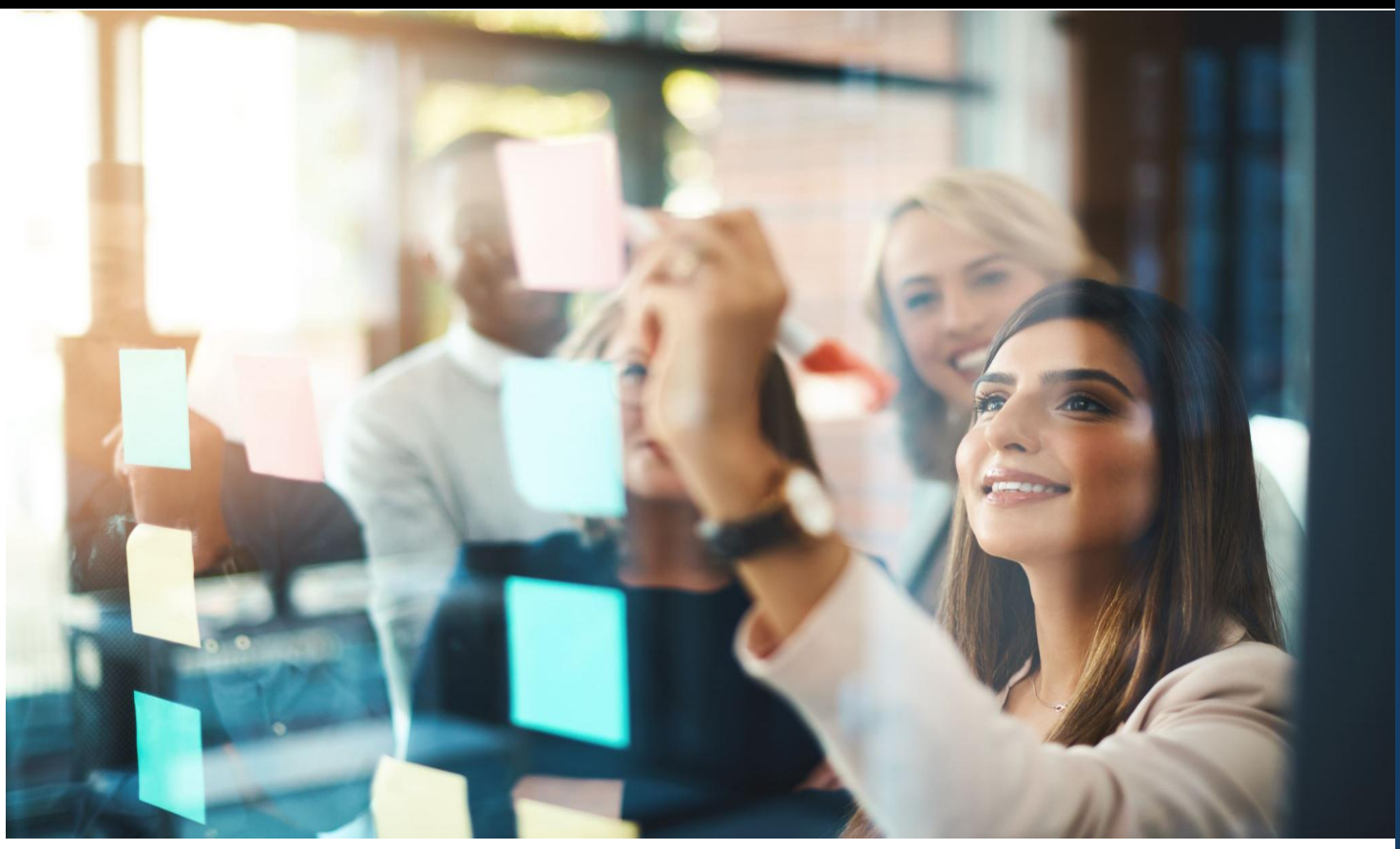
HHM CERTIFIED PUBLIC ACCOUNTANTS

Employee Benefits Guide



2027

Welcome to Your Benefits Guide!

At Henderson Hutcherson McCullough, we're committed to supporting your physical, mental, and financial well-being with a comprehensive and competitive benefits package. Our goal is to provide high-quality benefits while balancing value and affordability.

This guide offers an overview of the benefits available to you, helping you make informed choices for yourself and your family. We encourage you to explore the details and reach out to Human Resources with any questions—we're here to help you make the most of your benefits.

For a quick summary, refer to the Benefits At-a-Glance section on **page 4**. Additional resources, including Summary Plan Descriptions, Summary of Benefits and Coverage, carrier plan documents, and more, are available by logging into Employee Navigator.



Important Notice – Summary of Material Modifications

This Benefits Guide serves as a Summary of Material Modifications ("SMM") to the Summary Plan Description ("SPD") for the HHM Health and Welfare Plan and describes certain changes to the Plan for the 2027 plan year. Please read this Guide carefully and keep it with your SPD and other Plan materials for future reference.

This Guide does not replace the SPD or other governing Plan documents. If there is any discrepancy between the information in this Guide and the official Plan documents, the terms of the official Plan documents will govern. The Plan Sponsor reserves the right to amend or terminate the Plan in accordance with the terms of the Plan documents.

For additional information about the Plan or your benefits, or if you have questions regarding the information contained in this Guide, please contact the Plan Administrator.

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Benefits at a Glance

Your benefits help you stay healthy, protect your income, and plan for the future. They're part of your total compensation at Henderson Hutcherson McCullough – so explore your options, discover what's available to you, and make the most of these resources.

What's Included in Your Benefits Package?

Health and Wellness

- **Medical, Dental, and Vision Insurance** – Choose from a range of plans to find the coverage that best meets your needs.
- **Virtual Visits TextCare** – Save time and money with online or phone visits for conditions that don't require in-person care.
- **Mental and Emotional Well-Being Resources** – Employee Assistance Program (EAP).
- **Wellness Programs** – Access to fitness discounts and wellness incentives.
- **Supplemental Health Benefits** – Add an extra layer of financial protection with optional coverage such as accident and critical illness to help cover unexpected out-of-pocket medical expenses.



Financial Security

- **Health Savings Accounts (HSA)** – Tax-advantaged ways to manage healthcare and dependent care expenses.
- **Dependent Care Flexible Spending Account (DCFSA)** - Tax-advantaged ways to manage healthcare and dependent care expenses.
- **Health Reimbursement Arrangement (HRA)** – Save on healthcare costs with an employer-funded account that helps reimburse eligible medical expenses, reducing your out-of-pocket costs for care.
- **Life Insurance** – Coverage to protect your loved ones in case of the unexpected.
- **Disability Insurance** – Income protection if you're unable to work due to a covered illness or injury.

