WENSPOK COMPANIES™

2026
TEAM MEMBER BENEFITS GUIDE

Benefit Enrollment

Newly Eligible Team Members

As a newly eligible team member, you are eligible for benefits the first of the month following 60 days of employment. New Crew Members are required to work for Wenspok for one year and average 30 hours per week over the course of the year to become eligible for the benefits.

Current Team Members

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

Any changes you make during open enrollment become effective January 1.

Changing Your Benefits During the Year

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

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

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

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

Online Enrollment

Both new team member benefits enrollment and open enrollment is done online through the **ADP** website.

In order to complete your enrollment, you need:

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

Need to Know Updates and Info

- What is new with you? Did you have a baby, get married?
- Online Enrollment dates:
  - **November 24th, through December 8th, 2025**

2026 Open Enrollment Announcements

Open enrollment for your 2026 benefits will be **Monday, November 24th through Monday, December 8th**. You'll be able to complete your elections easily and securely online.

Once the ADP portal is live, you'll receive a welcome email with instructions to get started. We understand how important it is to choose the right coverage for you and your family, so we've designed the process to be as smooth and hassle-free as possible.

Important: **This is a passive enrollment, meaning if you do not log into ADP to make changes, your current benefit elections will automatically carry over into 2026. All elections made during this period will take effect on January 1st, 2026.**

2026 MEDICAL PLAN UPDATES

We're renewing our medical coverage with Gravie, but there are several key changes to the plan design:

- **Network Transition**: The medical network is moving from Aetna to Cigna OAP. The following facilities will no longer be in-network:
  - CERIS, Inc.
  - Post Falls Hospital, LLC
  - Pacwest Healthcare

  Find an in-network provider here: CIGNA Provider Directory
- **Pharmacy Benefit Manager**: The PBM is changing to Express Scripts. If this affects you, Gravie will contact you directly. Expect communication in November.

  Find where your prescription may land on the formulary: Here
- **ComfortFit Plan Adjustments:**
  - Out-of-Pocket Maximum will increase from $7,900 to $8,500
  - Emergency Copay will be $950
  - Advanced imaging will be no charge after OOPM
  - Prescriptions: If a generic alternative is available but not chosen, the prescription cost will apply toward your out-of-pocket maximum (OOPM) instead of copay **brand formulary and brand non-preferred tiers*

MEDICAL RATE CHANGES & TAX SAVINGS

Due to rising healthcare costs, we've made thoughtful plan design changes to help manage premiums for all participants. While employee rates will increase, there's a silver lining: higher payroll deductions can help reduce your taxable income, potentially saving you money.

Example:

Jane Doe earns $60,000 annually	>	Monthly Premium Increase: $50 Her monthly premium increases from $200 to $250	>	Annual Pretax Deduction Increase: $600 Estimated tax savings (22% bracket): $132

Bottom Line: Pretax deductions help offset premium increases and keep more money in your pocket.

OTHER BENEFIT CHANGES

Our dental, vision, group life & AD&D, voluntary life and AD&D, and worksite benefits (Accident and Critical Illness) will transition from MetLife to The Standard beginning in 2026.

We have provided the provider search tools for you to locate an in-network dental and vision provider:

Ameritas - Find a Provider
VSP Vision Care | Vision Insurance

More information will be included in your benefit guide so keep an eye out for more Open Enrollment communication!

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WENSPOK COMPANIES

Your Health Benefits

Medical Insurance

Wenspok is excited to announce they will continue to offer two medical plan options through **Gravie**! Please take the time to understand the features and differences of each plan so that you choose the coverage that is best for you and your family.

Each medical plan includes in- and out-of-network benefits, which means you can choose any provider that you would like. However, you will pay less out of your pocket when you choose a network provider. Locate a Cigna OAP network provider at CIGNA Provider Directory or call 855-451-8365.

