Evernest

2026

EMPLOYEE BENEFITS GUIDE

HOURLY EMPLOYEES

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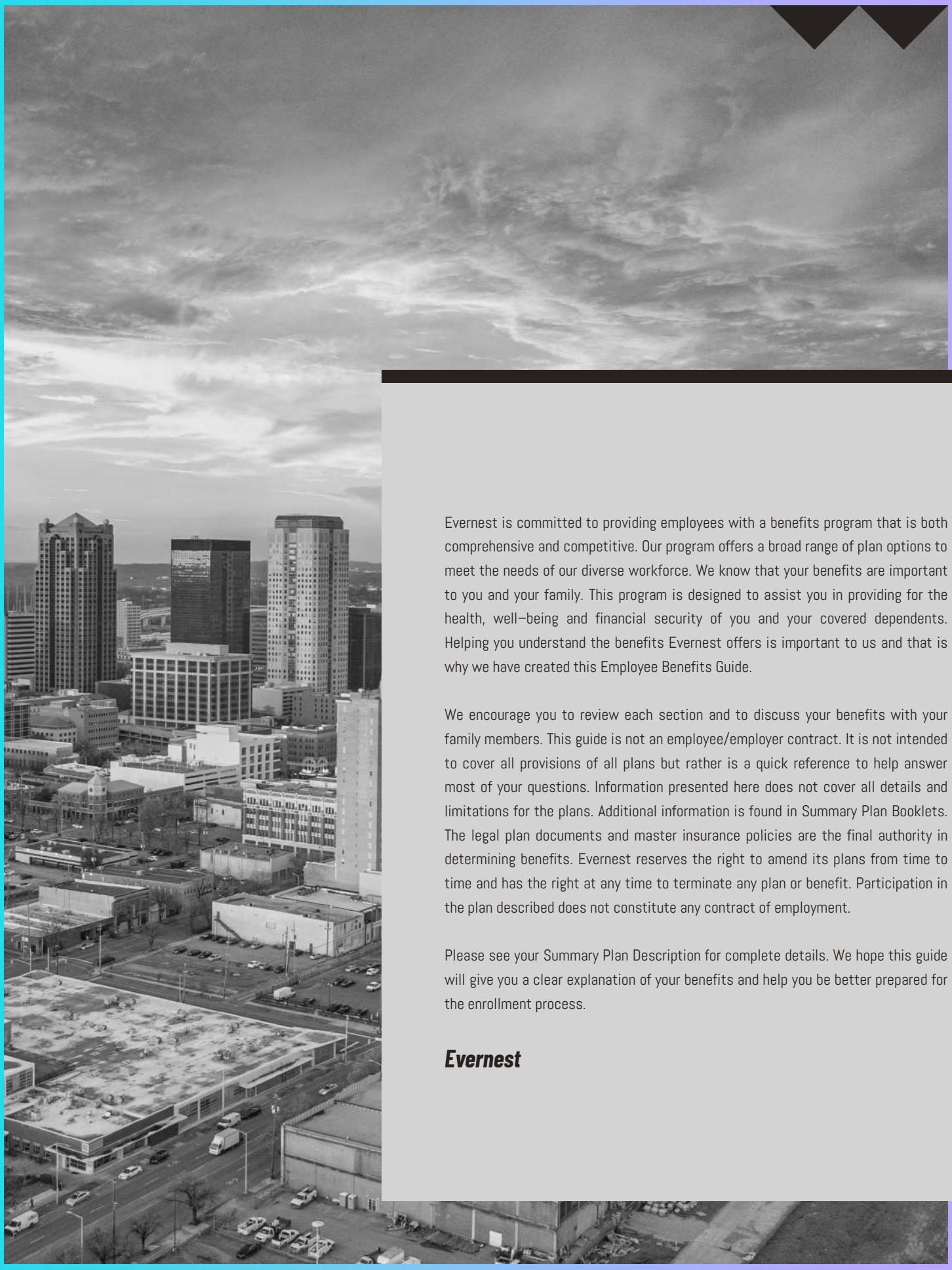


Evernest is committed to providing employees with a benefits program that is both comprehensive and competitive. Our program offers a broad range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family. This program is designed to assist you in providing for the health, well–being and financial security of you and your covered dependents. Helping you understand the benefits Evernest offers is important to us and that is why we have created this Employee Benefits Guide.

We encourage you to review each section and to discuss your benefits with your family members. This guide is not an employee/employer contract. It is not intended to cover all provisions of all plans but rather is a quick reference to help answer most of your questions. Information presented here does not cover all details and limitations for the plans. Additional information is found in Summary Plan Booklets. The legal plan documents and master insurance policies are the final authority in determining benefits. Evernest reserves the right to amend its plans from time to time and has the right at any time to terminate any plan or benefit. Participation in the plan described does not constitute any contract of employment.