Eligibility and Enrollment

Who is Eligible?

Employee

Full-time employees working at least 30 hours per week are eligible for benefits on the first of month following 30 days of employment.

Dependents

If you're eligible for benefits, it's likely your dependents are too:

- Your legally married spouse.
- Your children, stepchildren, adopted children (including children placed for adoption), are eligible for coverage up to the age of 26, or beyond age 26 if they are incapable of self-care due to a physical or mental disability.

Electing Your Benefits

- As a new hire, you may participate in the company's benefits on the first day of the month following 30 days of employment.
- Each year, during open enrollment.
- Within 30 days of a qualifying life event as defined by the IRS.

Qualifying Life Events (QLEs)

During Open Enrollment, you have the opportunity to elect the benefit plan that is best for you and your family. Carefully review all your options; once you make an election, you cannot change it until the next enrollment period unless you experience a Qualifying Life Event (QLE), sometimes referred to as a family status change. A QLE is an event that may impact your eligibility or a dependent's eligibility. Examples of QLEs include:

- Marriage, divorce, legal separation, or annulment
- Birth or adoption (including placement for adoption) of a child
- A Qualified Medical Child Support Order
- Death of a spouse or child
- A change in your dependent's eligibility status
- Loss of coverage from another health plan
- Change in your residence or workplace (if your benefit options change)
- Loss of coverage through Medicaid or the Children's Health Insurance Program (CHIP)
- Becoming eligible for a federal or state premium assistance program under Medicare, Medicaid, or CHIP
- Significant cost or coverage changes to your underlying plan
- Enrollment in a coverage option through the federal marketplace or a state-based exchange

If you experience a Qualifying Life Event (QLE), you have 30 days (60 days only when the QLE is the loss of Medicaid or CHIP coverage or becoming eligible for a premium assistance subsidy from Medicaid or CHIP) to notify Human Resources and update your coverage. If you miss this window, you won't be able to make changes until the next annual open enrollment period. Please note that any benefit changes may also affect your premium contributions.

Online Enrollment

Your benefits support physical, mental and financial wellness for you and your family. Take advantage of them!

With the Employee Navigator Online Enrollment System, you and your family can access your benefits information anytime, anywhere. Use Employee Navigator to view plan details, coverage amounts, and costs.

Getting Started

Visit www.employeenavigator.com/benefits/account/login to enroll in your benefits.

First-time users:

Select **Register as a New User** and enter:

- **Company ID: HHMCPAS**

Next, create your username and password. Your password must be at least 8 characters and include 4 unique characters.

Review and accept the Terms of Use, then select Next to continue.

Returning users:

Log in using your existing username and password.

If you need help accessing your account, select **Forgot Username?** or **Forgot Password?**

Once logged in, follow the prompts to review and select your benefits.

Final Step

To submit your benefit elections and beneficiary designations, be sure to select **Click to Sign** on the Enrollment Summary page.

Employee Navigator Mobile App

After completing your registration online, you may download the **Employee Navigator** mobile app for convenient access to your benefits anytime. If your company utilizes SSO through payroll, the app may not be available.

Online Documents

Employee Navigator provides easy access to important benefit documents, including the Summary of Benefits and Coverage (SBC), annual notices, carrier summaries, coverage booklets, and claim forms. These resources offer detailed information on HHM benefit plans to help you plan for care. You and your dependents can access Employee Navigator anytime, from work or home.



Employee Contributions

To make health coverage more affordable, Henderson Hutcherson McCullough pays a substantial portion of the premiums. Your share is deducted from your paycheck, making it easy to stay covered and manage costs.

Monthly Premiums

Medical and Prescription Drugs

Monthly Premiums		Full Premium	Employer Contribution	Employee Contribution
BCBST PPO Network P	Employee Only	$730.32	$279.37	$450.95
	Employee + Spouse	$1,533.67	$146.67	$1,387.00
	Employee + Child(ren)	$1,336.48	$179.32	$1,157.16
	Employee + Family	$2,216.52	$33.89	$2,182.63
BCBST HDHP Network S	Employee Only	$478.25	$620.37	$0.00*
	Employee + Spouse	$1,004.32	$757.78	$246.54
	Employee + Child(ren)	$875.20	$747.28	$127.92
	Employee + Family	$1,451.49	$911.82	$539.67
BCBST HDHP Network P	Employee Only	$524.28	$622.72	$0.00*
	Employee + Spouse	$1,100.99	$762.70	$338.29
	Employee + Child(ren)	$959.43	$751.57	$207.86
	Employee + Family	$1,591.19	$918.84	$672.35

*Please note: Henderson Hutcherson McCullough contributes $142.12 per month to your HSA for BCBST HDHP Network S and $98.44 per month for BCBST HDHP Network P (Individual coverage only).

Dental

Monthly Premiums		Full Premium	Employer Contribution	Employee Contribution
BCBST Base	Employee Only	$28.38	$28.38	$0.00
	Employee + Spouse	$76.78	$28.38	$48.40
	Employee + Child(ren)	$76.78	$28.38	$48.40
	Employee + Family	$76.78	$28.38	$48.40
BCBST Buy-Up	Employee Only	$33.66	$28.38	$5.28
	Employee + Spouse	$104.54	$28.38	$76.16
	Employee + Child(ren)	$104.54	$28.38	$76.16
	Employee + Family	$104.54	$28.38	$76.16

Vision

	BCBST Vision
Employee Only	$8.00
Employee + Spouse	$15.99
Employee + Child(ren)	$16.80
Employee + Family	$26.39

For your convenience, your age-banded Voluntary Life/AD&D and Short-Term Disability premiums have been pre-calculated for you in Employee Navigator.

IRS Code Section 125
The Henderson Hutcherson McCullough benefits plans fall under Section 125 of the IRS Code, allowing you to pay for Medical, Dental, Vision, and Flexible Spending Account contributions with pre-tax dollars. This reduces your taxable income and increases your take-home pay. Because of this tax advantage, the IRS requires your elections to stay in place for the full plan year unless you experience a qualifying event. You may choose to waive participation and pay all contributions with after-tax dollars instead. If you want to do so, contact Human Resources.

