



ARTISAN LANE

FURNITURE COLLECTIVE

EMPLOYEE BENEFITS 2026



**AMERICAN
LEATHER**



**BENCHMARK
MODERN**

**BROOKLINE
FURNITURE**



WHAT'S INSIDE

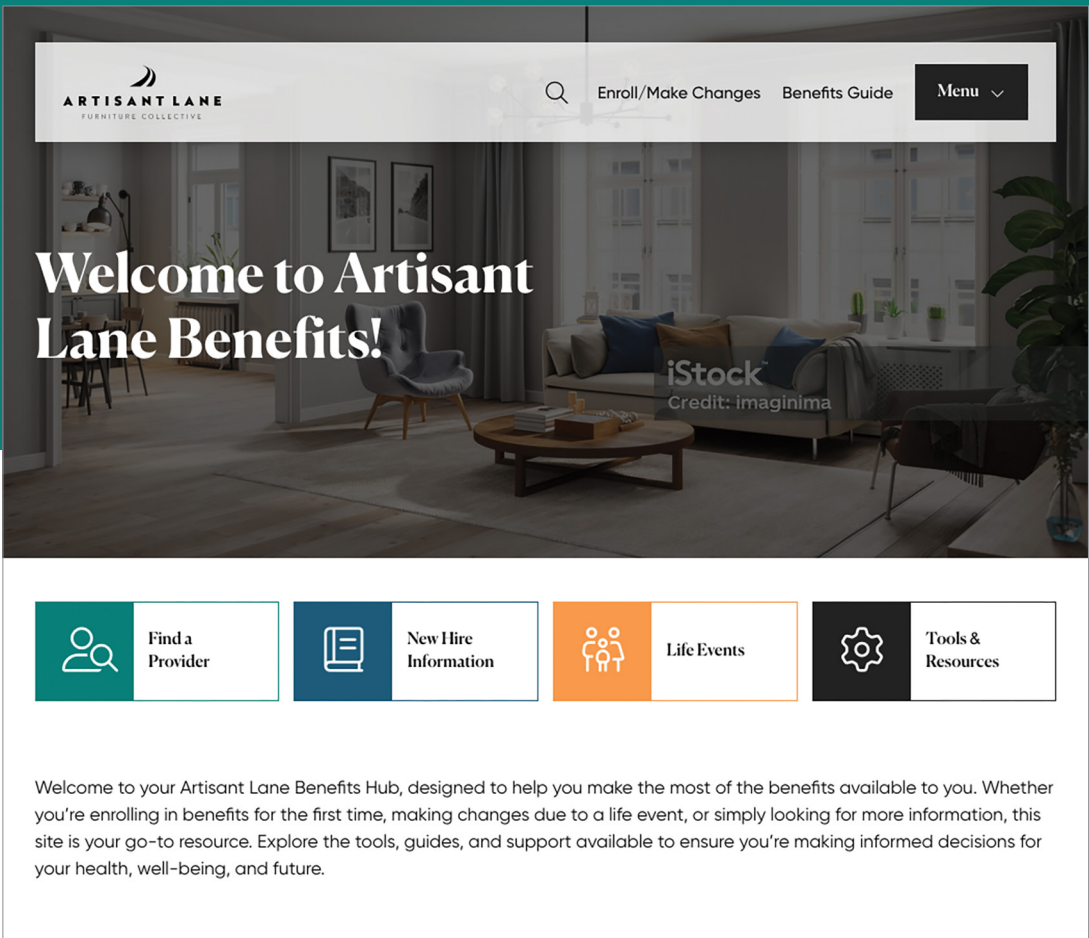


WELCOME TO YOUR BENEFITS

At American Leather, Benchmade, Brookline Furniture, and Lee Industries, we are pleased to provide you with a wide range of competitive benefits that are a vital part of your total compensation. You have the flexibility to select from a variety of benefits to keep you and your family healthy and provide financial protection in the event of unforeseen circumstances.

This brochure was designed to answer some of the basic questions you may have about your benefits and serve as a summary of material modifications for the upcoming plan year. If you have any questions at all, please contact your Human Resources Department.

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EXPLORE YOUR BENEFITS ANYTIME, ANYWHERE

We're excited to introduce artisanlanebenefits.com Your redesigned go-to resource for learning about your benefits. From health plans to retirement, you'll find easy-to-understand information, helpful tools, and updates all in one place.



Check it out today and take charge of your benefits!



ELIGIBILITY



Full-time employees working 30 or more hours per week are eligible for benefits on the first of the month following 30 days of employment. You may also enroll your eligible dependents in certain plans.

Generally, for the purpose of the benefit program, eligible dependents are defined as:

- Your legal spouse.
- A dependent “child” up to age 26, regardless of student or marital status may be enrolled for the medical plan, dental plan, vision, and voluntary benefits.
 - (“Child” includes the employee’s natural child, legally adopted child, stepchild, a child of your child who is your dependent for federal income tax purposes at the time application for coverage of the child is made, or a child for whom a participant has received a court order requiring you to have financial responsibility for providing health insurance.)
 - Disabled Child: A medically certified disabled child may be covered on the medical plan regardless of age (no age limit).

Documentation may be requested to confirm dependent eligibility.