Please see your Summary Plan Description for complete details. We hope this guide will give you a clear explanation of your benefits and help you be better prepared for the enrollment process.

Evernest

ELIGIBILITY & ENROLLMENT

WELCOME TO YOUR NEW EMPLOYEE BENEFITS

WHO IS ELIGIBLE

All full-time associates working at least 40 hours per week are eligible for the full range of benefits provided by Evernest. You may also enroll your eligible dependents.

EFFECTIVE DATE OF COVERAGE

During the plan year, eligible new hires will be subject to a waiting period determined by the applicable benefit. Most plans will become effective the first of the month following the waiting period.

WHEN TO ENROLL

Benefit eligible associates initially have the two following opportunities to enroll in the associate benefits program:

NEW HIRE ENROLLMENT New hires have thirty days from their date of hire to enroll in Evernest's benefit coverages. Most plans become effective first of the month following the date of hire. Associates not enrolling during this period must wait until the next open enrollment to elect coverage (Evidence of Insurability forms may be required for certain coverages).

OPEN ENROLLMENT For the 2026 plan year, Evernest's annual open enrollment period will take place beginning Monday, November 17, 2025 and will close Monday, December 1, 2025. During this time, all benefit elections will be made through Paycor. All changes and elections will be effective January 1.

WHEN YOU CAN MAKE CHANGES

Evernest benefits plan year is from January 1 to December 31. Generally, you can only change your benefit choices during the annual Benefits Enrollment period or if you have an IRS "Qualifying Event" during the year, which includes:

- Marriage or Divorce
- Birth, adoption or placement for adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that results in cancellation of your benefits
- Your dependent child is no longer eligible
- Loss of coverage through a parent's plan
- Becoming eligible for Medicare or Medicaid during the year

If you have a life event change, you must submit notification to Human Resources within 30 days of the qualifying event. Depending on the type of change, you may need to provide proof documentation (for example, a marriage license or birth certificate). If you do not submit notification within 30 days, you will have to wait until the next annual Open Enrollment period to make benefit changes.

WHEN COVERAGE ENDS

Benefits end on the last day of the month in which your employment with Evernest ends, or when you cease to meet eligibility guidelines. COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) continuation of coverage is available for eligible terminations for medical, dental and vision coverages.

MEDICAL INSURANCE

UNITED HEALTHCARE

Evernest offers two medical plan options administered by United Healthcare.

Both plans use the same network of providers who have agreed to charge discounted rates to plan members. The amount you pay for health care will vary depending on whether or not you use in- network providers and facilities. You always have the choice to go to any provider, but you'll pay less if you stay within the United Healthcare network.

	HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	PPO PLAN
Deductible ***Individual / Family*** ***Coinsurance***	$3,000 / $6,000 80%	$2,500 / $5,000 80%
Out-of-Pocket Max. ***Individual / Family***	$6,000 / $12,000	$5,000 / $10,000
Inpatient Services ***Inpatient Facility***	80% after deductible	80% after deductible
Emergency Room	80% after deductible	$250 hospital copy
Maternity Services	80% after deductible	80% after deductible
Physician Office Visits ***Primary Care***	80% after deductible	$30 copay
Outpatient Services ***Outpatient Surgical***	80% after deductible	80% after deductible
Outpatient Diagnostics	80% after deductible	80% after deductible
Rehabilitation Services	80% after deductible	80% after deductible
Home Health Care	80% after deductible	80% after deductible
Prescription Drug ***Tier 1*** *(Preferred Generic Drugs)* ***Tier 2*** *(Generic Drugs)* ***Tier 3*** *(Preferred Brand-Name Drugs)* ***Tier 4*** *(Non-Preferred Drugs)*	*After deductible* $10 $50 $150 $300	*After deductible* $10 $35 $70 $125

MEDICAL INSURANCE EMPLOYEE WEEKLY CONTRIBUTIONS		
	HDHP	PPO PLAN
Employee Only	$11.51	$46.48
Employee + Spouse	$129.05	$239.53
Employee + Child(ren)	$92.88	$166.27
Employee + Family	$227.91	$380.28

HEALTH SAVINGS ACCOUNT (HSA)

FLORES : HDHP PLAN ELIGIBLE

If you choose to enroll in the HSA Plan, you can contribute to your HSA through pre-tax payroll deductions. The HSA is a tax-advantaged account that helps you pay for qualified health care expenses. You can use the money in the account to pay for medical expenses for yourself, your spouse or your dependent children (even if they are not covered by your HDHP medical plan). If you are 65 or older, or have other first-dollar coverage, you may not be eligible for this account. If you have questions, contact Human Resources.

ADVANTAGES TO USING AN HSA

SAVE TAX-FREE

This is a great way to save money and budget for medical expenses. Contributions to your HSA are payroll deducted and are tax-free.

PAY TAX-FREE

When you use your HSA to pay for eligible health expenses, you don't pay taxes.

