2026

Legacy Everi Employee Benefits Guide

Enroll October 1-17

www.everibenefits.com

Welcome to Your 2026 Benefits

Hi Everi-One,

At Everi, we deeply value each member of our team. In recognition of your dedication and hard work, we've curated a robust benefits package tailored to cater to the diverse needs of our employees, ensuring you and your family's health and prosperity.

Contained within this 2026 Benefits Guide is a wealth of information that has been crafted based on feedback from all of you – our esteemed teammates. We have invested significant time and effort into researching, evaluating, and refining the benefits we offer. The result is a set of offerings aimed at best serving the Everi family's collective needs.

We invite you to explore this guide thoroughly. It will equip you with insights about benefit options, enrollment procedures, and processes for making any necessary changes. We've strived to provide comprehensive information, but we understand that there may be areas where you seek further clarity. Should you have questions or require a deeper understanding of a particular benefit, please do not hesitate to connect with our People and Culture Team at benefits@everi.com.

Wishing you and your family a healthy and productive year ahead.

– Your Benefits Team

Our Promise To You

You play an important role in the ongoing success of our company. Each employee is vital to maintaining our brand image through daily positive interactions with customers. In Everi-thing you do, you represent Everi and a critical link to those we serve.

With that in mind, the Everi Benefits Program is designed to recognize the diverse needs of our workforce. Our program continues to:

- Provide competitive and comprehensive benefit options
- Maintain a program that considers individual needs
- Offer plans to provide long-term financial security for you and your family

Understanding the importance of our employees to the ongoing success of our company, we are committed to providing a first class benefits program which provides a mix of basic and optional benefits. However, our ability to continue to offer a competitive plan and maintain our employee pricing is a direct result of you and your ability to help us control our costs. Over the last couple of years, we have emphasized using in-network services as much as possible to contain costs. To continue to keep premium costs flat, we want to reiterate the importance of you selecting in-network doctors and services and becoming familiar with and accustomed to using our Health Advocate and Teledoc service partners. Thank you for helping us stay ahead of the health care cost curve!

Please review this benefit guide carefully and select the benefits which best meet the health care needs for you and your family.

In the event of any conflict between this document and the Summary Plan Description (SPD), the provisions of the Summary Plan Description (SPD) shall prevail.

BENEFITS

The following basic benefits are provided to you at no cost, though we still require some information from you to fully take advantage of:

- Group Life Insurance with Guardian
- Short-Term Disability Insurance: Guardian
- Long-Term Disability Insurance: Guardian
- Employee Assistance Program: Lyra
- Savings Plan: Must be enrolled in an Everi Medical, Dental or Vision Insurance Plan
- Identity Theft Protection: AURA

OPTIONAL BENEFITS

You may elect coverage in the following benefits for yourself and your spouse (including domestic partners), and dependents:

- Medical: Aetna, HRA, HSA, or PPO
- Pharmacy: Navitus
- Dental: Guardian
- Vision: Guardian
- Flexible Spending Account (FSA): WEX
- Voluntary Life: Guardian
- Critical Illness, Accident, and Hospital Indemnity: Guardian
- 401(k): Empower
- Legal: LegalEASE
- Pet Insurance: Nationwide

ERISA requires that employees receive various documents throughout the year. These documents will be distributed electronically. You will receive a notice at the time that the document is furnished, detailing the significance of the document. The notice will advise the you of your rights to have the opportunity, to access documents furnished electronically on the Everi portal and to request and receive (free of charge) paper copies of any documents received electronically.

Table of Contents

Eligibility / Open Enrollment

ELIGIBILITY

You are eligible for the benefits described here if you are a regular full-time employee working at Everi at least 30 hours per week. Your spouse / approved legal domestic partner and dependent children, are eligible for some benefits, including:

- Medical
- Dental
- Vision
- Flexible Spending Accounts*
- Employee Assistance Program
- Voluntary Employee & Dependent Life Insurance

See page 18 for detailed information on FSA expenses for dependents.

If you choose benefits coverage for a dependent who does not qualify to be claimed on your federal income tax return, you may have to pay taxes on the amount of money Everi contributes to his or her medical and/or dental benefits as this money is considered taxable income and must be reported to the IRS.

You May Enroll Your Eligible Children Up to the Ages Shown Below

COVERAGE	AGE
Medical	Up to age 26
Dental	Up to age 26
Vision	Up to age 26
Voluntary Life	Unmarried up to age 26
Health Care Reimbursement	End of calendar year in which dependent turns 26
Dependent Care Reimbursement	Up to age 13

Note: In certain instances, dependents may qualify to continue coverage beyond the age limits listed above. Check with your administrator or Benefits Team for more details.

Required Documentation

You must provide the required documentation to the Benefits Team if any of the below apply to you:

- You are adding a dependent
- You are adding a domestic partner
- You are adding a dependent outside of open enrollment and/or your initial eligibility period

Acceptable Documents

- For a spouse: Marriage certificate or declaration
- For a domestic partner: Affidavit of Domestic Partnership (available from People Operations)
- For a child: Certified birth certificate or court order establishing conservatorship for your grandchild and/or listing you as the parent.
- Social Security Cards or ITNs for all dependents.

Please note: All documentation submitted to People Operations in support of the Affidavit of Domestic Partnership is confidential and will only be shared with carriers and payroll as related to your coverage, eligibility, and taxable eligibility. Only members of People Operations will have access to this information.

***Link:** How to Upload Documents*

OPEN ENROLLMENT

Open Enrollment begins in the fall of each year. During this time, you may add or change your current benefit elections or remove dependents from coverage. The elections you make will become effective at the beginning of the next calendar year and will remain in effect through the end of the calendar year. You cannot change your elections outside of open enrollment unless you experience a qualified "life event".

CHANGE OF STATUS / LIFE EVENTS

You have 30 days from the date of the "life event" to notify the Benefits team and change your benefit elections. If you do not make your election changes within this timeframe, your changes cannot be made until the next open enrollment period. The following are examples of "life events" you may experience during the course of the year which may allow you to change your election outside of open enrollment:

- Change in status (includes: marital status, death,birth/adoption of a child, employment, dependent satisfies or ceases to satisfy eligibility requirements)
- Dependent's open enrollment
- FMLA special requirements
- Changes due to a judgment, decree or court order
- Entitlement to Medicare or Medicaid

Coverage will become effective the first of the month following the date of the status change with the exception of birth, adoption, and death. Birth, adoption, and death will be effective the date of the event provided you notify People Operations within 30 days of the life event. Additional payroll deductions may be incurred depending on the date of your enrollment.

NEW HIRES

Benefits for full-time new hires start the first of the month following their date of hire. Employees who are on a part-time or on-call status and regularly work less than 30 hours per week are not eligible for health and wellness benefits. Part-time employees are eligible to participate in the Everi 401(k) retirement plan.

WHEN EMPLOYMENT TERMINATES

Your life and disability, and EAP coverage, and flexible spending account will end on your termination date. Your medical, dental, and vision benefits end on the last day of the month following your termination.

COBRA

After your coverage terminates, you may be entitled to continue coverage through COBRA. Plan benefits eligible to be continued through COBRA include: medical, dental, vision, and medical flexible spending account.

Paying for Care – An Overview of Terms

PROCESSING

Claims:
Claims are requests for your plan to pay for services you receive. We use these to check what your plan will cover and the amount we'll pay. You can find updated status and amounts billed for your claim on your member website or the Aetna Health app.

Explanation of Benefits (EOB) statements:
An Explanation of Benefits, or EOB, statement shows a breakdown of how we process your claims. It is not a bill and may not show the current balance you owe. Anytime something changes with your claim, you'll get a new statement.

Provider bills:
Bills show the amount you actually owe for services. You'll get this from your provider. You can make payments for what you owe directly to your provider or through the "Pay Your Provider" link on each of your claims.

Coordination of benefits:
Some members have health coverage under more than one health plan. When this happens, we work with the other carriers to decide which plan pays first and which plan pays second, based on the rules in your plan documents. We call this process "coordination of benefits," or COB.

YOU PAY

Deductible:
Each year, you pay 100% of your covered expenses until you meet your deductible amount.

For most plans, eligible preventive care is covered at 100% with no deductible when you use network providers.

YOU + THE PLAN PAY

Cost sharing:
Once you meet your deductible, you share the cost with the plan. Your share may be in the form of coinsurance and/or copayments (also called copays).

Coinsurance:
A fixed percentage. For example, if your care is $100 and your coinsurance is 20%, you pay $20.

Copay:
A fixed dollar amount. For example, you may pay $25 per doctor office visit.

THE PLAN PAYS

Out-of-pocket maximum:
The maximum you pay each year for covered expenses. Once you hit your maximum, the plan pays 100% of covered expenses for the rest of the year.

