ita group









2027
Benefits Guide

ANNUAL ENROLLMENT: NOVEMBER 11 – NOVEMBER 25, 2026

Your 2027 Benefits Guide

Use this Benefits Guide to see what's new and to learn about your benefit plan options.

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This benefit summary describes the benefit plans available to you as a team member of ITA Group. The details of these plans are contained in the official plan documents that have been provided to you by your employer, including some insurance contacts. This summary is meant only to cover the highlights of each plan. It does not contain all the details that are included in your summary plan description as described by the Employee Retirement Income Security Act (ERISA).

If there is ever a question about one of these plans, or if there is a conflict between the information in this summary and the formal language of the plan documents, the formal wording in the plan documents will govern. Please note that the benefits described in the summary may be changed at any time and do not represent a contractual obligation on the part of ITA Group.

This guide highlights the main features of many of the benefit plans sponsored by ITA Group. 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. ITA Group 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:

If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see page 27 for more details.

Welcome to Your Benefits

We are committed to providing competitive benefit programs that are flexible enough to meet your individual needs. Our comprehensive benefits are carefully designed to give you the tools you need to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances, and help you build long-term security for retirement.

Getting the most from your benefits is up to you. You know your family, your goals, and your lifestyle best. This benefits guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family, and be sure to act before the enrollment deadline.

Eligibility

You and your eligible family members may participate in the 2027 team member benefits program if you worked at least 1,000 hours in the previous fiscal year.

DEPENDENT ELIGIBILITY

You can enroll the following dependents in our group benefit plans:

- Your legal spouse
- Your eligible children up to age 26 for medical, dental, and vision coverage regardless of student status; your unmarried, eligible children up to age 26 for 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, and disability has to have occurred prior to age 25

Enrollment

November 11 - 25, 2026

This Open Enrollment is a passive enrollment, meaning if you do not take action to enroll, most of your 2026 benefits will roll over into 2027. You must elect **Flexible Spending Account (FSA)** and **Health Savings Account (HSA)** if you wish to participate in these benefits in 2027. Your current FSA and HSA elections will not roll over.

QUALIFYING LIFE EVENTS

Your benefit elections made during Open Enrollment are effective January 1, 2027. You may not make changes to your elections unless you experience a qualifying life event, including change in legal marital status (marriage, divorce, death of spouse), change in dependents (birth, adoption), change in employment status (termination, part-time), or if you gain/lose coverage elsewhere.

IMPORTANT

If you need to make a change before the next open enrollment period due to a change in status, you must submit the required documentation **WITHIN 31 DAYS** of the qualifying life change event.
Log in to ADP to process a Qualifying Life Event.

How to Enroll

1 LOG IN

Log into ITA Group at **https://workforcenow.adp.com/workforcenow/login.html**.

2 CHOOSE YOUR MEDICAL PLAN

Utilize **Plan Advisor** to help choose the lowest cost, best value health plan based on you and your families' medical needs. Below is a tax bracket from **Forbes.com** that will assist you with the tax bracket question at the beginning of the tool. Enter in specific health information for you and your enrolled family members. The tool will take into account the cost of care of the health information you provide by prepopulating some of the fields. You may change the number if the specific service(s) **do not apply to you. Click Analyze My Data for your complete results.**

ESTIMATED TAX BRACKETS FOR 2027

	Salary Range			
Bracket	Single Taxpayers	Married filing Separately	Head of Household	Married filing Jointly
10%	$0-$12,400	$0-$12,400	$0-$17,000	$0-$24,800
12%	$12,401-$50,400	$12,401-$50,400	$17,701-$67,450	$24,801-$100,800
22%	$50,401-$105,700	$50,401-$105,700	$67,451-$105,700	$100,801-$211,400
24%	$105,701-$201,775	$105,701-$201,775	$105,701-$201,750	$211,401-$403,550
32%	$201,776-$256,225	$201,776-$256,225	$201,750-$256,200	$403,551-$512,450
35%	$256,226-$640,600	$256,226-$384,350	$256,201-$640,600	$512,451-$768,700
37%	$640,601 +	$384,351 +	$640,601 +	$768,701 +

3 ENROLL BY NOVEMBER 25

You must make any changes to your elections November 11 - November 25. Benefits elected during Open Enrollment are effective January 1, 2027.



Benefits Definitions

DEDUCTIBLE

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

COINSURANCE

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

OUT-OF-POCKET MAXIMUM

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges, or health care your plan doesn't cover.

COPAYMENT

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

NETWORK

The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

NETWORK PROVIDER

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

PROVIDER

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

OUT-OF-NETWORK PROVIDER

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "nonparticipating" instead of "out-of-network provider".

REFERRAL

A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you may need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

PREMIUM

You typically pay premiums through payroll deductions.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

A type of health plan that has lower monthly premiums, but higher deductibles and out-of-pocket limits, than a traditional health plan. HDHPs are often coupled with an HSA (Health Savings Account).

Team Member Semi-Monthly Contributions

MEDICAL	$2,000 PPO	$3,000 PPO	$4,000 HDHP
Team Member Only	$162.68	$116.49	$86.32
Team Member + Spouse	$347.29	$241.19	$175.56
Team Member + 1 Child	$283.35	$198.69	$147.31
Team Member + Children	$458.31	$306.75	$233.23
Family	$480.27	$318.44	$239.87

VISION	
Team Member Only	$2.94
Team Member + Spouse	$5.59
Team Member + Child(ren)	$6.33
Family	$8.36

DENTAL	LOW PLAN	HIGH PLAN
Team Member Only	$14.44	$19.60
Team Member + Dependent	$28.11	$38.49
Team Member + 2 Dependents	$57.94	$79.75

ACCIDENT	
Team Member Only	$5.81
Team Member + Spouse	$8.42
Team Member + Child(ren)	$11.64
Family	$24.25

CRITICAL ILLNESS - TEAM MEMBER & CHILD(REN)						
	$10,000		$15,000		$20,000	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
Under 29	$2.30	$3.35	$3.45	$5.03	$4.60	$6.70
30-39	$3.25	$4.70	$4.88	$7.05	$6.50	$9.40
40-49	$5.80	$9.00	$8.70	$13.50	$11.60	$18.00
50-59	$9.00	$14.45	$13.50	$21.68	$18.00	$28.90
60-69	$13.00	$20.90	$19.50	$31.35	$26.00	$41.80
70+	$21.10	$24.70	$31.65	$37.05	$42.20	$49.40

