in housekeeper who cares for qualified dependents
- Service for family members who cannot take care of themselves and are dependent on you for more than half of their support. The dependent must spend at least 8 hours a day in the home if care is provided outside the home.

How are dependent care claims processed?

Most dependent care claims are turned around within 3 working days. Dependent care payments are based on the current balance in your account at that time. If the funds are not currently available in your dependent care account when the claim is processed, the payment will not be made until the next contribution is received.

How will I know a claim has been paid?

You will get an explanation of benefits (EOB) each time one of your FSA claims is paid. It will provide a summary of your account to date. Your paid claim will also appear on your member website once it is processed.

(Continued)

Here's how a dependent care FSA works

Here's an example of how you can reduce your taxes and increase your take-home pay by enrolling in a dependent care flexible spending account.

Deposits (reduction in taxable income)	**$4,000**
Federal income tax savings*	**$800**
FICA tax savings**	**$306**
Yearly tax savings, increase in take-home pay	**$1,106**

*Assumes federal income tax rate of 20%

**Includes Social Security tax rate of 6.2% and Medicare tax rate of 1.45%

Plan carefully!

To get the most out of your plan, you should estimate your future expenses as closely as possible.

All expenses must be for services you received during the plan year. Most plans allow you 90-120 days after the plan year ends to submit your expenses for the services you received during the plan year.

It is important to note that funds not requested within those 90-120 days will be forfeited. Not all plans have this feature. Please refer to your plan document for your plan details.

There are a couple of things you can do to estimate your expenses:

- Complete the FSA worksheets provided by UMR
- Visit our UMR member website and use the online FSA calculator

Grace periods

If your plan has a grace period, you may still make qualified FSA purchases up to 75 days after your plan year and be paid back from your prior year FSA.

Plans with this feature usually allow you to submit your expenses up to 45 days after the end of the grace period.

Not all plans have this feature. Please refer to your plan document for your plan details.

Status change exception

You usually cannot change the amount you contribute to your FSA during the plan year. The only exception is if you have a **qualified change in status** permitted by IRS regulations. Those changes include:

- **Marital status**
  (example: marriage or divorce)
- **Dependent status**
  (example: birth of a baby)
- **Employment status**
  (example: loss of job)

(Continued)

Your dependent care FSA worksheet

Dependent care expenses cover expenses not claimed on your income tax return, up to a maximum of $7,500 per household. You must decide whether to use the FSA or claim the tax credit. Please review the terms of your benefit plan as you complete this worksheet.

Expense	Weekly cost	X	Number of weeks	Cost estimate
Day care for children younger than age 13	$	X		$
Day care for a dependent older than age 13 (such as a parent or spouse) who is incapable of self-care due to mental or physical disability	$	X		$
Total estimated annual dependent day care expenses				$
Maximum of $7,500, divided by number of pay periods during the plan year				$

Check your FSA balance online

At **umr.com**, there are no hassles and no waiting – just the answers you're looking for, anytime, night or day.

Sign in now to:

- File a claim online
- Upload receipts and track expenses
- View a copy of your EOB
- View up-to-the-minute account balances
- View your account activity, claims history and payment history
- Download plan information, forms and notifications
- Add or update a direct deposit account

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Important Contacts

Coverage	Contact	Phone	Website
Medical	UMR	800- 826-9781	www.umr.com
Dental (Group # 915682)	SunLife	800-247-6875	www.sunlife.com/us
Vision (Group # 915682)	SunLife/VSP	800-786-5433	www.vsp.com
Basic Life & AD&D (Group # 915682)	SunLife	800-247-6875	www.sunlife.com/us
Voluntary Life & AD&D (Group # 915682)	SunLife	800-247-6875	www.sunlife.com/us
Long Term Disability (Group # 915682)	SunLife	800-247-6875	www.sunlife.com/us
Ross & Yerger Client Manager	Heather Allen	601-944-0952	Hallen@rossandyerger.com
Ross & Yerger Producer	Will Garner	601-944-0960	wgarner@rossandyerger.com
Ross & Yerger Producer	Marcus Burger	601-944-9701	mburger@rossandyerger.com

This benefit summary describes the benefit plans available to you as an employee of Gestalt Community School. The details of these plans are contained in the official plan documents that have been provided to you by your employer, including some insurance contacts.