gravie	Option 1 – ComfortFit Plan	Option 2 - Traditional
Network	Cigna OAP Network	
Deductible (Individual | Family)	None	$5,000 | $10,000
Co-insurance (Plan | Member)	100% | 0%	80% | 20%
Out-of-pocket Max (Individual | Family)	$8,500 | $17,000	$7,900 | $15,800
ACA Preventive Care Services	100% Covered	
Office Visits (Primary | Specialist)	No Cost	$30 Copay | $50 Copay
Telemedicine (Teladoc)	No Cost	No Cost
Urgent Care	No Cost	$75 Copay
Outpatient Diagnostic Lab & X-Ray	Office & Clinic setting: No Cost Hospital setting: No Cost after OOPM	Deductible then Coinsurance
Advanced Imaging	No Cost after OOPM	Deductible then Coinsurance
Emergency Room & Services	$950 Copay	$500 Copay
Mental Health Office Visit	No Cost	$30 Copay
Inpatient Hospital	No Cost after OOPM	Deductible then Coinsurance
Outpatient Hospital	No Cost after OOPM	Deductible then Coinsurance
Chiropractic	No Cost	$50 Copay
Prescription Drug Coverage	**Express Scripts**	
Tier 1 (Generic)	No Cost	$10 Copay
Tier 2 (Preferred Brand)	No Generic Available: $75 Generic Available: No Cost after OOPM	$50 Copay
Tier 3 (Non-Preferred Brand)	No Generic Available: $100 Generic Available: No Cost after OOPM	50% Coinsurance after Deductible
Tier 4 (Non-Formulary)	No Cost after OOPM	50% Coinsurance after Deductible
Specialty Drugs	No Cost with IMARx	No Cost with IMARx
Mail Order Drugs	2x Retail	2x Retail

IMA Rx Savings Program

PHARMACY
ADVOCATES PROGRAM

IMA Rx is a *FREE* program to you and your family members, available through your employer.

Get enrolled today and start receiving eligible medications delivered to your home at a $0.00 copay through this program benefit.

Eligible medications include specialty and high-cost brand named medications that are covered through your employers' primary prescription insurance plan.

PHARMACY PROGRAM THAT SAVES YOU TIME AND MONEY

Once enrolled, IMA Pharmacy Advocates Program provides the following services free:

+ Specialty Medication Assistance
+ High-cost Brand Name Medication Assistance
+ Pharmacy Related Questions
+ Managing Medication Adherence
+ Provider Office/Patient Liaison

Participation Matters

By participating in this new pharmacy benefit, this saves you and the health plan time & money - which translates into more stable premiums over time.

Protecting private health information

IMA Rx is separate from your employer and will not share any of your personal health information.

CALL TODAY!

IMA Rx (IMA Pharmacy Advocate Program) is here to answer questions and provide further assistance with enrollment completion.

Feel free to reach out to your trusted pharmacy advocate representative.

By phone: 866.530.9989 | or email: *imarx@imacorp.com*

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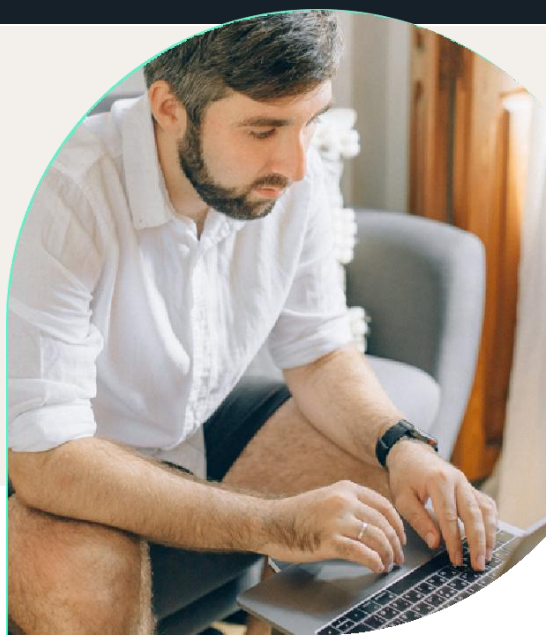
MORE BENEFITS. FEWER ASTERISKS.

Teladoc HEALTH



Gravie health plan members have access to virtual care — including general medical, dermatology, and mental health — through Teladoc Health, the world leader in whole person virtual care.

For many Gravie health plan members, these services are included at no additional cost. Check your benefits summary for more information.

General Medical

24/7 access to virtual care for a broad range of everyday health issues. With access to board-certified doctors anytime, anywhere, you can avoid unnecessary trips to the doctor's office and costly visits to the ER. Schedule an appointment or choose to talk to a provider right away.

Treatment for a wide range of everyday conditions:

- Flu
- Sinus problems
- Upper respiratory infection
- Pink eye
- Bronchitis
- Nasal congestion
- Sore throat
- Seasonal allergies
- Cold
- Arthritis
- Rash/poison ivy

24/7
access to care by web, phone, or mobile app

90%
satisfaction rate

92%
resolution rate on first visit

How it works:

01 | Initiate
Initiate contact through Teladoc's app, website or by phone

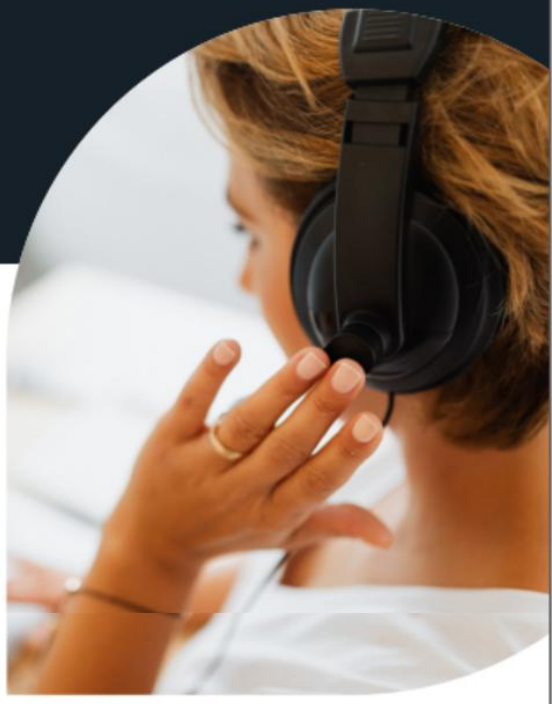
02 | Request
Request an immediate visit or schedule a visit at a preferred time

03 | Visit
Visit with the physician via phone or video

04 | Resolve
Physician posts a visit summary to your file and sends RX to your pharmacy if necessary

GRAVIE care™

Health benefits just got a whole lot easier.



Let's face it, the health insurance industry has a bad rap when it comes to customer service. Complicated bills, long wait times, and confusing jargon . . . we all avoid it if we can.

Gravie is changing the narrative. We believe that health benefits are only effective when members understand how to use them, which is why Gravie Care is included with every plan.

Proactive

The Gravie Care team goes beyond fielding phone calls and answering questions — anticipating members' needs, helping resolve issues before or as they arise, and closing cases in record time. Gravie equips brokers with relevant tools and reporting to help employers and their employees stay informed and supported throughout the year.

Exceptionally useful

Today's consumers expect more from their service providers. Gravie Care offers an exceptional recruitment and retention tool for employers with a service that exceeds employees' expectations about their health benefits. With licensed insurance experts on speed dial, every employee will have access to helpful support when they have questions about bills, costs, network coverage, and beyond.

Simply, better

95% Gravie Care satisfaction

Gravie's Customer Satisfaction Score is 95% compared to the industry average of 74%.

"The customer service is definitely better with Gravie versus your mainstream carrier."

Gravie Member

Gravie Care advisors help you evaluate plan options, verify network coverage, locate providers, decipher EOBs and bills, and so much more.

You are just a phone call or secure message away from someone who's on your side, willing to go the extra mile to help you make the most of your health plan year-round.

Call:
855.451.8365

Secure message:
member.gravie.com/contact

The Network

Gravie partners with Cigna to provide broad access to quality coverage.

The Cigna Healthcare® OAP Network gives you access to a network of physicians, clinics, hospitals, and other health care providers who have agreed to deliver quality, cost-effective health care services.

Remember, staying in-network is important for avoiding any unexpected charges.

Before receiving care, you can easily search for doctors, specialists, clinics, and more. All you need to do is log in to your account at member.gravie.com and click the "Doctors" link from your health plan.

Traveling? We've got you covered.

Wherever you go in the US, you'll have access to the broad Cigna Healthcare OAP network. For details on your travel coverage, contact Gravie Care.

Your generic drugs are 100% covered.

For preferred brand, non-preferred brand, and specialty drugs you'll want to look up and verify how your prescriptions are classified to confirm how you'll be billed. Log in to your gravie account at member.gravie.com and click the "Pharmacy" link on your health plan to search for your prescription drugs.

With a growing nationwide network of more than 1.6 million health care professionals and nearly 6,400 facilities, Cigna Healthcare offers you a range of quality choices to help you stay healthy.

Cigna Healthcare analysis of actual providers contracted as part of the Cigna Healthcare Open Access Plus Network for Shared Administration as of July 2025. Data is subject to change.

gravie

MORE BENEFITS. FEWER ASTERISKS.

GRAVIE pay

Just another way we're improving how people purchase and access healthcare.

Gravie Pay improves access to healthcare by allowing you to pay for out-of-pocket medical expenses **at your own pace**.

Simple, streamlined, flexible

- No cost to you
- No interest
- No credit check
- Available through Gravie's member site
- Powered by Paytient
- Supported by Gravie Care™

Get care

Get the care you need, including medical procedures and prescriptions that are subject to your out-of-pocket responsibility.

Initiate Gravie Pay

Access Gravie Pay through your member account and use Gravie Pay to pay your portion of bills you receive from your provider.