Child rate included in the team member rate. Can elect $5k or $10K increments on your child(ren)

CRITICAL ILLNESS - SPOUSE				
	$5,000		$10,000	
Age	Non-Tobacco	Tobacco	Non-Tobacco	Tobacco
Under 29	$1.23	$1.80	$2.45	$3.60
30-39	$1.68	$2.55	$3.35	$5.10
40-49	$3.03	$4.95	$6.05	$9.90
50-59	$4.88	$7.98	$9.75	$15.95
60-69	$7.08	$11.55	$14.15	$23.10
70+	$11.68	$12.68	$23.35	$25.35

Body and Mind

Medical Plan

Our medical plans are administered by Wellmark. Please review your Summary of Benefits and Coverage (SBC) for additional coverage information and full plan details. Elections you make during Open Enrollment will be effective January 1, 2027, and remain in effect until December 31, 2027, unless you experience a qualifying life event.

You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lowest out-of pocket costs. In-network providers charge members reduced, contracted rates instead of their typical fees. Providers outside the plan's network set their own rates,
so you may be responsible for the difference if a provider's fees are above the Reasonable and Customary (R&C) limits.
For a complete listing of in-network providers, visit **www.Wellmark.com**.

CONSIDER YOUR COVERAGE

When choosing between ITA Group's medical plans, it all comes down to how much you want to spend from your paycheck and whether you are comfortable with lower or higher out-of-pocket expenses and deductibles when you need care.

If you prefer to pay less out of your paycheck and are okay with higher out-of-pocket costs and a higher deductible when you need care, then the HDHP might be the right fit. With the HDHP you are eligible to contribute to a Health Savings Account (HSA).

If you prefer to pay more out of your paycheck and have a lower out-of-pocket expense and deductible when you need care, you might prefer one of the traditional PPO plans.

REGISTER ONLINE

Your connection to great healthcare is only a click away. Register for an account at www.Wellmark.com so you can access time saving tools, find tips for healthy living, choose a doctor, manage your EOBs, and more.

DOWNLOAD THE MOBILE APP
With the Wellmark mobile app, you've got the tools you need to manage your healthcare from your smartphone. The mobile app is available in the Apple and Google Play stores.

APPLE **GOOGLE**



Medical Plan Comparison - Wellmark

	$2,000 BLUE PPO	$3,000 BLUE PPO	$4,000 HDHP BLUE PPO
	IN-NETWORK		
DEDUCTIBLE			
Individual	$2,000	$3,000	$4,000
Family	$4,000	$6,000	$7,000
ANNUAL OUT-OF-POCKET (OOP) MAXIMUM			
Individual	$5,000	$6,000	$4,000
Family	$10,000	$12,000	$7,000
BENEFIT DETAILS			
Coinsurance	20%	20%	0%
Preventive Care	No Charge	No Charge	No Charge
Preventive Eye Exam	No Charge	No Charge	No Charge
Primary Care Physician (PCP)	$25 Copayment	$35 Copayment	Deductible, 0% Coinsurance
Specialist	$40 Copayment	$50 Copayment	Deductible, 0% Coinsurance
Doctor on Demand Virtual Visits	No Charge	No Charge	No Charge
Urgent Care	$25 Copayment	$35 Copayment	Deductible, 0% Coinsurance
Emergency Room	Deductible, 20% Coinsurance	Deductible, 20% Coinsurance	Deductible, 0% Coinsurance
Inpatient Hospital	Deductible, 20% Coinsurance	Deductible, 20% Coinsurance	Deductible, 0% Coinsurance
Outpatient Hospital	Deductible, 20% Coinsurance	Deductible, 20% Coinsurance	Deductible, 0% Coinsurance
Outpatient Surgery	Deductible, 20% Coinsurance	Deductible, 20% Coinsurance	Deductible, 0% Coinsurance
Lab/X-Ray (Outpatient)	Deductible, 20% Coinsurance	Deductible, 20% Coinsurance	Deductible, 0% Coinsurance
OUT-OF-NETWORK**			
Deductible	$2,000 / $4,000	$3,000 / $6,000	$5,500 / $11,000
Coinsurance	30%	40%	0%
Out-of-Pocket Maximum (OOP)	$5,000 $10,000	$6,000 $12,000	$5,500 $11,000

*** When visiting out-of-network providers, costs may be higher, and providers may ask for full payment at time-of-service.*

UNDERSTANDING YOUR DEDUCTIBLES

In the $2,000 PPO plan and the $3,000 PPO plan, the individual deductible in addition to the overall family deductible means that an individual participant has their own individual deductible in addition to the total family deductible. This means one family member can meet their individual deductible and start receiving plan benefits even if the family deductible hasn't been met yet.

In the $4,000 HDHP plan, all participants' out-of-pocket expenses count toward the family deductible until it is met. The family deductible can be met by any one or combination of plan participants, at which time the plan will begin paying services for all participants.