ROLLOVER FUNDS

You own your HSA, therefore funds rollover from year-to-year and you can take them with you, even if you retire or leave the Evernest.

HEALTH SAVINGS ACCOUNT (HSA)			
COVERAGE TIER	**2026 IRS MAXIMUM CONTRIBUTION**	**EVERNEST ANNUAL CONTRIBUTION**	**EMPLOYEE ANNUAL MAXIMUM CONTRIBUTION**
Employee Only	$4,400	$100	$4,300
Employee + Spouse	$8,750	$100	$8,650
Employee + Children	$8,750	$100	$8,650
Employee + Family	$8,750	$100	$8,650
HSA Holder 55+	Are eligible to contribute an extra $1,000 as a "catch-up" contribution - these contributions are 100% tax deductible from gross income.	N/A	$1,000

- You can use your HSA dollars immediately following your HSA account activation, once contributions have been made to your account.
- You may use HSA dollars to pay for qualified dental and vision expenses, however cosmetic procedures are not covered.
- The following expenses may not be reimbursed from an HSA: Premiums for Medicare supplemental policies; expenses covered by another insurance plan; expenses incurred prior to the date the HSA was established. Over-the-counter drugs purchased without a prescription no longer qualify as a medical expense (except insulin).

FLEXIBLE SPENDING ACCOUNT (FSA)

FLORES

You can save money on your healthcare and / or dependent day care (DCRA) expenses with an FSA. You set aside funds each pay period on a pretax basis and use them tax-free for qualified expenses. You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings come in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

HOW THE FSA WORKS

- You decide the annual amount you want to contribute to either or both FSA's based on your expected healthcare and / or dependent childcare / elder care expenses.
- Your contributions are deducted from each paycheck before income and Social Security taxes, and deposited into your FSA.
- When you incur a qualified expense, you can either pay with the FSA Reimbursement Account Card or submit the expenses through the your FSA online tool for reimbursement. Remember to save all receipts; you'll need them for reimbursements.
- If you have more than $680 remaining in your account at the end of the plan year, that money will not rollover into the next plan year. You will have until 3/31/2026 to submit claims for reimbursement for any expenses with a date of service in 2026.

HOW THE LIMITED FSA WORKS

- A Limited FSA allows for reimbursements of only dental and vision expenses when you are also enrolled in a Health Savings Account. It allows you to set aside money for vision and dental care while keeping your HSA funds available for broader medical expenses.

2026 IRS MAXIMUM		
	FSA	**DEPENDENT CARE FSA**
Qualified Expenses	Health, Dental, and Vision	Childcare for children under 13
Maximum Contributions	$3,400	$7,500 or $3,750 if married filling
Exclusions	Cannot contribute to an HSA Account	You and your spouse (if applicable) must work or be a full-time student

