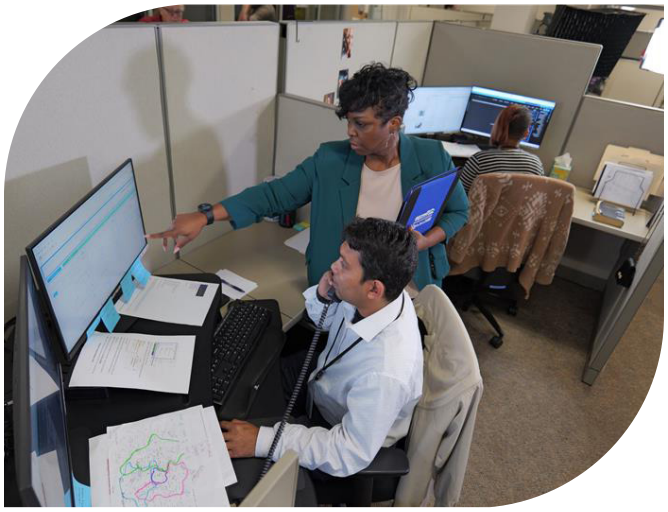


2026
Enrollment Guide

ANNUAL ENROLLMENT: NOVEMBER 17-24, 2025

OUR BENEFITS PROGRAM HAS YOU COVERED

Most days, we all count on our simple routines to get us through. Getting the kids to school, beating the traffic to work, and finishing dinner in time to enjoy a favorite hobby. But sometimes things don't always go as planned. Like when your head cold turns into the flu, and you have to be out of work. Or your son's football game ends with a broken leg. Or even when your spouse learns he or she needs an extensive root canal. That's when Tempo, Inc's benefits are there to help you.

What's Inside

This guide highlights the main features of many of the benefit plans sponsored by Tempo, Inc. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. Tempo, Inc, reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

Important Contacts

RESOURCE	PHONE	WEBSITE
Member Assistance Program	**877.660.3806**	**www.liveandworkwell.com**
Teladoc Virtual Medical & Mental Health Care	800.835.2362	www.teladoc.com
Medical UMR (Group #76415229)	800.826.9781	www.umr.com
Pharmacy True Rx (Group # TRUE1922)	866.921.4047	www.truerx.com/members
High-Cost Prescription Access SHARx Program Option 1	314.451.3555	Sharx@sharxplan.com
Alight Health Pro Concierge British Gordon	800.513.1667 x 6534	British.Gordon@alight.com myhealthpro@alight.com
Health Savings Account HSA Bank	866.357.5232	www.hsabank.com
Flexible Spending Account Employee Benefits Corporation (EBC)	800.346.2126	www.ebcflex.com
Dental MetLife	MetLife (Group #: 5780941) 800.638.5433	www.metlife.com
Vision MetLife		
Life and AD&D Insurance Mutual of Omaha (Policy #G000CM51)	800.877.5176	www.mutualofomaha.com
Short-Term Disability and Long-Term Disability Mutual of Omaha (Policy #G000CM51)		
Voluntary Worksite Benefits (Hospital Indemnity, Accident & Critical Illness) UnitedHealthcare (Policy #305603)	UnitedHealthcare (Policy #305603) 888.299.2070	www.myuhc.com
Figo Pet Insurance	844.738.3446	https://uqr.to/25alc
Holmes Murphy Benefits Analyst Nancy Fuentes	214.265.2298	NFuentes@holmesmurphy.com
Human Resources	972.579.2015	Benefits@tempopartners.com

Refer to this list when you need to contact one of your benefit vendors. For general information contact your Human Resources Department or your Holmes Murphy & Associates Benefits Analyst.

Benefit Overview

Below is an overview of our benefits program, which gives you the coverage you need for all types of things life brings your way. Tempo, Inc's benefit plans allow you to choose the options that work best for your own needs — and your pocketbook. The key to getting the most from our benefits program is to take an active role in understanding and using the plans so that you are getting the best value for the money you spend. Check out your benefits on our new microsite at https://mytempobenefits.com.

Benefits Available To You	
Medical and Prescription Drug	**High-Cost Prescription Program**
Dental Plan	**Short-Term Disability**
Vision Plan	**Long-Term Disability**
Basic Life & AD&D Insurance (Employer Paid) and Voluntary Life & AD&D (Employee-paid)	**Voluntary Worksite Benefits (Hospital Indemnity, Accident, & Critical Illness Insurance)**
Alight Health Concierge	**Employee Assistance Program (EAP)**
Pet Insurance	

Employee Eligibility

You are eligible to enroll in Tempo, Inc's benefit plans if you are a **REGULAR, FULL-TIME PARTNER** scheduled to work **AT LEAST 30 HOURS PER WEEK**. As a regular, full-time partner, you are eligible for benefits on the first day of the month following 30 days of continuous service. For example, if you are hired on June 3, 2026, your benefits will be effective on August 1, 2026.

Dependent Eligibility

You may also cover your eligible dependents, including:

- Your legal spouse or qualified domestic partner.
- Your eligible unmarried children up to age 26 for medical, dental, and voluntary life coverage.
- "Children" are defined as your natural children, stepchildren, legally adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

If your child becomes ineligible for coverage (i.e., turning age 26 under the medical plan), you must notify Human Resources at Benefits@tempopartners.com

2026 Open Enrollment

INITIAL ENROLLMENT

When you first join Tempo, Inc, you have 30 days to enroll yourself and your dependents for benefits. If you enroll on time, coverage begins the first day of the month following 30 days of continuous service. If you do not enroll within 30 days of becoming eligible, you will automatically be enrolled in company-sponsored benefits such as Basic Life and Accidental Death & Dismemberment (AD&D) Insurance, and the Employee Assistance Program (EAP), but you will have to wait until the next annual Open Enrollment to enroll for other benefits and make changes to coverage.

ANNUAL OPEN ENROLLMENT

Open Enrollment for the January 1, 2026 – December 31, 2026, plan year will take place from November 17, 2025 – November 24, 2025. **You must enroll online in Paycom by logging into www.paycomonline.net/v4/ee/web.php/app/login**. You will need your username, password and the last four digits of your Social Security number. Once you are logged in you will select the "Enroll Now" option under the My Benefits section and then select "Start Enrollment". You will be guided through the steps to make your benefit selections. Be sure to review and verify your personal information. Once you've completed the steps for enrollment be sure to complete the process by clicking "Sign and Submit" and printing your confirmation statement. Contact Human Resources at **Benefits@tempopartners.com** with any questions regarding the Paycom system.