Medical Plan Highlights

Medical Benefits*	BCBST PPO Network P	BCBST HDHP Network S	BCBST HDHP Network P
Network Name	Network P	Network S	Network P
Deductible: Individual / Family	$2,500 / $5,000	$8,500 / $17,000	$8,500 / $17,000
Out-of-Pocket Maximum: Individual / Family	$4,600 / $9,200	$8,500 / $17,000	$8,500 / $17,000
HRA Medical Deductible and Out-of-Pocket Maximum: Individual / Family	N/A	The individual is responsible for the first $3,500 of the total individual deductible ($8,500) and the remaining $5,000 is split 80% HHM-HRA ($4,000) and 20% Individual ($1,000). The Family is responsible for the first $7,000 of the family deductible ($17,000) and the remaining $10,000 is split 80% HHM-HRA ($8,000) and 20% Family ($2,000). The out-of-pocket maximum is $4,500 individual and $9,000 for Family.	
Out-of-Pocket Maximum After HRA: Individual / Family	N/A	$4,500 / $9,000	$4,500 / $9,000
Covered Services Overview			
Preventive Care	100%*		
Office Visit - Primary Care Physicians	$50 Copay	Deductible then 100%**	Deductible then 100%**
Office Visit - Specialists	$50 Copay	Deductible then 100%**	Deductible then 100%**
Urgent Care	$50 Copay	Deductible then 100%**	Deductible then 100%**
Emergency Room	$250	Deductible then 100%**	Deductible then 100%**
Most Other Services	70% after deductible	Deductible then 100%**	Deductible then 100%**
Pharmacy - Retail Network			
Preventive	N/A	$10/$35/$60 Copay	$10/$35/$60 Copay
Generic	$10	Deductible then 100%**	Deductible then 100%**
Preferred	$60	Deductible then 100%**	Deductible then 100%**
Non-Preferred	$90	Deductible then 100%**	Deductible then 100%**
Specialty (Self-Administered)	$90	Deductible then 100%**	Deductible then 100%**

*Review plan documents for out-of-network benefits, prior authorization requirements, limits on the number of visits per year and service restrictions.

**Deductible must be met before services are covered at 100%.

Spousal Surcharge

The Medical Plans include a provision that benefit eligible employees may only cover a spouse as a dependent if the spouse does not have access to medical coverage through their employer. If you choose to cover your spouse that has access to other medical coverage through their employer, you will be charged a surcharge of $100 per month. Employees will be required to complete a Spousal Coverage Affidavit each year at open enrollment. The affidavit is located in our enrollment system, Employee Navigator.

GoodRx



Why do I need GoodRx?

Prescription drug prices are not regulated. The cost of a prescription may differ by more than $100 between pharmacies across the street from each other!

How can GoodRx help me?

GoodRx gathers current prices and discounts to help you find the lowest cost pharmacy for your prescriptions. The average GoodRx customer saves $276 a year on their prescriptions. GoodRx is 100% free. No personal information is required.

How do I find discounts for my drug?

It's easy. Just go to www.goodrx.com, type in your drug's name in the search field, and click the "Find the Lowest Price" button. It will even help you spell the name of your prescription. You can also download and use the GoodRx app.

Pharmacy Tips

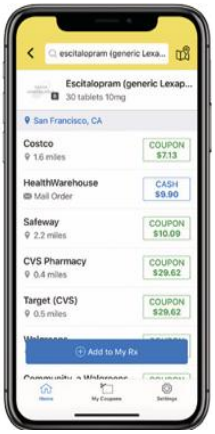
Choose Generics or Over-the-Counter Medications

Save on prescriptions by opting for generics, which have the same active ingredients and safety standards as brand-name drugs.



Check Prices in Advance

Log into your mobile app to compare drug costs by pharmacy location and save money.



Important Note: Do not change or substitute your medication without first consulting your provider, as it may affect your treatment and health.

TextCare

If you need access to medical care, TextCare provides board-certified providers via text message - 24/7.

Services include:

- Direct access to on-demand, high-quality care
- Discuss primary and urgent care needs, chronic condition management and routine medication needs
- Get support finding and scheduling a specialist visit
- Appointments are not required, simply text for care
- Accessible via text message and video chat - there's no app to download and no fees or copays to use the service!
- Available to all those eligible for the Henderson Hutcherson McCullough group health plan



Scan the QR code to save the TextCare contact directly to your phone!

Frequently Asked Questions

Q: How do I contact TextCare?
A: Send a text message to 423-922-8182. Your care team will respond within 5 minutes. Appointments are not required, and there is no app to download.

Q: What can I use TextCare for?
A: Your care team can help with any health or medical question and should be your first point of contact for any issue. Even if your issue cannot be resolved virtually, the care team provides expert care navigation and will refer you to specialty providers.

Q: Will my TextCare team be able to understand my question or issue via text?
A: Yes! You can chat, upload pictures, or one-click into a video visit with your provider.

Q: What if I need additional care outside of TextCare?
A: Your TextCare provider may refer you to other high quality, low-cost providers and specialists.

Q: What if I need medication to treat my diagnosis?
A: Your TextCare provider can prescribe medication, and the prescription will be sent to a local pharmacy.

Q: What if my initial visit requires a follow-up?
A: Your care team will reach out via text message to schedule a follow-up appointment.

Q: Should I go to an Urgent Care or the ER?
A: Many urgent care and emergency room visits end up being unnecessary. TextCare is available to you 24/7 and can help triage the situation to avoid a lengthy trip to the ER. However, we encourage you to call 911 or go to the ER if you are experiencing a medical emergency.

Q: Who is eligible for this service? Can my family use TextCare?
A: Yes! TextCare is available to all those eligible for the Henderson Hutcherson McCullough group health plan.

Q: Will my employer have access to my health information?
A: No! All patient information is strictly confidential. TextCare is managed by One to One Health, a workplace healthcare provider headquartered in Chattanooga, Tennessee. One to One Health complies with all HIPAA and healthcare regulations to maintain your privacy, ensuring your health information is kept confidential.

Employee Assistance Program

When life gets tough, it's helpful to have someone in your corner to listen.
That's what you get from DisabilityGuidance—an employee assistance program that offers confidential counseling for individuals covered under a Symetra group disability policy.

Program Highlights

Up to **five** confidential sessions with a counselor, financial planner or attorney are available to you and your eligible family members each calendar year. An additional five sessions are available if you have a covered disability claim. Sessions are per household and may be divided among the three types of professionals. While all types of sessions can be held over the phone, in-person counseling sessions are also available. These services are included in the overall premium, so no additional payment is required to use the program.