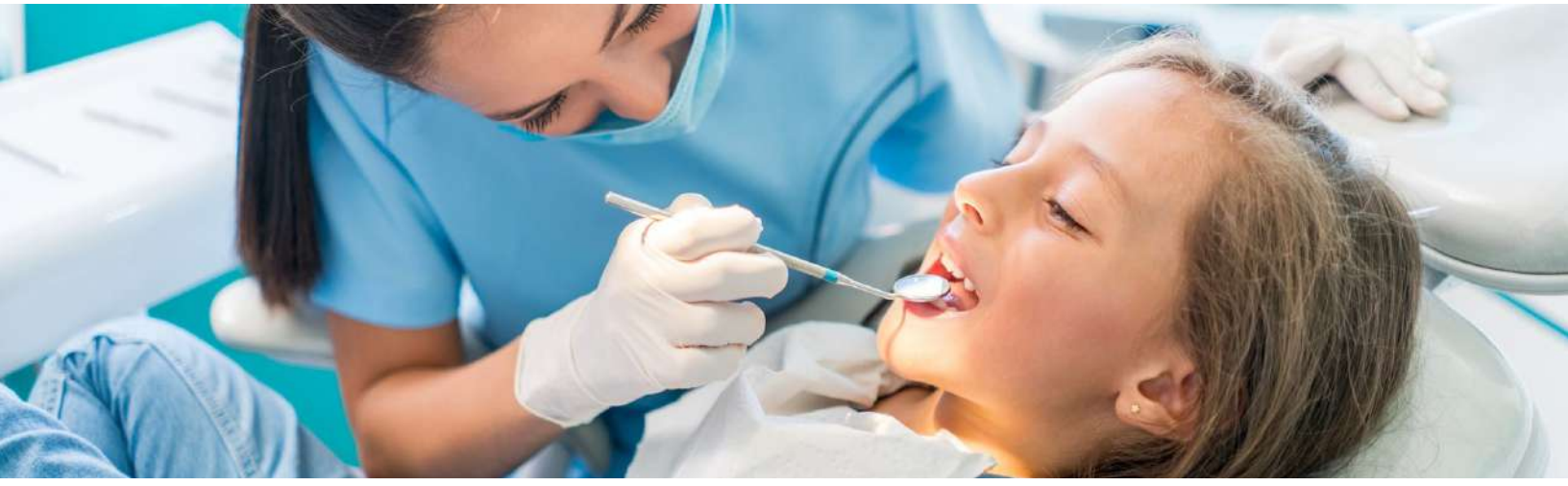
DENTAL INSURANCE

EQUITABLE

Evernest offers dental coverage to you through Equitable. Your dental plan provides coverage to help with the cost of many dental services including routine cleanings, x-rays, restorative and prosthetic services. The plan includes an extensive network of dental providers. Maximize your benefits by selecting an in-network dentist to save more on all covered services and avoid balance billing.

DENTAL INSURANCE	
Type A – Preventive (Includes Exams, Cleanings, and X-Rays)	100%
Type B – Basic (Includes Fillings and Simple Extractions)	80%
Type C – Major (Includes Oral Surgery, Crowns, and Dentures)	60%
Calendar Year Deductible Applies to: **Individual** **Family**	Basic and Major $50 $150
Calendar Year Maximum **(Applies to A,B,C services)**	$1,500
Orthodontia	50%
Orthodontia Lifetime Maximum	$1,000
Out of Network Reimbursement	90th Percentile

DENTAL INSURANCE EMPLOYEE WEEKLY CONTRIBUTIONS	
COVERAGE TIER	**RATE**
Employee Only	$6.92
Employee + Spouse	$14.16
Employee + Child(ren)	$15.12
Employee + Family	$24.37



VISION INSURANCE

EQUITABLE

Evernest offers vision coverage to you through Equitable. Receive the maximum benefits and pay less out-of-pocket by visiting an in-network provider. The A comprehensive vision exam is available every 12 months and you may purchase eyewear in the form of an eyeglass frame and lenses, or contact lenses.

VISION INSURANCE	
Eye Examination *(every 12 months)*	$10 Copay
Contact Lens Evaluation and Fitting *(every 12 months)* **Elective** **Medically Necessary**	$130 Allowance Covered in full
Materials / Eye wear *(every 12 months)* **Single Vision Eyeglass Lenses** **Lined Bifocal Eyeglass Lenses** **Lined Trifocal Eyeglass Lenses** **Lenticular Eyeglass Lenses**	$25 Copay $25 Copay $25 Copay $25 Copay
Frame Allowance *(every 24 months)* **Standard Frames**	$130 Allowance

VISION INSURANCE EMPLOYEE WEEKLY CONTRIBUTIONS	
COVERAGE TIER	**RATE**
Employee Only	$1.37
Employee + Spouse	$2.75
Employee + Child(ren)	$2.33
Employee + Family	$3.84

BASIC LIFE INSURANCE AND AD&D

EQUITABLE

Evernest provides Basic Life and AD&D coverage to you at no cost. Full-time employees receive coverage of $25,000.

Enrollment is automatic. In the event of your death, the amount of your basic life insurance will be paid to your beneficiary. If your death is the result of an accident, your beneficiary will receive an additional AD&D payment, which is equal to your basic life coverage. If you become dismembered as defined by the plan, a portion of the AD&D benefit will be payable to you.

ADDITIONAL LIFE INSURANCE AND AD&D

EQUITABLE

Employees can purchase additional life insurance and AD&D coverage in $10,000 increments up to a maximum of $500,000. If you enroll in the voluntary life you are automatically enrolled in the Voluntary AD&D. Coverage elected over the Guaranteed Issue amount of $150,000 will require an evidence of insurability (i.e. completing a health questionnaire) to be provided to the insurance carrier before the insurer will consider the additional coverage.

You can also purchase a policy for your spouse in $5,000 increments up to $250,000 not to exceed the employees election. An option is also available to cover your children for $10,000 not to exceed the employee's coverage. Coverage elected over the Guaranteed Issue amount of $25,000 will require an evidence of insurability (i.e. completing a health questionnaire) to be provided to the insurance carrier before the insurer will consider the additional coverage.

Amounts over the Guarantee Issue or participants considered to be a late entrant require evidence of insurability (i.e. completing a health questionnaire) to be provided to the insurance carrier before the insurer will consider the additional coverage.

AGE	WEEKLY EE RATE PER $1,000	WEEKLY SP RATE PER $1,000
15-24	$0.017	$0.018
25-29	$0.020	$0.020
30-34	$0.025	$0.026
35–39	$0.028	$0.028
40–44	$0.030	$0.031
45–49	$0.044	$0.044
50–54	$0.065	$0.065
55–59	$0.117	$0.118
60–64	$0.178	$0.179
65–69	$0.339	$0.340
70+	$0.548	$0549

	WEEKLY CHILD RATE PER $1,000
Life and AD&D	$0.043

SHORT TERM DISABILITY

EQUITABLE

Evernest offers Short-Term Disability (STD) coverage through Equitable. The STD plan is designed to help you meet your financial needs if you become unable to work due to illness or injury. Disability insurance provides partial income protection when an employee is unable to work due to illness or injury.