NEW HIRE ENROLLMENT

If you are a new Tempo, Inc partner, you will be able to enroll in benefits through Paycom Employee Self Service after your hire date. Benefits will become effective on the first day of the month following 30 days of employment. To enroll, navigate to www.paycomonline.net/v4/ee/web.php/app/login and enter your username, password and the last four digits of your Social Security number. Select "Enroll Now" under the My Benefits section and then select "Start Enrollment". You will be guided through the steps to make your benefit selections. Be sure to review and verify your personal information. Once you've completed the steps for enrollment be sure to complete the process by clicking "Sign and Submit" and printing your confirmation statement. Contact HR at Benefits@tempopartners.com with any questions regarding the Paycom system.

MAKING CHANGES TO COVERAGE

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment unless you have a qualified status change or you or your eligible dependents become eligible for coverage through special enrollment rules.

If you have a qualified status change or you have another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 31 days of the event, or within 60 days following the birth or placement for adoption of your dependent child, by contacting Human Resources.
If you do not enroll by this deadline, you will have to wait until the next Open Enrollment to make new elections.

Qualified status changes include, but are not limited to:

- Change in number of eligible dependents due to birth, adoption, placement for adoption, or death
- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in residence or workplace that changes you or your dependent's eligibility for coverage
- Change in employment status, such as starting or ending employment, for you, your spouse, or your children
- End of the maximum period for COBRA coverage

For a more complete list of qualified status changes, refer to the Summary Plan Description.

SPECIAL ENROLLMENT RULES

If you choose not to enroll yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents at a later date if:

- You or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.-

You must enroll within 60 days of the qualified events shown in the "Special Enrollment Rules" above.

If your dependent also had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents to this coverage if the other coverage was terminated "for cause" (including failure to pay the required premiums on time).

If you have a special enrollment event and want to enroll for health coverage, contact Human Resources at **Benefits@tempopartners.com**.

Scan this code to get started and register and/or sign in to your account on **www. paycomonline.net/v4/ee/web.php/app/login**.

paycom®

Choosing a Medical Plan

Tempo, Inc's medical options all provide coverage for the same types of expenses, such as doctor's office visits, preventive care, prescription drugs, and hospitalization. You choose the option that makes the most sense for you and your family based on your needs and what you want to pay for coverage.

When it comes to medical coverage, Tempo, Inc, offers you these choices through **UMR**:

- **Plan 1** – HSA-Compatible Plan
- **Plan 2** – PPO Copay Plan

EXCLUSIVE PROVIDER ORGANIZATIONS (EPO)

The EPO plan only offers in-network benefits through the UnitedHealthcare Choice Plus Network. When you need care, only in-network providers will be covered under your health plan. If you choose to receive care from an out-of-network provider, you will be responsible for 100% of the cost.

All of the providers in the United Healthcare Choice Plus Network change frequently. To find out if your doctor participates in the network, go to **www.umr.com** and click on Find Physician, Laboratory or Facility.

Medical Insurance Comparison

	HSA- Compatible Plan		PPO Copay Plan	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Indivdual Deductible	$3,500	Out-of-Network Benefits Offered for Certain States	$2,000	Out-of-Network Benefits Offered for Certain States
Family Deductible	$7,000		$4,000	
Individual OOPM	$4,500		$7,150	
Family OOPM	$9,000		$14,300	
Lifetime Maximum	Unlimited		Unlimited	
	YOU PAY		**YOU PAY**	
Preventive Care	$0	Out-of-Network Benefits Offered for Certain States	$0	Out-of-Network Benefits Offered for Certain States
Primary Care Physician	0% After Deductible		$15 Copay $0 < 19 Yrs	
Specialist (Designated/Non-Designated Provider)	0% After Deductible		$50 / $100 Copay	
Diagnostics, X-Ray, and Lab Services	$0		20% After Deductible	
Urgent Care	0% After Deductible		$25 Copay	
Emergency Room	0% After Deductible		$300 Copay + 20% After Deductible	
Inpatient Hospital Care	0% After Deductible		20% After Deductible	
Outpatient Surgery	0% After Deductible		20% After Deductible	

Prescription Drug Coverage

If you enroll in one of the Tempo, Inc medical plans, you will automatically receive prescription drug coverage provided through **TrueRx**. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order program.

RETAIL PRESCRIPTION PROGRAM

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. Prescriptions you fill at non-participating pharmacies are not covered. You may find a list of participating pharmacies at **www.truerx.com**.

MAIL ORDER PROGRAM

The mail order program offers a convenient and cost-effective way to fill prescriptions for medications you take on a regular basis (maintenance medications). When you use the mail order program, you receive a 3-month supply of medication for the cost of a 2.5-month supply. Your medications are mailed directly to your home. To order prescriptions through the mail order program, you can go to the **www.truerx.com/member** website and manage your mail order prescriptions from there or ask your doctor to call 866.921.4047.

SPECIALTY PRESCRIPTION PROGRAM

Specialty medications are high-cost and may be used to treat rare or complex conditions. If you use a specialty medication, you are encouraged to take advantage of personalized support designed to help you get the most out of your treatment plan. Once you enroll, experience personalized one-on-one support from pharmacists and nurses specially trained in your disease condition as part of the Clinical Management Programs for certain specialty conditions. They will track your progress; help you maintain your therapy and answer your questions. Visit **www.truerx.com** to learn more.

Drug Tier	HSA Compatible Plan	PPO Copay Plan
In-Network Only		
Retail Prescriptions (up to 31-day supply)		
Deductible	Combined Medical & RX	N/A
Tier 1 ($) generic and some brands; lowest cost	*$10 Copay	$20 Copay
Tier 2 ($$) preferred brand drugs; mid-range cost	*$35 Copay	$40 Copay
Tier 3 ($$$) mostly brand drugs; highest cost	*$60 Copay	$75 Copay
Mail Order Prescriptions (up to 90-day supply)		
Tier 1 ($) generic and some brands; lowest cost	*$25 Copay	$50 Copay
Tier 2 ($$) preferred brand drugs; mid-range cost	*$87.50 Copay	$100 Copay
Tier 3 ($$$) mostly brand drugs; highest cost	*$150 Copay	$187.50 Copay

* HSA Plan – Rx Copays will apply after deductible has been met

SHARx: High-Cost Prescription Assistance

WHAT IT IS:
SHARx helps employees enrolled in the medical plan get access to high-cost medications—often at little or no cost. Tempo, Inc covers the full cost of the SHARx program for you and your family.

WHO IS ELIGIBLE:
Employees and dependents enrolled in an Tempo, Inc's medical plan who take medications that cost $350 or more per month (for example: insulin, Humira, Eliquis, or Xarelto).

TIMING:
Setup takes about 2–4 weeks, depending on how quickly your provider responds. Respond promptly to any requests for information to avoid delays.