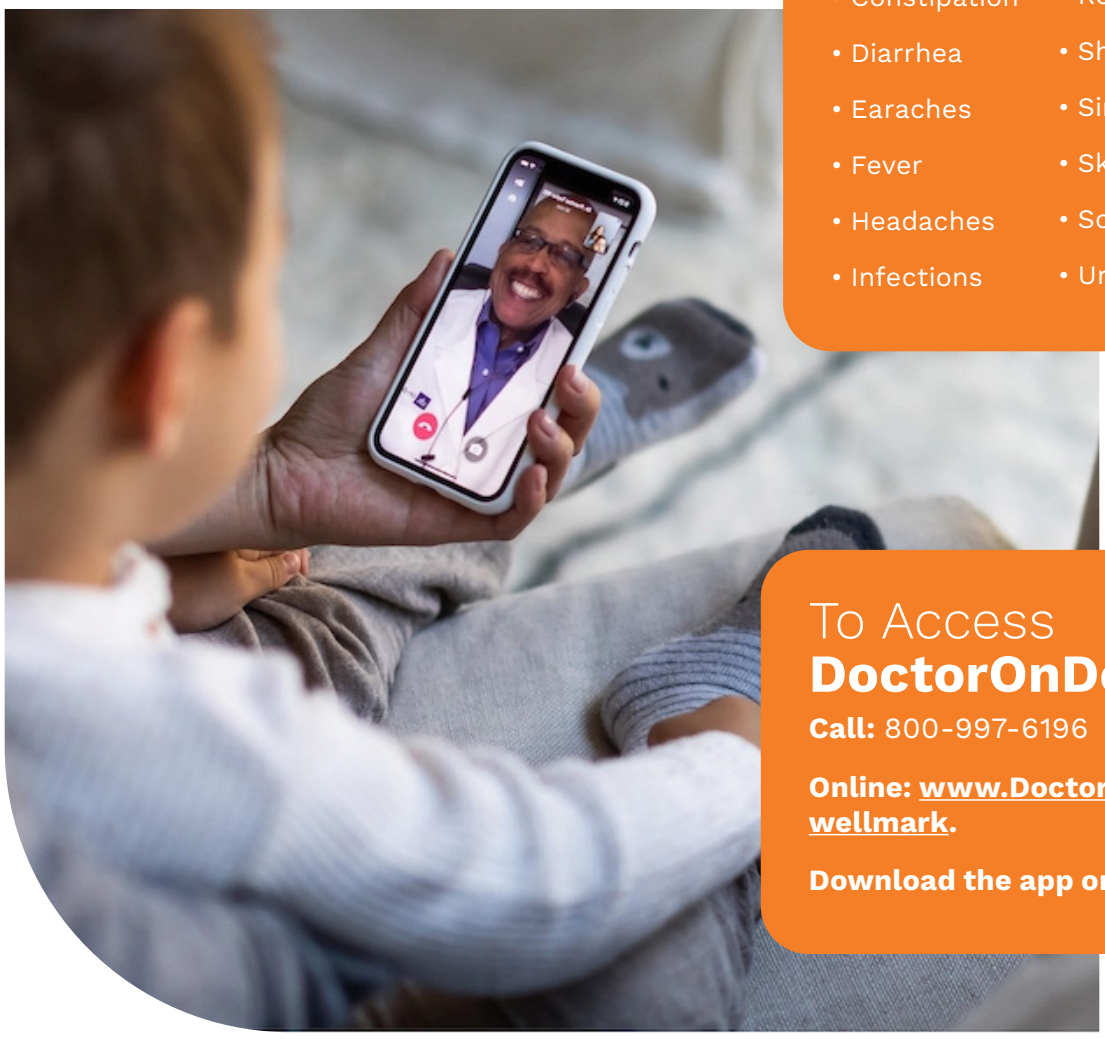
Telehealth - DoctorOnDemand

Doctor on Demand is a convenient option for scheduling virtual doctor visits from your own home. With Doctor on Demand, you don't have to drive to the doctor's office or sit in a waiting room when you're sick—you can see your doctor from the comfort of your own bed or sofa.

- See a board-certified, licensed, telehealth trained doctor on your schedule with on-demand virtual visits 24/7, including holidays.
- Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby, in less time than your usual doctor visit.
- Avoid costly copays and deductibles of the ER and urgent care clinic.
- $0 Cost!

Schedule a virtual appointment with board-certified doctors and pediatricians who can diagnose, treat and prescribe most medications for minor medical conditions such as:

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and flu
- Constipation
- Diarrhea
- Earaches
- Fever
- Headaches
- Infections
- Insect bites
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections



To Access **DoctorOnDemand:**

Call: 800-997-6196

Online: www.DoctorOnDemand.com/wellmark.

Download the app on the App Store or

Pharmacy - MedOne Rx

If you enroll in one of the ITA Group medical plans, you will automatically receive prescription drug coverage. Prescriptions are provided through MedOne Rx.

See **medone-rx.com** for information about drugs and drug quantities that require prior authorization by MedOne before they will be covered by the plan. Drugs listed on the MedOne-Rx drug list are covered. Drugs not on this drug list are not covered. You pay the discounted cost of your prescription drugs until your in-network deductible is met. For out-of-network prescription drugs, you may be balanced billed.

		$2,000 PPO	$3,000 PPO	$4,000 HDHP
PHARMACY BENEFITS				
Deductible	Individual	$100	$100	Same as medical
	Family	$200	$200	
Out-of-Pocket Maximum	Individual	$3,000	$3,000	Same as medical
	Family	$6,000	$6,000	
Retail 30-day supply	Tier 1	$10 Copayment	$10 Copayment	Deductible, 0% Coinsurance
	Tier 2	$25 Copayment	$30 Copayment	
	Tier 3	$40 Copayment	$50 Copayment	
	Preferred Specialty	$250 Copayment	$250 Copayment	
	Non-Preferred Specialty	25% up to $350 Copayment	25% up to $350 Copayment	
Mail order 90-day supply	Tier 1	2 Copayments	2 Copayments	Deductible, 0% Coinsurance
	Tier 2			
	Tier 3			
	Specialty			



SPECIALTY PRESCRIPTION PROGRAM

Specialty medications are excluded from the plan. Those taking a specialty medication should contact an RxAlly Patient Care Coordinator at 877-794-2218.

A specialty medication treats complex medical conditions such as cancer, psoriatic arthritis, and multiple sclerosis, and often requires specific handling and storage requirements.