TYPE OF BENEFIT	BENEFIT AMOUNT
Weekly Benefit Amount	66.67%
Maximum Weekly Benefit	$2,500
Minimum Weekly Benefit	$25
Pre-Existing Condition	3/12
Elimination Period	Accident / Sickness– 15 Days
Benefit Duration	11 Weeks

STD BENEFIT PREMIUM CALCULATION

Use the below formulas to calculate your STD benefit and premium

STD Benefit:

(Annual Salary / 52) X 66.67% = Benefit Amount

STD Premium:

(Benefit Amount / $10) x (Rate) = Premium

Age	Weekly Rate per $10	Age	Weekly Rate per $10
15-24	$0.117	45-49	$0.069
25-29	$0.108	50-54	$0.083
30-34	$0.031	55-59	$0.097
35-39	$0.071	60-64	$0.103
40-44	$0.063	65+	$0.120

LONG TERM DISABILITY

EQUITABLE

Evernest offers Long-Term Disability coverage through Equitable. Long Term Disability coverage can provide you with peace of mind knowing you will have income replacement in the event of an extended disability due to an illness or accident.

TYPE OF BENEFIT	BENEFIT AMOUNT
Monthly Benefit Amount	66.67%
Maximum Monthly Benefit	$8,500
Minimum Monthly Benefit	Greater of 10% or $100
Pre-Existing Condition	3/12
Elimination Period	90 Days
Benefit Duration	SSNRA

LTD BENEFIT PREMIUM CALCULATION

Use the below formulas to calculate your LTD benefit and premium:

(Annual Salary / 12) x 66.67% = Benefit Amount

LTD Premium:

(Monthly Earnings (rounded to the nearest dollar) / $100) x Rate (see table below) = Premium

Age	Weekly Rate per $100	Age	Weekly Rate per $100
15-24	$0.012	45-49	$0.131
25-29	$0.019	50-54	$0.200
30-34	$0.029	55-59	$0.342
35-39	$0.048	60-64	$0.298
40-44	$0.084	65+	$0.145

HOSPITAL INDEMNITY

EQUITABLE

IMPORTANT: THIS IS A FIXED INDEMNITY POLICY, NOT HEALTH INSURANCE

THIS FIXED INDEMNITY POLICY MAY PAY YOU A LIMITED DOLLAR AMOUNT IF YOU'RE SICK OR HOSPITALIZED. YOU'RE STILL RESPONSIBLE FOR PAYING THE COST OF YOUR CARE.

- **THE PAYMENT YOU GET ISN'T BASED ON THE SIZE OF YOUR MEDICAL BILL.**
- **THERE MIGHT BE A LIMIT ON HOW MUCH THIS POLICY WILL PAY EACH YEAR.**
- **THIS POLICY ISN'T A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE.**
- **SINCE THIS POLICY ISN'T HEALTH INSURANCE, IT DOESN'T HAVE TO INCLUDE MOST**

FEDERAL CONSUMER PROTECTIONS THAT APPLY TO HEALTH INSURANCE.

LOOKING FOR COMPREHENSIVE HEALTH INSURANCE?

- **VISIT HEALTHCARE.GOV OR CALL 1-800-318-2596 (TTY: 1-855-889-4325) TO FIND HEALTH COVERAGE OPTIONS.**
- **TO FIND OUT IF YOU CAN GET HEALTH INSURANCE THROUGH YOUR JOB, OR A FAMILY MEMBER'S JOB, CONTACT THE EMPLOYER.**

QUESTIONS ABOUT THIS POLICY?

- **FOR QUESTIONS OR COMPLAINTS ABOUT THIS POLICY, CONTACT YOUR STATE DEPARTMENT OF INSURANCE. FIND THEIR NUMBER ON THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS' WEBSITE (NAIC.ORG) UNDER "INSURANCE DEPARTMENTS."**
- **IF YOU HAVE THIS POLICY THROUGH YOUR JOB, OR A FAMILY MEMBER'S JOB, CONTACT THE EMPLOYER.**

HOSPITAL INDEMNITY

EQUITABLE

Evernest offers Hospital Indemnity insurance coverage through Equitable. Hospital Indemnity insurance is an extra layer of protections that gives you a cash payment to cover out-of-pocket expenses when you have a qualifying hospital stay. See the benefits summary for a full list of accidents under this plan.