Medical Benefits

	Choice POS II (HRA)		Choice POS II (PPO) (Copays do not apply towards annual deductible)	
HRA Fund Individual Family	$500 / $1,000 *See HRA Proration schedule on page 8 of the Benefits Guide		N/A	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Individual / Family	$1,250 /$2,500	$4,500 / $9,000	$1,000 / $2,000	$3,750 / $7,500
Out of Pocket Maximum* *(includes copays, deductibles and Rx)* Individual / Family	$4,500 / $9,000 **Only the amount you pay for in-network covered expenses counts towards your in-network OOP maximum. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network OOP maximum.*	$9,000 / $18,000	$5,000 / $10,000 **Only the amount you pay for in-network covered expenses counts towards your in-network OOP maximum. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network OOP maximum.*	$10,000 / $20,000
Coinsurance	10% after deductible	50% after deductible has been met	25% after deductible has been met	50% after deductible has been met
PCP – Office Visit **Specialist – Office Visit**	10% after deductible 10% after deductible	50% after deductible 50% after deductible	$15 copay / visit $40 copay / visit	50% after deductible 50% after deductible
Preventive Care Well Baby, Child, & Adult	Covered 100%	50% after deductible	Covered 100%	50% after deductible
In-Patient Hospitalization	20% after deductible	No Benefit*	20% after deductible	No Benefit*
Out-Patient Ambulatory **Out-Patient Hospital**	10% after deductible 25% after deductible	No Benefit* No Benefit*	10% after deductible 25% after deductible	No Benefit* No Benefit*
ER **Urgent Care** **Labs, X-Rays** **CT, Pet, MRI – Office** **CT, Pet, MRI – Hospital**	25% after deductible $75 copay 25% after deductible 10% after deductible 25% after deductible	25% after deductible No Benefit* No Benefit* No Benefit* 50% after deductible	$500 copay $50 copay 25% after deductible 10% after deductible 25% after deductible	$500 copay No Benefit* No Benefit* No Benefit* 50% after deductible
Prescription Drugs Retail (30 day supply) Tier 1 Tier II Tier III Tier IV - Specialty Mail Order (90 day supply)	 $5 $40 $65 20% up to $100 2.5 x retail***	 Full retail charged at point of sale** No Benefit No Benefit	 $5 $40 $65 20% up to $100 2.5 x retail***	 Full retail charged at point of sale** No Benefit* No Benefit*

**In-network only for outlined benefits except for emergencies or your claim for procedures may be denied. **Members would be responsible for full retail price at point of service but can submit a direct manual claim which will be processed at contracted cost minus in network copay. ***A 90 day supply of maintenance medications can also be filled at retail at in network copays outlined. Cost share is based on place of service.*

	HRA	PPO
Coverage	**Bi-Weekly**	**Bi-Weekly**
Employee Only	$50.88	$76.61
Employee + Spouse	$191.50	$224.33
Employee + Child(ren)	$164.14	$188.76
Employee + Family	$243.47	$303.66

Find a provider

- Go to http://www.aetna.com to locate a doctor or facility.
- Log-in or sign-in a guest and then select “Aetna Open Access Plans.”
- Next, choose “Aetna Choice® POS II (Open Access)” and search by provider.

A Summary of Benefits and Coverage (SBC) has been designed to assist you with better understanding the coverage being offered to you. The SBC is available on SharePoint. A paper copy is also available, free of charge, by emailing benefits@everi.com.

Medical Benefits - NEW HSA Plan!

	Choice POS II (HSA)	
HSA Fund Individual / Family	$500 / $1,000	
	In-Network	Out-of-Network
Annual Deductible Individual / Family	$2,000 /$4,000	$4,500 / $9,000
Out of Pocket Maximum* *(includes copays, deductibles and Rx)* Individual / Family	$5,000 / $10,000 Indiv. Max $5,000 **Only the amount you pay for in-network covered expenses counts towards your in-network OOP maximum. The amount you pay for out-of-network covered expenses counts toward both your in-network and out-of-network OOP maximum.*	$10,000/ $20,000
Coinsurance	20% after deductible	50% after deductible
PCP – Office Visit **Specialist – Office Visit**	20% after deductible 20% after deductible	50% after deductible 50% after deductible
Preventive Care Well Baby, Child, & Adult	Covered 100%	50% after deductible
In-Patient Hospitalization	20% after deductible	50% after deductible
Out-Patient Ambulatory **Out-Patient Hospital**	20% after deductible 20% after deductible	50% after deductible 50% after deductible
ER **Urgent Care** **Labs, X-Rays** **CT, Pet, MRI – Office** **CT, Pet, MRI – Hospital**	20% after deductible 20% after deductible 20% after deductible 20% after deductible 25% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible 50% after deductible
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	HSA
Coverage	**Bi-Weekly**
Employee Only	$48.39
Employee + Spouse	$181.54
Employee + Child(ren)	$155.74
Employee + Family	$230.76

Find a provider

- Go to http://www.aetna.com to locate a doctor or facility.
- Log-in or sign-in a guest and then select “Aetna Open Access Plans.”
- Next, choose “Aetna Choice® POS II (Open Access)” and search by provider.

A Summary of Benefits and Coverage (SBC) has been designed to assist you with better understanding the coverage being offered to you. The SBC is available on SharePoint. A paper copy is also available, free of charge, by emailing benefits@everi.com.

Health Savings Account - NEW!

A Health Savings Account (HSA) is a tax-advantaged account that you own and use to pay for qualified medical expenses. You, your employer, or both can contribute to your HSA, up to annual IRS limits. Funds roll over year to year if you don't spend them, and the account stays with you even if you change jobs or retire. HSAs are typically paired with a High Deductible Health Plan (HDHP). Contributions, earnings, and qualified withdrawals are all tax-free, making HSAs a powerful way to save for both current and future health care expenses.

Who is eligible for an HSA?

To be eligible, you must:

- Be enrolled in a qualified High Deductible Health Plan (HDHP).
- Not be covered by any other non-HDHP plan.
- Not be enrolled in Medicare.
- Not be claimed as a dependent on someone else's tax return.

How do contributions work?

Both you and your employer can contribute to your HSA, up to the IRS annual limit. Contributions are made pre-tax through payroll deductions, or you can make after-tax contributions and claim them on your tax return. The funds are yours immediately and remain in your account year to year.

What if there is a balance in an HSA?

Unlike FSAs, there is no "use it or lose it" rule. Any unused balance carries over year to year and can accumulate tax-free. You can even invest HSA funds once a minimum balance is reached, allowing the account to grow like a retirement account for future health expenses.

What is the difference between an HSA and FSA?

HSA: Only available if enrolled in an HDHP; funds roll over year to year; owned by you, not the employer; contributions can be invested.

FSA: Available with many plan types; typically "use it or lose it" at year's end; employer-owned account; no investment options.

What are qualified expenses for an HSA?

Qualified medical expenses include most out-of-pocket costs such as deductibles, copays, prescriptions, dental, and vision expenses. A full list can be found in IRS Publication 502. Non-medical withdrawals are subject to taxes and penalties before age 65.

What does the IRS require me to report on my taxes concerning my HSA?

Your HSA custodian will send you tax forms each year:

- Form 5498-SA (reports contributions).
- Form 1099-SA (reports distributions).
- You'll also need to file IRS Form 8889 with your tax return.

What if I terminate my employment during the plan year?

Your HSA belongs to you, not your employer. The account and funds remain yours, even if you leave your job, retire, or change health plans. You may continue to use the money for qualified expenses at any time.

For more information on HSAs, visit: www.irs.gov search Publication 502 and Publication 969

HSA – Aetna

The HSA plan includes a personal Health Savings Account (HSA) you own and control.

Everi contributes $500 for individual coverage or $1,000 for those covering dependents (see Proration Schedule below).

The money in this account is yours to use for qualified medical expenses now or in the future—even if you change plans or leave the company.

HSA Proration Schedule

Plan	Jan.	Feb.	March	April	May	June
Individual	$500	$458.34	$416.68	$375.02	$333.36	$291.70
Family	$1,000	$916.67	$833.34	$750.01	$666.68	$583.35
Plan	**July**	**Aug.**	**Sept.**	**Oct.**	**Nov.**	**Dec.**
Individual	$250.04	$208.38	$166.72	$125.06	$83.40	$41.74
Family	$500.02	$416.69	$333.36	$250.03	$166.70	$83.37

2026 IRS HSA Contribution Limits

Individual Coverage: $4,400

Family Coverage: $8,750

Catch-up (age 55+): Additional $1,000

Piper Jordan

Health Reimbursement Arrangement (HRA)

A health reimbursement arrangement (HRA) is an employer-funded account that is designed to reimburse employees for qualified medical expenses that are paid for out-of-pocket. There are no annual contribution limits on HRAs. However, the employer usually sets the contribution below the annual deductible. HRAs are often designed to operate with a high deductible health plan (HDHP), thereby reducing premium costs while encouraging employees to spend wisely. Your employer sets up the HRA, determines the amount of money available in each employee's HRA for the coverage period, and establishes the types of Expenses the funds can be used for.

Who is eligible for an HRA?

HRAs are employer-established benefit plans. An HRA may reimburse medical care expenses only if they are incurred by employees or and dependents. HRA coverage must be in effect at the time the expense is incurred.

How do contributions work?

HRAs are funded completely by employer contributions. These employer contributions are generally excluded from your gross income, essentially making it tax-free money. Different from HSAs or Health FSAs, employees cannot make contributions to an HRA.

What if there is a balance in an HRA?

Amounts that remain at the end of the year may be carried over to the next year. *See SPD. Your employer is not permitted to refund any part of the balance to you. These amounts may never be used for anything but reimbursements for qualified medical expenses.

Will I have any administrative costs under the HRA plan?

Generally, no. Your employer bears the entire cost of administering the HRA plan while you are an employee.

What is the difference between an HRA and FSA?

HRAs are employer-funded, which means your employer determines the amount that goes into the HRA account. FSAs can be funded by employee and employer contributions. FSA contributions are deducted from your salary, usually on a pre-tax basis. You determine how much to contribute to your FSA account.

What are qualified expenses for an HRA?

Qualified medical expenses are those specified in the plan that would generally qualify for medical expense deduction. An extensive list can be found in the IRS document, Publication 502 at www.irs.gov.

What does the IRS require me to report on my taxes concerning my HRA?

Nothing. Your HRA is a health benefit.

What if I terminate my employment during the plan year?

If you cease to be an Eligible Employee (i.e., you die, retire or terminate employment), your participation in the HRA Plan will end unless you elect COBRA continuation coverage. You will be reimbursed for any medical care expenses incurred prior to your termination date, up to your account balance in the HRA. Any unused portions will be unavailable after termination of employment.

For more information on HRAs, visit: www.irs.gov search Publication 502 and Publication 969

HRA – Aetna

The HRA plan includes a fund that can be used to pay for medical expenses covered under the Plan. HRA funds cannot be used to cover Rx copays. The HRA fund is $500 for individual coverage or $1,000 for those covering dependents. Once the HRA fund is exhausted, the member is responsible for meeting the remainder of the calendar year deductible plus any applicable coinsurance. Unused balances will roll over to the next plan year but will be limited to the deductible maximum amount. Funds will be prorated based on the effective date of your coverage.

(See Proration Schedule below.)