ENROLL THROUGH YOUR ADP LOGIN

1. Visit workforcenow.adp.com or access your ADP app between November 10 and November 19.
 - o If you are already registered, use your user ID and password to get started.
 - o If you are not registered, go to the ADP website workforcenow.adp.com or download the ADP app and click on "Create Account". The registration code is **ALHOLDINGS-newhire**.
2. Start Enrollment by clicking **Enroll Now**, which will bring you to the **Myself>Benefits>Enrollments** screen where you can click **Start Enrollment**.
3. Once you have made your selections, you will need to click **Submit Enrollment**. Note that your benefit elections will not be processed until you click **Submit Enrollment**. If you click **Save for later**, your changes will not be submitted to the HR team.
4. Your new benefits will take effect on January 1, 2026.



SPEAK WITH A BENEFIT COUNSELOR TO ENROLL

If you are a benefit-eligible employee, you can speak with a professional benefit counselor onsite to learn more about your benefit options and complete your enrollment in 2026 benefits.

During your individual appointment, the benefit counselor will review your 2026 benefit options, answer your questions, and enroll you and your dependent(s) in the coverage that best fits your needs.

Speak with your manager for more information about your appointment with a benefit counselor!

In preparation for your meeting, please be ready to provide the following information:

- Date of Birth
- Social Security Number (if applicable)
- Address & Phone Number
- Beneficiary Information: name, phone number, DOB, address, and SSN (if applicable)
- Dependent Information: name, phone number, DOB, address, and SSN (if applicable)
- Proof of dependent eligibility: If you are enrolling dependents, please bring documentation such as a marriage certificate, birth certificate, adoption paperwork, or other legal guardianship documents. You may also be asked to provide your most recent tax return or other official document showing the dependent relationship.

HOW TO ENROLL



MEDICAL PLAN



**BlueCross
BlueShield**



American Leather, Benchmade, Brookline Furniture, and Lee Industries offer medical plans through **BlueCross BlueShield of Texas (BCBSTX)** to give you flexibility in managing care for you and your family. You may enroll in one of two medical plan options (Gold or Silver). Each plan includes access to the BlueChoice PPO network.

New for 2026: Our pharmacy benefits will be managed through Welldyne.

You may visit any doctor or specialist of your choice without a referral. When you use an in-network provider, you will receive benefits at a higher level resulting in fewer out-of-pocket expenses. The table on page 7 provides a general summary of your medical benefits and shows the amount you pay; please refer to your Summary Plan Description (SPD) for additional details. You can find the SPD as well as other BCBS documents at [artisanlanebenefits.com](https://www.artisantlanebenefits.com).



HOW TO FIND A NETWORK PROVIDER

Finding an in-network doctor is easier than ever. Most importantly, you are in control when searching on www.bcbstx.com. After logging into **Blue Access for Members**, your search results are personalized according to your health plan, so you get the information you need to make the right decisions for you and your family.

You can locate BlueChoice PPO Network providers by calling Member Services at 800-521-2227 or by visiting bcbstx.com/find-care and searching *BlueChoice PPO*.

PPO PLANS & OUT-OF-NETWORK CLAIMS

You pay less when using in-network providers. Out-of-network claims are reimbursed at the BCBSTX allowable amount and you are responsible for any difference between the allowable amount and the amount charged by the provider.

MEDICAL PLAN ID CARDS

All enrollees will receive new ID cards by mail to their homes. Log in to ADP to make sure your current address is on file.

PLAN YEAR ACCUMULATORS

All deductible and out-of-pocket amounts accumulate on a plan year basis (January 1 – December 31).



BLUE ACCESS FOR MEMBERS (BAM)SM

BCBSTX helps you get the most out of your health care benefits with **Blue Access for Members (BAM)SM**. You and all covered dependents age 18 and up can create a BAM account.

With BAM, you can:

- Use our Provider Finder[®] tool to search for a health care provider, hospital, or pharmacy
- Request or print your ID card
- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Use our Cost Estimator tool to find the price of hundreds of tests, treatments, and procedures
- Download our app
- Sign up for text or email alerts

It's Easy to Get Started!

1. Go to bcbstx.com/member
2. Click Log Into My Account
3. Use the information on your BCBSTX ID card to sign up

Or, text* **BCBSTXAPP** to **33633** to get the BCBSTX App, which lets you use BAM while you're on the go.



DOWNLOAD THE BCBSTX APP

Stay connected with BCBSTX and access important health benefit information wherever you are.

- Find an in-network doctor, hospital, or urgent care facility
- Access your claims, coverage, and deductible information
- View and email your member ID card
- Log in securely with your fingerprint
- Access Health Care Accounts and Health Savings Accounts
- Download and share your Explanation of Benefits
- Get Push Notifications and access to the Message Center

Text BCBSTXAPP to 33633 to get the app or download it from the app store

• Message and data rates may apply. Terms and conditions and privacy policy at bcbstx.com/mobile/text-messaging.

•• Currently only available on iPhone[®]. iPhone is a registered trademark of Apple Inc.



MEDICAL PLAN COMPARISON

Below is a comparison of your medical plan options.