HOSPITAL INDEMNITY COVERAGE BENEFIT OVERVIEW	
Hospital Services	Admission: $500 / Confinement : $100 per day
ICU Hospital Services	Admission: $1,000 / Confinement : $200 per day
Wellness Benefit	$50
HOSPITAL INDEMNITY EMPLOYEE WEEKLY CONTRIBUTIONS	
Employee Only	$2.16
Employee + Spouse	$4.56
Employee + Child(ren)	$3.57
Employee + Family	$5.97

ACCIDENT INSURANCE

EQUITABLE

Evernest offers Accident insurance coverage through Equitable. Accident insurance is an extra layer of protections that gives you a cash payment to cover out-of-pocket expenses when you suffer an unexpected, qualifying accident. See the benefits summary for a full list of accidents under this plan.

ACCIDENT COVERAGE BENEFIT OVERVIEW	
Burns	Up to $10,000
Coma	$10,000
Dislocations and Fractures	Up to $6,000
Lacerations	Up to $400
Wellness Benefit	$50
Accidental Death	Employee: $50,000 Spouse: $25,000 Child: $12,500
ACCIDENT INSURANCE EMPLOYEE WEEKLY CONTRIBUTIONS	
Employee Only	$3.11
Employee + Spouse	$5.37
Employee + Child(ren)	$6.64
Employee + Family	$8.90

CRITICAL ILLNESS

EQUITABLE

Evernest offers Critical Illness coverage through Equitable. Critical Illness insurance may help you cover expenses not covered by your health insurance. It's a cash payment you receive if you ever experience a serious illness like, cancer, a heart attack, or a stroke, giving you the financial support to focus on recovery.

CRITICAL ILLNESS COVERAGE BENEFIT OVERVIEW	
Employee	$10,000, $20,000, or $30,000
Spouse	$10,000, $20,000, or $30,000; Not to exceed 100% of EE amount
Child(ren)	$10,000, $20,000, or $30,000; Not to exceed 50% of EE amount
Heart Attack, Major Organ Failure, Stroke	100%
WEEKLY RATE PER $1,000 OF COVERAGE	
AGE	RATE
<40	$0.120
40-49	$0.279
50-59	$0.540
60+	$0.845

VALUE ADDED PROGRAMS

United Healthcare members have access to electronic newsletters and personalized health tools such as health trackers and assessments. Additionally, UHC offers a number of support tools and resources to help you and dependents take charge of your healthcare.

VIRTUAL VISITS

With 24/7 Virtual Visits, you can connect to a provider by phone or video through myuhc.com or the United Healthcare App. A Virtual Visits can treat common conditions such as flu, sore throats, headaches, and allergies.

BEHAVIORAL HEALTH SUPPORT

Behavioral Health Support services are available for you and your family to access anytime, anywhere. You can search for providers, visit your personalized emotional support page, and access resources and tools at myuhc.com.

UHC REWARDS

UHC Rewards is included in your medical plan at no additional cost. With UHC Rewards a variety of actions lead to rewards. You can earn up to $300 per year by participating in UHC Rewards and completing the qualified actions.

To get started, you can scan the QR code below to download the UHC app or visit myuhc.com. You can then sign in or register and select UHC Rewards to start receiving rewards.

EMPLOYEE ASSISTANCE PROGRAM

COMPSYCH THROUGH EQUITABLE

Evernest, LLC offers ComPsych services through Equitable to you at no cost. The ComPsych EAP is part of your benefits package and offers total well-being services to you, your spouse, and dependents under the age of 26. This is a free and totally confidential service.

- **Counseling** - 3 In-person, virtual, or telephonic sessions are available. Individual, family, and couples counseling are included.
- **Crisis Support** - Mental health professional are available by phone 24 hours, 7 days a week, 365 days a year.
- **Legal & Financial Consultations** - Resources are available to assist individuals regarding legal and financial issues.
- **Online Portal** - Access to articles, resources, healthy-living tips, and webinars at www.guidanceresources.com.
- **Identity Theft Services** - Resources to help repair your credit and good name.

Contact your Employee Assistance Program for 24/7 support, resources and information