HRA Proration Schedule

Plan	Jan.	Feb.	March	April	May	June
Individual	$500	$458.34	$416.68	$375.02	$333.36	$291.70
Family	$1,000	$916.67	$833.34	$750.01	$666.68	$583.35
Plan	**July**	**Aug.**	**Sept.**	**Oct.**	**Nov.**	**Dec.**
Individual	$250.04	$208.38	$166.72	$125.06	$83.40	$41.74
Family	$500.02	$416.69	$333.36	$250.03	$166.70	$83.37

Piper Jordan

Pharmacy: Navitus

Welcome to Navitus, your prescription benefit provider.

Navitus is excited to provide you with our full service pharmacy benefits. You have access to more than 65,000 retail pharmacies nationwide including but not limited to the following pharmacies:

- CVS
- Walgreens
- Sav-on
- Vons
- Smiths
- HEB
- Walmart
- Sam's Club
- Other local pharmacies

You can continue to use your current Medical/RX card.

If you have lost your card, you can reach out to Aetna or log onto your Aetna member portal to request and print new cards.

Navitus mail Order/Online Pharmacy

Under your new prescription benefit program, Navitus Mail Order is your new service provider. With this change you need to obtain new prescriptions from your physician(s) for your 90 day supplies.

You have two options for using your Navitus Mail Order service:

- **Traditional:** Orders place with a live representative on the phone, automated refill option or by mail.
- **On-line:** Place your order online at Navitus.com.

Your pharmacy benefit allows you the option to fill your 90 day maintenance medications at any retail pharmacy under the same benefit as the Navitus Mail Order pharmacy.

Questions:

For any concerns or general assistance please call our Customer Service Help Desk at 1-844-268-9789. Available 24/7.

You can continue to use your current Medical/RX card. If you have lost your card, you can reach out to Aetna or log onto your Aetna member portal to request and print new cards.

5 Ways to Save

1. Stay in the network

In-network doctors, labs, hospitals and other health care providers charge lower, negotiated rates. Plus, your coinsurance is lower. You can use the provider search tool at Aetna.com to find network providers.

2. Get preventive care

Keep up with preventive services to catch any problems early. You pay nothing as long as you stay in the network.

3. Pay less for prescriptions

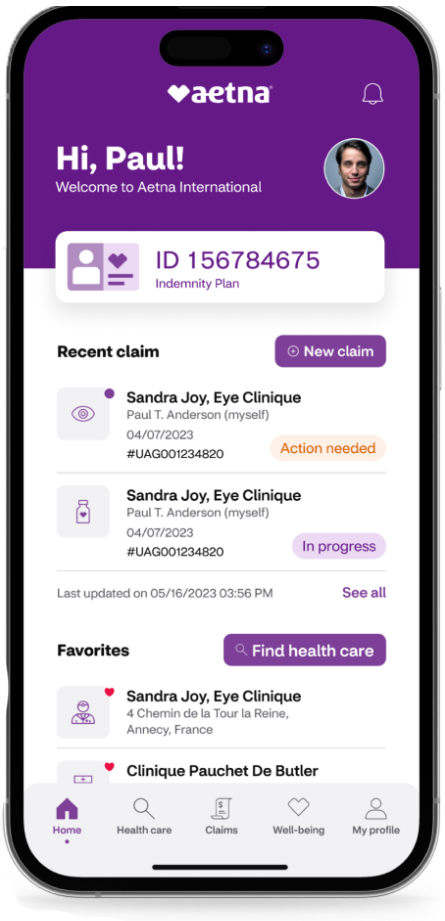
Generic drugs can be just as effective as name-brand, and they usually cost less. You can also save by using your plan's home delivery service for regular prescriptions.

4. Compare costs before you go

Use your cost-of-care tools to compare costs before you go to the doctor.

5. Use the ER for emergencies only

Visit an urgent care center or walk-in clinic for non-life-threatening medical issues.



Aetna® Member Website and Aetna Health℠ App

Manage your benefits, connect to care, handle claims — from anywhere..

As a member, you can:

- View your health plan summary and get information about what's covered
- Track spending and progress toward your deductible or maximums for you and your family
- View and pay claims, and even see the breakdown of your costs, like what's covered by your plan and what you're responsible for
- Use tools to help you choose quality in-network providers
- Get personalized reminders to help improve your health

Once you're a member, here's how you can connect:

- Your Aetna member website
  Go to Aetna.com to create an account and log in to your member website.
- The Aetna Health app
  Get the Aetna Health app by texting "GETAPP" to 90156 for a link to download the app and create an account. Message and data rates may apply.*
- Provider search tool
  You can find providers by name, specialty and location. You'll also find maps, directions and more. You can also look for providers who speak different languages. Visit Aetna.com to get started.

Teladoc: Medical Experts at Your Fingertips

Telemedicine

Feel better now! 24/7 access to a doctor is only a call or click away—anytime, anywhere with a $0 visit fee for general medical issues. With Teladoc, you can talk to a doctor by phone or online video to get a diagnosis, treatment options and prescription, if medically necessary. Save time and money by avoiding crowded waiting rooms in the doctor's office, urgent care clinic or ER. Just use your phone, computer, smartphone or tablet to get a quick diagnosis by a U.S.-licensed physician.

General Medical

- Treatment for common medical issues such as colds, flu, poison ivy, respiratory infections, bronchitis, pink eye, sinus problems, allergies, urinary tract infections and ear infections
- 10-minute average doctor response time
- Includes spouse and dependents — from children to seniors
- If you are caring for an aging parent or loved one, you can provide them access to $49 visits
- U.S. board-certified doctors with an average 20 years practice experience

Nutrition

- Registered dietitians help you develop a personalized eating plan or manage health conditions like diabetes or high blood pressure
- $59 per consultation

Dermatology

- Upload images for a quick, convenient, and discreet treatment plan within 2 business days for skin conditions such as rash, acne, psoriasis, suspicious moles, and more
- $75 per consult, plus one follow-up question

Scan the QR code to access Teladoc

Employees can access the Teladoc benefit through the My Benefits Work app and via: mybenefitswork.com

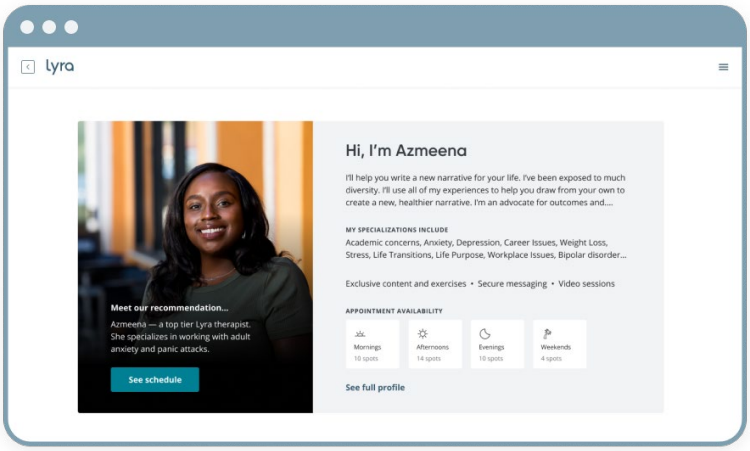
As long as you are enrolled in an Everi Medical, Dental, or Vision plan, you and your immediate family members have access to the Teladoc benefit for $0 consult fee.

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

Mental Wellness

Find confidential care for your emotional and mental health, how, when, and where you need it. Whether you're feeling stressed, anxious, or depressed, support from Lyra can get you back on your feet.

- **Guided self-care with a coach:** Get a care plan crafted by your Lyra coach and learn new mental health strategies at your own pace.
- **In-person & video therapy:** Meet with a therapist for diagnosis and treatment of mental health conditions like depression, PTSD, and more.
- **Medication Management:** Consult with a specialized physician on mental health medications.
- **Mental Health Coaching:** Get to the root of your challenges with effective care from a mental health coach via video or live messaging.
- **Essentials:** Tap into self-led wellness tools anytime, anywhere



lyra

No matter what you're dealing with, Lyra can help

Confidential care from the best quality providers, so you can feel better faster.
How Lyra works:

- **Getting started is easy:** Share what you're dealing with, get care recommendations, and book an appointment. Lyra members waste less time looking for care and spend more time feeling better.
- **The best coaches, therapists and physicians available nationwide:** Our providers are ready to meet you where you are — via live video, live messaging, or even in-person. Many use digital lessons and exercises to enhance your care experience between sessions.
- **High-quality care that works:** Lyra is dedicated to offering the best care possible and supporting only treatments that are the most effective at relieving symptoms, typically within a short period of time.
- **Tap into additional work-life services:** Receive expert advice to help you stay on top of your busy life, including legal, financial, identity theft, and dependent care services.

Who is eligible?

All eligible employees, dependents, and COBRA members have access to 12 coaching or therapy sessions, per person per year, at no cost to you.

Employees and their dependents enrolled in the Aetna health plan have access to continued care, including coaching, therapy, and medication management support from a Lyra network provider. These sessions are billed through the health plan and subject to in-network outpatient mental health cost-sharing, as defined under your health plan.

Learn more at everi.lyrahealth.com

care@lyrahealth.com | (877) 235-0870

Lyra Learn

On Demand Courses and Live Workshops

- Workshops change monthly.
- Gather better sleep.
- Get tools to manage stress.
- Minding mental health.
- and so much more!

Gatherings

Virtual listening discussion sessions with thought-provoking topics related to current events, diversity, equity, inclusion, and mental health.

To get started, visit: **learn.lyrahealth.com** and enter your customer code: @everi969

Lyra Health, Inc. works in partnership with Lyra Clinical Associates P.C. and other contracted partners to be your Lyra care team and deliver clinical services. For care exclusions, please see the Lyra FAQ.

Dental Benefits

PREVENTIVE ADVANTAGE

Members can access preventive care without having the benefit deducted from their annual maximum. The entire annual maximum benefit amount is preserved for other dental needs. Examples of preventive care benefits include: oral exams, cleanings, x-rays and flouride treatments (until the age of 19.) For full benefit detail please refer to the carrier benefit summaries provided online.