	GOLD PPO PLAN		SILVER PPO PLAN	
Benefit	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
DEDUCTIBLES AND MAXIMUMS				
PLAN YEAR DEDUCTIBLE				
Individual	\$2,000	\$6,000	\$3,000	\$6,000
Family	\$4,000	\$12,000	\$6,000	\$12,000
PLAN YEAR MEDICAL OUT-OF-POCKET MAXIMUM				
Individual	\$4,500	\$15,000	\$7,000	\$20,000
Family	\$9,000	\$30,000	\$14,000	\$40,000
COVERED SERVICES				
Preventive	No charge	40% Coinsurance	No charge	50% Coinsurance
Physician (In-Person or Telemedicine)	\$20 copay	Deductible & 40% Coinsurance	\$25 copay	Deductible & 50% Coinsurance
Specialist (In-Person or Telemedicine)	\$80 copay	Deductible & 40% Coinsurance	\$100 copay	Deductible & 50% Coinsurance
X-Ray/Lab	No charge	Deductible & 40% Coinsurance	No charge	Deductible & 50% Coinsurance
Emergency Room Facility	\$500 copay & 20% Coinsurance	\$250 copay & 20% Coinsurance	\$500 copay & 20% Coinsurance	\$250 copay & 20% Coinsurance
Urgent Care Copay	\$100 copay	Deductible & 40% Coinsurance	\$100 copay	Deductible & 50% Coinsurance
Hospital Inpatient	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
Outpatient Surgery	Deductible & 20% Coinsurance	Deductible & 40% Coinsurance	Deductible & 20% Coinsurance	Deductible & 50% Coinsurance
PRESCRIPTION BENEFIT				
30-DAY RETAIL SUPPLY				
Tier 1: Generic	\$10 copay		\$10 copay	
Tier 2: Preferred Brand	\$30 copay		\$35 copay	
Tier 3: Non-Preferred	\$50 copay		\$70 copay	
Tier 4: Specialty	\$100 copay		\$120 copay	
90-DAY MAIL ORDER SUPPLY				
Tier 1: Generic	\$25 copay		\$25 copay	
Tier 2: Preferred Brand	\$75 copay		\$87.50 copay	
Tier 3: Non-Preferred	\$125 copay		\$175 copay	



TELEMEDICINE WITH MD LIVE



When you need care – anytime, day or night – or when your primary care provider is not available, telemedicine can be a convenient option. With telemedicine, you don't have to drive to the doctor's office or clinic, park, walk into, or sit in a waiting room when you're sick – you can see your doctor from the comfort of your own bed or sofa.

TALK THERAPY

Speak with a licensed counselor, therapist or psychiatrist for support with virtual visits, available by appointment. You can choose who you want to work with for issues such as anxiety, depression, trauma and loss, or relationship problems.

MDLIVE[®]



**BlueCross.
BlueShield.**

REGISTER TODAY SO YOU ARE READY WHEN YOU NEED CARE



Avoid germs in the ER, urgent care clinic, or doctor's office.



See a board-certified, licensed, telehealth-trained doctor on your schedule with on-demand virtual visits 24/7, including nights, weekends, and holidays.



Get treated for more than 80 common conditions including colds, flu, allergies, and more.



Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby in less time than your usual doctor visit.



Avoid costly copays and deductibles of the ER and urgent care clinic.



USING TELEMEDICINE IS AS EASY AS ONE, TWO, THREE

STEP 1. REGISTER NOW

Setting up your secure account takes only minutes. Visit www.mdlive.com or, call 888-726-3171. You can also download the MDLIVE app for an easier way to visit with a doctor.



STEP 2. REQUEST A VISIT

You can have a doctor visit right away or schedule an appointment all by phone, computer or our app.

STEP 3. FEEL BETTER

Get treated by one of our doctors who can prescribe medication if necessary.

2026 WELLNESS PROGRAM

WE'VE HEARD YOUR FEEDBACK — AND WE'RE MAKING A CHANGE.

Beginning in 2026, the Artisan Lane companies will introduce a **new and improved Wellness Program** to better support your total well-being. We're partnering with a new wellness vendor to bring you a smoother, more engaging experience with easier tracking, more personalized tools, and better access to the resources that matter most to you.

While we finalize program details, here's what you can expect:

- There **will** be a Wellness Program in 2026.
- All medically-enrolled employees and spouses will continue to have the opportunity to earn a monthly premium incentive by completing simple wellness activities.
- Exact requirements and the new vendor name will be announced before the program launch in early 2026.

Stay tuned for more information later this year on how to register and earn your 2026 Wellness Incentive.



DENTAL PLAN



Our dental coverage is provided by Cigna. All employees have the option to enroll in the Dental PPO plan. As a member of the Dental PPO plan, you may use dentists outside of the Dental PPO plan network. American Leather, Benchmade, and Brookline employees can also enroll in the DHMO plan. If you are enrolled in the DHMO plan, you must use in-network providers only in order for benefits to be paid. The DHMO provides set copay amounts for services received.

