

2027

Benefits Guide

ARONA Home Essentials

First Iowa Title Corporation
Boone County•Marshall County•Webster County

Aterra Real Estate

ACE Hardware

INTEGRATED MSP

FOL-DA-TANK

ATERRA CONSTRUCTION SERVICES

BERNAU CAPITAL PARTNERS

GLOBE ACCEPTANCE SINCE 1914

IVY LANE CORPORATION

PET SUPPLIES PLUS
Minus the hassle.

HICKORY PARK RESTAURANT CO.

RENT-ALL

DM

Welcome to Your 2027 Benefits Guide

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

This benefit summary describes the benefit plans available to you as an employee of Bernau Capital Partners. 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 Bernau Capital Partners.

Disclaimer: This guide provides a summary of plan highlights. This is not a binding contract. In the event of any difference between the information contained herein and the plan documents, the plan documents will supersede and control over this guide. Please consult the Summary Plan Description for information on covered charges, limitations, and exclusions.

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Getting *Started*

Important Contacts

COVERAGE	CONTACT	PHONE	WEBSITE
Medical	Wellmark	800-524-9242	www.wellmark.com
Telehealth	Doctor on Demand	800-997-6196	www.DoctorOnDemand.com
Health Savings Account	P&A Group	716-852-2611	www.padmin.com
Flexible Spending Accounts	P&A Group	716-852-2611	www.padmin.com
Dental	Delta Dental of Iowa	800-544-0718	www.deltadentalia.com
Vision	Delta Dental of Iowa	800-544-0718	www.deltadentalia.com/vision
Life and Disability	Mutual of Omaha	800-877-5176	www.mutualofomaha.com
Voluntary Benefits	Mutual of Omaha	800-755-6000	www.mutualofomaha.com
Employee Assistance Program	Bree Health	800-327-2255	login.breehealth.com
Pet Insurance	Spot	888-343-2340	www.spotpet.link/bernaucapital
Human Resources	Rachel West	515-225-9029	hr@bernaucapital.com



Welcome!

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.

HOW DO I ENROLL?

1. Log in to ADP

If you do not make changes, your current elections will roll over, except for the Health Savings Account and Flexible Spending Account. **The HSA and FSA require an active election, or you will not be enrolled or 2027.**

2. Choose Your Plan

Verify your personal information and make any changes to your elections if necessary.

3. Enroll

Based off of the best value plan for your needs, enroll in your benefits.

The deadline to enroll in benefits is November 13, 2026. All benefit elections must be received within the Open Enrollment window. Benefit elections will not be accepted after November 13, 2026.

WHEN IS ANNUAL ENROLLMENT?

The Annual Enrollment period is **October 29-November 13, 2026** . If you do not take action to enroll, your 2026 benefits (with the exception of FSA and HSA contributions) will roll over into 2027.

FSA and HSA contributions require an active election every year, so be sure to make that election if applicable.

You will not be able to enroll or make changes to your elections until the next Open Enrollment, unless you experience a Qualifying Life Event (QLE).

QUALIFYING LIFE EVENT

Your benefit elections made during Open Enrollment will be effective January 1, 2027. You may not make mid-year 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 your spouse's Open Enrollment.

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 60 DAYS** of the qualifying life change event.

Log into ADP or contact Human Resources to process a Qualifying Life Event.



Eligibility

You and your eligible family members may participate in the employee benefits program if you're a regular, full-time employee working a minimum of 30 hours per week.

DEPENDENT ELIGIBILITY

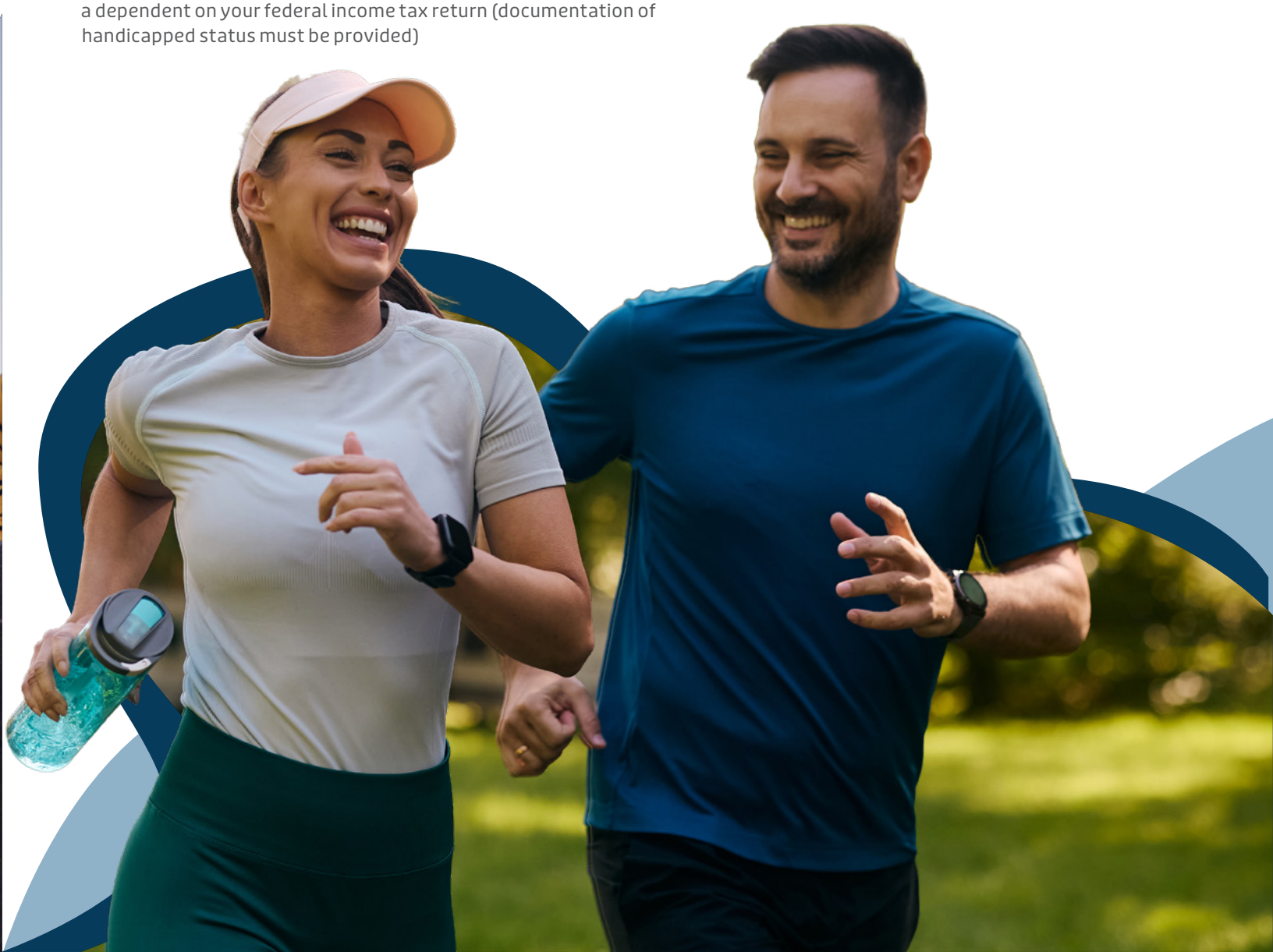
You can enroll the following dependents in our group benefit plans:

- Your legal spouse. Employees will pay a $100 monthly surcharge to cover a spouse on the medical plan if they have access to insurance elsewhere.
- Children up to age 26*
- A child under the age of 26 who is your natural child, stepchild, legally adopted child, or child for whom you have obtained legal guardianship
- Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax return (documentation of handicapped status must be provided)

NEW-HIRE ELIGIBILITY

New hires can join the plan the first of the month following 30 days of employment. Spouses and dependent children of the employee are also eligible to participate in our benefit plans.

**Enrolled children lose coverage when they turn 26 and will be mailed COBRA enrollment information.*



Employee Bi-Weekly Contributions

MEDICAL	Wellmark $5,000 HDHP	Wellmark $5,000 PPO	Wellmark $2,000 PPO	Wellmark $5,000 HMO Iowa Only	Wellmark $2,000 HMO Iowa Only
Employee	$54.86	$58.53	$163.23	$39.55	$159.71
Employee & Spouse	$339.36	$373.07	$487.71	$316.10	$428.83
Employee & Child(ren)	$299.60	$343.87	$432.14	$284.28	$374.24
Family	$498.12	$511.11	$786.64	$476.99	$693.43

There will be a $100 per month surcharge applied to the medical premiums if you are covering a spouse who has coverage available through his/her employer sponsored plan and still chooses to be on the Bernau Capital Plan.

DENTAL	
Employee	$16.11
Employee & Spouse	$32.51
Employee & Child(ren)	$39.16
Family	$62.99

VISION RATES	
Employee Only	$4.35
Employee & Spouse	$8.52
Employee & Child(ren)	$8.78
Family	$12.39

ACCIDENT	LOW PLAN	HIGH PLAN
Employee	$3.32	$4.83
Employee & Spouse	$5.31	$7.56
Employee & Child(ren)	$6.53	$9.23
Family	$9.19	$12.66

HOSPITAL INDEMNITY	
Employee	$9.55
Employee & Spouse	$21.96
Employee & Child(ren)	$13.18
Family	$26.35

Bernau Capital pays the full cost of the Basic Life/AD&D & Long-Term Disability. The Voluntary Life, Voluntary Short-Term Disability, and Critical Illness rates are based upon your age and benefit.

Please see rate charts in the benefit guide or log into ADP to calculate your premium.



Employee Weekly Contributions

MEDICAL	Wellmark $5,000 HDHP	Wellmark $5,000 PPO	Wellmark $2,000 PPO	Wellmark $5,000 HMO Iowa Only	Wellmark $2,000 HMO Iowa Only
Employee	$27.43	$29.27	$81.61	$19.78	$79.86
Employee & Spouse	$169.68	$186.54	$243.85	$158.05	$214.41
Employee & Child(ren)	$149.80	$171.94	$216.07	$142.14	$187.12
Family	$249.06	$255.55	$393.32	$238.50	$346.72

There will be a $100 per month surcharge applied to the medical premiums if you are covering a spouse who has coverage available through his/her employer sponsored plan and still chooses to be on the Bernau Capital Plan.