Repayment

Select a monthly repayment plan that works for you, paying at your own pace without fees or interest.

Questions? Call 866.863.6232 or send a secure message at member.gravie.com/contact

Where Should I Go For CARE?

Seeking care at an appropriate place of treatment can help you save money and time. Use the chart to help guide you to the most time and cost-effective place of treatment.

Virtual Care – Minor Medical Conditions

Access virtual care to treat minor medical conditions. Connect with a board-certified doctor via video or phone when, where and how it works best for you. Visit the Teledoc app or call to talk with a doctor 24/7.*

- Colds and flu
- Rashes
- Sore throats
- Headaches
- Stomachaches
- Fever
- Allergies
- Acne
- Urinary tract infections and more

› Costs the same or less than a visit with your primary care provider (PCP)
› Appointments typically in an hour or less
› No need to leave home or work

Convenience Care Clinic

Treats minor medical concerns. Staffed by nurse practitioners and physician assistants. Located in retail stores and pharmacies. Often open nights and weekends.

- Colds and flu
- Rashes or skin conditions
- Sore throats, earaches, sinus pain
- Minor cuts or burns
- Pregnancy testing
- Vaccines

› Same or lower than provider's office
› No appointment needed

Health Care Provider's Office

The best place to go for routine or preventive care, or to keep track of medications. Many primary care physicians offer virtual care. Contact your PCP to schedule an in-person or virtual care visit.

- General health issues
- Preventive care
- Routine check-ups
- Immunizations and Screenings

› May charge copay / coinsurance and / or deductible
› Usually need appointment
› Short wait times

Urgent Care

For conditions that aren't life threatening. Staffed by nurses and doctors and usually have extended hours.

- Fever and flu symptoms
- Minor cuts, sprains, burns, rashes
- Headaches
- Lower back pain
- Joint pain
- Minor respiratory symptoms
- UTIs

› Cost lower than emergency room (ER)
› No appointment needed
› Wait times vary

Emergency Room

For immediate treatment of critical injuries or illness. Open 24/7. "Freestanding" ER locations are becoming more common in many areas. Because these ERs are not inside hospitals, they may look like urgent care centers. When you receive care at an ER, you're billed at a much higher cost than at other health care facilities. If a situation seems life threatening, call 911 or go to the nearest ER.

- Sudden numbness, weakness
- Uncontrolled bleeding
- Seizures or loss of consciousness
- Shortness of breath
- Chest pain
- Head injury/major trauma
- Blurry or loss of vision
- Severe cuts or burns
- Overdose

› Highest cost
› No appointment needed
› Wait times may be long

Dental Insurance

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

The dental plan includes in- and out-of-network benefits, which means you can choose any dentist that you would like. However, you will pay less out of your pocket when you choose a The Standard network dentist. To find a participating dentist, please contact The Standard at **800-547-9515** or visit Dental and Vision Member Services | The Standard.

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

In-Network Plan Information	
Deductible (Individual | Family)	$50 | $150
Annual Maximum Benefit – Per Person	$1,500
Dependent Age Limit	26 Years
Preventative & Diagnostic • Oral examinations (2 per 12 months) • Bite Wing X-Rays (1 per 12 months) • Fluoride (1 per 12 months for children age 14 and under) • Cleanings (2 per 12 months)	100% Covered, Deductible Waived
Basic Services • Space maintainers • Simple extractions • Complex extractions • Sealants (age 14 and under) • Fillings for Cavities	80% Covered After Deductible
Major • Dentures • Anesthesia • Endodontics (surgical and non-surgical) • Periodontics (surgical and non-surgical) • Onlays • Crowns (1 in 10 years per tooth) • Dental implant services • Prosthodontics (1 in 10 years)	50% Covered After Deductible
Orthodontia • Treatment for adults and children	Plan pays 50%
Orthodontia Lifetime Maximum	$1,500 per person

Dental Insurance

Max Builder℠

The Standard dental plan includes a valuable feature that allows plan participants to carry over part of their unused annual maximum. At least one claim must be submitted during the benefit year while staying at or under the plan-specific threshold amount.

By seeing a Network Provider, an extra reward, called the PPO Bonus, is earned. Employees and their covered dependents may accumulate rewards up to the stated maximum carry-over amount, then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions.

If no dental claims are submitted during a benefit year, all accumulated rewards will be lost. MaxBuilder rewards can building again the next year.

Benefit guidelines are outlined below.