MAXIMUM ROLLOVER

Save your dental annual maximum dollars for a time when you need them most! With Maximum Rollover, Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). The MRA can be used in future years, if you reach the plan's annual maximum. To qualify, you must submit a claim for covered services and you must not exceed the paid claims threshold during the benefit year. You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit. You will receive an annual MRA statement detailing your account and those of your dependents.

Login to www.guardiananytime.com and download your Dental ID card.

FIND DENTAL PROVIDERS NEAR YOU:

- Log on to www.guardianlife.com
- At the top of the screen select "Connect with us" and then "Find a Provider"
- Select "PPO: DentalGuard Preferred" network option
- Enter your search information
- Click the eyeglass button to start search

Benefit Comparison	In-Network	Out-of-Network
	DentalGuard Preferred	
Network		
Life Benefit Amount	$50	$50
Waived for Preventive	Yes	Yes
Annual Maximum	$1,750	$1,750
Type 1: Preventive Care		
Exams	100%	100%
X-Rays	100%	100%
Cleanings (Plan covers up to 4/year!)	100%	100%
Fluoride Treatment	100%	100%
Space Maintainers (applies to covered persons under age 16)	100%	100%
Sealants	100%	100%
Type 2: Basic Care		
Fillings	80%	80%
Endodontics (Root Canal)	80%	80%
Periodontics (Gum Disease)	80%	80%
Simple Extractions	80%	80%
Type 3: Major Care		
Waiting Period	No waiting period	No waiting period
Crowns, Inlays, Onlays	60%	60%
Bridges and Dentures	60%	60%
Implants	60%	60%
Repairs and Adjustments	60%	60%
Type 4: Orthodontia – Adult and children coverage		
Coinsurance	50%	
Lifetime Maximum	$2,000	
Dependent Eligibility		
Dependents Eligible to Age	26	
Full Time Students to Age	26	

Threshold	Max Rollover Amount	Max Rollover Account Limit
$700	$350	$1,250

NOTE: Maximum Rollover applies to new entrants who join the plan with 3 months or less remaining in the benefit year, as of the next benefit year.

DENTAL GUARDIAN

Coverage	Bi-Weekly
Employee Only	$7.35
Employee + Spouse	$14.46
Employee + Child(ren)	$18.40
Employee + Family	$27.55

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Vision Benefits

Everi will provide vision coverage through Guardian utilizing the VSP Vision Network. The summary of your benefits is outlined below.

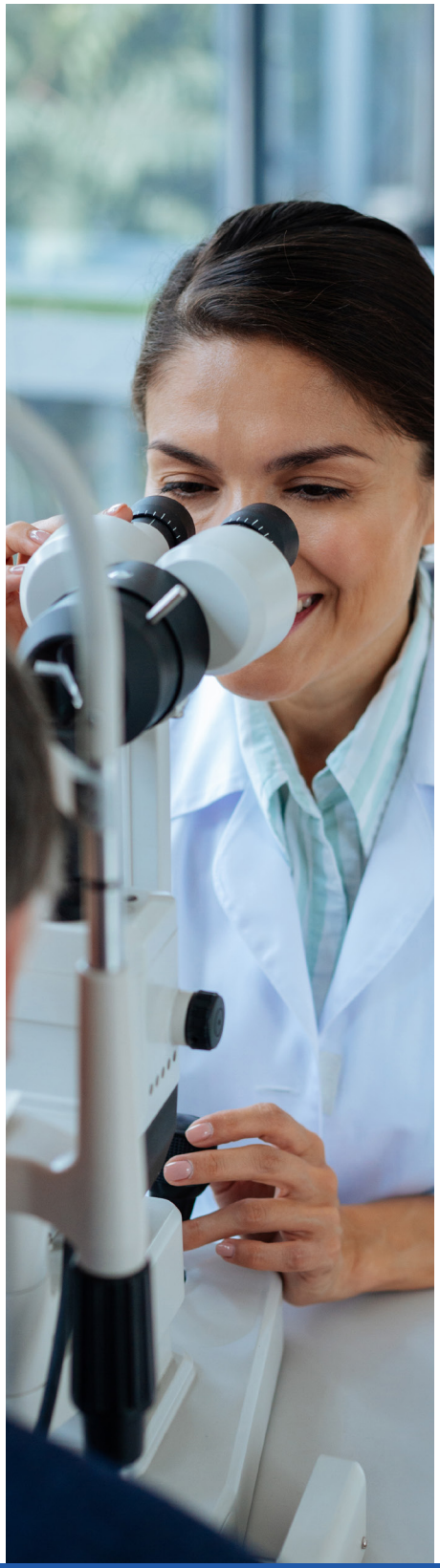
Benefit Comparison	In-Network	Out-of-Network
Network	**VSP Choice**	
Life Benefit Amount		
Frequency	12 / 12 / 12	
Deductibles	$10 Exam – $25 Lenses or Frames	
Copays / Allowances		
Exam	$10 Copay	$39 Allowance
Frames	$130 Allowance	$46 Allowance
Single Vision Lenses	$25 Copay	$23 Allowance
Bifocal Lenses	$25 Copay	$37 Allowance
Trifocal Lenses	$25 Copay	$49 Allowance
Lenticular Lenses	$25 Copay	$64 Allowance
Contacts		
Contact Lenses Medically Necessary	$25 Copay	$210 Allowance
Contact Lenses Elective	$130 Allowance	$100 Allowance

Vision Guardian

Coverage	Bi-Weekly
Employee Only	$1.14
Employee + Spouse	$2.19
Employee + Child(ren)	$2.15
Employee + Family	$3.26

TO FIND VISION PROVIDERS NEAR YOU:

- Log on to: www.guardianlife.com
- Select “Connect with us” and then click “Find a Provider”at the top of the screen
- Click “Find a Visual Provider”
- Click “VSP Vision”



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FSA – Medical & Dependent Care

Medical Flexible Spending Account

A medical FSA 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. This saves you money by reducing your taxable income.

What does it cover?

There are thousands of eligible items, including:

- Copays and coinsurance
- Doctor visits and surgeries
- Over-the-counter medications (first aid, allergy, asthma, cold/flu, heartburn, ect.)
- Prescription drugs
- Birthing and lamaze classes
- Dental and orthodontia
- Frames, contacts, prescription sunglasses, ect.

Funds on Day 1

Schedule that surgery, buy those eyeglasses or finally get those braces. All of your FSA funds are available to spend right away. Use you benefits debit card at the point of purchase.

Discount

Think of it like a discount on healthcare expenses at stores such as Amazon, Target, CVS, Walmart, Walgreen's and more. Dollars you contribute are taken out of your paycheck before tax which means a $100 purchase would actually cost you over $130 without a medical FSA.*

Fast fact: Medical FSA

Don't know how much to elect? Determine how much you spent on healthcare expenses last year and estimate the amount you'll spend this year using our eligible expense list. Any funds you contribute to the medical FSA must be spent by the end of the plan year.

Have questions?

Available Monday-Friday, 6am-9pm CST, with the exception of some major holidays.

Questions: 1-866-451-3399

Email: customerservice@wexhealth.com

Submit a form: forms@wexhealth.com

Live chat: go to www.wexinc.com, hover over Solutions and select Participants/Employees.

Dependent Care Flexible Spending Account

A dependent care FSA allows you to put aside a portion of your paycheck before taxes for eligible dependent care expenses each year.

What does it cover?

The list includes but is not limited to, eligible:

- Childcare center, babysitter, nanny (birth through age 12)
- Summer day camp
- Before- or after-school care
- Disabled dependent and/or spouse care
- Elder care

Save Money

The dependent care FSA lets you pay for eligible dependent care expenses while you reap the benefits of additional tax savings. You're spending the money either way. This way, eligible childcare and other dependent care costs are a little less.

Save Strategically

Submit all of your dependent care expenses at the end of the plan year for one lump sum reimbursement to give yourself a hard-earned "bonus."

View our interactive eligible expense list at https://www.wexinc.com/resources/benefits-toolkit/eligible-expenses/

**Based on a 30% tax bracket.*

Dependent Care FSA: Fast fact

For recurring costs, submit our Recurring Dependent Care form. It makes claim filing simple because you only need to submit one form once in order to get reimbursed each pay period.

How do I get a card?

We'll automatically mail you two debit cards to the address listed in your account the first time you enroll. If you're already enrolled, continue using the debit card you have.

Additional Cards

You can request additional debit cards for your spouse or dependents from your online account. Log in, under Accounts select Banking/Cards.

Expiring Debit Card

We will automatically mail you a new debit card 30 or more days prior.

Lost or Stolen Cards

If your debit card is lost or stolen, you can report it in your online account or mobile app and request a new card.

Fitness Discounts – Resources To Help You Reach Your Best Health

The Company encourages employees to achieve and maintain a healthy lifestyle through physical fitness.

To qualify for the Gym Membership Reimbursement Program you must be:

- A full-time employee.
- Employed by Everi for a minimum of 6 months.

Stay Healthy with Aetna

- Log in to aetna.com and look for the “Stay Healthy” tab.
- You’ll find discounts on fitness and much more.

Program Benefits:

- On a monthly basis, the Employee will be reimbursed the lesser of: a) up to $25 per month or b) the actual monthly fee on a monthly basis regardless of the type of membership (annual or monthly). A semi-annual/annual charge submitted by the Employee will be reimbursed to the Employee in equal monthly installments in relation to the membership period covered and in accordance with the Policy.
- Eligible fees include the annual or monthly fees for an individual membership at a facility that offers a full complement of exercise equipment and programs for cardiovascular and body strengthening (“Fitness Center”).
- Gym membership, yoga, and dance studio reimbursements are available.
- New: Subscription based fitness services such as: Tonal, The Mirror, and Peloton, etc. are now eligible for the gym membership reimbursement.

How to get your reimbursement:

- A Health Reimbursement Request and copy of the receipt must be submitted to People Operations before the 25th of each month (the “Submission Period”) for which reimbursement is requested.
- Amounts will be submitted by People Operations to Payroll for reimbursement and included on the first paycheck of each month.
- Any expenses not submitted to People Operations within the Submission Period will not be eligible for reimbursement, and an employee must be employed when the reimbursement is submitted to Payroll to be eligible.
- Recreational activities, weight-loss programs, smoking-cessation programs, and other similar programs, although encouraged as part of an overall fitness program, do not qualify for reimbursement.