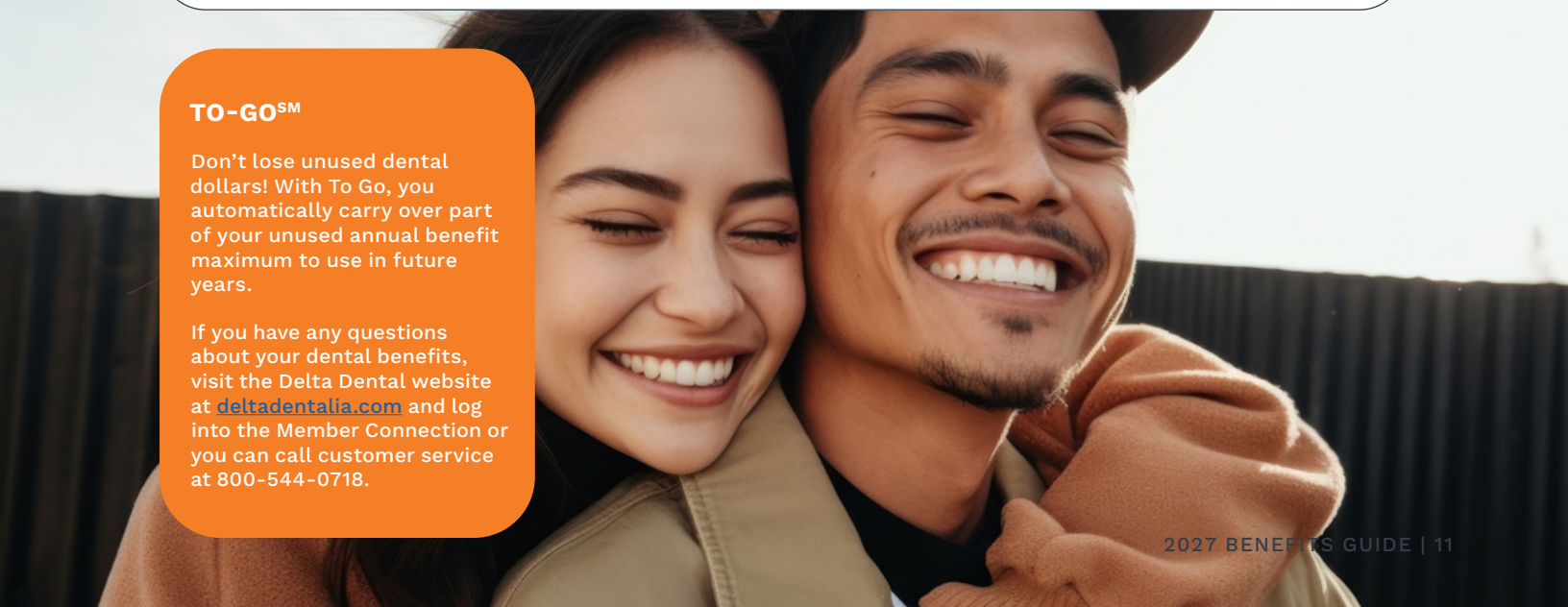
SCAN TO LEARN MORE!

Dental - Delta Dental

Dental insurance helps pay for dental care and includes regular checkups, cleanings, and x-rays. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery. Dental coverage is offered for basic and major services. You and your eligible dependents may enroll in one of the two dental coverage options administered by Delta Dental.

To find an in-network provider, visit **https://www.deltadental.com/us/en/member/find-a-dentist.html.**

IN-NETWORK PLAN FEATURES	LOW		HIGH	
Annual Calendar Year Deductible **Annual Maximum**	**PPO** $25/Person $1,000	**Premier** $50/Person $1,000	**PPO** $25/Person $1,500	**Premier** $50/Person $1,500
Diagnostic & Preventive Care • Dental cleaning • Oral evaluation • Fluoride application • X-Rays • Sealant applications • Space maintainers	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Routine and Restorative Services • Emergency treatment • General anesthesia/sedation • Restoration of decayed or fractured teeth • Limited occlusal adjustments • Routine oral surgery • Posterior maintenance therapy w/o alternate processing	Deductible, 10% Coinsurance	Deductible, 20% Coinsurance	Deductible, 10% Coinsurance	Deductible, 20% Coinsurance
Major Services • Endodontic services • Periodontal services • Cast restorations • Prosthetic services	N/A		Deductible, 50% Coinsurance	Deductible, 50% Coinsurance
Orthodontia only covers children up to age 19.				
Orthodontia Services	N/A		Deductible, 50% Coinsurance	Deductible, 50% Coinsurance
Orthodontia Lifetime Maximum	N/A		$1,500	



TO-GO℠

Don't lose unused dental dollars! With To Go, you automatically carry over part of your unused annual benefit maximum to use in future years.

If you have any questions about your dental benefits, visit the Delta Dental website at deltadentalia.com and log into the Member Connection or you can call customer service at 800-544-0718.

Vision - Delta Vision

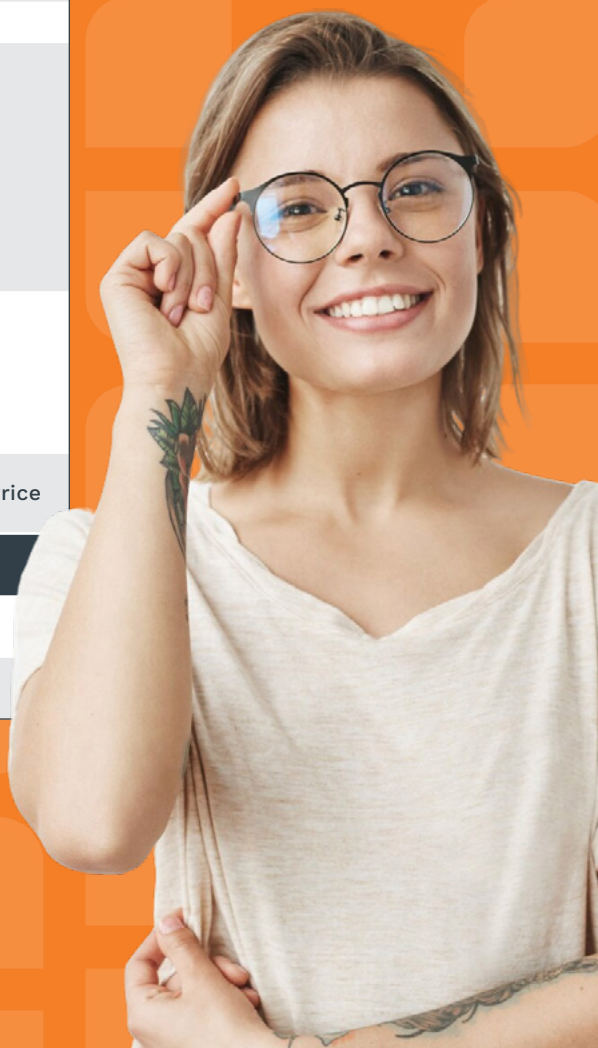
ACCESS NETWORK

Driving to work, reading a news article, and watching TV are all activities you likely perform every day. Your ability to do these activities, however, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Our vision insurance is provided by Delta Vision and entitles you to specific eye care benefits. Our vison plan helps you save on eyeglasses and contact lenses through set dollar allowances or discounts.