CIGNA DENTAL PLAN – PPO	
BENEFIT	IN-NETWORK
Deductible (Individual/Family)	\$50/\$150
Annual Maximum	\$2,000
Preventive Care	Covered 100%, deductible waived
Basic Care (sealant, fillings, etc.)	Deductible, 80%
Major Care (root canal, crown, etc.)	Deductible, 50%
Orthodontia (Children up to 19th birthday)	Deductible, 50%
Orthodontia Maximum	\$1,500
Weekly Cost	
Employee	\$7.90
Employee + Spouse	\$15.91
Employee + Child(ren)	\$21.07
Employee + Family	\$29.07

CIGNA DENTAL PLAN – DHMO (LIMITED AVAILABILITY)	
BENEFIT*	IN-NETWORK
Deductible (Individual/Family)	\$0
Annual Maximum	N/A
Preventive Care	No Charge
Basic Care (sealant, fillings, etc.)	\$0–\$12
Major Care (root canal, crown, etc.)	\$210–\$490
Orthodontia (Children up to 19th birthday)	\$480–\$515
Orthodontia Maximum	N/A
Weekly Cost	
Employee	\$3.18
Employee + Spouse	\$5.04
Employee + Child(ren)	\$6.90
Employee + Family	\$8.20

* See Cigna's fee schedule for a full list of covered procedures and rates. The fee schedule can be located at [ArtisanLaneBenefits.com](https://www.artisantlanebenefits.com).



Our vision coverage is provided through **EyeMed**, with two plan options available. While you may visit any provider, you'll receive the highest level of benefits and the lowest out-of-pocket costs when you use an in-network provider. To find an in-network eye doctor, visit www.eyemed.com

EYEMED VISION PLAN	BASE PLAN		PREMIUM PLAN	
	IN-NETWORK	OUT-OF- NETWORK	IN-NETWORK	OUT-OF- NETWORK
Exam Every 12 months	\$10 copay	\$40	\$10 copay	\$50
Frames Every 24 months	\$0 copay; \$130 allowance, 20% off balance over \$130	\$91	\$0 copay; \$180 allowance, 20% off balance over \$180	\$91
Single/Bi-/Tri-Focal Lenses Every 12 months	\$20 copay	\$30–\$70	\$25 copay	\$30–\$70
Conventional Contact Lenses Every 12 months	\$0 copay; \$130 allowance, 15% off balance over \$130	\$130	\$0 copay; \$180 allowance, 15% off balance over \$180	\$144
Weekly Cost				
Employee	\$1 .52		\$3 .32	
Employee + Spouse	\$2 .90		\$5 .31	
Employee + Child(ren)	\$3 .05		\$5 .42	
Employee + Family	\$4 .48		\$8 .74	

VISION PLAN

FLEXIBLE SPENDING ACCOUNTS



Flexible Spending Accounts (FSAs), through Navia, allow you to pay for eligible health care and dependent care expenses using tax-free dollars. **There are two types of FSAs – the Health Care FSA and the Dependent Care FSA:**



HEALTH CARE FSA

Contribute up to \$3,400 per year, pretax to pay for services not covered by your medical, dental or vision plan such as copays, coinsurance, deductibles, prescription expenses, lab exams and tests, contact lenses, and eyeglasses.

- Receive a debit card to pay for eligible medical expenses (funds must be available in your account).
- Eligible expenses include medical copays, coinsurance, deductibles, eyeglasses, and over-the-counter medications prescribed by your doctor.



DEPENDENT CARE FSA

Contribute up to \$7,500 per year, pretax, or \$3,750 if married and filing separate tax returns to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. You cannot use your Health Care FSA to pay for Dependent Care expenses.

- You must submit claims and be reimbursed if you enroll in this FSA; no debit cards are provided.
- This FSA can only be used to pay for eligible dependent care expenses, including day care, after-school programs, and elder care programs.



USE IT OR LOSE IT

Submit claims up to **March 31** of the following year for expenses from January 1 to December 31. If you do not spend all the money in this FSA by **March 31**, per IRS regulations, unused dollars will be forfeited for pretax contributions.

Please note that you are able to roll over up to \$680 of your unused 2026 FSA dollars to the 2027 plan year.



LIFE &

DISABILITY



Disability insurance can keep you financially stable should you become disabled and unable to work. It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive a monthly income. These benefits are offered at no cost to you as an employee.

SHORT-TERM DISABILITY

American Leather, Benchmade, Brookline Furniture, and Lee Industries provide you with Short-Term Disability coverage through Lincoln Financial Group. The benefit amount is based on 60% of your income, up to \$500 per week. This amount may be offset by other income benefits, including any local or state disability. Benefits begin at the time of disability for accidents and after seven days for illnesses. This coverage can provide benefits for up to a maximum of 13 weeks if continuously disabled.

LONG-TERM DISABILITY

As an added protection to ensure your financial stability, American Leather, Benchmade, Brookline Furniture, and Lee Industries also provide you with Long-Term Disability coverage through Lincoln Financial Group. If your disability extends beyond 90 days, this coverage can replace 60% of your earnings, up to a maximum of \$6,000 per month. Your benefits may continue to be paid until you reach normal retirement age as long as you meet the definition of disability.

SHORT-TERM DISABILITY BENEFITS AT A GLANCE

Coverage	60% of your weekly earnings to a \$500 maximum for 13 weeks
When Benefits Begin	Benefit begins immediately for an accident and after 7 days for illness

LONG-TERM DISABILITY BENEFITS AT A GLANCE

Coverage	60% of your pre-disability earnings, up to a maximum benefit of \$6,000 per month until you recover or reach your Social Security Normal Retirement Age, whichever is sooner
When Benefits Begin	Benefit begins after 90 days of disability

A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are, or could be, qualified by education, training, or experience.