WHAT IF I DON'T ENROLL?
High-cost medications that can be sourced through SHARx will not be covered under the regular pharmacy benefit.

HOW IT WORKS

If you're prescribed a high-cost medication, you'll receive a welcome email from SHARx with instructions.

Click the link in the email to set up your SHARx account and complete your advocacy request.

A SHARx Patient Care Coordinator will work directly with you and your doctor to help you apply for patient assistance programs and secure your medications.

Most prescriptions are free through SHARx; some may require a small copay.

NEED HELP?
Call SHARx at 314-451-3555, Option 1
Email sharx@sharxplan.com
SHARx Member Portal: app.sharxplan.com

Visit www.sharxplan.com for details and a list of eligible medications.

Wellness

At Tempo, Inc, we take our health and wellness management seriously. That is why this year, we will continue to offer a Wellness Program to our partners. The wellness program is designed to help each Tempo, Inc partner, if enrolled in the medical plan, to identify any personal health risks through a biometric screening assessment – free of charge! Good health is good for each of us personally, and it's good for our business. With you and your families' participation, we believe we will be successful in improving the lives of our partners!

Be sure to complete your biometric screening or annual check-up and age-appropriate cancer screening in 2026. Your participation will help lower what you pay for medical insurance in 2027. In addition to being good for your health, it's also good for the health of your wallet.

TAKE ACTION! To get your wellness premium discount for the 2027 plan year, all eligible employees on the medical plan must complete their biometric screening or annual check-up and age-appropriate cancer screening in 2026.

Starting with the first pay period in January 2026, partners who did not meet the full wellness requirements in 2025 will pay higher premiums than those who did.

2026 MEDICAL PLAN EMPLOYEE WEEKLY DEDUCTIONS

Weekly Medical Premiums	HSA Compatible Plan (Wellness Rates)	HSA Compatible Plan (Non-Wellness Rates)
Employee Only	$23.43	$46.50
Employee + Spouse	$70.87	$93.94
Employee + Children	$64.47	$87.55
Employee + Family	$99.06	$122.14

Weekly Medical Premiums	PPO Copay Plan (Wellness Rates)	PPO Copay Plan (Non-Wellness Rates)
Employee Only	$49.00	$72.08
Employee + Spouse	$125.86	$148.94
Employee + Children	$115.63	$138.70
Employee + Family	$174.52	$197.59

Start Your Wellness Journey Today!

Looking to maintain a healthy lifestyle? Manage your health and wellness with confidence. Participate in our free and comprehensive employee wellness program and make a lasting impact. Align your goals, stay motivated, celebrate successes, and redefine what health and wellness means to you.

- Log into **marqueewell.com** or scan the QR code to download the MyWellPortal app.
- **Select** 'Register for a new account,' **and enter the company code** 'Tempo, Inc' **to create a personal profile.**

WELLNESS PROGRAM

Looking to maintain a healthy lifestyle? Manage your health and wellness with confidence. Participate in our free and comprehensive employee wellness program and make a lasting impact. Align your goals, stay motivated, celebrate successes, and redefine what health and wellness means to you.

Resources at your fingertips to balance both work and wellness!

- **Wellness Portal & Mobile App:** Technology at your fingertips
- **Unlimited Access to Health Coaches:** Experts answering your questions & helping you reach your goals
- **Wellbeing Place Blog:** Weekly posts focused on trending health and wellness topics
- **On-Demand Wellness Videos:** Learn to cook, meditate, or workout when it's convenient for you
- **Personal Health Assessments:** Questionnaires to help identify health risk areas
- **Wellness Challenges:** Opportunities to compete against your coworkers with wellness-focused goals
- **Monthly Webinars:** Educate yourself on how to make the best decisions for your well-being
- **Gym Membership Discounts:** Access to discounts at gyms nationwide

How Do I Get Started?

1. Log into marqueewell.com or scan the QR code to download the MyWellPortal app.
2. Select 'Register for a new account,' and enter the company code 'tempo' to create a personal profile.

HEALTH PRO RESOURCES - ALIGHT

With Health Pro Connection and your Health Pro you have the tools to support your healthcare needs, while maximizing your benefits.

Log in to your personalized Health Pro Connection to:

- View information about your health plan coverage
- Choose in-network top-notch medical, dental and vision professionals
- Compare costs and make informed healthcare decisions
- Contact your Health Pro and view status of current requests

Connect with your Health Pro to:

- Find which lower-cost medications are available
- Set up medical appointments that fit your schedule
- Confirm benefits coverage was properly applied and get help solving billing issues
- Connect you with other benefits offered by your employer

Scan this code to get started and register and/or sign in to your account on **alight.com**.

OR

Call: **800.513.1667**

NON-SURGICAL OTHOPEDIC TREATMENT - REGENEXX

Tempo partners with Regenexx to offer an alternative to surgery for musculoskeletal and orthopedic conditions. Covered as an in-network benefit under both Tempo medical plans, Regenexx procedures use your body's own stem cells and platelets to treat injuries to bone, cartilage, muscle, tendons and ligaments — eliminating the need for up to 70% of elective orthopedic surgeries.

These are same-day, outpatient procedures that are minimally invasive, require less recovery time and reduce the need for followup care and pain medication. In the event of an injury or chronic pain, a Regenexx physician will provide a full evaluation and personalized treatment plan.

Telehealth

If something is on your mind —big or small—talking to an expert can help. Our licensed therapists are available seven days a week. Choose your therapist, pick a time that is convenient for you and then talk to the therapist from the privacy of home or anywhere you feel comfortable.

Through **teladoc.com** or the Teladoc app, you can choose to connect remotely with a virtual primary care physician (PCP). Make an appointment 24/7. See a virtual PCP for preventive care, follow-up visits, and checkups for ongoing conditions (like asthma, diabetes).