DENTAL	
Employee	$8.06
Employee & Spouse	$16.26
Employee & Child(ren)	$19.58
Family	$31.50

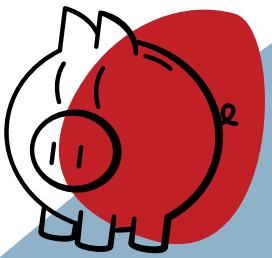
VISION	
Employee Only	$2.18
Employee & Spouse	$4.26
Employee & Child(ren)	$4.39
Family	$6.20

ACCIDENT	LOW PLAN	HIGH PLAN
Employee	$1.66	$2.41
Employee & Spouse	$2.66	$3.78
Employee & Child(ren)	$3.27	$4.61
Family	$4.59	$6.33

HOSPITAL INDEMNITY	
Employee	$4.41
Employee & Spouse	$10.13
Employee & Child(ren)	$6.08
Family	$12.16

Bernau Capital pays the full cost of the Basic Life/AD&D & Long-Term Disability. The Voluntary Life, Voluntary Short-Term Disability, and Critical Illness rates are based upon your age and benefit.

Please see rate charts in the benefit guide or log into ADP to calculate your premium.



Body and Mind

Medical Benefits

Your medical plans will be offered through Wellmark. Please review your Summary of Benefits and Coverage (SBC) for additional coverage information and full plan details.

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

Preferred Provider Organizations (PPO)

The PPO plans offer in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because network providers discount their fees. And, with in-network providers, you generally do not have to file claims.

If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses.

High Deductible Health Plan (HDHP)

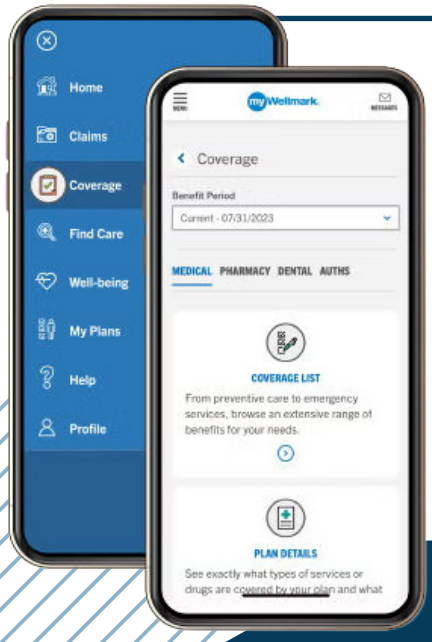
The High Deductible Health Plan is also a nationwide PPO network. You have coverage for both in- and out-of-network providers. The HDHP has higher deductibles and no office visit co-payments. Once you've met your deductible, you no longer have to pay anything for covered services. This also applies to prescription drugs. The HDHP is compatible with a Health Savings Account.

Health Maintenance Organization (HMO)

The two HMO plan options are only available to employees who reside and seek medical care in the state of Iowa. This plan only offers in-network coverage. You will only have coverage for out-of-network claims in the case of a life or limb threatening emergency. This plan also requires that you designate a Primary Care Physician.

Find a Provider

Visit www.Wellmark.com and click "Find a Provider". You can enter your location, your network (PPO or HMO) and enter specific provider criteria to find an in-network provider that meets your needs.



REGISTER ONLINE

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

DOWNLOAD THE MOBILE APP

With the MyWellmark mobile app, you've got the tools you need to manage your healthcare — all from your smartphone. The mobile app is available in the Apple and Google Play stores.

GET IT ON Google Play

Download on the App Store

Medical Plans At A Glance

WELLMARK BCBS - PPO PLANS

	$2,000 PPO	$5,000 PPO	$5,000 HDHP
BENEFITS IN-NETWORK ANNUAL DEDUCTIBLE - Calendar Year			
Individual	$2,000	$5,000	$5,000
Family	$4,000	$10,000	$10,000
OUT-OF-POCKET (OOP) MAXIMUM - Calendar Year			
Individual	$6,000	$5,000	$5,000
Family	$12,000	$10,000	$10,000
BENEFIT DETAILS			
Virtual Visits	$25 Copayment	$25 Copayment	Deductible
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%
Primary Care Physician (PCP)	$25 Copayment	$25 Copayment	Deductible
Specialist	$50 Copayment	$50 Copayment	Deductible
Urgent Care	$25 Copayment	$25 Copayment	Deductible
Emergency Room	$300 Copayment	$300 Copayment	Deductible
Inpatient Hospital	Deductible, 20%	Deductible	Deductible
Outpatient Hospital	Deductible, 20%	Deductible	Deductible
Outpatient Surgery	Deductible, 20%	Deductible	Deductible
Eye Exam	1 routine exam per year $50 Copayment	1 routine exam per year $50 Copayment	1 routine exam per year Deductible
Lab/X-Ray (Outpatient)	Deductible, 20%	Deductible	Deductible
BENEFITS OUT-OF-NETWORK			
Deductible - Individual / Family	$2,500 / $5,000	$6,000 / $12,000	$5,000 / $10,000
Coinsurance	30%	30%	30%
Out-of-Pocket Maximum- Individual /Family	$6,000 / $12,000	$10,000 / $20,000	$10,000 / $20,000

Please note: If you go to an out-of-network provider, your cost may be higher and your provider may ask you to pay the actual charge for your care at the time of your visit.

The medical plans all have an embedded deductible. If you are enrolled in a family plan, each family member has an individual deductible in addition to the overall family deductible. This means that if an individual in the family reaches his or her single deductible before the family deductible is reached, his or her services will be paid by the insurance company.



Medical Plans At A Glance

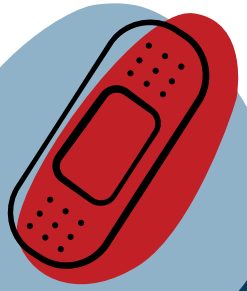
WELLMARK BCBS - HMO PLANS

These plans are only offered to employees located in Iowa. Providers outside of Iowa are not covered by the HMO network.