BASIC LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (AD&D)

Life insurance pays a lump-sum benefit to your beneficiary(ies) to help meet expenses in the event of your death. AD&D Insurance pays a benefit if you die or suffer certain serious injuries as the result of a covered accident. In the case of a covered accidental injury (e.g., loss of sight, loss of a limb), the benefit you receive is a percentage of the total AD&D coverage you elected based on the severity of the accidental injury.

Basic Life Insurance and AD&D through Lincoln Financial Group is available at no cost to you and is paid for by your employer. Eligible employees are covered in the amount of either \$30,000 or one and one-half times your basic annual earnings, up to a maximum of \$150,000.

VOLUNTARY LIFE INSURANCE AND AD&D

Voluntary Life Insurance and AD&D is available for purchase through Lincoln Financial Group in addition to your employer-provided basic coverage. You pay the full cost of this coverage through payroll deductions. The premium is based on your age as well as the amount of coverage you select.



THE RESOURCES YOU NEED TO MEET LIFE'S CHALLENGES

*EmployeeConnect*SM offers professional, confidential services to help you and your loved ones improve your quality of life.



IN-PERSON GUIDANCE

Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect*SM, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings



UNLIMITED 24/7 ASSISTANCE

You and your family can access the following services anytime — online, on the mobile app or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning, and more
- Legal information and referrals for family law, estate planning, and consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning



ONLINE RESOURCES

*EmployeeConnect*SM offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit [GuidanceResources.com](https://www.guidanceresources.com) or download the *GuidanceNow*SM mobile app. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets, and more



EMPLOYEE ASSISTANCE PROGRAM

EMPLOYEECONNECTSM COUNSELORS ARE EXPERIENCED AND CREDENTIALLED.

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice, and referrals. All counselors hold master's degrees, with broad-based clinical skills and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

You'll receive customized information for each work-life service you use.

CONFIDENTIAL HELP 24 HOURS A DAY, SEVEN DAYS A WEEK FOR EMPLOYEES AND THEIR FAMILY MEMBERS. GET HELP WITH:



Family



Emotional Issues



Relationships



Parenting



Legal



Stress



Addictions



Financial

To take advantage of the *EmployeeConnect*SM program or for more information, visit [GuidanceResources.com](https://www.GuidanceResources.com) (username: LFGSupport, password: LFGSupport1), download the GuidanceNowSM mobile app or call **888-628-4824**.





ADDITIONAL BENEFITS

THROUGH THE LINCOLN FINANCIAL GROUP PROGRAM



LIFEKEYS®

No matter how well you plan, unexpected challenges will arise. When they do, help and support are nearby – thanks to LifeKeys® services from Lincoln Financial Group. LifeKeys® services include:

- Access to GuidanceResources® Online, which includes:
 - 24/7 access to the Working Advantage discount network where you can save up to 60% on a variety of products and services
 - Support tools and advice on a wide range of topics including legal, financial, family, and career
- Online resources for protection against identity theft
- Online will preparation through EstateGuidance®
- Guidance and support for your beneficiaries, including:
 - Grief counseling – advice, information, and referrals
 - Legal support services, including estate and probate law, real estate transactions, or survivor benefits
 - Financial services such as estate planning, budgeting, bankruptcy, or investments
 - General support services such as planning a memorial service, finding child or elder care, or financing your home
 - To access LifeKeys, visit [GuidanceResources.com](https://www.guidanceresources.com)



WELLNESSPATH®

Whether you want to save more or need to pay off debt, getting your finances in order may improve your overall well-being. Lincoln WellnessPATH® provides tools and personalized steps to help manage your financial life.

From creating a budget to building an emergency fund to paying down debt, our easy-to-use online tool helps you turn information into action so you can focus on both short- and long-term goals, such as providing protection for your loved ones. Register or log in to [LincolnFinancial.com](https://www.lincolnfinancial.com) to start using WellnessPATH® today.





TRAVELCONNECT®

TravelConnect® can provide assistance if you face a medical emergency while traveling 100 or more miles from home. Whether traveling for business or leisure, if you are enrolled in life and/or AD&D insurance, you and your loved ones can count on *TravelConnect*® for responsive and caring support – 24 hours a day, 7 days a week. *TravelConnect*® can assist with:

- Emergency pet boarding and/or return
- Return of traveling companion
- ID recovery assistance
- Emergency travel arrangements
- Lost or stolen travel documents
- Medical and dental referrals
- Medication and vaccine delivery

For a complete list of *TravelConnect*® services, go to mysearchlightportal.com and enter your group ID: LFGTravel123.

To contact *TravelConnect*®, call 866-525-1955 in the US or Canada, or 603-328-1955 from anywhere in the world.



MEDICARE ENROLLMENT SUPPORT PROGRAM

Whether you're retiring, actively working, or have a loved one turning 65, Medicare Choice Group can help you confidently navigate your Medicare journey.