This summary is meant only to cover the highlights of each plan. It does not contain all the details that are included in your summary plan description as described by the Employee Retirement Income Security Act (ERISA).

If there is ever a question about one of these plans, or if there is a conflict between the information in this summary and the formal language of the plan documents, the formal wording in the plan documents will govern. Please note that the benefits described in the summary may be changed at any time and do not represent a contractual obligation on the part of Gestalt Community School.

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues.

- Retirement, taxes, mortgages, budgeting and more

For additional guidance, we can refer you to a local financial professional and arrange to reimburse you for the cost of an initial one-hour in-person consult.

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Help for New Parents

ParentGuidance℠ supports you through the process of becoming a biological or adoptive parent, including:

- Preparing for the baby emotionally and financially
- Finding child care
- Planning for back-to-work and other issues

Free Online Will Preparation

EstateGuidance® lets you quickly and easily create a will online.

- Specify your wishes for your property
- Provide funeral and burial instructions
- Choose a guardian for your children

GGFL-1597

Contact EAPBusiness Class℠ Anytime

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Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: EAPBusiness

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

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EAPBusiness Class Anytime

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TDD: 800.697.0353
Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: EAPBusiness

Benefits Definitions

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

Copayment

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

High-Deductible Health Plan (HDHP)

A type of health plan that has lower monthly premiums, but higher deductibles and out-of- pocket limits, than a traditional health plan.

HDHPs are often coupled with an HSA (Health Savings Account)

Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

In-Network Provider

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Out-of-Network Provider

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of- network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Benefits Definitions

Out-of-Pocket Maximum

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician

assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Referral

A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

You should read the following notices even if you plan to waive health coverage at this time.

HIPAA Special Enrollment Rights

Loss of Other Coverages
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 the 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 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 plan. However, you must apply within 30 days from the date of your marriage.

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 plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

Women's Health and Cancer Rights Act of 1998
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:

1. All stages of reconstruction of the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and

3. 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. If you would like more information on WHCRA benefits, call your plan administrator.

The Newborns' and Mothers' Health Protection Act (NMHPA)
This was enacted in 1996 to provide protections to mothers and their newborn children with respect to the length of hospital stays after childbirth. Under the NMHPA, group health plans may not restrict mothers' and newborns' benefits for hospital stays after childbirth to less than:

48 hours following a vaginal delivery; and
96 hours following a delivery by cesarean section.

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

Notice of Medicare Part D Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with your plan 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. The Group Health Plan has determined that the prescription drug coverage offered by your Medical 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 Can You Join A Medicare Drug Plan?

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

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage: Visit www.medicare.gov.

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

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

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

COBRA

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

- The parent-employee dies.
- The parent-employees' 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:

1. The end of employment or reduction of hours of employment;

2. Death of the employee.

3. The employee's becoming entitled to Medicare benefits (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.

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 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.

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 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, 2025. your State for more information on eligibility.

ALABAMA - MEDICAID

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA - MEDICAID

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS - MEDICAID

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA - MEDICAID

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+)

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

FLORIDA - MEDICAID

Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA - 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

INDIANA - MEDICAID

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

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS - MEDICAID

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY - 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: 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

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – MEDICAID AND CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA - MEDICAID

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI - MEDICAID

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA - MEDICAID

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-308
Email: HHSHIPPProgram@mt.gov

NEBRASKA - MEDICAID

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA - MEDICAID

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE - MEDICAID

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – MEDICAID AND CHIP

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)

NEW YORK - MEDICAID

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, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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

Health Insurance Marketplace Coverage Options and Your Health Coverage

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.

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.

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. 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 Human Resources.

[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.

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights - You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices - You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures - We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.

We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling
- 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive.
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services
We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court.

Our Responsibilities

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

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

- Effective Date of this Notice – 10/1/2025

Ross & Yerger