To find an in-network provider, please visit **https://www.deltadentalia.com/find-a-provider/.**

EYEGLASS LENSES, MATERIALS, AND FRAMES	INSIGHT NETWORK MEMBER COST
Single Vision Lenses	$0 copayment
Bifocal Lenses	$0 copayment
Trifocal Lenses	$0 copayment
Lenticular Lenses	$0 copayment
Progressives Lenses Tier 1 Tier 2 Tier 3 Tier 4	 $85 $95 $110 80% of charge less $120, plus $65 Copay
Frames	80% of balance over $150
Lens Options Standard Polycarbonate Standard Plastic Scratch Coating Tint UV Treatment Standard Anti-reflective Coating Premium Anti-reflective Coating Other Lens Options	 $40 Copay $15 Copay $15 Copay $15 Copay $45 Copay Starting at $57 80% of Charge
Contact Lens Fitting/Evaluation Conventional Contact Lens Disposable Contact Lens Medically Necessary Contacts	 85% Of balance over $120 Balance over $150 $0
Laser Surgery	85% of Retail Price or 95% of Promotional Price
FREQUENCY OF SERVICES	
Lenses or Contacts	Once every calendar year
Frames	Once every 2 calendar years



Employee Assistance Program (EAP)-

New York Life

We understand that we all face serious problems at some time in our lives. ITA Group is committed to providing help during those times.

The EAP is designed to assist team members and families with personal challenges in many different areas including

- depression
- stress management
- drug and alcohol abuse
- relationships
- grief
- domestic violence
- legal and financial issues
- parenting
- childcare and elder care

Participation in the EAP is voluntary, confidential, and free of cost. For those who require referrals for long-term treatment, there may be fees for the services of outside providers. However, EAP counselors will coordinate referrals, whenever possible, to take advantage of existing insurance coverage and community resources in order to minimize costs.



24 HOURS A DAY, 7 DAYS A WEEK
Professional counselors are available to provide you with support, guidance, and resources.

New York Life
(800) 344-9752
guidanceresources.com
Web ID: NYLGBS
Company Name: ITAGR

FIRST TIME VISIT?
Click Register and enter
Organization Web ID: NYLGBS
Company Name: ITAGR



Funding Accounts

Health Savings Account (HSA) - Optum Bank

WHAT'S A HEALTH SAVINGS ACCOUNT?
A Health Savings Account (HSA) is a way for you to save pre-tax dollars that can be used to pay for qualified healthcare expenses like deductibles, copays, coinsurance, prescriptions, and vision and dental expenses.

HOW MUCH CAN I CONTRIBUTE in 2027?

- Team member only coverage: $4,500
- Team member plus dependents coverage: $9,000
- If you are 55 or older, you can make an additional annual catch-up contribution of $1,000
- ITA Group will contribute $500 annually to your HSA if you enroll in theHDHP plan. This amount will be distributed on a per-pay period basis.

HSAs AND YOUR TAXES
All withdrawals from your HSA are tax-free, as long as you use the money to pay for eligible health care expenses. In addition, all the money in the account is yours and will never be forfeited. It rolls over from year to year, and you can take it with you if you leave the company or retire. After age 65, you can withdraw funds for any reason without a tax penalty — you pay ordinary income tax only if the withdrawal isn't for eligible health care expenses.

Note: You won't pay federal taxes on HSA contributions. However, you may pay state taxes depending on your residence. Consult your tax advisor to learn more.

For a list of eligible expenses, see IRS Publication 502, available at www.irs.gov.

Who is Eligible for an HSA?

- **Must be enrolled in a high deductible health plan**
- **Cannot be covered by any other medical plan that is not a qualified HDHP. This includes a spouse's medical coverage unless it's also a qualified HDHP**
- **Cannot be enrolled in a traditional health care FSA in the same calendar year**
- **Cannot be enrolled in Medicare, including Parts A or B, Medicaid, or Tricare**
- **Cannot be claimed as a dependent on another person's tax return**
- **Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months**



ITA HSA Overview

- $2.00 initial enrollment fee
- $3.25 monthly admin fee

Flexible Spending Accounts (FSA) - Alerus

Tax-advantaged FSAs are a great way to save money. The money you contribute to these accounts comes out of your paycheck without being taxed, and you withdraw it tax-free when you pay for eligible health care and dependent care expenses.

HEALTH CARE FSA

Who can participate?
Team Members who are not enrolled in the HDHP plan.

What are the contribution limits?
Team Members can contribute up to $3,500 in 2027.

What happens at the end of the year?
A balance over $700 will be forfeited at the end of the year.
Any remaining balance of $700 or less can be used the following plan year once funds are rolled over mid-April. Estimate your contributions carefully so you can avoid losing money.

You are able to file claims through March 31, 2028, however claims must be incurred during the 2027 plan year.

LIMITED PURPOSE FSA

Who can participate?
Team Members enrolled in either of the HDHP plan.

What are the contribution limits?
Team Members can contribute up to $ 3,500 for 2027. You can use the funds for any qualified dental or vision expenses. No medical plan co-pays, deductibles, prescription drugs or alternative healthcare are eligible expenses through a LP-HFSA.

What happens at the end of the year?
A balance over $700 will be forfeited at the end of the year. Any remaining balance of $700 or less can be used the following plan year once funds are rolled over mid-April. Estimate your contributions carefully so you can avoid losing money.

DEPENDENT CARE FSA

Who can participate?
Any Team Member.

What are the contribution limits?
Team Members can contribute up to $7,500 annually per family or $3,750 if filing separately.

What happens at the end of the year?
FSA funds are use it or lose it and expire at the end of each year. You are able to file claims through March 31, 2028, however claims must be incurred during the 2027 plan year. Unlike the Health Care FSA, your full election for the plan year is not available on the day your plan starts. For the Dependent Care FSA, you can only be reimbursed for qualified expenses up to the amount you have contributed to your FSA up to that point in time. As your contributions accrue, claims for reimbursement can be processed.

What's an Eligible Expense?