Gym membership reimbursements are taxable income under IRS code. Therefore, amounts reimbursed to an Employee will be reported as taxable income to the Internal Revenue Service and is subject to FICA, Medicare, federal, state, and local taxes. Employees should consult with a physician before beginning a physical regimen.

Disability Benefits

Everi provides each employee with company-paid Short-Term (STD) and Long-Term (LTD) Disability Insurance benefits at no cost to you. Each full time employee is automatically enrolled in both plans. Both benefits are tax-preferred, and these benefits are taxed per pay check.

Short Term Disability

Benefit Comparison	Description
Eligibility Definition	All Eligible Employees
Benefit Amount	60% of weekly payroll
Weekly Benefit Maximum	$4,500 maximum
Day Benefits Begin - Accident / Sickness	8th day / 8th day
Maximum Benefit Duration	12 weeks
Pre-Existing Condition Limitations	Not Applicable

Long Term Disability

Benefit Comparison	Description
Eligibility Definition	All Eligible Employees
Benefit Amount	60% of monthly payroll
Monthly Benefit Maximum	$10,000 maximum
Elimination Period	90 days
Benefit Duration	Social Security Normal Retirement Age (SSNRA)
Own Occupation Period	The first 36 months of benefit payments
Basic Monthly Earnings Definition	Earnings means your monthly earnings excluding expense accounts, and any other extra compensation. Earnings include the average of your bonuses & commissions for the previous 24 months.
Mental Illness/Substance Abuse Limitation	24 months lifetime maximum
Pre-Existing Condition Limitations	3/12
Pre-Existing Condition Definitions	Lookback / Continuously Covered
Waiver of Premium	We waive your premiums for this coverage while you are entitled to receive a monthly benefit payment from Everi.

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Group Life Insurance

Group Life is provided to all eligible employees at no cost to you. You also have the option to purchase additional life insurance for you and your family.

GROUP LIFE

Benefit Comparison	Description
Eligibility Definition	All Actively at Work Full Time Employees
Life Benefit Amount	2x Salary up to $750,000 Total
Guaranteed Issue Amount	Underwriting may be required, depending on amount and / or age
Age Reduction Schedule	Age 70: 25% Age 75: 35%
Conversion	Yes, with restrictions
Portability	Yes, with age and other restrictions, including evidence of insurability
Waiver of Premium	For employees disabled prior to age 60, with premiums waived until age 65, if conditions are met
Accelerated Death Benefit	Yes

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Voluntary Life Insurance

Everi permits insurers to offer employees of Everi certain voluntary insurance programs. Whether you choose to enroll in any of these programs is completely optional and voluntary. Everi does not make a contribution towards the cost of these programs and employees pay the full cost of premiums on an after-tax basis. Everi does not sponsor, maintain, endorse, recommend, or promote these voluntary programs. Everi involvement regarding these voluntary insurance programs is strictly limited to allowing the insurer access to employees to publicize these programs and Everi may perform certain ministerial functions such as payroll deduction and forwarding employee premium payments to the insurer. Everi does not receive any consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions. Accordingly, these voluntary insurance programs are subject to ERISA and related regulations. All questions or claims regarding these programs should be directed to the insurer.

Evidence of Insurability

If you elected Voluntary Life Insurance and wish to increase your coverage amount, please complete an Evidence of Insurability Form. If you waived Voluntary Life for yourself or spouse at your initial enrollment and or are enrolling in amounts above the Guaranteed Issue amount, Evidence of Insurability is required.

Directions for filling out the Evidence of Insurability form and requirements can be found in SharePoint and during your enrollment session.

VOLUNTARY LIFE

Benefit Comparison	Description
Eligibility Definition	All Actively at Work Full Time Employees
Life Benefit Amount	$10,000 up to $500,000
Employee Guaranteed Issue Amount	$150,000
Spouse Life Benefit	$10,000 up to $500,000
Spouse Guaranteed Issue Amount	$50,000
Dependent Child Benefit	$10,000
Dependent Child Guaranteed Issue Amount	$10,000
Age Reduction Schedule	Age 70: 25% Age 75: 35%

Ages	Monthly Summary Rates – Per $1,000 of Benefit
00 - 19	$0.040
20 - 24	$0.040
25 - 29	$0.040
30 - 34	$0.090
35 - 39	$0.150
40 - 44	$0.200
45 - 49	$0.320
50 - 54	$0.580
55 - 59	$0.860
60 - 64	$1.500
65 - 69	$2.640
70 - 99	$4.510
Children	$0.22

Legal Benefits - Planned and Unplanned Events

Protect your family's future during unpredictable economic uncertainty. LegalEASE offers valuable benefits to shield your family and savings from unexpected personal legal issues as well as safeguard you during unpredictable economic uncertainty.

What you get with a

LegalEASE plan:

- An attorney with expertise specific to your personal legal matter
- Access to a national network of attorneys with exceptional experience that are matched to meet your needs
- In- and out-of-network coverage
- Concierge help navigating common individual or family legal issues

Learn more

For more information, visit: legaleaseplan.com/everi

To learn more, call: 800-248-9000 and reference "Everi Payments Inc."

A legal insurance plan can ease the biggest stresses - finding and paying for legal expertise when you need it most. LegalEASE offers an insurance plan that supports and protects you and your loved ones from unexpected personal legal issues amid uncertain economic times. The value of a LegalEASE insurance plan. Being a member saves costly legal fees and provides coverage for:

HOME & RESIDENTIAL

Purchase of Primary Residence, Sale of Primary Residence, Refinancing of Primary Residence, First Time Home-Buyer, Vacation or Investment Home Sale/Purchase/Refinancing, Home Equity Loan Assistance, Property Tax Assessment, Tenant Dispute, Tenant Security Deposit Dispute, Landlord Dispute with Tenant, Security Deposit Dispute with Tenant, Construction Defect Dispute, Neighbor Dispute, Noise Reduction Dispute, Boundary or Title Dispute, Zoning Application, Foreclosure

AUTO & TRAFFIC

Traffic Ticket, Serious Traffic Matters (Resulting in Suspension or Revocation of License), Administrative Proceeding (Regarding Suspension or Revocation of License), First-time Vehicle Buyer, Vehicle Repair and Lemon Law Litigation, DUI/DWI Defense

ESTATE PLANNING & WILLS

Will or Codicil, Complex Will, Living Will, Health Care Power of Attorney, Living Trust Document, Probate of Small Estate

FINANCIAL & CONSUMER

Debt Collection: Pre-litigation Defense & Trial Defense, Garnishment Defense, Bankruptcy (Chapter 7 or 13), Tax Audit, Tax Defense, Student Loan Refinancing/Collection Defense, Repossession Defense, Document Preparation, Consumer Dispute, Small Claims Court, Construction/Renovation/Home Repair Dispute, Mail Order or Internet Purchase Dispute, Bank Fee Dispute, Cell Phone Contract Dispute, Personal Property Protection, Warranty Dispute. Healthcare Coverage Disputes and Records, Financial Advisor, Identity Theft Defense

FAMILY

Separation, Divorce, Post-Divorce Proceedings, Prenuptial Agreement, Name Change, Guardianship/Conservatorship, Adoptions, Child Custody/Support Involving Never-Married Parents of a Child, Protection from Domestic Violence, Juvenile Court Proceeding, School Administrative Proceeding, Immigration Assistance, Parental Responsibility Matters, Elder Law

GENERAL

Initial Law Office Consultation, Review of Simple Documents, Civil Litigation Defense, Incompetency Defense, Administrative Hearing Representation, Discounted Contingency Fees, Mediation, Habeas Corpus Proceedings, Misdemeanor Defense, Identity Theft Assistance, Restraining Order Assistance

Plan Details:

$8.64 per pay-period*, via payroll deduction

Who's covered:

- Employee
- Spouse
- Dependent Children– Up to age 26
- Parents
  Elder Benefits designed for Plan member's and Spouse's parents

**Based on a 26 pay-period deduction schedule on voluntary product*

Limitations and exclusions apply. This benefit summary is intended only to highlight benefits and should not be relied upon to fully determine coverage. More complete descriptions of benefits and the terms under which they are provided are received upon enrolling in the plan. Group legal plans are administered by Legal Access Plans, L.L.C. or LegalEASE Home Office: 5151 San Felipe, Suite 2300, Houston, TX. This legal plan may not be regulated as insurance in some states, but is available in all states. Underwritten by Virginia Surety Company in all states except where underwriting is not required but the product is available. Please contact LegalEASE for complete details.

Accident Insurance - NOW ENHANCED

Guardian

If you and your family are active, chances are, you're no stranger to a hospital emergency room. Even with medical insurance, a fall while bicycle riding or your child's sprained ankle at soccer practice can cost you a bundle in out-of-pocket expenses. Are you financially prepared for all of the medical and non-medical costs of treatment and recovery from a serious injury?