Confidential counseling
Trained counselors with a master's or doctorate degree are just a phone call away to provide you the right resources for stress, anxiety, job pressures, substance abuse, and grief and loss.

Legal support
Talk to an attorney about legal concerns such as divorce, real estate transactions, debt and bankruptcy, and more.

Need legal representation?
A general guidance consultant will refer you to a qualified attorney in your area for a free 30-minute consultation. Any customary legal fees after that are reduced by 25%.

Financial information and resources
A certified public accountant or financial planner can provide financial information and guidance on topics like debt, taxes, retirement planning, credit card or loan problems, and more.

Online Resources and Tools

Get trusted, professional information about relationships, work, school, children, wellness, legal or financial issues, and more.

Turn to GuidanceResources® online for:
- Timely articles, tutorials, videos and self-assessments.
- "Ask the Expert" personal responses to your questions.
- Searches for child or elder care, attorneys and financial
- planners.

Call ComPsych with any questions or for more information:

Phone: 1-888-327-9573
TDD: 1-800-697-0353

First-time users, follow these simple steps:

1. Go to guidanceresources.com and click "Register."
2. Provide your organization web ID: **SYMETRA**
3. Create a user name and password.

If you have problems registering or logging in, send an email to memberservices@compsych.com or call 1-888-327-9573.

Preventive Care

As part of your Henderson Hutcherson McCullough medical plan, preventive care is covered at no cost when you use an in-network provider. Preventive care is an effective way to detect health issues early, when they're most treatable, so it's important to get your annual checkup and recommended screenings.

Preventive Care is Covered 100% With In-Network Providers!

Preventive Care Covered for All Adults

- Wellness visits and screenings, including blood pressure, cholesterol, diabetes, depression, and others
- Screenings for certain types of cancer, including lung cancer
- Alcohol and tobacco use screening and counseling
- HIV and Hepatitis B/C screenings (for certain ages and risk factors) and HIV prevention medication
- Obesity screening and counseling
- Certain vaccinations (Flu, COVID-19, Hepatitis A & B, HPV, MMR, Tdap, and others)

Preventive Care for Women (Including Pregnant Women)

- Well-woman visits
- Osteoporosis screening (for women 65+ or younger with risk factors)
- Gestational diabetes screening (for pregnant women)
- Preeclampsia screening (during pregnancy)
- STI screenings and counseling
- FDA-approved birth control methods (pills, IUDs, implants, etc.) and counseling
- Lactation counseling and breast pump coverage

Preventive Care for Children and Adolescents

- Wellness screenings, including vision, hearing, depression, and others
- Newborn screenings (hearing, PKU, sickle cell, hypothyroidism, etc.)
- Autism screening (at 18 and 24 months)
- Obesity screening and counseling
- Certain vaccinations (DTaP, Polio, MMR, Hepatitis A & B, Flu, HPV, COVID-19, and more)



Wellness Benefits/Programs

Program Details

This Henderson Hutcherson McCullough program is designed to promote the health and wellness of Henderson Hutcherson McCullough employees by partially reimbursing the employee for expenses associated with approved health/physical fitness club memberships. It is meant to reimburse Henderson Hutcherson McCullough employees for expenses related to the employee's activity only.

Henderson Hutcherson McCullough will reimburse ½ of employee's monthly dues for health club memberships up to a maximum of $360 per year ($30 per month). This benefit does not apply in Chattanooga, TN.

As a condition of participating in the plan Staff Member agrees to:

- Fill out and sign the Henderson Hutcherson McCullough Health Club Reimbursement Agreement form.
- Provide proof of membership and dues and submit to Human Resources with this document upon signing up for the plan.
- Verify membership fees annually upon request.
- Notify Henderson Hutcherson McCullough if your health club membership terminates.
- Reimburse Henderson Hutcherson McCullough by payroll deduction for any months which reimbursement was received while not a member of a health club.

Please see Human Resources for details regarding approved facilities.



Health Reimbursement Arrangement

A Health Reimbursement Arrangement (HRA) is an employer-funded account that helps pay deductible and out-of-pocket expenses for you and your covered dependents. The purpose of the HRA is to contribute toward the payment of in-network deductible expenses incurred by you, as an employee, or for one of your covered family members.

Employees and covered dependents enrolled in the BCBST HDHP Network S & BCBST HDHP Network P plan are automatically enrolled in the HRA administered by BCBS Tennessee.

How the HRA Works

Your BCBS Tennessee plan has an embedded HRA. Follow along with the example below to better understand how the HRA will help pay for medical expenses.

To learn more about the underlying plan with BCBS Tennessee, see BCBS Tennessee plan documents.

	BCBST HDHP Network S & BCBST HDHP Network P	
HRA Example	**Individual Maximum**	**Family Maximum**
You pay first:	$3,500	$7,000
HRA pays second:	80% of remaining deductible ($4,000)	80% of remaining deductible ($8,000)
You pay remaining:	20% of remaining deductible ($1,000)	20% of remaining deductible ($2,000)
Employee TOTAL Out-of-Pocket Maximum	**$4,500**	**$9,000**

Individual limits may still apply.

Please Note:

Copays are an out-of-pocket expense that count toward your underlying out-of-pocket maximum, but copays are not eligible for HRA reimbursement.



Health Savings Account

A Health Savings Account (HSA) is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses or to use as a retirement savings tool.

If you enroll in our HSA-eligible medical plan—BCBST HDHP Network S & BCBST HDHP Network P — you are eligible to enroll in the HSA offered by Henderson Hutcherson McCullough and administered by HealthEquity.

Henderson Hutcherson McCullough will also contribute to your HSA! See the chart below for the IRS-mandated annual contribution maximums, as well as the company's contribution amounts.

	IRS Annual Contribution Limit
Employee Only	$4,500
Employee + Family	$9,000
Catch Up Contribution for Age 55 and Over	$1,000

The IRS allows you to contribute the maximum annual contribution as long as you remain eligible through December 31 of the following year. If you are concerned that you may not remain eligible for the entire period, you may wish to prorate contributions based on the number of months you were HSA eligible.

What Types of Healthcare Expenses Can an HSA Pay For?

There are thousands of HSA-eligible items. The list includes, but is not limited to:

- Coinsurance, copays, and deductibles
- Medical care and prescriptions
- Dental care and orthodontia
- Eye exams, eyeglasses, and LASIK surgery
- Eligible over-the-counter medications and supplies

For a complete list of IRS-qualified healthcare expenses, visit **irs.gov/publications/p502** or scan this QR code.