	$2,000 HMO – Iowa Only	$5,000 HMO – Iowa Only
BENEFITS IN-NETWORK - ANNUAL DEDUCTIBLE - Calendar Year		
Individual	$2,000	$5,000
Family	$4,000	$10,000
OUT-OF-POCKET (OOP) MAXIMUM - Calendar Year		
Individual	$6,000	$5,000
Family	$12,000	$10,000
BENEFIT DETAILS		
Virtual Visits	$25 Copayment	$25 Copayment
Preventive Care	Covered at 100%	Covered at 100%
Primary Care Physician (PCP)	Designated PCP - $20 Copayment Other PCP - $25 Copayment	Designated PCP - $20 Copayment Other PCP - $25 Copayment
Non-PCP Office Visit	$25 Copayment	$25 Copayment
Specialist	$50 Copayment	$50 Copayment
Urgent Care	$25 Copayment	$25 Copayment
Emergency Room	$300 Copayment	$300 Copayment
Inpatient Hospital	Deductible, 20%	Deductible
Outpatient Hospital	Deductible, 20%	Deductible
Outpatient Surgery	Deductible, 20%	Deductible
Eye Exam	1 routine exam per year $50 Copayment	1 routine exam per year $50 Copayment
Lab/X-Ray (Outpatient)	$50 Copayment per Provider 20% Facility Coinsurance	$50 Copayment per Provider 0% Facility Coinsurance
BENEFITS OUT-OF-NETWORK		
Deductible – Individual / Family	No Benefits Available	No Benefits Available
Coinsurance	No Benefits Available	No Benefits Available
Out-of-Pocket Maximum– Individual /Family	No Benefits Available	No Benefits Available

Please note: These plans require that you designate a Primary Care Physician. There is no coverage for out-of-network benefits!

All of the medical plans have an embedded deductibles. If you are enrolled in a family plan, each family member has an individual deductible in addition to the overall family deductible. This means that if an individual in the family reaches his or her single deductible before the family deductible is reached, his or her services will be paid by the insurance company.



Pharmacy

CVS

	$2,000 PPO, $5,000 PPO, $2,000 HMO, $5,000 HMO	$5,000 HDHP
Rx Deductible	$100 Single / $300 Family (waived for tier 1)	Same as Medical
Retail 30-day supply		
Tier 1	$10 Copayment	Deductible
Tier 2	$30 Copayment	Deductible
Tier 3	$50 Copayment	Deductible
Specialty	Preferred - $100 Copayment / Non-Preferred – 50% Coinsurance	Deductible
Mail Order 90-day supply		
Tier 1	$30 Copayment	Deductible
Tier 2	$90 Copayment	Deductible
Tier 3	$150 Copayment	Deductible

If you have a chronic condition and take specialty medications, you must purchase these through a designated specialty pharmacy that provides the best available pricing and additional support. If you have a prescription that meets this requirement, BCBS will contact you and provide you with the necessary information to fill your prescription.

Following the letter from BCBS, PrudentRx will reach out to coordinate your specialty prescription. PrudentRx offers a third-party (manufacturer) copay assistance program that may help save you money on your specialty medications.

If you do not enroll in the program, you will be required to pay 30% coinsurance. This will not count toward your out-of-pocket maximum.

Medications Delivered to Your Home

Home delivery is a convenient, cost-effective and safe option for medications you take regularly.
Make sure you have your ID card ready.
Follow the steps below to set up home delivery.

1. Call **866-611-5961** to enroll with FastStart.
2. Visit **www.caremark.com** and select **Register Now**.
3. Create a new, unique User ID.
4. Select **Start Mail Service** under the **Prescriptions Tab** in your portal
5. Send in your new 90-day prescription. Select **Request New Prescription** and complete the required information so CVS can reach out to your doctor.
6. You can also call customer service for assistance.



Telehealth Benefits

DOCTOR ON DEMAND

We've all been there—it's the middle of the night and you have a sick child. Or maybe you are trying to get an appointment with your primary care provider but the first appointment isn't for two weeks. Good news... there's an easier way! Telehealth is a convenient option for scheduling virtual doctor visits from your own home. With telehealth, you can 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
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections
- Infections
- Insect Bites
- Mental Health

With telehealth:

- See a board-certified, licensed, telehealth trained doctor on your schedule with on-demand virtual visits 24/7, including holidays.
- Get treated for more than 80 common conditions including colds, flu, allergies, and more.
- Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby, in less time than your usual doctor visit.
- Avoid costly copays and deductibles of the ER and urgent care clinic.

Getting Started is Easy

Download the "Doctor On Demand" app or visit **DoctorOnDemand.com**.

Have your Wellmark BCBS member ID card ready.

Create an account or sign in.

Call 800-997-6196 with any questions 24/7.



Dental Benefits

Delta Dental of Iowa

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. The dental plan also includes 100% coverage for preventive care. You and your eligible dependents may enroll in dental coverage options administered by Delta Dental.