Benefit Threshold	**Up to $750**	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	**Up to $250**	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	**$150**	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	**Up to $1,000**	Maximum possible accumulation for Max Builder and PPO Bonus combined

The Standard will credit each participant's account based on amounts identified by the previous carrier. The credit is available only to those initially insured at the effective date of 01/01/2026. The credit, and any amounts earned under The Standard's plan, will not exceed the maximum carryover proposed for the plan selected.

Vision Insurance

Wenspok offers a vision insurance plan through **The Standard** using the **VSP Choice Network**. You will maximize the plan benefits when you choose a network provider. Locate a network provider at **800-877-7195 or visit** Dental and Vision Member Services | The Standard.

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

Why do I need an annual eye exam if I have perfect vision?

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

Plan Information	Description	In-Network Copays
Routine exams (every calendar year)	• Comprehensive exam of visual functions and prescription of corrective eyewear. • Covered in full after co-pay	$10 Copay
Frames (every calendar year)	• Up to $150 allowance • Costco and Walmart allowance will be the wholesale equivalent	$25 Copay
Standard Corrective Lenses (every calendar year)	• Single vision, lined bifocal, lined trifocal, lenticular	$25 Copay
Lens enhancements	• Standard Polycarbonate for dependent children at no additional cost • Ultraviolet Coating • Additional enhancements available	See benefit summary
Contacts (instead of glasses) (every calendar year)	• Up to $150 allowance	$25 Copay

Team Member Rates

Medical Coverage

Option 1 – ComfortFit Plan	Wenspok Premium Contribution Per Month	Team Member Premium Per Month	Team Member Premium per Check 24 Deductions per Year
Team Member Only	$583.19	$249.94	$124.97
Team Member + Spouse	$1,193.71	$642.76	$321.38
Team Member + Child(ren)	$940.39	$506.36	$253.18
Team Member + Family	$1,570.98	$845.91	$422.96

Option 2 – Traditional Plan	Wenspok Premium Contribution Per Month	Team Member Premium Per Month	Team Member Premium per Check 24 Deductions per Year
Team Member Only (ACA)	$608.22	$155.37	$77.69
Team Member Only	$534.51	$229.08	$114.54
Team Member + Spouse	$1,093.39	$588.75	$294.38
Team Member + Child(ren)	$861.48	$463.88	$231.94
Team Member + Family	$1,438.80	$774.74	$387.37

Dental Coverage

	Team Member Premium Per Month	Team Member Premium per Check 24 Deductions per Year
Team Member Only	$29.53	$14.77
Team Member + Spouse	$59.83	$29.92
Team Member + Child(ren)	$77.47	$38.74
Team Member + Family	$107.45	$53.73

Vision Coverage

	Team Member Premium Per Month	Team Member Premium per Check 24 Deductions per Year
Team Member Only	$5.77	$2.89
Team Member + Spouse	$11.39	$5.70
Team Member + Child(ren)	$9.92	$4.96
Team Member + Family	$15.50	$7.75

Life and Accidental Death & Dismemberment Insurance

Basic Life and AD&D Insurance

Wenspok provides you with basic life and AD&D insurance at no cost to you.

- Benefit Amount: **1x Salary up to $200,000**
- Benefits Reduction Schedule
  - To 65% at age 65
  - To 50% at age 70

Voluntary Life and AD&D Insurance

Depending on your personal situation, basic life and AD&D insurance might not be enough coverage for your needs. Wenspok provides you the option to purchase voluntary life and AD&D insurance at group rates through **The Standard**. You may also purchase voluntary coverage for your spouse and eligible children.

A breakdown of your Voluntary Life and AD&D rates will be located on the online enrollment platform, ADP.

Coverage options:

- **Team Member**: $10,000 increments up to $500,000; guarantee issue: $100,000**.**
- **Spouse**: $5,000 increments up to $250,000; guarantee issue: $30,000.
- **Dependent Child(ren)**: Choose from $1,000, $2,000, $4,000, $5,000 or $10,000; guarantee issue: full benefit. Dependent Child(ren) coverage includes children from live birth through age 25.

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

Employee Assistance Program

The Standard to provides all employees and their eligible dependents with an Employee Assistance Program.

Clinicians are available 24/7 by phone, online, live chat, email, or text to provide connections to resources, support, and guidance. There is also an EAP app for mobile devices. Your program includes up to three face-to-face assessment and counseling sessions per issue.

Using the EAP is confidential – information will be released only with your permission or as required by law. Some of the available services include:

Confidential Counseling

- Depression, grief, loss, and emotional well-being
- Family, marital, and other relationship issues
- Life improvement and goal setting
- Addictions such as alcohol and drug abuse
- Stress or anxiety with work or family
- Identity theft and fraud resolution
- Online will preparation
- Support for financial and legal concerns
- Referrals for important needs like education, adoption, travel, daily living and care for children, elderly loved ones, or pets through WorkLife Services

Contact EAP

888.293.6948
24 hours a day, 7days a week
Healthadvocate.com/standard3

A Helping Hand When You Need It

Rely on the support, guidance and resources of your Employee Assistance Program.