Using Your Funds

Upon enrollment, HealthEquity will send you a debit card, which can be used at the time of purchase of HSA-eligible items.

The account acts like a regular checking account with a debit card that accrues interest. All money in the account is owned by you and is fully vested as soon as it is deposited. Funds can accumulate over time and the account is portable. **Any unused monies left in your HSA at the end of the calendar year will roll over to the next year for you to use.**

When you use the funds for qualified health expenses, you will not pay taxes. If you use the money for other expenses, you'll pay a tax and a penalty fee.

Dependent Care Flexible Spending Account (DCFSA)

A Dependent Care Flexible Spending Account (DCFSA) is a tax-advantaged benefit that allows you to set aside pre-tax dollars to pay for eligible dependent care expenses. By contributing through payroll deductions before taxes are calculated, you can reduce your taxable income and save money on qualified care expenses.

This plan helps cover eligible childcare or disabled dependent care expenses while you work. You can contribute on a pre-tax basis per plan year:

- $7,500 if single or married filing jointly
- $3,750 if married and filing separately

Eligible expenses include:

- Licensed nursery schools, qualified childcare centers, and preschool
- After-school programs and summer camps (for children under 13)
- Adult daycare facilities

How the DCFSA Works

- Elect an annual contribution amount during enrollment.
- Contributions are deducted from your paycheck on a pre-tax basis.
- Pay for eligible dependent care expenses.
- Submit claims for reimbursement to HealthEquity.

Important DCFSA Rules

- Dependent Care FSA: Unused funds will NOT be returned to you or carried over to the following year. You must incur claims for reimbursement prior to December 31st of each plan year.

HealthEquity®



Dental Benefits



The Henderson Hutcherson McCullough dental plan helps you save on essential care, making services like cleanings, exams, and procedures more affordable. It also supports your long-term oral health by covering preventive care, helping you avoid serious dental issues. Henderson Hutcherson McCullough provides dental coverage through BCBS Tennessee.

BCBS Tennessee PPO Plan

You'll get the highest benefits and lower out-of-pocket costs when using a BCBS Tennessee network dentist. If you visit a non-network dentist, you'll be responsible for the difference between the covered amount and the actual charges, and you may need to file claims.

Dental Plan Name	BCBST Base	BCBST Buy-Up
In-Network Benefits		
Calendar Year Maximum	$1,000	$2,000
Deductible: Individual / Family	$50 / $150	$50 / $150
Preventive Services: Exam, Cleaning, X-Rays, Sealants	100%	100%
Basic Services: Fillings, minor Oral Surgery, periodontic services	80%	80%
Major Services: Crowns, Dentures and Bridgework, periodontic surgery, anesthesia, Root Canals	50%	50%
Orthodontia: - Covered members - Benefit percentage - Lifetime maximum	 Not covered Not covered Not covered	 Children only (up to age 26) 50% $1,500

For Additional Dental Benefit Resources

Go to **https://bcbst.com** or call 800-565-9140.

Vision Benefits

The Henderson Hutcherson McCullough vision plan helps you save on eye care and eyewear. With coverage for exams, prescription glasses, contact lenses, and more, you can keep your vision healthy while reducing out-of-pocket costs.



Your vision health is important. Henderson Hutcherson McCullough offers coverage through BCBS Tennessee to help you stay on top of eye care. Regular exams detect vision changes, spot health issues, and keep you seeing clearly.

What to Remember:
Save money and time by choosing an in-network provider.
- In-network: Pay a copay at the time of service.
- Non-network: Pay the full cost upfront and submit a claim for reimbursement.

Vision Plan Name	BCBST Vision
Network Name	EyeMed
In-Network Benefits	
Copay - Examination - Materials	 $10 copay $10 copay
Lenses (12 Months) - Single vision - Bifocal - Trifocal	 $10 copay $10 copay $10 copay
Frames (12 Months)	Up to $150 allowance; 20% off balance over allowance (in-network)
Contact Lenses (12 Months) in lieu of frames and lenses - Fit & Follow up - Elective - Medically Necessary	 $55 copay Up to $150 allowance; 20% off balance over allowance (in-network) No charge after copay

For Additional Vision Benefit Resources

Go to **https://bcbst.com** or call 800-565-9140.

Where to Go for Care

Choose the right healthcare resource. Where you go for medical services can make a big difference in how much you pay and how long you wait to see a healthcare provider. Here is a brief outline to help guide you through the different healthcare setting options:



Virtual Care

For your convenience, you have access to licensed doctor visits by phone through TextCare. For more details on Virtual Visits and the conditions they best address, please see **page 10.**

In-Person Care

Your Doctor's Office
Visiting your doctor's office for non-urgent care is a cost-effective choice when you need in-person care, especially if telemedicine isn't available or suitable for your condition.

Retail Clinics
Retail clinics, found in pharmacies, supermarkets, and retail stores, offer affordable, convenient care for in-person, non-urgent needs—an easy alternative to a doctor's office visit. Retail clinic visits are good options for conditions such as:

- Cold or flu
- Sinus infections
- Mild allergies
- Vaccinations or basic screenings
- Minor sprains, burns, or rashes
- Headaches or sore throats

Urgent Care / Walk-in Clinics

Urgent care centers, sometimes called walk-in clinics, are often open in the evenings and on weekends, making them a convenient place to go when you need non-emergency care. Urgent Care is a good option for conditions such as:

- Cold, flu, and fever
- Strains, sprains, and breaks
- Infections
- Rashes/Mild burns
- Ear pain
- Animal or insect bite
- Fever over 101.5°

Important! Some facilities that look like urgent care clinics are actually freestanding emergency rooms, which may not be in-network. These can cost as much as—or more than—a hospital ER. Always check with your healthcare provider to confirm network participation and avoid unexpected costs.

Emergency Room

Hopefully, you'll never need it, but for true emergencies, always go to the **emergency room**. Some examples of emergencies include:

- Severe chest pain
- Sudden shortness of breath
- Signs of a possible stroke
- Open wounds
- Sudden or unexplained loss of consciousness
- Broken bone
- Severe burn or bleeding

For non-emergencies, the Emergency Room can mean long waits and high costs, and some health plans may not fully cover the visit. When possible, consider urgent care or telehealth for faster, more affordable care.

Life and AD&D Benefits

Life insurance protects your loved ones in unexpected times of need.