- Receive cash benefits based on covered injuries, treatments and services and they go directly to you
- Child Organized Sports benefit pays additional 20% benefit for a child injured while playing organized sports*
- Guaranteed acceptance for you and eligible family members
- Health Screening Benefit gives you $50 back for your routine health screenings, such as a mammogram or colonoscopy

** The child must be insured by the plan on the date the accident occurred. The child must be age 18 or younger.*

Accident	Guardian	Guardian
Benefit Comparison	**LOW PLAN**	**HIGH PLAN**
Wellness Screening	Health Screening Benefit - $50, payable once per insured per year	Health Screening Benefit - $50, payable once per insured per year
Accident Emergency	$150 for Emergency Room Services	$250 for Emergency Room Services
Ambulance/Air Ambulance	$300 / $1,500	$600 / $2,500
Accident Follow-Up Visit	$75 (6 visits)	$100 (6 visits)
Physical Therapy	$35 per day up to 10 days	$50 per day up to 10 days
Rehabilitation	$75 per day up to 15 days	$150 per day up to 15 days
Accident Physician's Treatment	$75	$125
Hospital / ICU Admission	$1,250 normal | $2,500 ICU	$2,000 normal | $4,000 ICU
Hospital Confinement	$100 per day up to 1 year	$200 per day up to 1 year
Intensive Care Confinement	$200 per day up to 15 days	$400 per day up to $15 days
Wellness Benefit	$50 per insured per year	$50 per insured per year
Blood & Plasma	$500	$500
Transportation	$0.50 per mile, limited to $500/round trip, up to 3 times per accident	$0.50 per mile, limited to $800/round trip, up to 3 times per accident
Family Lodging	$150/day, up to 30 days for companion hotel stay	$200/day, up to 30 days for companion hotel stay
Appliance	Schedule up to $500	Schedule up to $600
Prosthesis	1: $1,500 | 2 or more: $3,000	1: $1,500 | 2 or more: $3,000
X-Ray	$75	$125
General Anesthesia	$100, 2 times per accident	$100, 2 times per accident
Child Organized Sports	25% increase to child benefits	25% increase to child benefits
Common Injuries		
Fractures - Open/Closed Reduction Lacerations, Knee cartilage, Dislocations etc	Schedule up to $6,000 Schedule up to $6,000	Schedule up to $10,000 Schedule up to $12,000
AD&D and Catastrophic Loss		
Accidental Death/Common Carrier - EE	$25,000 / 200% of AD&D	$50,000 / 200% of AD&D
Accidental Death/Common Carrier - SP	$5,000 / 200% of AD&D	$25,000 / 200% of AD&D
Accidental Death/Common Carrier - CH	$5,000 / 200% of AD&D	$25,000 / 200% of AD&D
Dismemberment	Schedule up to 100% of AD&D Benefit	Schedule up to 100% of AD&D Benefit
Coma	$10,000	$20,000
Paralysis	50% AD&D for paraplegia / 100% for quadriplegia	50% AD&D for paraplegia / 100% for quadriplegia
Tier	**Low Plan (Per Pay Period)**	**High Plan (Per Pay Period)**
Employee	$4.31	$6.50
Employee & Spouse	$7.28	$10.93
Employee & Child(ren)	$7.67	$11.10
Family	$10.65	$15.54

Hospital Indemnity Insurance - NOW ENHANCED!

Guardian

Hospital Indemnity Insurance pays a lump-sum benefit if you or a covered family member is hospitalized. An injury or illness that requires a hospital stay can happen to anyone at any time, and usually comes when you least expect it. Your medical insurance may cover hospital bills, but it may not cover all of the costs associated with a hospital stay. This is where Hospital Indemnity Insurance benefit can help.

- Supplements your medical plan – no matter what type of other coverage you have
- Health Screening Benefit gives you $50 back for your routine health screenings, such as a mammogram or colonoscopy
- Guaranteed acceptance for you and eligible family members

Hospital Indemnity	Guardian	Guardian
Benefit Comparison	LOW PLAN	HIGH PLAN
Type of Plan	Group Hospital Indemnity – HSA Compatible	Group Hospital Indemnity – HSA Compatible
Coverage	Sickness and Injury	Sickness and Injury
Benefit Amount	$1,000 / $2,000 per admission to a max of 2 admissions per year, per insured, max of 3 admissions, per year, per covered family	$1,500 / $3,000 per admission to a max of 2 admissions per year, per insured, max of 3 admissions, per year, per covered family
Daily Confinement	$100 per day to a max of 30 days per year, per insured	$200 per day to a max of 30 days per year, per insured
Daily ICU Confinement	$200 per day to a max of 30 days per year, per insured	$400 per day to a max of 30 days per year, per insured
Waiting Period for Maternity	Included with no 9 month limitation, subject to pre-ex	Included with no 9 month limitation, subject to pre-ex
Wellness Benefit	$50 once per year, per insured, max of 3 per family per year	$50 once per year, per insured, max of 3 per family per year
Pre-Existing Condition	3/12	3/12
Portability	Yes	Yes

HOSPITAL INDEMNITY INSURANCE RATES

Per Pay Period Premium

PLAN OPTIONS:	LOW PLAN	HIGH PLAN
Employee	$4.20	$8.20
Employee + Spouse	$7.73	$15.10
Employee + Child(ren)	$7.73	$15.10
Family	$13.65	$26.67

Piper Jordan

Critical Illness Insurance - NOW ENHANCED!

When you or a family member suffers a serious illness like a heart attack, cancer or stroke, Critical Illness Insurance can help with the expenses that medical insurance doesn't cover, like deductibles or out-of-pocket costs or services.

- Provides a lump-sum benefit for each eligible diagnosis, paid directly to you so you decide how to use it
- Benefit is paid upon diagnosis so you get the funds to offset upcoming out-of-pocket expenses
- Guaranteed acceptance for you and eligible family members – and children are covered at no additional cost
- If you are increasing and or adding new coverage you must complete an EOI form when you enroll. Initial enrollments at age 70 or older require medical questions.
- Health Screening Benefit gives you $50 back for your routine health screenings, such as a mammogram or colonoscopy

CRITICAL ILLNESS – Guardian Benefit Comparison

COVERED CONDITIONS	First Occurrence / Second Occurence
Benefit Amount	$15,000 or $30,000
Heart Attack	100% / 100
Heart Failure	100% / 100%
Stroke	100% / 100%
Major Organ Failure	100% / 0%
End Stage Renal Failure	100% / 50%
Permanent Paralysis	100%
Invasive Cancer	100% / 100%
Loss of Sight	100%
Coma	100%
Cancer in Situ	30% / 30%
Benign Brain Tumor	100% / 100%
Loss of Hearing	100%
Alzheimer's Disease	50%-100%
Advanced Parkinson's Disease	100%
Coronary Arteriosclerosis	30%
ALS/Lou Gehrig's Disease	100%
Advanced Multiple Sclerosis	100%
Loss of Speech	100%
Huntington's Disease	30%
Severe Burn	100%

Critical Illness Insurance - NOW ENHANCED!

Guardian

ADDITIONAL CHILDHOOD COVERED CONDITIONS	First Occurrence / Second Occurence
Cerebral Palsy	100% of child benefit (25% of EE amount)
Cleft Lip/Palate	100% of child benefit (25% of EE amount
Club Foot	100% of child benefit (25% of EE amount)
Cystic Fibrosis	100% of child benefit (25% of EE amount)
Down's Syndrome	100% of child benefit (25% of EE amount)
Muscular Dystrophy	100% of child benefit (25% of EE amount)
Spina Bifida	100% of child benefit (25% of EE amount)
Type 1 Diabetes	100% of child benefit (25% of EE amount)
Does Diagnosis prior to plan effective date count as first occurrence?	No
Issue Age or Attained Age?	Issue Age
ADDITIONAL OCCURRENCE	**100% after 3 months for Subsequent Diagnosis (different illness); 50% after 12 months for Recurrence of same illness (as noted above)**
Waiver of Premium	No
Wellness Benefit	$50 per insured per year
Skin Cancer	$500
ADDITIONAL FEATURES	
Benefit Reduction	50% at Age 70
Portability	Yes
Pre-Existing Condition	3 month / 12 month
Guaranteed Issue	$30,000

Stroke: Stroke must be severe enough to cause neurological deficits at least 30 days after the event

Heart Failure: An insured must be placed on an organ transplant list in order to be eligible for the heart failure benefits.

Coronary Arteriosclerosis: Coronary Arteriosclerosis must be severe enough to require a coronary artery bypass graft.

Organ Failure: Organ failure includes both lungs, liver, pancreas or bone marrow and requires the insured to be placed on an organ transplant list.

Kidney Failure: An insured must be placed on an organ transplant list in order to be eligible for the kidney failure benefits.

$15,000 Benefit Amount Per Pay Period						
Issue Age	**< 30**	**30-39**	**40-49**	**50-59**	**60-69**	**70+**
Employee: $15,000	$3.39	$4.70	$8.96	$16.64	$25.77	$49.67
Spouse: $7,500	$1.87	$2.56	$4.78	$8.79	$13.56	$25.83
$30,000 Benefit Amount Per Pay Period						
Employee: $30,000	$6.37	$8.92	$17.27	$32.29	$50.14	$97.30
Spouse: $15,000	$3.36	$4.67	$8.93	$16.62	$25.75	$49.64
CHILD (childbirth to 26 years)						
Child cost is included with employee election						

Financial Wellness: Identity & Digital Protection

Everi will cover the cost of Total Individual for all benefit eligible employees! Employees have the option to buy-up to Total Family or the Ultimate plan. Please see below for a comprehensive list of plan features for both Total and Ultimate.

With Every Click, Scroll, and 'Like', We Are Putting Ourselves At Risk.

Aura (formerly Identity Guard) offers a smart, simple way to stay safe online. Technology is essential to daily life. We use websites, devices, and apps that enable us to do nearly everything. But as the digital world grows more complex and advanced, so do online scams, cybercriminals, and predators.

- **Financial Fraud Protection:** Credit monitoring & alerts, credit lock, and financial tools to help keep your assets safe.
- **Identity Fraud Protection:** Get alerts if threats to your identity, SSN, online accounts, and more are detected.
- **VPN & Online Privacy:** Secure your devices, keep your online activities private, and keep hackers at bay. Monitor your social media feeds for reputation & privacy risks.
- **Digital Vault:** Securely store and share sensitive data, digital files, and passwords with military-grade encryption—all in one place.
- **Family Safety (Family Plans Only):** Child & elder fraud prevention tools like parental controls & cyberbullying protection, alert stharing, scam **protection, and more. Covers 10 additional adults and unlimited minors.**
- **Identity Restoration:** If ID theft occurs, Aura offers a generous $5M in ID theft insurance*, White Glove Resolution Service, 24/7 customer care, and lost wallet protection with $500 emergency cash.

Aura does all of this and more from one easy-to-use mobile or desktop app.

Download the Aura app or login to start!