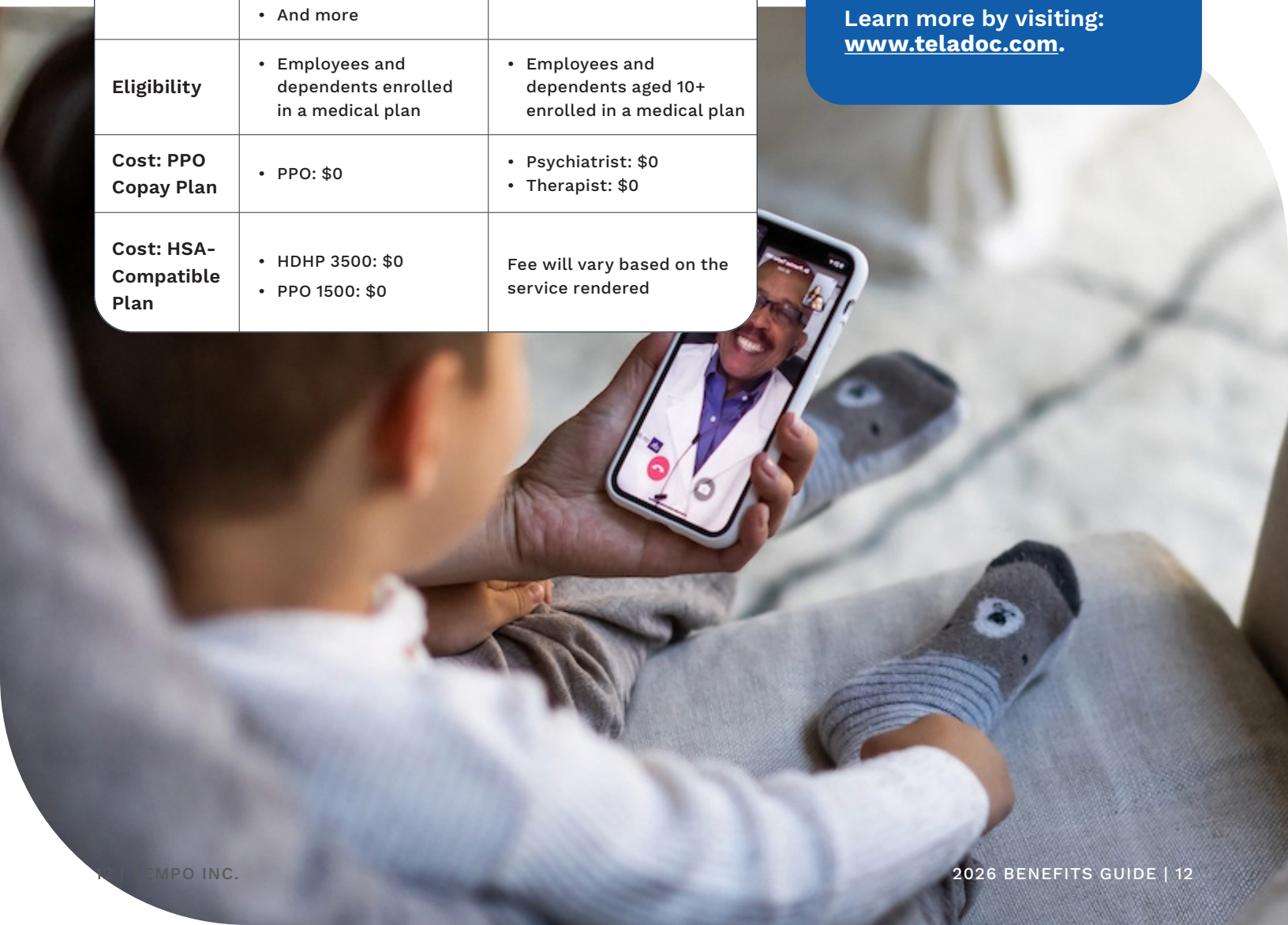
Doctors can diagnose and treat a wide range of non-emergency medical conditions including:

	PHYSICAL WELL-BEING	MENTAL WELL-BEING
Symptoms Treated	• Allergies • Cold or flu • Fever • Minor skin conditions • Nausea • Sinus infections • Stomachache • UTI • And more	• Anxiety • Depression • Parenting concerns • Relationship issues • Substance Abuse • Trauma and PTSD
Eligibility	• Employees and dependents enrolled in a medical plan	• Employees and dependents aged 10+ enrolled in a medical plan
Cost: PPO Copay Plan	• PPO: $0	• Psychiatrist: $0 • Therapist: $0
Cost: HSA-Compatible Plan	• HDHP 3500: $0 • PPO 1500: $0	Fee will vary based on the service rendered

How it works:

- Download the app, go online or call us to set up your account or log in
- Complete or update a brief medical history
- Request a visit and talk to a doctor within minutes

Learn more by visiting: www.teladoc.com.



Dental - PPO Plan

Tempo, Inc's Dental Plans are administered through MetLife and provide you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings, and orthodontia for children up to age 19.

You will not need a dental ID card to receive dental services. When you visit the dentist, give the provider your Social Security number and the MetLife group number.

PPO PLAN BENEFITS

The Dental PPO allows you the freedom to visit any dentist, without referrals, for all of your dental care. If you receive care from one of MetLife's preferred dentists, you'll pay less for your care.

If you choose a non-preferred dentist, your share of the costs will generally be higher, and you may need to file your own claims. Go to **www.metlife.com** and select your network "PDP Plus" to find a dentist.

PDP Plus Plan Feature	Premium Plan - PPO
Individual / Family	$50 / $150
Annual Benefit Maximum (per person per calendar year, non-orthodontia services)	$2,250
Annual Orthodontia Benefit (per child per lifetime)	$1,000
Preventive Services (Exams, routine cleanings, fluoride treatments, sealants, space maintainers)	No Charge Deductible Waived
Remember to take advantage of your FREE cleanings twice per year! (In-Network Providers Only)	
Basic Services (X-rays, extractions, fillings, periodontics)	You pay 20% after deductible
Major Services (Crowns, inlays, onlays, bridges, dentures)	You pay 50% after deductible
Out of Network	Maximum Allowable Charge (MAC)

EMPLOYEE WEEKLY DEDUCTIONS	
Employee Only	$2.68
Employee + Spouse	$5.70
Employee & Children	$6.56
Employee + Family	$10.31

Dental - HMO Plan

The Dental HMO allows you to receive treatment at a known fee schedule. There are no out-of-network benefits available through the Dental HMO, however you will pay a lower premium. Go to **www.metlife.com** and enter your DHMO plan code: MET290.