Symetra Basic Life and AD&D Benefits

Life insurance provides financial protection for your loved ones in the event of your death, easing their burden during a difficult time. It helps cover funeral costs, outstanding debts, and daily expenses, ensuring their financial stability and well-being.

Henderson Hutcherson McCullough provides you with Basic Life insurance coverage equal to $15,000. This coverage protects your family or other beneficiaries in the event of your death while you are actively employed with the company.

Accidental Death and Dismemberment (AD&D) coverage offers an additional benefit if your death results from a covered accident or injury.

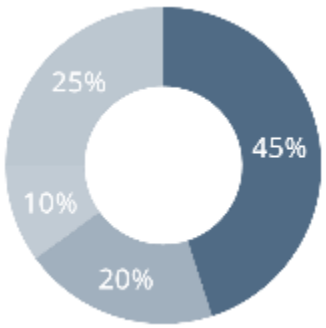
Life benefits will decrease with age and end upon retirement or leaving the company. See Human Resources for more information.

Basic Life and AD&D	Coverage
Life Benefit	$15,000
Accidental Death and Dismemberment Benefit	$15,000

Important Facts About Beneficiaries

Beneficiaries are the individuals or entities you choose to receive benefits from your policy. If you don't designate a beneficiary, benefits will be paid to your estate. Here's what you need to know:

- You can change your beneficiary at any time.
- You may designate one or multiple beneficiaries and allocate payment percentages accordingly.
- To select or update your Life Insurance beneficiary, visit Employee Navigator.
- Note: If you live in a community property state (e.g., California), your spouse must consent to any primary beneficiary other than them.



Voluntary Life and AD&D Benefits

In addition to company-provided Basic Life and AD&D coverage, you can purchase additional Term Life and AD&D insurance at discounted group rates through Symetra. This coverage is paid with after-tax dollars via convenient payroll deductions.



Voluntary Life and AD&D	Employee	Spouse	Child(ren)
Increments	$10,000	$5,000	$10,000
Maximum Benefit	$300,000	$150,000	$10,000 (birth to 2 weeks: $1,000; 2 weeks to 6 months: $2,000)
Guarantee Issue Amount	$100,000	$10,000	$10,000

Life benefits gradually reduce with age and will end upon termination of employment or retirement, unless converted into an individual policy.

Guarantee issue is a pre-approved amount of coverage that does not require proof of good health. It is available during your initial eligibility period (upon hire). If you are outside your initial eligibility period, you can apply for Voluntary Life and AD&D insurance at any time, but proof of good health is required. This means completing a health questionnaire (Evidence of Insurability), with coverage subject to Symetra's approval based on a review of your health history.

Voluntary Life and AD&D Rates: See Employee Navigator.

Disability Benefits

Disability insurance helps replace your income if you're unable to work due to illness or injury. It helps provide you with financial security when you need it most. Henderson Hutcherson McCullough offers Short-Term and Long-Term Disability benefits to all eligible employees.

Symetra Short-Term Disability (STD) protects your paycheck, replacing lost income if you're unable to work due to a short-term illness, injury, or pregnancy. This voluntary benefit is 100% employee-paid. Log into Employee Navigator for rates.

Symetra Long-Term Disability (LTD) protects your income by providing long-term financial support if you're unable to work due to a qualifying injury or illness. Benefits can continue up to SSNRA. This coverage is provided by Henderson Hutcherson McCullough at no cost to you.

Disability Benefits	Short-Term Disability	Long-Term Disability
Benefit Amount	60%	66.67%
Benefit Maximum	$2,000 per week	$5,000 per month
When Benefits Begin	Accident: 7 days / Illness: 7 days	90 days
Maximum Benefit Duration	13 weeks	SSNRA
Pre-Existing Condition Limitation	3 / 12	3 / 12



Supplemental Health Benefits

Customize Your Benefits Package with Supplemental Health Benefits. You may purchase additional insurance from Symetra that will help to cover additional out-of-pocket expenses. These policies offer direct-to-the-policyholder cash payouts to help cover what other insurance doesn't. Coverage options are available for you, your spouse, and your child(ren). Your premiums are paid through payroll deductions on an after-tax basis. These policies are portable, which means that you can keep them should you change jobs or retire.

Symetra | Accident

The Accident plan pays you benefits to help cover out-of-pocket medical and other costs in case of an off-the-job accident.

Symetra | Critical Illness

The Critical Illness plan helps you protect you and your family from the unexpected cost of fighting a life-threatening illness. Cancer is covered under Critical Illness policy.

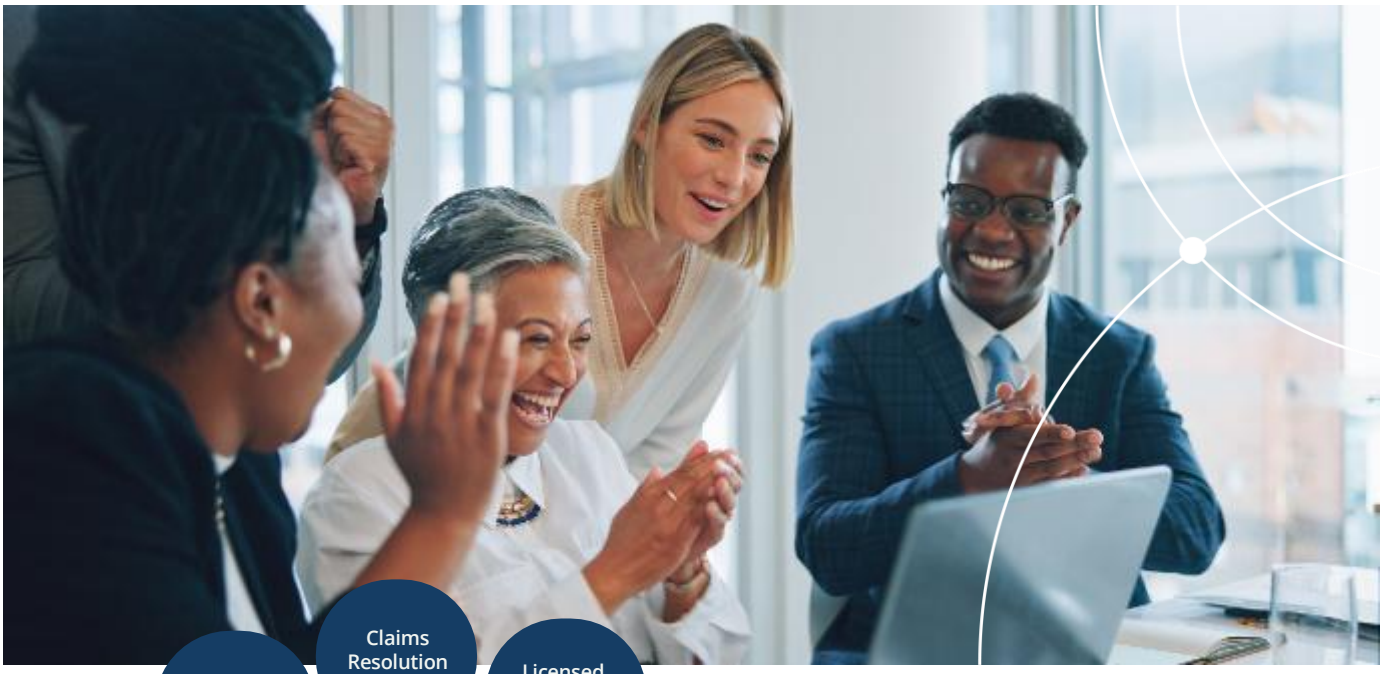
To learn more about our Supplemental Health plans, visit **https://symetra.com** or call 800-796-3872.