Medicare Choice Group is your trusted partner for Medicare and Individual Health enrollment services at any stage of life. Licensed advisors provide one-on-one support to help you understand your options, compare plans, and make informed decisions—all at no cost to you.

During your personal consultation, you'll receive step-by-step guidance to help you:

- Understand eligibility, timing, and enrollment steps
- Compare coverage options and costs
- Avoid late enrollment penalties
- Coordinate your employer and Medicare benefits

Schedule your free consultation today:
visit medicarechoicegroup.com/artisan-lane or call 855-970-4437

We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all your options.

CA License 6001510



MEDICARE CHOICE
GROUP



ACCIDENT INSURANCE

Since accidents can happen at any time, it's important to be prepared. That is why we are happy to offer voluntary Accident Insurance from Chubb. You have the option of customizing your coverage by selecting between two 24-hour plans to best suit you and your family.

This policy can help cover the out-of-pocket costs associated with an accident by paying you a benefit depending on the injuries you suffer and the treatment you receive. You can use the money as you see fit, whether to pay for expenses associated with your accident, such as an emergency room copay, or to pay for childcare so you can get to the doctor for a follow-up visit. The policy does not coordinate with any other coverage, so you can still receive benefits on top of what your medical plan provides. Plus, the policy will pay you a wellness benefit of up to \$75 when you complete a qualified health assessment.



CRITICAL ILLNESS INSURANCE

Voluntary Critical Illness coverage from Chubb provides you with a lump sum cash benefit in the event you or a loved one is diagnosed with a covered condition, such as cancer, heart attack, or stroke. It can help provide financial protection so you can focus on what's really important – getting better.

You pick the level of coverage that provides the right protection for your family. During this enrollment period, you will have the opportunity to select up to \$30,000 in coverage for yourself, up to \$15,000 in coverage for your spouse, and up to 25% of your coverage for your child(ren) without answering any medical questions. Plus, the policy will pay you a \$50 wellness benefit when you complete a qualified health assessment.

CRITICAL ILLNESS COVERED CONDITIONS

ALS	Coronary Artery Obstruction
Alzheimer's Disease	End Stage Renal Failure
Benign Brain Tumor	Heart Attack
Cancer	Major Organ Failure
Carcinoma In Situ	Skin Cancer
Coma	Stroke

HOW THE PLAN WORKS

- Tom suffered a relatively small stroke.
- He was hospitalized for five days.
- He began rehab to get back to where he was physically before the stroke.
- Tom submitted his claim and received a lump-sum payment of \$10,000.

BENEFIT AMOUNT

Employee	\$5,000 – \$30,000 in \$5,000 increments
Spouse	\$5,000 – \$15,000 in \$5,000 increments
Children	\$1,000 – \$15,000

ACCIDENT & CRITICAL ILLNESS



LONG-TERM CARE & HOSPITAL INDEMNITY



LIFETIME BENEFIT TERM INSURANCE WITH LONG-TERM CARE

LifeTime Benefit Term Insurance with Long-Term Care coverage through Chubb features premiums guaranteed for life and coverage for qualified long-term care expenses such as a nursing home, assisted living, or home care.

As Life Insurance: LifeTime Benefit Term protects your family with money that can be used any way you choose. It is most often used to pay for mortgage or rent, education for children and grandchildren, retirement, family debt, and final expenses.

For Long-Term Care: If you become chronically ill, LifeTime Benefit Term will pay you 4% of your death benefit each month you receive Long-Term Care. You can use this money any way you choose, and your life insurance premiums will be waived. Your death benefit will reduce proportionately each month as you receive benefit payments for Long-Term Care. Your life insurance will continue to help you protect your assets for 25 months. After 25 months of receiving Long-Term Care benefits, your death benefit will reduce to zero.

For Terminal Illness: After your coverage has been active for two years, you can receive 50% of your death benefit, up to \$100,000, if you are diagnosed as terminally ill.

During this enrollment period only, you will have the opportunity to elect up to \$75,000 in coverage for yourself and up to \$25,000 for your child(ren) without answering medical questions. You can elect up to \$75,000 for your spouse after answering a few medical questions.



HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity Insurance from Chubb is designed to help provide financial protection for covered individuals by paying a benefit due to a hospitalization. This benefit is paid directly to you and you can use it however you see fit, whether it's to meet out-of-pocket expenses or to pay extra expenses that aren't a result of hospitalization.

This policy is available for you, your spouse, and your children and can be used regardless of pre-existing conditions without undergoing a health exam. You have the option of selecting between two plans to ensure you have the coverage that best fits your needs.