PLAN FEATURE	PPO	Premier
Annual Deductible – Individual	$25	$50
Annual Deductible – Family	$75	$150
Annual Maximum – Per Person	$2,000	$2,000
Preventive Care	$0 - deductible waived	$0 – deductible waived
Basic Services *(Fillings, sealants, oral surgery)*	10% after deductible	20% after deductible
Major Services *(Crowns, onlays, inlays, bridges, dentures)*	50% after deductible	50% after deductible
Orthodontia Services Lifetime Maximum	$1,000	$1,000
Orthodontia Services – to age 19	50%	50%

Dental Network

You have two dental networks to choose from:

1. **Delta Dental PPO** network provides you with the lowest out-of-pocket costs. More than 30% of dentists in Iowa and 45% of dentists nationally participate in the PPO network.
2. **Delta Dental Premier** network is the largest network, with more than 90% of the dentists in Iowa, and 80% of dentists nationally participating.

To find a provider, visit: **www.deltadentalia.com**.



Vision Benefits

Delta Dental of Iowa

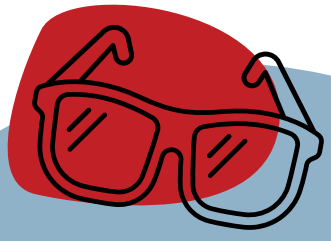
Driving to work, reading a news article, and watching TV are all activities you likely perform every day. Your ability to do these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Your vision insurance is provided by Delta Dental and entitles you to specific eye care benefits.

To find a provider, visit: **https://eyedoclocator.eyemedvisioncare.com/deltavisia/en-us.**

	IN-NETWORK	OUT-OF-NETWORK
EXAM		
Routine Eye Exam	$10 Copayment	Up to $35
MATERIALS & FRAMES		
Single Vision Lenses	$10 Copayment	Up to $25
Standard Lined Bifocal Lenses	$10 Copayment	Up to $40
Standard Lined Trifocal Lenses	$10 Copayment	Up to $55
Standard Progressive Lenses	$0 Copayment	Up to $40
Polycarbonate	$0 Copayment	N/A
Standard Scratch-Resistant Coating	$0 Copayment	N/A
UV Treatment	$0 Copayment	N/A
Solid or Gradient Tint	$0 Copayment	N/A
Standard Anti-Reflective Coating	$0 Copayment	N/A
Transitions	$75 Copayment	N/A
Frames	80% of balance over $150	Up to $75
Contact Lens: **Elective** **Medically Necessary**	 $150 Allowance $0 Copayment	 Up to $120 Up to $200
FREQUENCY OF SERVICES		
Comprehensive Eye Exam	12 Months	
Lenses / Contact Lenses (in lieu of one another)	12 Months	
Frames	24 Months	

This is not a full list of covered benefits. For a full list of covered benefits, please refer to the Vision Benefit Summary found here www.bernaubenefits.com .





Funding Accounts

Health Savings Account (HSA)

P&A GROUP

A Health Savings Account (HSA) is a way for you to save pretax dollars that can be used to pay for qualified healthcare expenses like deductibles, co-insurance, prescriptions, vision, and dental expenses. High deductible health plans have lower premiums and may result in lower annual medical costs. These plans offer several advantages to reward you for taking an active role in your healthcare spending.

- **Lower paycheck costs** — allowing you to keep control over more of your money
- **Tax-advantaged savings account** — enrolling in and contributing to a Health Savings Account (HSA) helps you pay your deductible and out-of-pocket costs
- **Comparable benefits** — these plans use the same networks that other plans offer, and in-network preventive care is still 100% covered

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 2027
- 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

HOW MUCH CAN I CONTRIBUTE TO AN HSA?

2027 HSA contribution limits are:

- Employee only coverage: $4,500
- Employee plus dependents coverage: $9,000
- If you are 55 or older, you can make an additional annual catch-up contribution of $1,000

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.



Eligible Expenses

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



Flexible Spending Account (FSA)

P&A GROUP

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

- Pay for eligible health care expenses, such as plan deductibles, copays, and coinsurance.
- Contribute up to $3,500 in 2027.

Who can participate?

You do not have to be enrolled in any of the medical plans to be eligible to participate in the Flexible Spending Accounts. If you are enrolled, employees that are enrolled in the traditional PPO or HMO plans are eligible to participate in the Health Care FSA. Employees who enrolled in the $5,000 HDHP are eligible to participate in the Limited Purpose FSA.

What is a Limited Purpose FSA?

A Limited Purpose FSA can be paired with a Health Savings Account. If you are participating in the LPFSA, you are only eligible to reimburse your dental and vision expenses. Medical expenses may not be reimbursed. If you are enrolled in the HDHP, you cannot enroll in the traditional Health Care FSA. You must enroll in the Limited Purpose FSA.

What happens at the end of the year?

FSAs are "Use It or Lose It" meaning if you do not spend your funds by the expense deadline, your funds will be forfeited. Unused monies are forfeited at the time of termination of employment unless COBRA is elected. The Company FSA plan allows a 2.5 month grace period after the plan year ends in which you can continue to incur eligible expenses and submit them for reimbursement.

DEPENDENT CARE FSA

Who can participate?

Any employee.

What are the contribution limits?

Employees can contribute up to $7,500 annually per family or $3,750 if filing separately.

What happens at the end of the year?

Dependent Care can only be reimbursed for expenses incurred in the plan year (1/1/2027 through 12/31/2027). FSA funds expire at the end of each year. Unlike the healthcare 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.



Eligible Expenses

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, babysitters, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at **www.irs.gov**.



HSA & FSA Comparison

This chart shows the features of the healthcare FSAs and HSAs.