Plan Name	Symetra Accident	Symetra Critical Illness
Covered Conditions	Ambulance, ER visits, Fractures, Dislocations, Major Diagnostic Exams, and more	Pays 100% of the following conditions: Invasive Cancer Stroke Heart Attack Major Organ Failure Occupational HIV End Stage Renal Failure Loss of Sight Loss of Speech Pays 25-30% of the following conditions: Sudden Cardiac Arrest Transient Ischemic Attack (mini stroke)
Wellness Benefit	$75	$50
Guarantee Issue (without medical questions)	Full Benefit Amounts	Employee: Up to $5,000, $10,000, $15,000, $20,000, or $25,000 Spouse: 50% of the Employee up to $12,500 Child(ren): $5,000 or $10,000

Important Disclaimer: Voluntary benefits are not directly sponsored or endorsed by your employer and are offered as optional coverage opportunities through third-party issuers based on your status as an employee. These benefits are exempt from many requirements of the Employee Retirement Income Security Act (ERISA), allowing employees to partner with external providers for participation.

Employee Care Center

The Employee Care Center (ECC) is here to advocate on your behalf and provide benefits education to empower you to make smart decisions for your own health and the health of your family. Their dedicated HIPAA-certified team of licensed Benefits Specialists can assist you with any benefits-related questions like claim resolution, benefit enrollment assistance, benefit education, and healthcare decision support. The ECC's mission is to ensure that your needs are met accurately and timely.





The ECC Team is here to help explain benefit plan offerings during Open Enrollment and throughout the year. They can guide you on how to access carrier sites to order ID cards and locate network providers. Additionally, the ECC Team can assist with escalated claims and advocate on your behalf.

Scan QR Code for ECC Card

Available Monday through Friday 8 am to 5 pm EST
Contact: 866-784-2242 or mybenefits@baldwin.com

Important Contacts

For general questions or assistance about your eligibility, payroll, life events or registration for open enrollment, contact Human Resources at 423-756-7771 or **slapinski@hhmcpas.com**.

Benefit Plan	Carrier	Phone Number	Website | Email
BCBS Tennessee Medical Benefits	BCBS Tennessee	800-565-9140	**https://bcbst.com**
Virtual Visits	TextCare	423-922-8182	N/A
Employee Assistance Program	Symetra	888-327-9573	**www.guidanceresources.com**
Supplemental Health Benefits	Symetra	800-796-3872	**https://symetra.com**
Health Savings Account	HealthEquity	866-889-8583	**https://healthequity.com**
Dependent Care Flexible Spending Account	HealthEquity	866-346-5800	**https://healthequity.com**
Dental Benefits	BCBS Tennessee	800-565-9140	**https://bcbst.com**
Vision Benefits	BCBS Tennessee	800-565-9140	**https://bcbst.com**
Life and AD&D Benefits	Symetra	800-796-3872	**https://symetra.com**
Disability Benefits	Symetra	800-796-3872	**https://symetra.com**
Employee Care Center	The Baldwin Group	866-784-2242	**mybenefits@baldwin.com**



Annual Notices

NOTE: If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the MEDICARE PART D NOTICE in this booklet for more details.

V2025.09.15

This package contains important information about your employee benefit plans. The notices included in this package describe certain rights, protections, and responsibilities that may apply to you and your eligible dependents under federal law and the terms of the plans.

Topics addressed in these notices may include health plan enrollment rights, privacy practices, wellness program information, prescription drug coverage, and other benefit-related provisions. Please review these materials carefully and keep them for future reference.

Following please find an index of the notices and disclosures incorporated below:

Index of Notices

Title of Notice or Disclosure	Page
Notice of HIPAA Special Enrollment Rights	-27-
Newborns' and Mothers' Health Protection Act	-27-
Women's Health and Cancer Rights Act	-27-
HIPAA Notice of Privacy Practices – Notice of Availability	-27-
Premium Assistance Under Medicaid & Children's Health Insurance Programs ("CHIP")	-27-
Your Rights and Protections Against Surprise Medical Bills	-31-
General Notice of COBRA Continuation Coverage Rights	-32-
Medicare Prescription (Part D) Creditable Coverage Notice	35-

PLAN ADMINISTRATOR CONTACT INFORMATION

Many of the notices contained in this package describe rights, protections, enrollment opportunities and other actions that may require you to contact the Plan Administrator identified below. If you have questions regarding any notice contained in this package, would like additional information about your benefit plans, or wish to exercise any rights described in these notices, please contact:

Plan Administrator:
Henderson, Hutcherson, McCullough PLLC
1200 Market Street | Chattanooga, TN 37402
Benefits Department
423-702-7225 | slapinski@hhmcpas.com

NOTICE OF HIPAA SPECIAL ENROLLMENT RIGHTS

If you are eligible for coverage under the plan but decline enrollment for yourself or your dependents (including your spouse) because of other health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer sponsoring the other coverage stops contributing toward the cost of that coverage). You must request enrollment within 30 days after the loss of coverage or cessation of employer contributions.

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

You may also have a special enrollment right if you or your dependent loses eligibility for Medicaid or a Children's Health Insurance Program (CHIP) plan or becomes eligible for a state Medicaid or CHIP premium assistance subsidy. In these circumstances, you must request enrollment within 60 days of the applicable event.