Need help? Aura is available 24/7 at support@aura.com or call (866) 324-3159

Monthly Rates

Plans	Total	Premier
Employee Only	Paid for by Everi	$9.00
Employee + Family	$10.00	$15.00

Per Pay Period

Plans	Total	Premier
Employee Only	Paid for by Everi	$4.15
Employee + Family	$4.62	$6.92

	Total	Ultimate
Financial Fraud Protection		
Credit Monitoring & Alerts	1-Bureau	3-Bureau
Annual Credit Report	1-Bureau	3-Bureau
Monthly Credit Score Tracker*	✔	✔
Credit, Bank & Account Freeze Assistance	✔	✔
Home & Auto Title Monitoring	✔	✔
Financial Account Opening & Takeover Monitoring	✔	✔
Financial Transaction Monitoring	✔	✔
Tax Fraud Prevention Assistance.	✔	✔
High-Risk Transaction Alerts	✔	✔
Experian Credit Lock		✔
Credit Score Simulator		✔
Privacy & Device Protection		
Password Manager	✔	✔
Automated Password Change	✔	✔
Email Alias	✔	✔
Safe Web Browsing	✔	✔
Privacy Protection Report	✔	✔
IP Address Monitoring	✔	✔
WiFi Security (VPN) & Antivirus	2 Devices	Unlimited
Online Safety Scan	✔	✔
Safety Checklist	✔	✔
Identity Theft Protection		
Privacy Assistant	✔	✔
Dark Web Monitoring for Personal Info, IDs & Accounts	✔	✔
Criminal, Court & Public Record Monitoring	✔	✔
USPS Address Monitoring	✔	✔
Social Media Monitoring, Privacy Checkup & Alerts		✔
Gamertag Monitoring		✔
Family Safety (For Family Plans Only, Unlimited # of Children)		
Parental Controls		✔
Child Cyberbullying Protection	✔	✔
Child Credit Freeze Wizard	✔	✔
Child SSN Monitoring & Alerts	✔	✔
Sex Offender Geo Alerts	✔	✔
Digital Vault	✔	✔
$5M Identity Theft Insurance* for Each Enrolled Adult	✔	✔
Child Safety Checklist	✔	✔

** As a component of becoming an Aura Plan member, Consumers receive identity theft insurance through a group policy issued to Aura which is underwritten and administered by American Bankers Insurance Company of Florida, an Assurant company. Checking & Savings Cash Recovery and 401(K) & HSA Cash Recovery are part of and not in addition to the Expense Reimbursement limit of liability. The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.*

Everi 401(K) Retirement Plan

Investing for the future is important, especially in today's economy. The Everi 401(k) Retirement Plan through Empower makes it easy for you to save for retirement by giving you the opportunity to defer your pay, pre-tax or Roth, up to set IRS limits, to take advantage of the company matching contribution. Contact People Operations for eligibility requirements and enrollment information.

Your Contribution

- You may contribute up to 75% of your per payroll compensation, up to the set annual IRS limits.
- You may modify contribution percentage anytime during the year.
- You may elect to contribute to the plan pre-tax or Roth Individuals age 50 and over. are eligible to make a catch-up contribution to the set annual IRS limits.
- Automatic Enrollment at 4% if you do not make any elections.
- Please refer to your enrollment packet for more information about contributions and auto enrollment.

Everi Matching Contributions

Everi will match employee deferral contributions, Roth or tax-deferred, with a formula equal to 50% of the first 10% of eligible compensation per pay period. Please refer to your 401(k) enrollment booklet for additional details regarding the plan.

FUND ACCESSIBILITY

If you qualify, you may access your 401(k) funds in the following ways:

- Death
- Permanent total disability
- Termination
- In-service withdrawal – rollover contribution
- 59 ½ in-service withdrawal
- Hardship distribution

LOAN OPTION

- Withdrawal up to $50,000 or 50% vested balance subject to IRS regulations.
- Minimum loan amount is $1,000.
- Participants can't have more than one outstanding loan at a time.
- Maximum term of loan – must be repaid within 5 years unless loan is used to purchase a primary residence which allow up to 15 years for repayment.
- Terminated participants have 90 days from the date of termination to repay outstanding loan balances.

Learn more at www.empower.com

ARE YOU MISSING OUT ON FREE MONEY FROM EVERI?

Everi's match contribution formula is equal to 50% of the first 10% of eligible compensation deferred per pay period.

So, the Everi 401(k) Retirement Plan through Empower makes it easy for you to save for retirement by giving you the opportunity to defer and invest your pay, pre-tax or Roth, up to set annual IRS limits while the company matches your contribution.

Pet Insurance from Nationwide®

Fetch the best health coverage for your pet this open enrollment. With two budget friendly options, there's never been a better time to sign up for My Pet Protection®, available only through your workplace benefits program.

- Get cash back on eligible vet bills: Choose 50% or 70% reimbursement [1]
- Just for employees: Preferred pricing offered only through your company
- Use any vet, anywhere: No networks, no pre-approvals

Nationwide® My Pet Protection® Plan Summary

Nationwide pet insurance helps you cover veterinary expenses so you can provide your pets with the best care possible without worrying about the cost.

My Pet Protection coverage highlights:

My Pet Protection is available in two reimbursement options (50% and 70%) so you can find coverage that fits your budget. All plans have a $250 annual deductible and $7,500 maximum annual benefit. Coverage includes[1]:

- Accidents
- Illnesses
- Hereditary and congenital conditions
- Cancer
- Behavioral treatments
- Rx therapeutic diets and supplements
- Lost pet advertising and reward expense
- Emergency boarding
- Loss due to theft
- Mortality benefit
- And more

What Makes My Pet Protection Different?

My Pet Protection is available only through your employer and is guaranteed issuance. It also includes benefits like lost pet advertising, emergency boarding and more. It's no surprise that My Pet Protection is the most paw-pular coverage plan from America's #1 pet insurer.

Did you know? Nationwide is the only insurer with coverage plans for birds and exotic pets. To enroll your bird, rabbit, reptile or other exotic pet, call 877-738-7874.

www.petinsurance.com/everi

Nationwide®

How to use your pet insurance plan

- Visit any vet, anywhere.
- Submit claim.
- Get reimbursed for eligible expenses.

vethelpline®

- 24/7 access to veterinary experts ($110 value)
- Available via phone, chat and email
- Unlimited help for everything from general pet questions to identifying urgent care needs

Nationwide PetRxExpress℠

- Save time and money by filling pet prescriptions at participating in-store retail pharmacies across the U.S.
- Rx claims submitted directly to Nationwide
- More than 4,700 pharmacy locations

[1] Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. Reimbursement options may not be available in all states. Products underwritten by Veterinary Pet Insurance Company (CA), Columbus, OH; National Casualty Company (all other states), Columbus, OH. Agency of Record: DVM Insurance Agency. All are subsidiaries of Nationwide Mutual Insurance Company. Nationwide, the Nationwide N and Eagle, and Nationwide is on your side are service marks of Nationwide Mutual Insurance Company. ©2022 Nationwide. 22GRP8795Q

[1] These are examples of general coverage; please review plan document for specific coverages. Some exclusions may apply. Certain coverages may be excluded due to pre-existing conditions. See policy documents for a complete list of exclusions.

Products underwritten by Veterinary Pet Insurance Company (CA), Columbus, OH; National Casualty Company (all other states), Columbus, OH. Agency of Record: DVM Insurance Agency. All are subsidiaries of Nationwide Mutual Insurance Company. Nationwide, the Nationwide N and Eagle, Nationwide is on your side, vethelpline and Nationwide PetRxExpress are service marks of Nationwide Mutual Insurance Company. ©2022 Nationwide. 22GRP8795C

BenefitHub

Everi is proud to team up with BenefitHub in order to bring you an amazing new benefit that provides exclusive discounts on just about everything – featuring all the brands you love!

Choose from 700+ different offers from your favorite brands!

A few ideas

- Take the vacation you've been dreaming of, and enjoy savings on your hotels, flights, rental cars.
- Get that new gadget you've been wanting.
- Find deals for your next trip to the movies, day out to the theme park, concert tickets and more!

Register your account – It's easy to set up and go!

- Find your benefits portal: Everi's BenefitHub portal can be found at: Everi.benefithub.com
- Sign up for your account: When you create your account, we will ask you for some basic contact information: **Everi.benefithub.com Referral Code: TTDBDU**
- Opt-In for emails: Be sure to opt-in for our emails, so you can receive the hottest deals right in your inbox.
- Get your benefits! As soon as you've registered, you can start using your benefits. Make sure you explore the site for discounts on just about anything!

BENEFIT SERVICE CENTER

An Advocate is ready to help!

We're proud to partner with Piper Jordan to provide personalized support that helps you and your family navigate your benefits with confidence.

Whether you're enrolling in coverage, dealing with a complex claim, or just have questions, Piper Jordan's team is here for you. Here's how they can help:

→ ENROLLMENT SUPPORT

- Help with your new hire or qualifying life event (QLE) enrollments
- Guidance on benefit options and enrollment deadlines
- Support with Medicare coordination and enrollment if needed

→ ID CARD SERVICES

- Help ordering or accessing benefit ID cards such as medical, dental, vision and flexible spending accounts
- Assistance with digital ID card access and replacement requests

→ CLAIMS & CONCIERGE SERVICES

- Help understanding and managing your benefit claims
- Assistance with appeals, denied services, prior authorization, and billing
- Coordination with providers and insurance carriers
- One-on-one support throughout the claims process

Piper Jordan's team includes multilingual, licensed benefits experts.

CONTACT

Call or Text: (866) 643-7110
8:00 AM - 7:00 PM CST M-F

Email:
everisupport@piperjordan.com

Nurturing employees & their families

POWERED BY PASSION

At Piper Jordan, our dedicated team specializes in Medicare education, questions, and enrollment support and direction. We guide employees and their families through the intricacies of Medicare, ensuring they understand their options and make informed decisions. Our services include comprehensive support for Medicare enrollment, answering any questions that arise, and providing direction to help individuals navigate the process with ease. With our compassionate approach and deep industry knowledge, we simplify the Medicare journey for your members, empowering them to optimize their healthcare coverage. As your steadfast partner in health, we are committed to being there for you and your family every step of the way.