MET 290 Plan Feature	MetLife DHMO
Office Visit	$5 Copay
Exams	$0 Copay
Cleanings	$0 Copay
Fluoride Treatment	$0 Copay
Bitewing X-Rays	$0 Copay
Panoramic X-Rays	$0 Copay
Sealants - Non-molars - Per Tooth	$0 Copay
Fillings - Amalgam - One Surface - Primary	$12 Copay
Crowns - Porcelain with Metal	$290 Copay
Dentures - Complete (Maxillary or Mandibular)	$440 Copay
Comprehensive Orthodontic Treatment - Child & Adult	$2,095 Copay

EMPLOYEE WEEKLY DEDUCTIONS	
Employee Only	$1.40
Employee + Spouse	$2.44
Employee & Children	$3.51
Employee + Family	$4.92

Vision

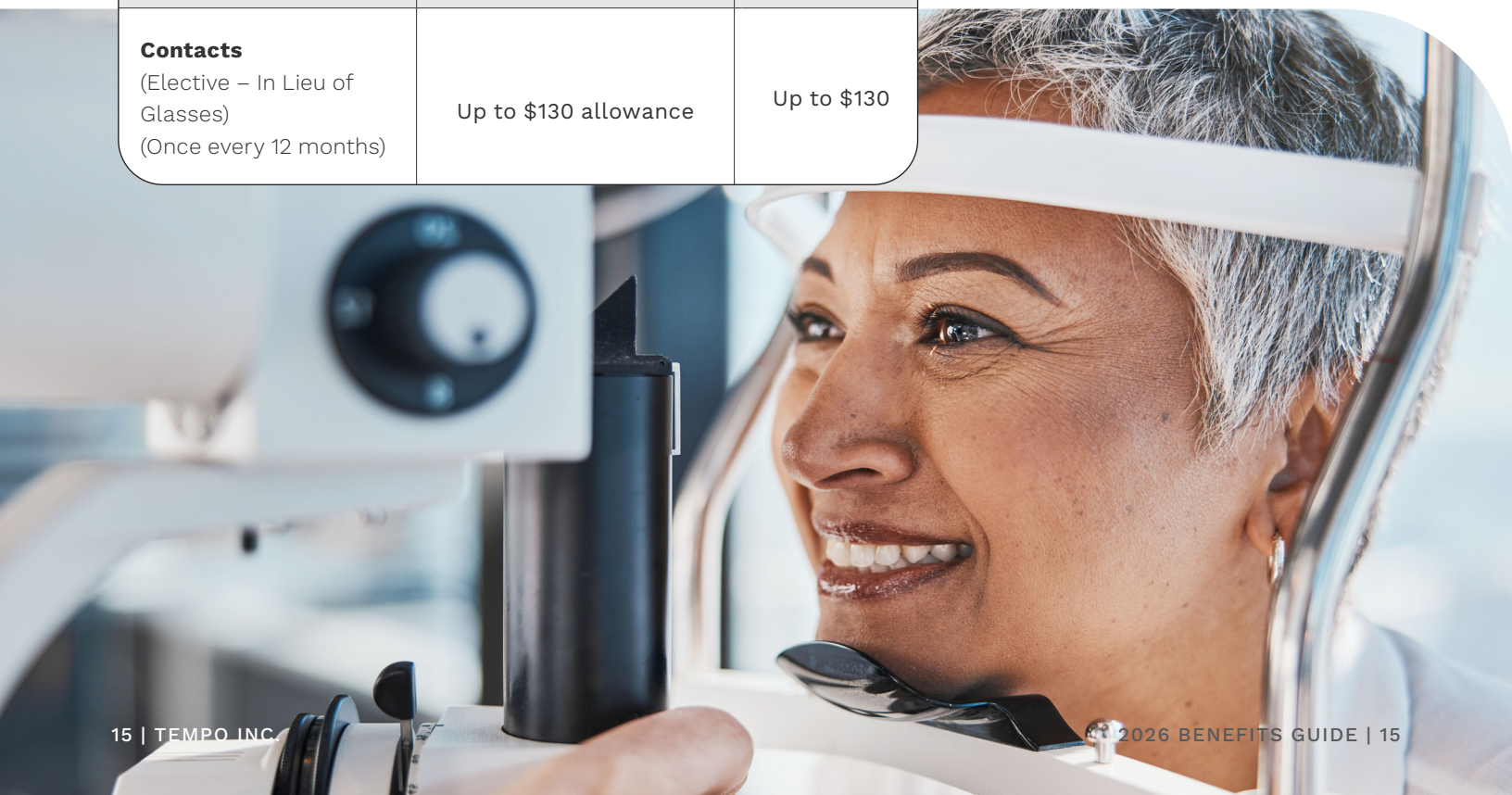
Tempo, Inc's Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through MetLife.

If you enroll in vision coverage, you can go to any eye care provider you choose for care. However, if you choose providers who are part of the MetLife network, you will receive a discount on services. To find a network provider (Superior Vision Network), go to **www.metlife.com**. You will not need a vision ID card to receive vision services. When you visit the optometrist, give the provider your Social Security number and the MetLife group number.

The Vision Plan is designed to cover eye care needs that are visually necessary. You have to pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

Plan Feature	In-Network	Out-of-Network
Exam (once every 12 months)	$10 copay	Up to $45
Contact Lens Exam (Fitting and Evaluation)	$25 Copay	See Below
Materials (Once every 12 months) **- Single Lenses** **- Bifocals - Lined** **- Trifocals - Lined** **- Lenticular**	$25 Copay	 Up to $30 Up to $50 Up to $65 Up to $100
Frames (once every 24 months)	$130 plan allowance, then 20% discount on remaining balance	Up to $70
Contacts (Elective – In Lieu of Glasses) (Once every 12 months)	Up to $130 allowance	Up to $130

EMPLOYEE WEEKLY DEDUCTIONS	
Employee Only	$1.40
Employee + Spouse	$2.81
Employee & Children	$3.35
Employee + Family	$5.12



Health Savings Account (HSA)

A Health Savings Account (HSA) is an account that you and Tempo, Inc may put money into to save for future medical expenses. There are certain advantages to putting money into this account, including favorable tax treatment. Log onto **www.hsabank.com** to register and set up your HSA Bank account online.

Any adult can contribute to an HSA if they:

- Have coverage under an qualified High Deductible Medical Plan
- Have no other first-dollar medical coverage (other types of insurance like specific injury insurance or accident, disability, dental care, vision care or long-term care insurance ARE permitted)
- Are not enrolled in Medicare
- Cannot be claimed as a dependent on someone else's tax return

You can use the money in the account to pay for any "qualified medical expense" permitted under federal tax law. This includes most medical care and services, and dental and vision care. You can use the money in the account to pay medical expenses for you, your spouse and/or dependent children.

Tempo, Inc will be front-loading their annual HSA contribution. Employees will see Tempo, Inc's total annual HSA contribution on the first payroll cycle of 2026. If you are a new hire, Tempo, Inc's contribution will be prorated based on when you join the plan.

Employee Only: $60.00/month = $720 annual

Employee + Spouse/Child(ren): $70.00/month = $840 annual

Employee + Family: $80.00/month = $960 annual

HSA BANK MOBILE

Visit **hsabank.com** or scan this code to maximize your healthcare dollars with HSA Bank.