	HSA	HEALTH CARE FSA
Available if you select these plans	High-Deductible Health Plan	Traditional PPO or HMO Plans You do not have to be enrolled in any medical plan to elect the Health Care FSA
How much you may contribute	Employee only coverage: $4,500 Employee plus dependents coverage: $9,000 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 any time after the HSA was established Medical Prescription drug Dental Vision Long-term care premiums	Out of pocket expenses incurred during the current calendar year (including the grace period): 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 2026 account balance for expenses incurred through 3/15/2027; Claims must be filed by 5/1/2027
If you don't use all your account balance each year	Any account balance carries over from year-to-year	Remaining balance is 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



Employee Assistance Program (EAP)

You and your eligible family members can trust **Bree Health's EAP** services to address your total well-being by providing barrier-free access to mental health and virtual life services.

CONFIDENTIAL ASSISTANCE

We ensure that your information and identity is kept completely confidential - even from your employer. Exceptions occur only when members are at risk of harming themselves or others or when the welfare of a child is in question.

Certified Life Coaching & Counseling

Certified support for personal and professional growth.

Health Advocacy

Navigate healthcare, find providers, and manage insurance.

Solutions Paths

Step-by-step guidance tailored to your well-being needs.

Legal & Financial Resources

Free consultations and expert advice.

Bree Video Library

Relaxation videos, meditations, and educational tools.

Virtual Concierge

Assistance with travel, dining, childcare, and more.

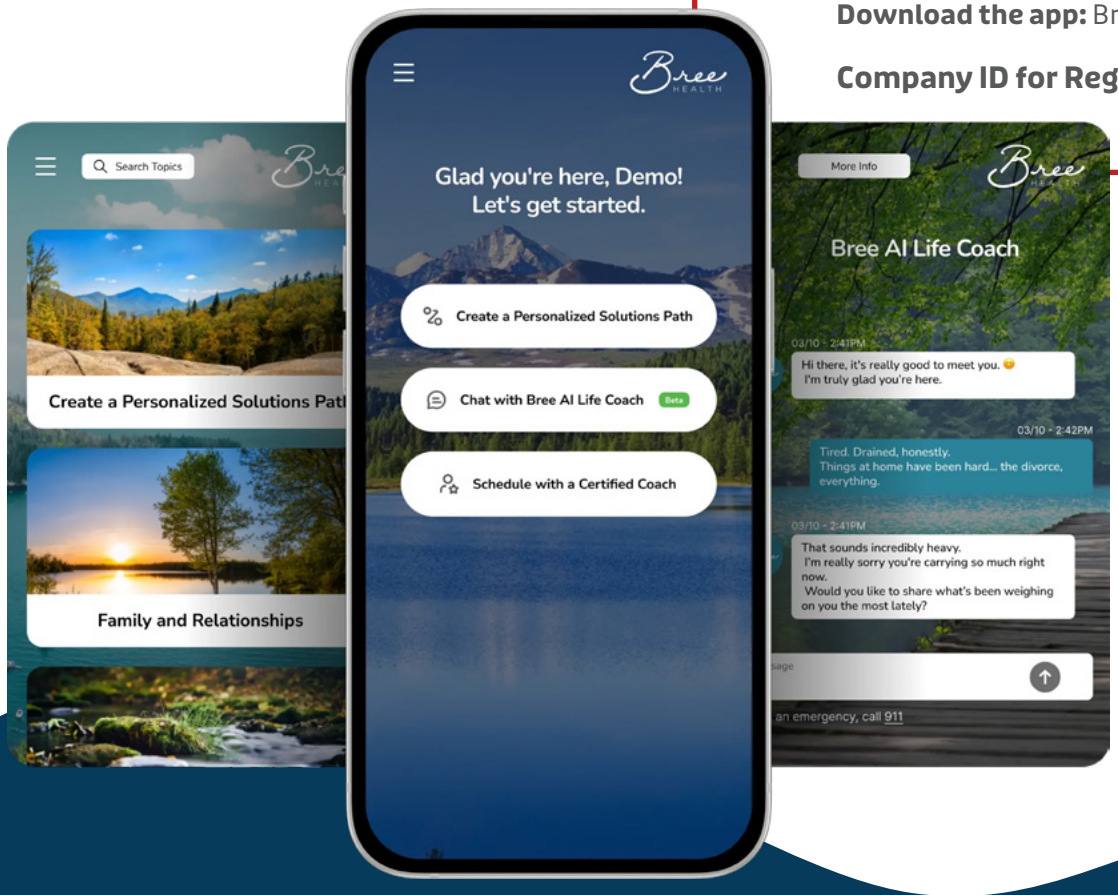
Exclusive Discounts

Special savings on entertainment, shopping, and travel.

Getting Started is Easy

Call: (800) 327-2255
Visit: login.breehealth.com
Download the app: Bree Health

Company ID for Registration: 10738



Life Insurance

Mutual of Omaha

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

The Basic Life and AD&D plan provides a benefit in the event of your death, dismemberment, or paralysis. This benefit is sponsored by Bernau Capital Partners and you will automatically be enrolled at no cost to you.

Your coverage will be a flat **$15,000**. Benefits will be reduced to 65% at age 65, and 50% at age 70.

SUPPLEMENTAL LIFE INSURANCE & AD&D

You may purchase additional life/AD&D insurance at group rates:

- Chose from $10,000 up to $500,000 in $10,000 increments. You can elect up to $100,000 at your new hire enrollment without having to go through medical underwriting.
- You pay the full cost of this plan. The amount deducted depends on your age and the amount of coverage elected.
- Benefits will be reduced to 65% at age 70, 45% at age 75, 30% at age 80, 20% at age 85, and 15% at age 90.
- Rates can be found by logging into ADP.
- When you terminate employment, you are eligible to port or convert your coverage if you submit an application to the carrier within 31 days.
- Please make sure your beneficiary is up-to-date. Your beneficiary should be updated within ADP and can be changed at any time. You do not need a qualifying life event to update your beneficiary.