Visit **workhealthlife.com/Standard3** to explore videos, guides, articles, webinars, self-assessments, calculators, and other resources online. Please refer to the Standard benefit summary for more plan details.

Additional Benefits

Accident

Wenspok provides you the option to purchase accident insurance through The Standard. Accidents are unexpected and can strike any member of your family. The costs associated with treatment can mount quickly. Fixed benefits are paid directly to you regardless of any other coverage you may have, and you can spend it any way you choose.

	SELECT PLAN			ENHANCED PLAN		
BENEFIT	**TEAM MEMBER**	**SPOUSE**	**CHILD**	**TEAM MEMBER**	**SPOUSE**	**CHILD**
ACCIDENTAL DEATH BENEFITS CATEGORY						
Basic Accidental Death	$25,000	$12,500	$6,250	$50,000	$25,000	$12,500
Accidental Death Common Carrier	100% of Accidental Death Benefit			100% of Accidental Death Benefit		
ACCIDENTAL DISMEMBERMENT/ FUNCTIONAL LOSS/ PARALYSIS BENEFITS CATEGORY						
Loss of one finger or one toe	2% of Accidental Death Benefit			2% of Accidental Death Benefit		
Loss of one hand or foot	15% of Accidental Death Benefit			15% of Accidental Death Benefit		
Loss of sight in eye or hearing in one ear	15% of Accidental Death benefit			15% of Accidental Death benefit		
Loss of sight in both eyes or hearing in ears	30% of Accidental Death Benefit			30% of Accidental Death Benefit		
Paralysis Two Limbs (paraplegia or hemiplegia)	30% of Accidental Death Benefit			30% of Accidental Death Benefit		
MEDICAL TREATMENT AND SERVICES BENEFITS CATEGORY						
Ground Ambulance	$300			$400		
Emergency Room	$150			$200		
Blood/Plasma/Platelets	$400			$500		
Tendon/Ligament/Rotator Cuff Repair of One	$550			$750		
Other Outpatient Surgery Benefit	$100			$300		
HOSPITAL BENEFITS CATEGORY						
Hospital Admission (1 time per accident)	$750			$1,250		
ICU Admission (1 time per accident)	$1,250			$1,500		
Hospital Confinement (Up to 365 Days)	$250 per day			$350 per day		
ICU Confinement (15 days per accident)	$300			$400		
Inpatient Rehabilitation (90 days per accident)	$125 per day			$150 per day		

A $100 health maintenance screening benefit will be paid once annually when an insured member receives one of the 22 covered health screening tests!

Semi-Monthly Rates	SELECT PLAN	ENHANCED PLAN
Team Member Only	$2.60	$3.39
Team Member + Spouse	$4.29	$5.52
Team Member + Child(ren)	$4.76	$6.26
Family	$7.58	$9.92

Critical Illness

Wenspok provides you the option to purchase critical illness insurance through The Standard. For many, a critical illness can expose an individual to an unexpected gap in protection. While health plans may help cover many of the direct costs associated with a critical illness, related expenses such as lost income, childcare, travel to and from treatment, high deductibles and co-pays may quickly diminish savings.

	Coverage Amount
Team Member	Flat Amount of $15,000 or $30,000
Spouse	Flat Amount of $7,500 or $15,000; Not to exceed 50% of Team Member Coverage
Dependent Child (at no additional cost)	50% of Team Member Coverage

Covered Conditions	Coverage Percentage
Benign Brain Tumor	100%
Invasive Cancer	100%
Non-Invasive Cancer	25%
Coronary Artery Disease with Recommendation of Bypass	25%
Loss of Sight	100%
Loss of Speech	100%
Loss of Hearing	100%
Coma	100%
Paralysis of 2 or more Limbs	100%
Heart Attack	100%
Occupational Hepatitis	100%
Parkinson's Disease	100%
Multiple Sclerosis	100%
Amyotrophic Lateral Sclerosis	100%
End Stage Renal (Kidney) Failure	100%
Major Organ Failure	100%
Bone Marrow Transplant	100%
Alzheimer's Disease	100%
Multiple Sclerosis	100%
Stroke	100%

Complete an annual health screening and get a $50 benefit once per calendar year!