Any amounts used for purposes other than to pay for "qualified medical expenses" are taxable as income and subject to an additional 20% penalty. Examples include:

- "Non-qualified medical expenses" under federal tax law (e.g., cosmetic surgery)
- Other types of health insurance unless specifically described above
- Medicare supplement insurance premiums
- Expenses that are not health related

After you turn age 65, the 20% penalty no longer applies. If you become disabled and/or enroll in Medicare, the account can be used for other purposes without paying the additional 20% penalty. **You may contribute the annual maximum amount as determined by the IRS, regardless of your plan's deductible. The maximum for 2026 is $4,400 for individuals and $8,750 for families. If you are over the age of 55, you are allowed to contribute an additional $1,000 to your HSA.**

- Anyone can contribute to your HSA
- The Company determines each year a discretionary pre-tax contribution to your HSA
- Any payroll deductions made through Section 125 for your HSA are on a pre-tax basis

Flexible Spending Account (FSA)

HEALTH CARE

If you are enrolling for coverage in Tempo, Inc's PPO Copay Medical Plan, you have the opportunity to pay for out-of-pocket medical, dental, and vision expenses through pre-tax dollars through a Health Care Flexible Spending Account (FSA). You must enroll in the plan during annual enrollment in order to participate for the plan year Jan 1, 2026 – December 31, 2026. This plan is administered by Employee Benefits Corporation (EBC).

A Health Care FSA is used to reimburse out-of-pocket medical expenses incurred by you and/or your dependents. Contributions to your FSA come out of your paycheck before any taxes are calculated, meaning you will not pay federal, state, or local income tax, or Social Security taxes on the portion of your paycheck that you contribute to your FSA. You should plan carefully and only contribute the amount of money you expect to pay out-of-pocket for eligible health care expenses during the plan year. If you do not use all of the money contributed to your FSA by December 31 of the plan year you will forfeit those excess contributions.

The maximum you can contribute to the Health Care FSA in 2026 is $3,400.

DEPENDENT CARE

As an employee of Tempo, Inc, you have an opportunity to set aside pre-tax payroll dollars to pay for daycare expenses for your dependent children or other eligible dependents on a tax-free basis. You (and your spouse, if you are married) must be working or a full-time student in order to be eligible for this type of FSA.

You must enroll in the plan during annual enrollment in order to participate for the plan year Jan 1, 2026 – December 31, 2026. This plan is administered by Employee Benefits Corporation (EBC).

The maximum you can contribute to the Dependent Care FSA in 2026 is $7,500 per family.

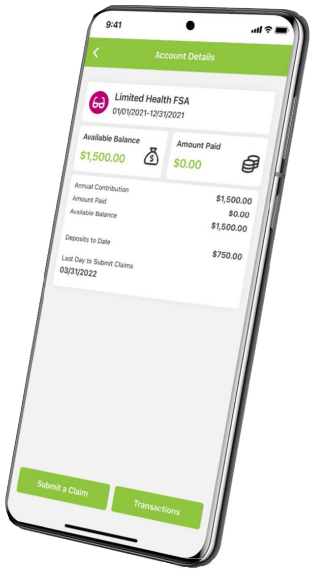
Just as with the Health Care FSA, you should plan carefully and only contribute the amount of money you expect to pay for eligible dependent care expenses during the plan year. If you do not use all of the money contributed to your Dependent Care FSA by December 31, you will forfeit those excess contributions.
Eligible expenses for use of money saved in a Dependent Care FSA are:

- Care for your dependent child who is under age 13
- Daycare, nursery school, and preschool expenses
- Before and after-school care
- Babysitting and nanny expenses
- Summer day camp
- Care for a dependent age 13 and older who is physically or mentally incapable of self-care and lives in your home.

EMPLOYEE BENEFITS CORPORATION (EBC) MOBILE APP

Download the EBC Mobile App from the App Store or Google Play to easily manage your Flexible Spending Account and other EBC-administered benefits.
With 24/7 access, you can:

- Check balances and transaction history
- Submit claims and track reimbursements
- Manage your benefits card
- Get real-time updates and support



Visit www.ebcflex.com or call 800.346.2126 to learn more.

Life and AD&D Insurance

Tempo, Inc offers life insurance coverage to provide financial protection in the event you or your dependents die while you are still working. Tempo, Inc also offers Accidental Death and Dismemberment (AD&D) Insurance for you and your family to help with expenses in the event you or a covered dependent die or becomes injured as a result of an accident. These coverages are administered through **Mutual of Omaha**.

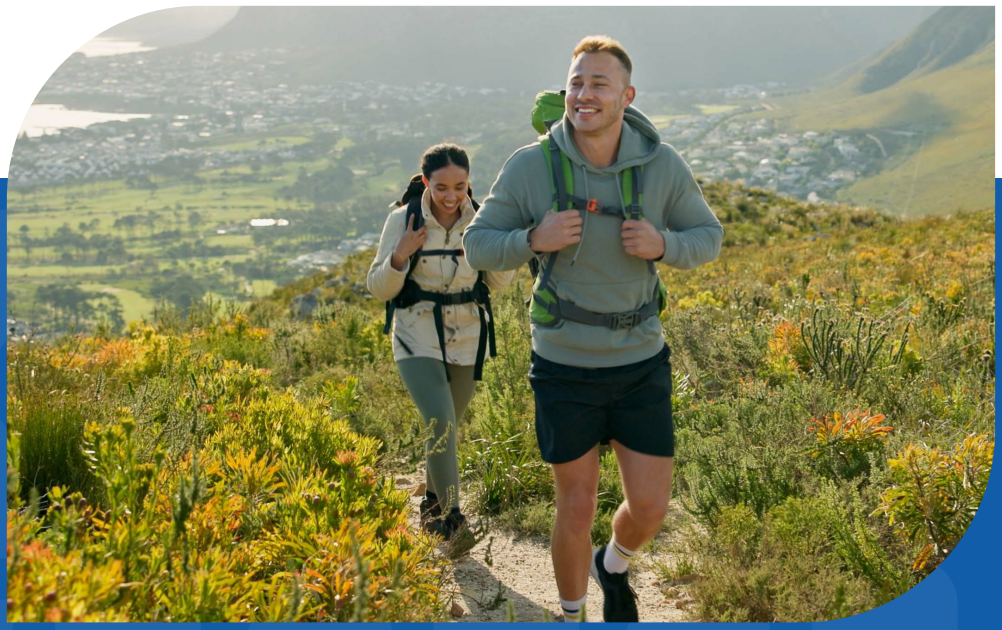
BASIC LIFE AND AD&D INSURANCE

Tempo, Inc automatically provides Basic Life Insurance for all eligible employees **at no cost**. Basic Life Insurance is equal to a flat amount of $25,000. The benefit is paid to your beneficiaries in the event of your death. The AD&D benefit is paid if your death is a result of an accidental injury.