CHUBB®

BCBSTX



LINCOLN FINANCIAL



CIGNA DENTAL



NAVIA BENEFITS



EYEMED



PROACTIVE MD

Lee Associates Only



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CONTACTS

American Leather & Benchmade: hrgroup@americanleather.com
 Brookline: Tammy Perez at tammy.perez@brooklinefurniture.com
 LEE: Mary Kathryn Woods at mkwoods@leeindustries.com

BENEFIT	PROVIDER		PHONE	WEBSITE
Medical Coverage	BlueCross BlueShield of Texas	BlueCross BlueShield of Texas Group Policy Number: 302786	800-521-2227	bcbstx.com
Pharmacy Coverage	Welldyne	Welldyne (effective 1/1/2026) RxGroup Number: TX302786 BIN: 008878 PCN: WDRX	1-833-318-6989	http://wellview.welldyne.com/
Dental	Cigna	Cigna Group Policy Number: 3341906	800-244-6224	mycigna.com
Vision	EyeMed	EyeMed Group Policy Number: VC-19	866-804-0982	eyemed.com
Flexible Spending Accounts (FSAs)	Navia Benefit Solutions	Navia Benefit Solutions	425-452-3500	www.naviabenefits.com/contact/ Email: customerservice@naviabenefits.com
LifeTime Benefit Term Insurance, Hospital Indemnity, Accident, and Critical Illness Insurance	Chubb	Chubb	855-241-9891	For questions: csmail@gotoservice.chubb.com To file a claim: claims@gotoservice.chubb.com
Disability	Lincoln Financial Group	Lincoln Financial Group STD Group Policy Number: 860056327 LTD Group Policy Number: 860056326	800-423-2765	lfg.com
Life Insurance	Lincoln Financial Group	Lincoln Financial Group Basic Life Group Policy Number: 010129984 Vol. Life Group Policy Number: 400130285	800-423-2765	lfg.com
Employee Assistance Program	Lincoln Financial Group	Lincoln Financial Group EmployeeConnect SM	888-628-4824	GuidanceResources.com Username: LFGSupport Password: LFGSupport1
	Lincoln Financial Group	LifeKeys [®]	855-891-3684	GuidanceResources.com First-time user: Enter Web ID LifeKeys
Medicare Education	Medicare Choice Group	Medicare Choice Group	855-970-4437	visit.medicarechoicegroup.com/artisan-lane

REQUIRED NOTICES

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

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 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 –

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)**.

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska Medicaid	Premium Payment Program: myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa Email: customerservice@myakhipp.com	866-251-4861
Arkansas Medicaid	http://myarhipp.com/	855-MyARHIPP (855-692-7447)
California Medicaid	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado Medicaid and CHIP	Medicaid: healthfirstcolorado.com CHIP: hcpf.colorado.gov/child-health-plan-plus HIBI: mycohibi.com	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
Florida Medicaid	flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	877-357-3268
Georgia Medicaid	HIPP: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2

Indiana Medicaid	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	800-403-0864 800-457-4584
Iowa Medicaid and CHIP	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid CHIP: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	800-338-8366 800-257-8563 888-346-9562
Kansas Medicaid	kancare.ks.gov	800-792-4884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP Email: KIHIPPPROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	ldh.la.gov/healthy-louisiana or www.ldh.la.gov/lahipp	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
Maine Medicaid	Enrollment: mymaineconnection.gov/benefits Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711
Massachusetts Medicaid and CHIP	mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 TTY/Relay: 711
Minnesota Medicaid	mn.gov/dhs/health-care-coverage	800-657-3672
Missouri Medicaid	dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana Medicaid	HIPP: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HIPP Email: HSHIPPProgram@mt.gov	800-694-3084
Nebraska Medicaid	ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: dhcnp.nv.gov	800-992-0900
New Hampshire Medicaid	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 800-852-3345 , ext. 15218
New Jersey Medicaid and CHIP	Medicaid: state.nj.gov/humanservices/dmahs/clients/medicaid CHIP: njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
New York Medicaid	health.ny.gov/health_care/medicaid	800-541-2831
North Carolina Medicaid	medicaid.ncdhhs.gov	919-855-4100
North Dakota Medicaid	hhs.nd.gov/healthcare	844-854-4825
Oklahoma Medicaid and CHIP	insureoklahoma.org	888-365-3742
Oregon Medicaid	healthcare.oregon.gov/Pages/index.aspx	800-699-9075

Pennsylvania Medicaid and CHIP	Medicaid: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	eohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RItte)
South Carolina Medicaid	scdhhs.gov	888-549-0820
South Dakota Medicaid	dss.sd.gov	888-828-0059
Texas Medicaid	hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	UPP: 877-222-2542
Vermont Medicaid	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia Medicaid and CHIP	coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington Medicaid	hca.wa.gov	800-562-3022
West Virginia Medicaid and CHIP	dhhr.wv.gov/bms/mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 855-699-8447
Wisconsin Medicaid and CHIP	dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming Medicaid	health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	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
dol.gov/agencies/ebsa
866-444-EBSA (3272)

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

PART A: GENERAL INFORMATION

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace (“Marketplace”). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options in your geographic area.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn’t meet certain minimum value standards (discussed below). The savings that you’re eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

DOES EMPLOYMENT-BASED HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.96%¹ of your annual household income, or if the coverage through your employment does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee’s cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.96% of the employee’s household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your

payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

WHEN CAN I ENROLL IN HEALTH INSURANCE COVERAGE THROUGH THE MARKETPLACE?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you’ve had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children’s Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage**. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility.

To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

WHAT ABOUT ALTERNATIVES TO MARKETPLACE HEALTH INSURANCE COVERAGE?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-

based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit healthcare.gov/medicaid-chip/getting-medicaid-chip for more details.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1. Indexed annually; see irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

LOSS OF OTHER COVERAGE

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

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact Human Resources.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice

- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

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

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

OUR USES AND DISCLOSURES

We may use and share your information as we:

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

YOUR RIGHTS

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

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

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

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a

different address.

- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

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

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

YOUR CHOICES

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

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

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

- Share information in a disaster relief situation

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

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

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

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

Run our organization

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

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

Pay for your health services

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

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

Administer your plan

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

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

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good,

such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

<https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>

Help with public health and safety issues

We can share health information about you for certain situations such as:

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

Do research

We can use or share your information for health research.

Substance Use Disorder Records

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

Comply with the law

If applicable, the Plan will not use or disclose substance use disorder records received from programs subject to the Confidentiality of Substance Use Disorder Patient Records regulations in civil, criminal, administrative, or legislative proceedings against you unless such disclosure is based on your written consent thereto or a court order. Prior to using or disclosing such information pursuant to a court order, the Plan will notify you and provide you with an opportunity to be heard. The Plan will not use or disclose substance use disorder records pursuant to a court order unless the order is accompanied by a subpoena or other legal requirement compelling disclosure.

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

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

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

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized

by law

- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

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

OUR RESPONSIBILITIES

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

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

CHANGES TO THE TERMS OF THIS NOTICE

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

Effective Date: 5/1/2026

Julio Wong

Privacy Officer

hrgroup@americanleather.com

214-972-9599

IMPORTANT NOTICE FROM ARTISANT LANE 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 Artisant Lane 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. **Artisant Lane has determined that the prescription drug coverage offered by the Artisant Lane 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 15 to December 7.

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

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

If you decide to join a Medicare drug plan, your current Artisant Lane coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Artisant Lane coverage, be aware that you and your dependents may not 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 Artisant Lane and don't join a Medicare drug plan within 63 continuous days after your current coverage

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

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Artisan Lane changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 01/01/2023

Name of Entity/Sender: Artisan Lane

Contact--Position/Office: Human Resources Department

Address: 4501 Mountain Creek Pkwy, Dallas, TX 75236

Phone Number: 214-972-9599

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

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

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

Disability Extension of 18-month Period of COBRA Continuation Coverage

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

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

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

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

CAN I ENROLL IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE AFTER MY GROUP HEALTH PLAN COVERAGE ENDS?

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

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

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

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

For more information visit

<https://www.medicare.gov/medicare-and-you>.

IF YOU HAVE QUESTIONS

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

numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact Navia Benefit Solutions, PO Box 3961, Seattle WA 98214. You may also contact Navia via email at cobra.support@naviabenefits.com or by phone at (800) 328-4337.

1. <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

ENROLLMENT NOTICE

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

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

These benefits will be provided subject to the same deductibles, copays, and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact Human Resources or your medical plan administrator.

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.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

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

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

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or

have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

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

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

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

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

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

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

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

In certain states, you may also have related state protections. Applicable state balance billing laws or requirements for noted states are as follows:

CALIFORNIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides a payment standard
- Protections do not apply to:
 - ground ambulance services
 - enrollees who consent to non-emergency out-of-network services
 - enrollees in self-funded plans

FLORIDA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- For PPOs, state payment standard applies to (1) emergency services and (2) non-emergency services provided by out-of-network professionals at in-network facilities
- For HMOs, state payment standard only applies to emergency services but the state also has a claim dispute resolution program in place
- Protections do not apply to:
 - ground ambulance services for PPO enrollees
 - PPO enrollees who consent to non-emergency out-of-network services

- enrollees of self-funded plans

NORTH CAROLINA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protections apply:
 - To HMO and PPO enrollees
 - For emergency services by out-of-network professionals
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - ground ambulance services
 - emergency services by out-of-network facilities
 - non-emergency services
 - enrollees of self-funded plans

PENNSYLVANIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
 - To HMO and PPO enrollees
 - For emergency services
 - Provided by all or most classes of health care professionals
- Protections do not apply to:
 - ground ambulance services
 - out-of-network facility emergency service charges, for PPO enrollees only
 - non-emergency services
 - enrollees of self-funded plans

TEXAS PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
 - To HMO, PPO, and EPO enrollees
 - For (1) emergency services by out-of-network professionals and facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
 - Provided by all or most classes of health care professionals
- State provides dispute resolution process
- Protections do not apply to:
 - ground ambulance services

- o enrollees who consent to out-of-network non-emergency services
- o enrollees of self-funded plans

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THE FOLLOWING PROTECTIONS:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - o Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - o Cover emergency services by out-of-network providers.
 - o Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
 - o Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed:

Visit <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act> for more information about your rights under federal law.

Visit <https://www.commonwealthfund.org/publications/maps-and-interactives/2022/feb/map-no-surprises-act> for more information about your rights under your state laws.

WELLNESS PROGRAM NOTICES

Wellworks is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete an annual physical examination with your primary care physician.

However, employees who choose to participate in the wellness program will receive an incentive of \$50 per participating employee or spouse per month for completing the criteria. Although you are not required to complete the physical examination, only employees who do so will receive the incentive.

PROTECTIONS FROM DISCLOSURE OF MEDICAL INFORMATION

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Artisan Lane may use aggregate information it collects to design a program based on identified health risks in the workplace, Wellworks will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources.



ARTISAN LANE
FURNITURE COLLECTIVE