Health Care FSA – Plan deductibles, copays, coinsurance, and other health care expenses. To learn more, see IRS Publication 502 at www.irs.gov.

Dependent Care FSA – Child day care, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at www.irs.gov.

Limited Purpose FSA – Qualified dental, and vision expenses and deductibles. Cannot be used for medical or prescription expenses

Transportation Benefit

Transportation plans allow you to set-aside pre-tax dollars to pay for qualified parking, transit passes, and vanpooling expenses. Reimbursements are available on a daily basis.

- **Federal parking $340/month**
- **Federal mass transit $340/month**
- **Massachusetts parking $325/month**
- **Massachusetts transit $325/month**



HSA & FSA Comparison

This chart shows the features of the Health Care FSAs and the HSA and compares the Limited Purpose Health Care FSA to the traditional Health Care FSA.

	HSA	LIMITED PURPOSE HEALTH CARE FSA*	HEALTH CARE FSA**
Available if you select these plans	High Deductible Health Plan	High Deductible Health Plan	$2,000 PPO or $3,000 PPO
How much you may contribute	$4,500 (team member only), $9,000 (all other coverage levels) Catch-up contributions of up to $1,000 for 2027 year for age 55+	Up to $3,500 for plan year	
Expenses you may pay from your account	Out of pocket expenses incurred during the current calendar year		
	Out-of-pocket Medical Prescription drug Dental Vision	Dental Vision	Medical Prescription drugs Dental Vision
Account balance available to reimburse expenses	Current account balance	Entire contribution amount elected for the plan year	
Time limits for using your account balance	No limit	Must use 2027 account balance for expenses incurred through December 31, 2027 Claims must be filed by March 31, 2028	
If you don't use all your account balance each year	Any account balance carries over from year-to-year	You must submit claims by March 31, 2027 for all expenses incurred through December 31, 2027 Any remaining funds over $700 will be forfeited	
How it saves you money	Your contributions are tax-free, which reduces your taxable income Any investment or interest earnings on your account balance is tax-free Distributions are tax-free if used for qualified healthcare expenses	Your contributions are tax-free, which reduces your taxable income and increases your take-home pay You pay for healthcare expenses with pre-tax dollars	



Income and Legal Protection

Life Insurance - New York Life

BASIC LIFE AND AD&D INSURANCE

The basic life and Accidental Death and Dismemberment (AD&D) plan provides a benefit in the event of your death, dismemberment, or paralysis. This benefit is sponsored by ITA Group: you are automatically enrolled at no cost to you. Your coverage is 1.5x your annual compensation rounded to $1,000, not to exceed $300,000. This benefit reduces to 65% at age 70, and 50% at age 75. Benefit terminates at retirement.

If you have a qualifying medical condition, you may apply for an accelerated benefit to receive a portion of your life insurance once during your lifetime. Amount of benefit is 50% of your life insurance in force, but not to exceed $100,000.

SUPPLEMENTAL LIFE INSURANCE

You may purchase additional life insurance at group rates:

- Available in increments of $10,000 up to $500,000
- You pay the full cost of this plan, and the amount deducted depends on the age of the associate and the amount of coverage elected
- If you do not elect this coverage when first becoming eligible or an election over $250,000 is made, you are subject to medical underwriting by the carrier

LIFE INSURANCE FOR SPOUSES AND DEPENDENTS

You may purchase additional dependent life insurance at group rates:

- Spousal life is available in increments of $5,000 up to a max of $100,000, not to exceed 100% of the team member amount
- Spouses can elect up to $50,000 without medical underwriting as a new hire
- Child life is available from birth to age 19 (26 if a full-time student): Increments of $2,500 up to a maximum of $10,000
  - Children are not subject to medical underwriting
  - The cost remains the same regardless of the number of children you have

Note: Upon loss of eligibility or termination of employment, you and/or your dependents may elect to continue your employer sponsored basic or voluntary term life Insurance coverage by either porting (continuing the same type of policy) or converting it (changing it to a new type of individual policy.)

Don't forget to designate a beneficiary!

MONTHLY COST FOR EACH $10,000 OF TEAM MEMBER & SPOUSE LIFE INSURANCE

Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Rate	$0.70	$0.90	$1.10	$1.50	$2.50	$4.20	$7.30	$11.18	$19.30	$34.80
Children	$0.247 per $1,000									

GUARANTEED ISSUE AND EVIDENCE OF INSURABILITY

Team Members and spouses who elect voluntary life and AD&D coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

IMPUTED INCOME

Under current tax laws, imputed income is the value of your basic life insurance that exceeds $50,000 and is subject to federal income, Social Security, and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

Disability - New York Life

At ITA Group, we want to do everything we can to protect you and your family. That's why ITA Group pays for the full cost of short- and long-term disability insurance - meaning that you owe nothing out of pocket.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Please note that you are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

SHORT-TERM DISABILITY	
Benefits Begin	7 days after incident
Maximum Benefit Period	17 Weeks
Income Replaced	60% of weekly earnings, up to $2,500
Exclusions	Work related accidents or injuries



LONG-TERM DISABILITY	
Benefit Amount	60% of monthly salary
Own Occupation Period	36 Months
Elimination Period	120 Days
Maximum Benefit Period	Later of MBP or SSNRA
Maximum Benefit Amount	$10,000
Survivor Benefit	3 Months
Zero Day Residual	Zero-day residual stipulates that full-time or part-time work in which the Team Member is performing all of the material duties of his or her regular, or some other occupation, will not interrupt the qualifying (elimination) period, or the period of disability
Pre-Existing Condition Waiting Period	Applies to all Team Members covered less than 12 months. In the event of a claim, the carrier will review information from 3 months prior to the Team Member being on this plan; if the disabling condition had been treated or diagnosed, there would be no LTD benefits for the first 12 months. After that time, benefits will be payable according to the terms of the contract.

Voluntary Benefits - New York Life

ACCIDENT INSURANCE

Accident insurance pays out a lump sum if you become injured because of an accident - even if the injuries you incur do not keep you out of work. While health insurance companies pay your provider or facility, accident insurance pays you directly.

How Does Accident Insurance Work?

Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of situations, including initial care, surgery, transportation and lodging, and follow-up care. Here's how it works:

- A set amount is payable based on the injury you suffer and the treatment you receive
- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit
- Coverage is available for you, your spouse, and eligible dependent children
- You do not need to answer medical questions or have a physical exam to get basic coverage
- Accident insurance covers injuries that happen off the job
- Benefit payments are not reduced by any other insurance you may have with other companies

Covered expenses typically include:

- Emergency room visits
- Hospital stays
- Fractures and dislocations
- Medical exams
- Physical therapy
- Transportation and lodging

CRITICAL ILLNESS INSURANCE

While medical insurance is vital, it doesn't cover everything. If you suffer from a serious illness, such as cancer, stroke, or a heart attack, medical insurance may not provide the coverage you need. Critical Illness insurance will ease the financial strain and help you focus on your recovery.

How Will a Critical Illness Claim Get Paid?

After purchasing Critical Illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a medical provider. The payment you receive can be used for many things including:

- Childcare costs
- Medical and living expenses
- Travel expenses for you and your family
- Lost wages from missed time at work

Covered Expenses Include:

- Heart attack
- Multiple Sclerosis
- Stroke
- Parkinson's disease
- Major organ failure
- Cerebral Palsy
- Advanced Dementia
- Amyotrophic Lateral Sclerosis (ALS)
- Advanced Parkinson's Disease

Legal & Identity Theft Protection- LegalShield

LegalShield provides the legal and identity theft protection you and your family need and deserve.

LegalShield Coverage Includes:

- Legal consultation and advice
- Court representation
- Dedicated provider law firm
- Legal document preparation and review
- Will preparation
- Letters and phone calls made on your behalf
- Speeding ticket assistance
- Divorce
- 24/7 emergency legal access

IDShield Coverage Includes:

- Identity consultation and advice
- Dedicated licensed private investigators
- Identity, credit, and financial account monitoring
- Child monitoring (family plan only)
- Full-service identity restoration
- Real-time alerts
- 24/7 emergency access
- Social media monitoring and online privacy reputation management

Scan the QR code or visit to **shieldbenefits.com/ita/overview** to learn more.

LEGALSHIELD FAMILY PLAN

$13.88
SEMI-MONTHLY

IDSHIELD

TEAM MEMBER PLAN	FAMILY PLAN
$3.73	$7.03
SEMI-MONTHLY	SEMI-MONTHLY

LEGALSHIELD & IDSHIELD

TEAM MEMBER PLAN	FAMILY PLAN
$17.10	$19.90
SEMI-MONTHLY	SEMI-MONTHLY





Additional Support

FEDlogic: Federal & State Program Advocacy

FEDlogic is a free, advocacy service provided through ITA Group that helps you and your family understand and maximize available federal and state benefits. FEDlogic's team includes former Social Security Administration professionals and benefit experts with decades of experience navigating complex government programs.

HOW FEDLOGIC CAN HELP

- Medicare and Medicare planning
- Social Security retirement benefits
- Disability benefits
- Supplemental Security Income (SSI)
- Medicaid
- Veteran and Tribal benefits
- COBRA and Healthcare.gov coverage options
- Support for critical illnesses, catastrophic claims, ALS, and dialysis
- Assistance for families with premature babies in the NICU

WHAT TO EXPECT

- Listen to your unique situation and goals.
- Explain benefit options in clear, easy-to understand terms.
- Help identify programs and benefits you may qualify for.
- Guide you through enrollment and application processes when appropriate.
- You AND your immediate and extended family can use FEDlogic

Employee Portal Access Code: ita26

For more information, contact FEDlogic at 877-837-4196, visit FEDlogicGroup.com, or email services@fedlogicgroup.com.

employees.fedlogicgroup.com

START WITH A SHORT QUESTIONNAIRE AND SCHEDULE A PRIVATE CONSULTATION.



Important Contacts

COVERAGE	CARRIER	PHONE	WEBSITE/EMAIL
Medical	Wellmark	800-524-9242	www.wellmark.com
Pharmacy	MedOne	888-884-6331	www.medone.com
Telemedicine	Doctor on Demand	800-997-6196	www.doctorondemand.com
Dental	Delta Dental	800-544-0718	www.deltadentalia.com
Vision	Delta Vision	800-544-0718	www.deltadentalia.com
Life and AD&D Disability Supplemental	New York Life	888-842-4462	www.myNYLGBS.com
Employee Assistance Program	New York Life	800-344-9752	guidanceresources.com Web ID: NYLGBS
Flexible Spending Accounts	Alerus	800-279-3200	www.alerus.com
Federal & State Programs	FEDLogic	877-837-4196	www.fedlogicgroup.com
People & Culture	ITA Group	(515) 326 3400	benefits@itagroup.com

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 9.96% of your annual household income (for 2026; this amount will increase to 10.22% for 2027), 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 (for 2026; and 10.22% for 2027).

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.

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.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP 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 https://www.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 Kathy Schnack at 515-326-3397 or kschnack@itagroup.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.

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:
Kathy Schnack
7000 Vista Dr, West Des Moines, IA 50266
515-326-3397
kschnack@itagroup.com

Your Information. Your Rights. Our Responsibilities.

This notice describes:

• HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

• YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

• HOW TO FILE A COMPLAINT CONCERNING A VIOLATION OF THE PRIVACY OR SECURITY OF YOUR HEALTH INFORMATION, OR OF YOUR RIGHTS CONCERNING YOUR INFORMATION

YOU HAVE A RIGHT TO A COPY OF THIS NOTICE (IN PAPER OR ELECTRONIC FORM) AND TO DISCUSS IT WITH PEOPLE & CULTURE AT 515-326-3426 OR **BENEFITS@ITAGROUP.COM** IF YOU HAVE ANY QUESTIONS.

Please review it carefully.

YOUR RIGHTS

You have the right to:

- Consent to most uses and disclosures of your health information
- 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 list of health care providers who have received your information through certain third parties
- Get a copy of this privacy notice
- Choose in advance whether to receive fundraising communications
- Discuss this notice with someone in our program
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

With your consent, we can use and share your information as we:

- Treat you
- Run our organization
- Bill for our services
- Fulfill your requests to share information with your consent
- Prevent multiple program enrollments
- Report about court-referred treatment
- Report to prescription drug monitoring programs

OUR USES AND DISCLOSURES

We may use and share your information without your consent 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
- For your medical emergencies
- 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
- Assist with cause of death inquiries
- Communicate within our program and with contractors
- Respond to management and financial audits and program evaluation
- Prevent or reduce crime in our program

In these circumstances, we must protect your information and limit how we use and share it

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.