***A breakdown of your Critical Illness rates will be located on the online enrollment platform, ADP.**

IMA Medicare Services

If the thought of enrolling in Medicare makes your head spin, you're not alone!

With over 10,000 individuals approaching Medicare age each day, the need for a trusted partner to help guide you through the Medicare enrollment process has become more important than ever.

IMA has an in-house Medicare Advisory Specialist to assist you with Medicare Supplements/Medigap Plans, Stand-alone Prescription Drug Plans, Medicare Advantage plans, as well as consulting on the Medicare enrollment process.

Comprehensive Support

The individualized process is fully customized, and each client is guided from beginning to end by our specialist. As healthcare needs and insurance plans change, we help to ensure you continue to have the best coverage to fit your individual needs.

Personalized Approach

Our Medicare Service Team utilizes a 1:1 approach to ensure specific, individualized needs are met to understand when to enroll.

Knowledgeable Advisors

Annually certified and extensively trained on the complexities of Medicare, our Specialist has 13 years of experience.

Support for our Clients

The IMA Medicare Service Team offers you direct access to Medicare experts, ensuring you never have to face the complexities alone. Our experienced team is well-versed in all aspects of Parts A, B, C, and D, helps compare Medicare Advantage and Medigap plans, tracks eligibility timelines, and much more.

CONTACT US TODAY

LEIGH BENNETT
Medicare Advisory Specialist
Direct: 972.759.3749
Toll-Free: 877.991.3656
leigh.bennett@imacorp.com

CATHERINE WHITE
Medicare Advisory Services Administrator
Direct: 972.725.2161
Toll-Free: 877.989.9835
catherine.white@imacorp.com

Mental Health Resources

988 Suicide & Crisis Lifeline

We can all help prevent suicide. The Lifeline provides 24/7, free and confidential support for people in distress, prevention and crisis resources for you or your loved ones, and best practices for professionals in the United States.

The 988 Suicide & Crisis Lifeline is a national network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week in the United States. We're committed to improving crisis services and advancing suicide prevention by empowering individuals, advancing professional best practices, and building awareness.

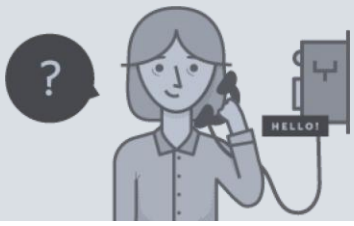
First, you'll hear an automated message featuring additional options while your call is routed to your local Lifeline network crisis center.

We'll play you a little music while we connect you with a skilled, trained crisis worker.

Then, a trained crisis worker at your local center will answer the phone.

This person will listen to you, understand how your problem is affecting you, provide support and get you the help you need.

Lifeline Center calls are FREE and CONFIDENTIAL, and we're available 24 / 7.



For more information on resources or to chat online with Lifeline visit
www.988lifeline.org

988 Suicide & Crisis Lifeline

988

CHAT WITH LIFELINE

Helpful Information

Insurance Terms

Copay or Copayment is an amount you pay for a covered medical service. Copays are usually paid at the time you receive the service.

Deductible is the amount you pay 100% before the insurance company begins to pay.

Out-of-Pocket Limit is the total amount you pay for covered services during a benefit year. These are the amounts you pay for copays, deductibles and coinsurance.

In-Network Providers contract with the insurance company and charge discounted fees. In-network providers or contracting providers apply to HMO, POS and PPO organizations.

Out-of-Network Providers do not contract with the insurance company. Non-contracting providers will probably bill you for the difference between the out-of-network provider's charge and the insurance company's "allowed" amount. You are responsible for the difference and this amount can be significant.

Primary Care Provider (PCP) are usually family practice physicians or pediatricians who are responsible for monitoring and coordinating all your medical care. If you are insured on a POS plan, you must coordinate all care through your PCP. If you need to see a Specialist, the PCP will provide you with a written referral before seeing the Specialist.

Specialists are physicians who have additional education and training for a specific condition. Examples of specialists are dermatologist, urologist, cardiologist, orthopedic surgeon, endocrinologist, ophthalmologist, thoracic surgeon, and pulmonologist, to name a few.

Generic Prescriptions

What are generic drugs? Generic drugs are identical to brand-name prescription drugs in dosage, safety, strength, quality and performance. Generics have the same active ingredients.

Inactive ingredients such as color or flavor may be different. This means you can save money without sacrificing quality.

What are brand name drugs? Name brand drugs are medications protected by a patent. This means the manufacturer who created the drug, has the sole right to sell it for a period of time. When the patent expires, other manufacturers can then apply to the FDA to sell generic versions of the drug.