OPTIONAL LIFE AND AD&D INSURANCE

In addition to Basic Life and AD&D Insurance, you may also purchase Optional Life and AD&D Insurance for yourself, your spouse, and your dependent children **(only if you enroll in coverage for yourself)**. **You pay for the cost** of Optional Life and AD&D Insurance on an after-tax basis through payroll deductions. **Please note that all future increases for spouses will be subject to Evidence of Insurability (EOI) and be approved by Mutual of Omaha before coverage will be effective.**

Optional Life Coverage	Increment	Maximum Coverage Available	Guarantee Issue Amount
Employee	$10,000	5x salary up to $500,000	$100,000
Spouse	$5,000	$250,000 not to exceed 100% of employee amount	$25,000
Child(ren)* 15 days of age – age 26	$2,000	$10,000	$10,000



EVIDENCE OF INSURABILITY

Late entrants must complete Evidence of Insurability (EOI) and be approved by Mutual of Omaha before coverage will be effective. A late entrant would be anyone not in their new hire waiting period. If you are currently in your new hire waiting period, you will also have to provide proof of insurability for amounts in excess of the guarantee issue amounts. IIf you or your spouse are currently enrolled in Tempo, Inc.'s Optional Life and AD&D plan, you can increase your benefit during open enrollment by one increment level up to the guaranteed issue amount with no EOI.

BENEFICIARY DESIGNATION

You must designate a beneficiary for Basic and Optional Life and AD&D Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You are always the beneficiary of any Dependent Life and AD&D Insurance you elect. **You can change your beneficiaries at any time during the year through Paycom**.

BENEFITS REDUCE AT AGE 65

When you or a covered dependent reaches age 65, Basic and Optional Life and AD&D Insurance benefits are reduced. For more information, refer to the Group Life Insurance booklet.

Age	Benefits Reduce By
65	35%
70	50%

Optional Life/AD&D Rate Table
Monthly Rates Automatically Calculate in Paycom

Rates Per $1,000	Employee Life	Spouse Life
Under 25	$0.11	$0.10
25-29	$0.11	$0.10
30-34	$0.11	$0.10
35-39	$0.13	$0.11
40-44	$0.18	$0.16
45-49	$0.27	$0.23
50-54	$0.44	$0.37
55-59	$0.71	$0.60
60-64	$1.11	$1.03
65-69	$2.10	$1.95
70-74	$4.29	$3.97
75+	$4.29	$3.97
AD&D Rate	$0.053	$0.037
Child Life/AD&D Rate	$0.250/$0.025	

Disability Insurance

Tempo, Inc offers you two disability plans that work together to cover all or part of your paycheck if you cannot work because of illness, injury, or pregnancy. Disability benefits are administered through **Mutual of Omaha**. The ability to earn an income is something to be protected – disabilities happen, and they happen more frequently than most think.

EMPLOYER-PAID SHORT-TERM DISABILITY

Short-Term Disability (STD) benefits are administered through Mutual of Omaha and are provided for all eligible full time-partners at no cost. To file an STD claim, call MOO at 800-877-5176.

Your STD benefits begin on the 15th calendar day of your disability if you are unable to work due to an injury or illness.

- Your benefit is paid at 60% of your weekly base salary to a maximum payment of $1,500/week
- Benefits may be paid for a maximum of 11 weeks

EMPLOYER-PAID LONG-TERM DISABILITY

Tempo, Inc offers and pays 100% for all eligible partners to have Long-Term Disability (LTD) benefits. Your LTD benefits will become payable on a monthly basis once you have been disabled for 90 days (when your STD benefit ends).

- Your benefit is paid at 60% of your monthly base salary to a maximum payment of $6,000/month
- Benefits may continue, if totally disabled, up to the Social Security Normal Retirement Age (SSNRA)
- The plan will not cover any disability caused by, or resulting from, a pre-existing condition that existed 3 months prior to your effective date of coverage, if the disability begins within the first 12 months after the effective date of coverage

Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers' Compensation).

Worksite Benefits

With voluntary worksite-benefits, benefits are paid directly to you, regardless of any other insurance you may have. The money can be used to help cover medical expenses (copays, deductibles, etc.), as well as non-medical expenses. These insurance policies are voluntary and are funded 100% by you through after-tax payroll deductions. These policies are guaranteed-renewable and are fully portable for life. Refer to your benefit summaries for further information on these plans.

ACCIDENT INSURANCE

UnitedHealthcare's Accident Insurance covers a wide range of injuries and accident-related expenses such as hospitalization, physical therapy, hospital intensive care, transportation and lodging plus coverage for injuries, medical services and treatment, accidental death, and catastrophic accidents that involve the loss of use of sight, hearing, speech, arms or legs. These benefits are designed to help pay for out-of-pocket costs that may not be covered by traditional health insurance.

Some benefit amounts are listed below:

- Accident Hospital Care – Admission: $800
- Air Ambulance: $1,200
- Emergency Room treatment: $100
- Concussion: $140
- Closed forearm: $240
- Closed upper arm fracture: $280
- Closed shoulder dislocation: $240

Please refer to your contract for additional benefit amounts.

HOSPITAL INDEMNITY

The Hospital Indemnity plan provides cash that can be used to help pay costs from a hospital stay and related to treatment, your health plan deductible, and other out-of-pocket expenses. As a note, this does not include observation.

- Hospital Admission (1 day per plan year): $1,000/day
- Hospital Confinement (up to 364 days per plan year: $150/day
- ICU Confinement (up to 364 days per calendar year): $150/day

CRITICAL ILLNESS

UnitedHealthcare's Critical Illness Insurance pays a lump-sum upon the diagnosis of a covered critical illness. This can be used to cover any expense to protect your quality of life while critically ill.

Benefits will be covered at 100% or 25%, depending on the condition. Some examples of conditions covered at 100% are a heart attack, heart failure, major organ failure, invasive cancer, chronic renal failure, permanent paralysis, stroke, coma, benign brain tumor, ALS, advanced Alzheimer's, etc. Some examples of conditions covered at 25% are non-invasive cancer and coronary artery disease. Child-only conditions are covered at 25% of employee's amount. Some examples include cerebral palsy, cleft lip/palate, cystic fibrosis, down syndrome, etc. Please refer to your contract for additional benefit amounts.

Evidence of Insurability is required if you are a late entrant to the Critical Illness plan, meaning that if you enroll after 31 days of first being eligible for benefits, you must complete EOI.