Medicare Support Center

POWERED BY PERFORMANCE

PHONE (866) 643-7110
EMAIL everisupport@piperjordan.com
6:00 AM to 5:00 PM Pacific Time, Monday through Friday

If you have any questions or need assistance with the Medicare enrollment process, feel free to contact us during these hours. Outside of our operating hours, please leave a voicemail, and we'll promptly assist you. We're dedicated to providing support for all your Medicare needs.

Reference & Resources

Benefit	Policy	Phone	Website
Medical – Aetna	187832	877-375-7907	www.aetna.com
Virtual Care - Teladoc	-	1-800-Teladoc	www.teladoc.com
Pharmacy – Navitus	-	844-268-9789	www.navitus.com
Dental – Guardian	462724	800-541-7846	www.guardianlife.com
Vision – Guardian Utilizing VSP Vision network	462724	877-814-8970	www.guardianlife.com
Short-Term Disability - Guardian	462724	800-268-2525	www.guardianlife.com
Long-Term Disability - Guardian	462724	800-538-4583	www.guardianlife.com
Basic Life – Guardian Voluntary Life – Guardian	462724	800-525-4542	www.guardianlife.com
Flexible Spending Account (FSA) – WEX		866-451-3399	www.wexinc.com
EAP – Lyra		877-235-0870	everi.lyrahealth.com Lyra Learn: learn.lyrahealth.com
Hospital Indemnity - Guardian	462724	800-268-2525	www.guardianlife.com
Critical Illness - Guardian	462724	800-268-2525	www.guardianlife.com
Accident - Guardian	462724	800-541-7846	www.guardianlife.com
AURA (formally Identity Guard)		866-324-3159	www.identityguard.com
401(k) - Empower	900090	877-778-2100	www.prudential.com/online/retirement
Pet Insurance by Nationwide	Everi	877-738-7874	www.PetInsurance.com/Everi
LegalEASE		800-248-9000	www.legaleaseplan.com/everi
Advocacy			
Piper Jordan Advocacy	-	866-643-7110	Email: everisupport@piperjordan.com

The benefit plan features illustrated in this Benefits Guide are provided for informational purposes only. They are illustrated to assist you in comparing plan provisions. Actual provisions of insurance coverage are furnished in the certificate of coverage; should a discrepancy arise, the certificate of coverage will prevail.

Brokerage & Consulting Services provided by:

Piper Jordan

Piper Jordan Health & Benefits Partners, LLC
8337 W. Sunset #150, Las Vegas, NV 89113
Tel: (702) 457-2268 | Fax: (702) 597-0159

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

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, 2023. Contact your State for more information on eligibility.

ALABAMA Medicaid

Website: http://myalhipp.com/

Phone: 1-855-692-5447

ALASKA Medicaid

The AK Health Insurance Premium Payment Program

Website: http://myakhipp.com/

Phone: 1-866-251-4861

Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS Medicaid

Website: http://myarhipp.com/

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA Medicaid

Health Insurance Premium Payment (HIPP) Program

http://dhcs.ca.gov/hipp

Phone: 916-445-8322

Email: hipp@dhcs.ca.gov

COLORADO Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/

Health First Colorado Member Contact Center:

1-800-221-3943/ State Relay 711

CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus

CHP+ Customer Service: 1-800-359-1991/ State Relay 711

Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program

HIBI Customer Service: 1-855-692-6442

FLORIDA Medicaid

https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/ hipp/index.html

Phone: 1-877-357-3268

GEORGIA Medicaid

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 678-564-1162 ext 2131

INDIANA Medicaid

Healthy Indiana Plan for low-income adults 19-64

Website: http://www.in.gov/fssa/hip/

Phone: 1-877-438-4479

All other Medicaid

Website: https://www.in.gov/medicaid/

Phone 1-800-457-4584

IOWA Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members

Medicaid Phone: 1-800-338-8366

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

Hawki Website: http://dhs.iowa.gov/Hawki

Hawki Phone: 1-800-257-8563

HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp

HIPP Phone: 1-888-346-9562

KANSAS Medicaid

Website: https://www.kancare.ks.gov/

Phone: 1-800-792-4884

KENTUCKY Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx

Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) MAINE Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms

Phone: -800-977-6740. TTY: Maine relay 711

MASSACHUSETTS Medicaid and CHIP

Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa

Phone: 1-800-862-4840

MINNESOTA Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp

Phone: 1-800-657-3739

MISSOURI Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

NEBRASKA Medicaid

Website: http://www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA Medicaid

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

NEW HAMPSHIRE Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/

Medicaid Phone: 609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

NEW YORK Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA Medicaid

Website: https://medicaid.ncdhhs.gov/

Phone: 919-855-4100

NORTH DAKOTA Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/

Phone: 1-844-854-4825

OKLAHOMA Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html

Phone: 1-800-699-9075

PENNSYLVANIA Medicaid

Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx

Phone: 1-800-692-7462

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

RHODE ISLAND Medicaid and CHIP

Website: http://www.eohhs.ri.gov/

Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA Medicaid

Website: https://www.scdhhs.gov

Phone: 1-888-549-0820

SOUTH DAKOTA Medicaid

Website: http://dss.sd.gov

Phone: 1-888-828-0059

TEXAS Medicaid

Website: http://gethipptexas.com/

Phone: 1-800-440-0493

UTAH Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip

Phone: 1-877-543-7669

VERMONT Medicaid

Website: http://www.greenmountaincare.org/

Phone: 1-800-250-8427

VIRGINIA Medicaid and CHIP

Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid

Phone: 1-800-432-5924

CHIP Phone: 1-800-432-5924

WASHINGTON Medicaid

Website: https://www.hca.wa.gov/

Phone: 1-800-562-3022

WEST VIRGINIA Medicaid

Website: http://mywvhipp.com/

Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN Medicaid and CHIP

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, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration
www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

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

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

U.S. Department of Labor Employee Benefits Security Administration Newborns' and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth.

Under the Newborns' Act, group health plans may not restrict benefits for mothers or newborns for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The 48-hour (or 96-hour) period starts at the time of delivery, unless a woman delivers outside of the hospital. In that case, the period begins at the time of the hospital admission.

The attending provider may decide, after consulting with the mother, to discharge the mother and/or her newborn child earlier. The attending provider cannot receive incentives or disincentives to discharge the mother or her child earlier than 48 hours (or 96 hours).

Even if a plan offers benefits for hospital stays in connection with childbirth, the Newborns' Act only applies to certain coverage. Specifically, it depends on whether coverage is "insured" by an insurance company or HMO or "self-insured" by an employment-based plan. (Check the Summary Plan Description, the document that outlines benefits and rights under the plan, or contact the plan administrator to find out if coverage in connection with childbirth is "insured" or "self-insured.")

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on state law. Many states have enacted their own version of the Newborns' Act for insured coverage. If your state has a law regulating coverage for newborns and mothers that meets specific criteria and coverage is provided by an insurance company or HMO, state law will apply.

All group health plans that provide maternity or newborn infant coverage must include in their Summary Plan Descriptions a statement describing the Federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length of stay in connection with childbirth for the mother or newborn child.

For more information, see the Frequently Asked Questions (FAQs) About the Newborns' and Mothers' Health Protection Act.

U.S. Department of Labor Employee Benefits Security Administration Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 (WHCRA) provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must provide coverage for certain services relating to the mastectomy, in a manner determined in consultation with the attending physician and the patient.

The required coverage includes:

- 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.

Under WHCRA, mastectomy benefits may be subject to annual deductibles and coinsurance consistent with those established for other benefits under the plan or coverage.

Group health plans, health insurance companies and HMOs covered by the law must provide written notification to individuals of the coverage required by WHCRA upon enrollment and annually thereafter.

Additional consumer information on WHCRA is available in the publication Your Rights After A Mastectomy.

Information for group health plans and employers on WHCRA and other health benefit law requirements is available in the publication Compliance Assistance Guide – Health Benefits Coverage Under Federal Law.

This fact sheet has been developed by the U.S. Department of Labor, Employee Benefits Security Administration, Washington, DC 20210. It will be made available in alternate formats upon request: Voice telephone: 202-693-8664; TTY: 202-501-3911. In addition, the information in this fact sheet constitutes a small entity compliance guide for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996.

Important Notices

Certificate of Creditable Coverage

You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA, when COBRA coverage ceases, if you request it before you lose coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage from the plan, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in other coverage if you are age 19 or older.

Health Insurance Portability and Accountability Act (HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. A copy of the Privacy Practices is available for medical, dental, and vision plans from Human Resources.

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 of her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Genetic Information Nondiscrimination Act (GINA)

The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members. GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

Mental Health Parity and Addiction Equity Act (MHPAEA)

The Mental Health Parity and Addiction Act of 2008 general requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employers plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at 702-910-3958.

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). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. 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.

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those establishes for other benefits under the plan. If you would like more information on WHCRA benefits, contact HR at 702-910-3958.

Michelle's Law

When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a postsecondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier. For additional information, contact your plan administrator at 702-910-3958.

Medicare Part D Creditable Coverage Notice

An Important Notice from All Western Mortgage About Your Prescription Drug Coverage and Medicare

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

- 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.
- Ave Maria University has determined that the prescription drug coverage offered by the Ave Maria University Welfare Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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 Ave Maria University coverage will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current Ave Maria University 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 with Ave Maria University 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.

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

Name of Entity/Sender: Med-Smart Inc.
Contact--Office: Human Resources
Address: 3185 St Rose Pkwy STE 330, Henderson, NV 89052
Phone Number: (702) 735-5075

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.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

This document is designed to provide basic information regarding benefit plans and programs available to eligible employees. This document merely summarizes the employee benefit plans and programs and does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the "plan documentation") for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former employee, or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual's rights under any employee benefit plan or program. Your employer reserves the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.

This brochure highlights recent plan design changes and is intended to fully comply with the requirements under the Employee Retirement Income Security Act (ERISA) as a Summary of Material Modifications. It should be kept with your most recent Summary Plan Description. Visit www.everibenefits.com for more information.