Provide consent when we use or share your information for most purposes

- You may provide a single consent for all future uses or disclosures for treatment, payment, and health care operations purposes.
- You may provide consent for more limited purposes (for example, to only disclose information to another health care provider for your treatment); however, doing so may affect the services we can provide you or how you pay for services.
- You may provide a general consent to share your information through certain third parties, such as a health information network or a research institution, where your treating health care providers can access it.

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 health care operations after you have provided consent for all those purposes. We are not required to agree to your request, and we may say "no" if, for example, it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.
- We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our health care operations with your health insurer. We will say "yes" unless a law requires us to share that information

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.

Discuss this notice with someone in our program

You can ask questions or obtain more information about this notice and our privacy practices by calling or emailing the contact person at the top of this notice.

Choose in advance about fundraising

You have the right to a clear and obvious notice in advance of, and a choice about whether to receive, fundraising communications for our program.

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.

With your consent, we may also use and share your information in the following ways:

- To whomever you name in a consent to share your information
- To prevent multiple enrollments in withdrawal management or maintenance treatment programs
- To report participation in treatment required by the criminal justice system
- To report prescribed substance use disorder treatment medications to a state prescription drug monitoring program when required by law

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.

Example 2: A doctor treating you for a chronic condition asks a doctor at our program about your health condition and medications you are taking, for example, to avoid complications

Bill and Pay for your health services

We can use and disclose your health information as we bill or 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, only as required by applicable law
- Preventing or reducing a serious threat to anyone's health or safety

For your medical emergencies

We can share your information during a bona fide medical emergency with the personnel and health care providers responding to your emergency, even when you are unable to consent because of the emergency

Do research

We can use or share your information for health research. Researchers cannot include any patient identifying information in their reports about the 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

Legal Proceedings and Court Orders

We must follow certain procedures before using or sharing your information for investigations and legal proceedings.

- We will not use or share your information or provide testimony about your information in any civil, administrative, criminal, or legislative proceedings against you without your written consent or a court order.
- We will only respond to a court order to use or share your health information if it is accompanied by a subpoena or other similar legal mandate requiring us to comply.
- We will only use or share your information in proceedings against you based on a court order after we have received notice and an opportunity to be heard or you tell us that you have received notice.

- We may use or share your information to respond to legal proceedings against our program based on a court order and you may not be notified in advance. You have the right to seek to overturn or change the court order after you learn about it.

Assist with cause of death inquiries

We can share patient identifying information about a deceased patient as required or allowed by laws that collect information relating to cause of death.

Communicate within our program and with contractors

We can share your information within our program, with an organization that has administrative control over our program, and with contractors who help us run our program.

Respond to management and financial audits and program evaluation

We can use or share your information to improve the quality of our services, obtain needed credentials, and cooperate with oversight agencies for activities authorized by law, as long as those who view or receive the information agree to destroy or return the information when they are finished and agree not to use it against you.

Prevent or reduce crime in our program

We may report to law enforcement when a patient commits or threatens to commit a crime within our program or against our staff

Redisclosure According to HIPAA

When you consent to uses and disclosures for all future treatment and payment purposes and to run our business, we may share your information with other substance use disorder treatment programs, doctors' offices, and health care businesses for those activities. If the person who receives it is subject to HIPAA, then they are allowed to use and share your information again without your consent for the purposes that HIPAA allows. Your information still cannot be used in legal proceedings against you unless (1) you consent or (2) based on a Part 2 court order and a subpoena (or similar legal requirement).

OUR RESPONSIBILITIES

- We are required to obtain your consent for most uses and sharing of your information.
- 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.

OTHER INSTRUCTIONS FOR NOTICE

- Effective Date of this Notice April 9, 2027.
- Privacy Contact – Kathy Schack,/VP – People & Culture, 7000 Vista Drive, West Des Moines, IA 50266, Phone Number: 515-326-3397
- In addition to the protections provided under HIPAA, certain states have privacy laws that provide individuals with additional rights or impose additional responsibilities on covered entities and health plans. To the extent that applicable state law is more protective of your health information than HIPAA, we will comply with such state law requirements. These additional protections will apply only to individuals who reside in those states.

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **ITA Group has determined that the prescription drug coverage offered by the ITA Group Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

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

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

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

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 ITA Group changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 01/01/2027
Name of Entity/Sender: ITA Group
Contact--Position/Office: Kathy Schnack/VP - People & Culture
Address: 7000 Vista Dr, West Des Moines, IA 50266
Phone Number: 515-326-3397

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: ITA Group Human Resources

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

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

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

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

Disability Extension of 18-month Period of COBRA Continuation Coverage

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child

stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

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

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

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

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

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

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

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

Human Resources
515-326-3426
7000 Vista Dr, West Des Moines, IA 50266

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

Women's Health and Cancer Rights Act

ENROLLMENT NOTICE

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- 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. Therefore, the following deductibles and coinsurance apply: $2,000 PPO - $2,000 single/$4,000 family deductible, 20% coinsurance; $3,000 PPO - $3,000 single/$6,000 family, 20% coinsurance; $4,000 HDHP - $4,000 single/$7,000 family deductible, 0% coinsurance. If you would like more information on WHCRA benefits, call your plan administrator at 515-326-3397.

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 515-326-3397 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.

Your Rights and Protections Against Surprise Medical Bills

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

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

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

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

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

YOU ARE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

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

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

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

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

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

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

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

If you believe you've been wrongly billed, you may contact CMS or the Iowa Insurance Division.

Visit **www.cms.gov** for more information about your rights under federal law.

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs.

If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

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

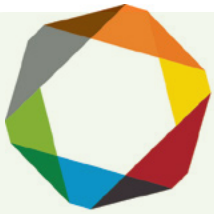
Iowa Medicaid and CHIP	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid CHIP: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	800-338-8366 800-257-8563 888-346-9562
Kansas Medicaid	kancare.ks.gov	800-792-4884 HIPP: 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, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866-444-EBSA (3272)

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



ita group®

2027 BENEFITS GUIDE