What's the difference? The cost of Generic drugs are usually much less than brand name drugs. Generic drugs cost less for one reason: drug manufacturers spend a lot of money on researching, developing, marketing and advertising brand name drugs. Manufacturers of generic equivalents do not have these expenses and the savings are passed on to you.

Generic Drug Programs — Several stores offer discount prescription programs offering a variety of generic drugs at a low price (usually $4). The prescriptions included on each store's list may vary. Check it out. You may be able you to save some money.

Generic insurance Tips to Saving Money

Be Smart — If your employer offers two or more medical plans, learn what your out of pocket cost will be for each plan and how much each plan will cost you. Then choose the plan best meeting your needs. You might be throwing money away by choosing the wrong medical plan.

Prevention — An annual routine physical might save your life and a bunch of money. An annual checkup allows your doctor to run lab tests to see if you have any health issues.

Over There — If medical coverage is available where your spouse works, you might save money by splitting your coverage between both employers. Many employers pay a higher percentage of the premium for single coverage.

Free Advice — Pharmacists know a lot about prescription drugs, so talk to yours about the drugs you take. Your pharmacist might be able to suggest a less expensive alternative you can ask your physician about and save money.

Urgent vs. Emergency — Consider going to an Urgent Care Center instead of the Emergency Room. Urgent Care Centers are similar to doctors offices and are much less expensive.

Notices

CMS PART D NOTICE OF CREDITABLE OR NON-CREDITABLE COVERAGE

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

Below are highlights to note:

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

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

Creditable Coverage	Non-Creditable Coverage
Gravie Medical Plans	**None (all plans are creditable)**

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

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

DATE:	01/01/2026
NAME OF ENTITY/SENDER:	Wenspok Resources
CONTACT—POSITION/OFFICE:	Payroll Department
ADDRESS:	9503 E Montgomery Ave
	Spokane Valley, WA 99206
PHONE NUMBER:	509-326-6333

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NOTICE: SPECIAL ENROLLMENT RIGHTS

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

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

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

NOTICE: HIPAA NOTICE OF PRIVACY PRACTICE

Your Information. Your Rights. Our Responsibilities.

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

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

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

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

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

How else can we use or share your health information?

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

Help with public health and safety issues	We can share health information about you for certain situations such as: ❖ Preventing disease ❖ Helping with product recalls ❖ Reporting adverse reactions to medications ❖ Reporting suspected abuse, neglect or domestic partner violence ❖ Preventing or reducing a serious threat to anyone's health or safety
Do research	❖ We can use or share your information for health research
Comply with the law	❖ We will share information about you if State or Federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	❖ We can share health information about you with organ procurement organizations. ❖ We can share health information with a coroner, medical examiner or funeral director when an individual dies.
Address workers' compensation, law enforcement and other government requests	We can use or share health information about you: ❖ For workers' compensation claims ❖ For law enforcement purposes or with a law enforcement official ❖ With health oversight agencies for activities authorized by law ❖ For special government functions such as military, national security and presidential protective services
Respond to lawsuits and legal actions	❖ We can share health information about you in response to a court or administrative order or in response to a subpoena.

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Our Responsibilities

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

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

NOTICE: CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

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When is COBRA Continuation Coverage Available?

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

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

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

How is COBRA Continuation Coverage Provided?

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

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

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

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

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If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

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

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

NOTICE (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): PATIENT PROTECTION – PRIMARY CARE DESIGNATION (HMO)

Your group health plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, your health insurer designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, see the contact information at the end of these notices.

NOTICE (ONLY APPLICABLE TO HMO GROUP HEALTH PLANS): PATIENT PROTECTION – OBSTETRICS & GYNECOLOGICAL CARE (HMO)

You do not need prior authorization from your group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, see the contact information at the end of these notices.

NOTICE: GRANDFATHERED HEALTH PLAN

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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

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

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

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

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

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2025. Contact your State for more information on eligibility.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party- liability/childrens-health-insurance-program-reauthorization- act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

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IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/Medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for- medicaid-health-insurance-premium-payment-program- hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

Notices

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

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

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 and posted electronically.

For more information, contact:

NAME:	Alisha Seaton
TITLE:	Director of Payroll and Benefits
ADDRESS:	9503 E Montgomery Ave
	Spokane Valley, WA 99206
PHONE NUMBER:	509-326-6333
OTHER CONTACT INFORMATION:	Alisha@wenspok.com

Effective date of this notice: 01/01/2026

WENSPOK COMPANIES

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Benefits Enrollment Guide

The information in this Benefits Guide is presented as only a summary of the provisions of the various plans. For specific plan details, and exclusions, you should refer to the actual plan documents. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.