To request special enrollment or obtain more information, contact your plan administrator.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles, copayments and coinsurance applicable to other medical and surgical benefits provided under this plan. These benefits will be provided in accordance with federal law.

HIPAA NOTICE OF AVAILABILITY OF THE NOTICE OF PRIVACY PRACTICES

Federal law requires certain health plans and health insurance issuers to maintain and provide a HIPAA Notice of Privacy Practices that describes how protected health information may be used and disclosed, as well as the rights individuals have regarding their health information.

The Notice of Privacy Practices is available upon request. To obtain a copy of the Notice of Privacy Practices applicable to your health coverage, contact the Plan Administrator, your employer's Human Resources Department, or your health insurance carrier, as applicable.

You may also have the right to receive a paper copy of the Notice of Privacy Practices at any time, even if you have previously agreed to receive the notice electronically.

If you have questions regarding the Notice of Privacy Practices or your privacy rights, please contact the appropriate Plan Administrator or insurer.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ **Phone: 1-855-692-5447**	**The AK Health Insurance Premium Payment Program** **Website: http://myakhipp.com/** **Phone: 1-866-251-4861** **Email: CustomerService@MyAKHIPP.com** **Medicaid Eligibility:** **https://health.alaska.gov/dpa/Pages/default.aspx**
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ **Phone: 1-855-MyARHIPP (855-692-7447)**	**Health Insurance Premium Payment (HIPP) Program** **Website:** **http://dhcs.ca.gov/hipp** **Phone: 916-445-8322** **Fax: 916-440-5676** **Email: hipp@dhcs.ca.gov**
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: **https://www.healthfirstcolorado.com/** **Health First Colorado Member Contact Center:** **1-800-221-3943/State Relay 711** **CHP+: https://hcpf.colorado.gov/child-health-plan-plus** **CHP+ Customer Service: 1-800-359-1991/State Relay 711** **Health Insurance Buy-In Program** **(HIBI): https://www.mycohibi.com/** **HIBI Customer Service: 1-855-692-6442**	**Website:** **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html** **Phone: 1-877-357-3268**
GEORGIA – Medicaid	**ILLINOIS – 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**	**Illinois Medicaid Premium Assistance Information** **Medicaid application website: https://abe.illinois.gov** **HIPP Hotline Number: 217-524-8268** **HIPP Email: hfs.boc.hipp@illinois.gov**
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**

Health Insurance Premium Payment Program **All other Medicaid** **Website: https://www.in.gov/medicaid/** **http://www.in.gov/fssa/dfr/** **Family and Social Services Administration** **Phone: 1-800-403-0864** **Member Services Phone: 1-800-457-4584**	**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	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ **Phone: 1-800-792-4884** **HIPP Phone: 1-800-967-4660**	**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	**MAINE – Medicaid**
Louisiana Medicaid Website: **https://www.ldh.la.gov/healthy-louisiana** **Medicaid Customer Service Line: 1-888-342-6207** **Louisiana Medicaid email: healthy@la.gov** **Louisiana Health Insurance Premium Program (LaHIPP) Website:** **https://www.ldh.la.gov/lahipp** **LaHIPP phone: 1-877-697-6703** **LaHIPP email: La.HIPP@la.gov** **LaHIPP fax: 1-888-716-9787** **LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084**	**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	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa **Phone: 1-800-862-4840** **TTY: 711** **Email: masspremassistance@accenture.com**	**Website:** **https://mn.gov/dhs/health-care-coverage/** **Phone: 1-800-657-3672**
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** **Phone: 573-751-2005**	**Website:** **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** **Phone: 1-800-694-3084** **Email: HHSHIPPProgram@mt.gov**
NEBRASKA – Medicaid	**NEVADA – Medicaid**

Website: http://www.ACCESSNebraska.ne.gov **Phone:** 1-855-632-7633 **Lincoln:** 402-473-7000 **Omaha:** 402-595-1178	**Medicaid Website:** http://dhcfp.nv.gov **Medicaid Phone:** 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	**Medicaid Website:** https://www.nj.gov/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	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ **Phone:** 1-800-541-2831	**Website:** https://medicaid.ncdhhs.gov/ **Phone:** 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare **Phone:** 1-844-854-4825	**Website:** http://www.insureoklahoma.org **Phone:** 1-888-365-3742
OREGON – Medicaid and CHIP	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx **Phone:** 1-800-699-9075	**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)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ **Phone:** 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	**Website:** https://www.scdhhs.gov **Phone:** 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov **Phone:** 1-888-828-0059	**Website:** Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services **Phone:** 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
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/	**Website:** Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access **Phone:** 1-800-250-8427

VIRGINIA – Medicaid and CHIP	WASHINGTON – Medicaid
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**	**Website:** https://www.hca.wa.gov/ **Phone: 1-800-562-3022**
WEST VIRGINIA – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
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)**	**Website:** https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm **Phone: 1-800-362-3002**
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ **Phone: 1-800-251-1269**	

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 5/31/2029)

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine,

anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Help Desk at 1-800-985-3059 or visit the CMS No Surprises website at www.cms.gov/nosurprises for more information about your rights under federal law.

Note: For insured medical plans, additional state law balance billing protections may apply. For details, please visit the insurance carriers web page or refer to a recent Explanation of Benefits for more information.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

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

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

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

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

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

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

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

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

How is COBRA continuation coverage provided? Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- ***Disability extension of 18-month period of COBRA continuation coverage.*** If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
- ***Second qualifying event extension of 18-month period of continuation coverage.*** If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends? In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

For more information visit. https://www.medicare.gov/medicare-and-you, or https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you have questions. Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes. To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator

MEDICARE PRESCRIPTION (PART D) CREDITABLE NOTICE

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 to demonstrate whether you have maintained creditable coverage and, whether you are required to pay a higher premium (a penalty) as a consequence thereof.

Important Notice About Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. **This information can help you decide whether 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. Your employer has determined that the prescription drug coverage offered by **BCBST** 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 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current prescription drug coverage through the employer will not be affected.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen

months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact your employer for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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This Employee Benefits Guide provides an overview of some of your benefit plan choices. It is for informational purposes only. It is not intended to be an agreement for continued employment, nor is this guide a legal plan document. If there is a disagreement or an ambiguity between this guide and the official plan documents, the provisions of the plan documents will govern.

In addition, the plans described in this guide are subject to change without notice. Continuation of any benefit plan or coverage is provided in compliance with federal and state laws. If you need additional information or have any questions about the benefits program, please contact Human Resources.

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