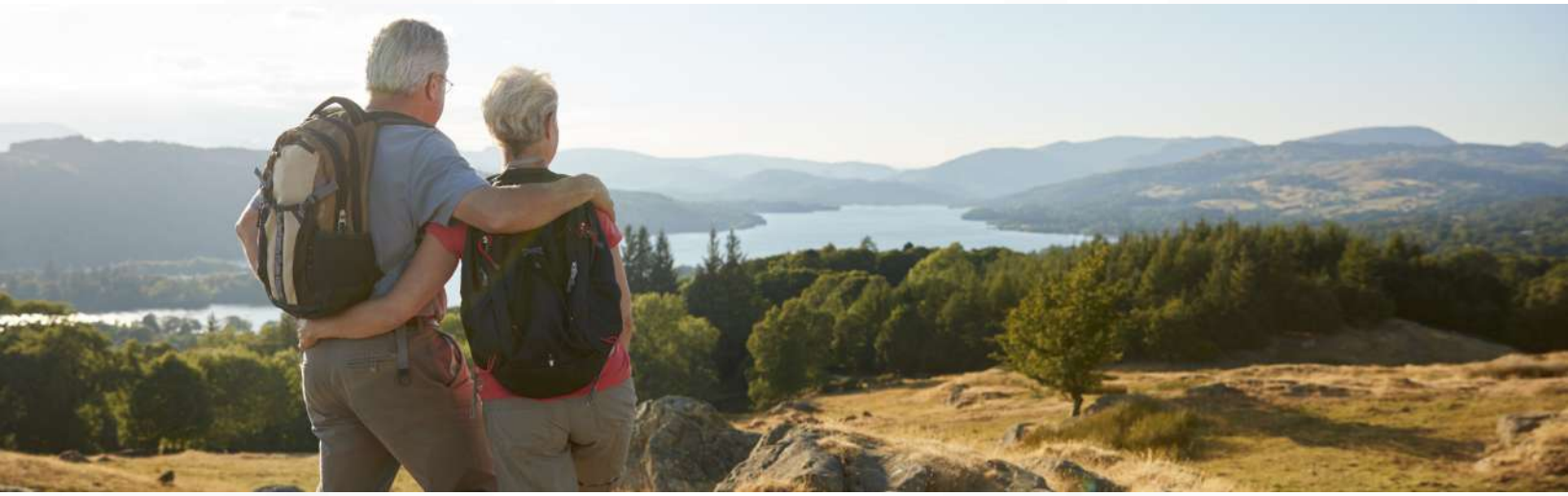
Call	TDD	Online	App	Web ID
(833) 256-5115	(800) 697-0353	guidanceresources.com	GuidanceNow℠	EQUITABLE3

401(K) RETIREMENT SAVINGS

Principal

Evernest urges every employee to prepare for their retirement. In support of this initiative, the 401k program provides a foundation for retirement income to eligible employees.

Evernest employees are eligible to enroll in 401(k) on the first of the month following 90 days of employment. Principal will send you an email once you are eligible to enroll.



HOLIDAYS, VACATION, PAID TIME OFF

HOLIDAY SEASON	
HOLIDAY	OBSERVED
New Year's Day Observed	Thursday, January 1
Memorial Day	Monday, May 25
Independence Day	Friday, July 3
Labor Day	Monday, September 7
Thanksgiving Day	Thursday, November 26
Day after Thanksgiving	Friday, November 27
Christmas Eve Observed	Thursday, December 24
Christmas Day	Friday, December 25

OBSERVED HOLIDAYS	
HOLIDAY	OBSERVED
Martin Luther King, Jr. Day	Monday, January 19
Presidents Day	Monday, February 16
Good Friday	Friday, April 3
Juneteenth	Friday, June 19
Columbus/Indigenous Peoples Day	Monday, October 12
Veteran's Day	Wednesday, November 11

PTO FOR HOURLY EMPLOYEES

Hourly employees are eligible for paid time off (PTO) used for vacation and sick days, in an amount accrued based on how many hours worked each week and the following formula:

- Employees with less than one year of service:
  - Accruing weekly at 0.7692 per week.
- Employees with over one year of service:
  - Accruing weekly at 1.5385 per week.

OBSERVED HOLIDAYS

Hourly employees have the opportunity to request two (2) Observed Holidays per year (up to 16 hours):

- Employees must request an Observed Holiday PTO to take an Observed Holiday off.
- Managers must approve the Observed Holiday PTO request before it can be taken.
- Employees can only request an Observed Holiday PTO on the actual day of the Observed Holiday.

CONTACT INFORMATION

CONTACT LIST FOR YOUR EMPLOYEE BENEFITS

CONTACT INFORMATION			
BENEFIT	**PROVIDER**	**PHONE**	**WEBSITE/EMAIL**
Medical	UNITED HEALTHCARE	866-414-1959	uhc.com/member-resources
Health Savings Account	FLORES	800-532-3327	flores247.com
Dental	EQUITABLE	866-444-6001	equitable.com/support
Vision	EQUITABLE	866-444-6001	equitable.com/support
Basic Life Insurance	EQUITABLE	866-444-6001	equitable.com/support
Additional Life Insurance	EQUITABLE	866-444-6001	equitable.com/support
Short-Term Disability	EQUITABLE	866-444-6001	equitable.com/support
Long-Term Disability	EQUITABLE	866-444-6001	equitable.com/support
Accident	EQUITABLE	866-444-6001	equitable.com/support
Critical Illness	EQUITABLE	866-444-6001	equitable.com/support
Hospital Indemnity	EQUITABLE	866-444-6001	equitable.com/support
401(K) Program	PRINCIPAL	800-547-7754	principal.com/welcome

NOTES

USE THIS PAGE FOR INFORMATION YOU FIND HELPFUL

NOTES

USE THIS PAGE FOR INFORMATION YOU FIND HELPFUL

DISCLOSURE NOTICES

As an employee of Evernest, LLC and participant in our employee benefit programs, you and your beneficiaries may have various rights and privileges related to these programs. Laws governing health care require us to provide you with these notifications. Listed below are important notices to retain for your records. In the past, many of these notices were sent individually and are now grouped together to more clearly communicate your rights, and to simplify distribution. If you have any questions, please contact Human Resources.