- Employee Guarantee Issue amount: $10,000
- Spouse Guarantee Issue amount: $5,000
- Child Guarantee Issue amount: $2,500

Accident Weekly Premium	
Employee Only	$3.30
Employee + Spouse	$4.90
Employee & Children	$4.45
Employee + Family	$6.05

Hospital Indemnity Weekly Premium	
Employee Only	$2.60
Employee + Spouse	$7.86
Employee & Children	$6.26
Employee + Family	$12.36

Critical Illness Weekly Rates	Employee		Employee + Spouse		Employee + Child(ren)		Employee + Family	
	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
Under 25	$2.40	$2.60	$3.75	$4.00	$2.95	$3.15	$4.30	$4.55
25-29	$3.40	$3.90	$5.30	$5.95	$3.95	$4.45	$5.85	$6.50
30-34	$4.50	$5.40	$7.00	$8.20	$5.05	$5.95	$7.55	$8.75
35-39	$6.40	$8.30	$9.75	$12.40	$6.95	$8.85	$10.30	$12.95
40-44	$9.90	$15.30	$15.05	$21.95	$10.45	$15.85	$15.60	$22.50
45-49	$16.80	$29.40	$24.35	$40.05	$17.35	$29.95	$24.90	$40.60
50-54	$24.70	$44.30	$35.50	$61.95	$25.25	$44.85	$36.05	$62.50
55-59	$36.80	$69.50	$51.05	$94.35	$37.35	$70.05	$51.60	$94.90
60-64	$59.10	$118.10	$77.55	$151.50	$59.65	$118.65	$78.10	$152.05
65-69	$81.90	$173.10	$108.40	$223.20	$82.45	$173.65	$108.95	$223.75
70-74	$54.10	$110.95	$73.63	$147.40	$54.65	$111.50	$74.18	$147.95
75+	$72.45	$138.05	$97.78	$179.50	$73.00	$138.60	$98.33	$180.05

Employee Assistance Program (EAP)

Available to all employees, our EAP partner Mutual of Omaha helps you and your family manage life's challenges with in-person, phone, and video counseling sessions, all at no cost to you. You can also get referrals to household services related to child/elder care, financial and legal help, and much more.

MENTAL WELL-BEING

You can receive up to three counseling sessions per issue per year. The sessions are a free and confidential service and are available by phone.

Licensed counselors can help with issues such as:

- Mental health concerns
- Emotional difficulties
- Domestic abuse
- Substance abuse
- Financial worries
- Grief and loss
- Relationship support
- Self-esteem and personal development
- Stress management
- Work-life balance

When you need in-the-moment emotional well-being support, counselors are here to help 24/7. You can call 1-800-316-2796.

WORK-LIFE ASSISTANCE

Mutual of Omaha also provides a wide variety of work-life support, with some services at no cost. A few of the services include:

- Daily life assistance: Resources for child, elder, or pet care, and household services
- Legal support: Wills and estate planning, family, civil, criminal, and real estate
- Financial services: Budgeting, mortgages, college funding, and issues
- Identity theft services: Fraud resolution and credit restoration coaching

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Benefit Advocacy Services

As a Tempo, Inc partner, you have access to a dedicated Holmes Murphy Benefits Analyst. Nancy Fuentes is available to you and your dependents to help assist you in your benefits-related questions. Simply call or email and Nancy will be available to help you. If she doesn't have an immediate answer, she will research it and get back to you in a timely manner without you waiting on hold. How easy is that?

Some of these questions may be:

- How do I order a new ID card?
- Is my doctor/dentist in the network or out of the network?
- What is my deductible and what does "co-insurance" mean?
- I received a bill from my doctor. Was my claim paid correctly?
- What is an "EOB" and how do I read it?
- I just need to get my teeth cleaned. What is my co-pay?
- How often can I get new eyeglasses/contacts?
- I paid for my prescription out of pocket. Where can I find a claim form?
- I can't find my Benefit Enrollment Guide. Can I get a new one?

Your Dedicated Benefits Analyst

NANCY FUENTES
SR. BENEFITS ANALYST

DIRECT: (214) 265-2298
TOLL FREE: (800) 882-5949

AVAILABLE MONDAY-FRIDAY from
8 AM TO 5 PM CENTRAL TIME

Required Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

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 9.12%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 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 at HR@tempopartners.com. 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 at HR@tempopartners.com.

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.

Comply with the law

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

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

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

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

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

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

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.

Important Notice from Tempo, Inc. 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 Tempo, Inc. 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Tempo, Inc. has determined that the prescription drug coverage offered by the Tempo Group Health Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Tempo Group Health Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from Tempo Group Health Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 decide to drop your current coverage with Tempo, Inc., since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Tempo Group Health Plan.

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

Since the coverage under Tempo Group Health Plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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] be affected.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that

you and your dependents will be able to get this coverage back.

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 Tempo, Inc. 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).

Date: [1/1/2026]

Name of Entity/Sender: Tempo, Inc.

Contact--Position/Office: [Human Resources]

Address: [911 Maryland Dr., Irving, TX 75061]

Phone Number: 972-579-2015

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 after the qualifying event occurs. You must provide this notice to: [Tempo, Inc].

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

Name of Entity: Tempo, Inc.

Address: 911 Maryland Drive, Irving, TX 75061

Phone Number: 972-579-2015

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

Expanded Coverage for Women's Preventive Care

Under the Affordable Care Act, Tempo, Inc. provides female plan participants with expanded access to recommended in-network preventive services, including contraceptives, without cost sharing.

Additional women's preventive services that will be covered without cost sharing requirements include:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- STI counseling, and HIV screening and counseling
- Contraception and contraceptive counseling

- Breastfeeding support, supplies, and counseling
- Domestic violence screening

For a description of what these items include, visit https://www.healthcare.gov/preventive-care-women/.

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;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

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 [972-579-2015].

ANNUAL NOTICE

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at [972-579-2015] for more information.

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.

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

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: KIHIPP.PROGRAM@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: HHSHIPPProgram@mt.gov	800-694-3084
Nebraska Medicaid	ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: dhcfp.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 RIte)
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:

Wellness Program Notices

The Tempo Wellness Program 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 a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for [triglycerides, glucose level, cholesterol, and blood pressure.] You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of [a premium differential for meeting all wellness requirements]. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive [the premium differential].

[A premium differential] may be available for employees who participate in certain health-related activities [biometric screening and complete any other required wellness activities] or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Human Resources at [HR@tempopartners.com].

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

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 Tempo, Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, [The Tempo Wellness Program] 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. The only individual(s) who will receive your personally identifiable health information is (are) [a health coach] in order to provide you with services under the wellness program.

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] at [HR@tempopartners.com].

ACCOMMODATIONS

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [HR@tempopartners.com] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Patient Protection Notice

[Tempo, Inc.] generally [allows] the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact [Human Resources] at [HR@tempopartners.com].

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from [Tempo, Inc.] or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact [Human Resources] at [HR@tempopartners.com].

2026 BENEFITS GUIDE