SPOUSAL AND CHILD LIFE INSURANCE & AD&D

You may purchase additional dependent life/AD&D 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 employee coverage.
- Can elect up to $25,000 without medical underwriting as a new hire.
- Child life is available in increments of $1,000, up to a maximum of $10,000. Children from birth to 14 days are not eligible for a benefit. Children from 14 days to 6 months are limited to a benefit of $1,000.
  - Children are not subject to medical underwriting
  - The cost remains the same regardless of the number of children you have

Guaranteed Issue and Evidence of Insurability

Employees 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 Coverage

Mutual of Omaha

At Bernau Capital Partners, we want to do everything we can to protect you and your family. That's why Bernau Capital Partners pays for the full cost of long-term disability insurance—meaning that you owe nothing out-of-pocket. You also have the opportunity to purchase voluntary short-term disability and pay the full cost through payroll deduction.

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 (STD)

Voluntary Short-Term Disability (STD) benefits are paid for through payroll deduction and you pay 100% of the cost if you choose to enroll. Your STD benefits will replace **60%** of your base pay, up to **$1,000 per week**. Your STD benefits begin on the 8th calendar day of your disability. The maximum benefit available is 25 weeks per STD claim.

To determine your monthly premium, refer to the charts below. The maximum benefit amount cannot exceed 60% of your gross weekly earnings or $1,000, whichever is less.

AGE	RATE PER $10 OF COVERED BENEFIT
Less than 44	$0.497
45-49	$0.597
50-54	$0.759
55-59	$1.066
60-64	$1.273
65+	$1.364

MONTHLY PREMIUM CALCULATION		EXAMPLE (42-year-old earning $40,000 per year)
List your annual earnings	$_____	$40,000
List your weekly earnings *(annual earnings divided by 52)*	$_____	$769.23
Calculate weekly benefit *(weekly earnings X 60%)*	$_____	$461.54
Value per $10 *(divide weekly benefit by $10)*	$_____	$46.15
Multiply by the premium factor for your age in chart	$_____	$0.497
Your Estimated Monthly Premium	$_____	$22.94

LONG-TERM DISABILITY (LTD)

If you are disabled and unable to work for more than 26 weeks, you may be eligible for Long-Term Disability (LTD) benefits. The Company automatically provides you LTD benefits that replace up to **50%** of your base pay, up to a maximum of **$10,000** per month. Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive.

You can continue to receive LTD benefits for up to a period of 24 months if you are unable to work in your own occupation. After 24 months, you may continue receiving LTD benefits if you are unable to work in any occupation.

Both Short-Term and Long-Term Disability have a pre-existing condition waiting period. The STD pre-existing condition exclusion is 3/6 and the LTD pre-existing condition exclusion is 3/12. This means if you have been treated for or diagnosed with a medical condition within 3 months of your effective date, benefits are not payable for that condition for a period of 6 months for STD or 12 months for LTD.

Accident Insurance

Mutual of Omaha

You have access to two accident plans that can be purchased through Mutual of Omaha. 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 medical insurance companies pay your provider or facility, Accident insurance pays you directly.

HOW DOES ACCIDENT INSURANCE WORK?

- 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.
- Benefit payments are not reduced by any other insurance you may have with other companies.
- If you terminate employment, you can convert your coverage and keep your in-force policy. Your coverage will only end if you stop paying your premium.

COVERED EXPENSES TYPICALLY INCLUDE:

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

For a full list of benefits payable, please refer to the Accident Benefit Summary.



Critical Illness Insurance

Mutual of Omaha

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.

ATTAINED AGE	Monthly $10,000	Monthly $20,000	Monthly $30,000
<29	$2.00	$4.00	$6.00
30-39	$3.00	$6.00	$9.00
40-49	$6.25	$12.50	$18.75
50-59	$15.05	$30.10	$45.15
60-69	$34.00	$68.00	$102.00
70-79	$62.15	$124.30	$186.45
80+	$88.75	$177.50	$266.25

*Premiums are based on the employee's attained age as of the effective date of the plan. Spouse premiums are based on the employee's age.

**Child coverage is included automactically and does not require separate premium.

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

HEALTH SCREENING BENEFIT

Mutual of Omaha will provide an annual benefit of $50 per insured per calendar year (up to 6 per family) if you recieve a health screening.

CRITICAL ILLNESS COVERAGED CONDITIONS

The critical illness policy provide a benefit for serveral conditions within the categories below. Pleae refer to the full benefit summary available at www.bernaubenefits.com for a full list of covered conditions and benefit payments.

- Autoimmune disorder (IBS)
- Cancer and benign tumor diagnoses
- Vascular and pulmonary conditions
- Neurological movement disorders
- Neurological brain and skull conditions
- Organ conditions

ELIGIBLE INDIVIDUAL	INITIAL BENEFIT	Guarnateed Issue Amount
Employee	$10,000, $20,000, or $30,000	$30,000
Spouse	Up to $10,000, $20,000, or $30,000 (up to a maximum for 100% of the employee benefit)	$30,000
Dependent Children	50% of Employee Benefit, up to $15,000	All child amounts are guaranteed

Hospital Indemnity Insurance

Mutual of Omaha

Hospital Indemnity insurance is a plan designed to pay for the costs of a hospital admission that may not be covered by other insurance. The plan covers employees who are admitted to a hospital or ICU for a any reason. Even if your medical insurance covers most of your hospitalization, you can still receive payments from your Hospital Indemnity insurance plan to cover extra expenses while you recover.