IMPORTANT INFORMATION

MEDICARE PART D NOTICE

Medical Plan: United Healthcare

About Your Prescription Drug Coverage and Medicare

This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. We have determined the prescription drug coverage offered by United Healthcare 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. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. 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 coverage will not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the plan administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare eligible individuals when you become eligible for Medicare Part D.

Visit http://www.cms.hhs.gov/CreditableCoverage/ which outlines the prescription drug plan provisions/options Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will be able to get this coverage back. Refer to plan documents or contact your provider or the plan administrator before making any decisions.

Note: In general, different guidelines exist for retirees regarding cancelation of coverage and the ability to get that coverage back. Retirees who terminate or lose coverage will not be able to get back on the plan unless specific contract language or other agreement exists. Contact the plan administrator for details.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher

premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage...
Contact the person listed in this notifications report. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage: Visit www.Medicare.gov or 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 800-MEDICARE (800-633-4227). TTY users should call (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 (800) 772-1213 (TTY 1-800-325-0778).

Remember to 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).

NOTIFICATIONS

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event. If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the plan administrator indicated in this notice.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

HIPAA regulations will be followed in administrative activities undertaken by assigned personnel when they involve protected health information (PHI) and e-PHI.

The company has adopted a policy that protects the privacy and confidentiality of PHI whenever it is used by company representatives. The private and confidential use of such information will be the responsibility of all individuals with job duties requiring access to PHI in the course of their jobs.

PHI refers to individually identifiable health information received by the company’s group health plans and/or received by a health care provider, health plan or health care clearinghouse, and includes information regarding medical conditions, health status, claims experience, medical histories, physical examinations, genetic information and evidence of disability.

All information related to enrollment, changes in enrollment and payroll deductions, aiding in claims problem resolution and explanation of benefits issues, and assistance in coordination of benefits with other providers will be maintained in confidence. Employees shall not disclose PHI from these processes for employment-related actions, except as provided by administrative procedures approved by Human Resources.

The Company will consider any breaches in the privacy and confidentiality of handling of PHI to be serious, and disciplinary action will be taken in accordance with our code of conduct.

Company records that are governed by this policy will be maintained for a period of no less than six years.

Questions or issues regarding PHI should be addressed with Human Resources.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information. ***As Required by Law***. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. However, you must request enrollment within 30 days or any longer period that applies under the plan, after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the plan administrator mentioned above.

GINA

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to any requests for medical information, if applicable. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Michelle's Law

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the Plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or the date coverage would otherwise terminate under the Plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the Plan, of a participant or beneficiary; and
- Have been enrolled in the Plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the Plan.

If you believe your child is eligible for this continued eligibility, you must provide to the Plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact the Plan Administrator.

Discrimination is Against the Law

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Company:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the plan administrator.

If your Company has fifteen (15) or more employees and you believe that The Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, refer to the Plan Administrator for Grievance Procedures or if you need help filing a grievance can be filed in person, by mail, fax, or email.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

WHCRA

The Women's Health and Cancer Rights Act (WHCRA) of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call your health insurance issuer for more information.

This notice informs you of the Federal regulation that requires all health plans that cover mastectomies to also cover reconstruction of the removed breast. If you have had or are going to have a mastectomy, you may be entitled to certain benefits. 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 lymphedemas.

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). These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at the number listed above.

NMHPA

Newborns' and Mothers' Health Protection Act requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your plan administrator.

For additional information about NMHPA provisions and how Self-funded non Federal governmental plans may opt-out of the NMHPA requirements, visit http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. 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: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – MEDICAID

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

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – MEDICAID

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

GEORGIA – MEDICAID

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – MEDICAID

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

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

KANSAS – MEDICAID

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

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – MEDICAID

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

MAINE – MEDICAID

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

MASSACHUSETTS – MEDICAID & CHIP

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

MINNESOTA – MEDICAID

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

MISSOURI – MEDICAID

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

MONTANA – MEDICAID

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – MEDICAID

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

NEVADA – MEDICAID

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

NEW HAMPSHIRE – MEDICAID

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

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – MEDICAID

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

NORTH CAROLINA – MEDICAID

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – MEDICAID

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – MEDICAID AND CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – MEDICAID AND CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – MEDICAID AND CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – MEDICAID AND CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT– MEDICAID

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – MEDICAID AND CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – MEDICAID

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – MEDICAID

Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – MEDICAID AND CHIP

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

U.S. DEPARTMENT OF LABOR
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. DEPARTMENT OF HEALTH & 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 1/31/2026)

2026