How Does Hospital Indemnity Insurance Work?

You pay monthly premiums for your Hospital Indemnity insurance plan. If you are admitted to the hospital for an injury or illness, your Hospital Indemnity plan makes cash payments to you. And with the payments going directly to you, you can use these emergency funds to pay for costs not covered by your medical insurance, medical insurance deductibles, copays and coinsurance, child care expenses while you are in the hospital or cost-of-living expenses as you recover.

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

Covered Expenses Include:

- Hospital admission - $1,000 per admission
- Hospital confinement - $100 per day
- ICU addmission - $2,000 per admission
- ICU confinement - $200 per day
- Newborn nursey care confinement - $75 per day
- Health screening benefit - $50 per insured person per year (up to 6 per family)
- Express benefit - $100 (payable in a short time frame upon notification of admission, with minimal verification needed)

Admission benefits are payable up to a combined total of 2 days per policy year, and are not payable on the same day. Confinement benefits are payable up to a combined total of 30 days per policy year and are not payable on the same day as admission benefits.



Other Information

Pet Insurance

SPOT

Spot plans help ensure your pet is covered from head-to-tail for unexpected accidents and injuries.

Spot Plans Help Cover Vet Bills for:

- Vet exam fees
- Behavioral issues
- Dental illnesses
- Surgery
- Microchip implantation
- Unexpected emergencies
- Hereditary conditions
- Prescription medications
- Diagnostics
- X-Rays & tests
- Cancer & growths
- Flexible plans for any budget
- And much more...

Simple & Easy Claims Process

1. Visit any vet in the U.S. or Canada
2. Submit your claim online
3. Get cash back for covered vet bills!

24/7 Pet Telehealth Helpline

Get unlimited virtual pet card from vet experts for your pet.

GET YOUR QUOTE TODAY:

- Visit spotpet.link/bernaucapital.
- **Call 888-343-2340.**
  When calling, use code: **EB_ARONA**.



Required Notices

HIPAA SPECIAL ENROLLMENT RIGHTS 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 60 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 60 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 60 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 60 days from the date of your marriage.

Medicaid or CHIP

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

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

For More Information or Assistance

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

HIPAA NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice is effective 10/26/2026

This notice describes:

- How medical information about you may be used and disclosed and how you can get access to this information;
- How health information about you may be used and disclosed;
- Your rights with respect to your health information; and
- How to file a complaint concerning a violation of the privacy or security of your health information, or of your rights concerning your information

Please review this notice carefully.

You have a right to a copy of this notice (in paper or electronic form) and to discuss it with Amy Linn at 515-657-8256 or alinn@bernaucapital.com if you have any questions.

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, including but not limited to, health care providers who have received your information through certain third parties
- Get a copy of this privacy notice
- 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

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

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

With your consent or as otherwise permitted under HIPAA, we can use and share your information as we:

- Process and Pay Claims
- Communicate with applicable providers treating you
- Administer the Plan
- Coordinate benefits with other coverage
- Fulfill your requests to share information with your consent
- Comply with appliable laws and regulations

OUR USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive, including but not limited to, helping with medical emergencies, communicating within our program and with our contractors
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues such as reporting crimes and threats of crimes and suspected child abuse and neglect
- Aid scientific 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, legal actions, court orders, audits and evaluations

In these circumstances, we must protect your information and limit how we use and share it. To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

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 or health care operations purposes.

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, if 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.

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 someone to act for you

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

File a complaint if you feel your rights are violated

You can complain if you feel we have violated your rights by contacting us using the information on page 1.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/index.html.

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, please contact 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 or payment for your care;
- Share information in a disaster relief situation; or
- Share information with someone authorized to act on your behalf

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

- If someone has authority to act as your personal representative, such as if someone has your 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.

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

- Marketing purposes (except as expressly permitted by HIPAA);
- Sale of your information; or
- Any other use or disclosure requiring your prior authorization under applicable law.

You may revoke any authorization at any time, except to the extent we have already relied on the authorization by notifying us in writing

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 & communicate within ours substance use disorder programs and with contractors

- We can use your health information and share it with professionals who are treating you.
- We can share your information within our substance use disorder programs and with an organization that has administrative control over our substance use disorder program, and with contractors who help us run our substance use disorder program.

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 may also use and share your information to prevent multiple enrollments in withdrawal management or maintenance treatment substance use disorder programs, to report participation in treatment required by the criminal justice system and to report prescribed substance use disorder treatment medications to a state prescription drug monitoring program when required by law.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

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

Pay for your health services

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

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

Administer your plan

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

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

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And in all cases, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, or legislative investigations or proceedings against you without (1) your consent or (2) a court order or subpoena.

Help with public health and safety issues

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

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

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. We can also share your identifying information to assist the federal Food and Drug Administration in notifying you or your doctor about unsafe products you may be using.

Aid scientific 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, court orders, and respond to lawsuits and legal actions

We may use or share your health information as permitted or required by law when responding to legal proceedings. This includes disclosures in response to a valid court order, warrant, subpoena, or other lawful process, consistent with HIPAA's rules for judicial and administrative proceedings (45 CFR §164.512(e)) and law enforcement requests (45 CFR §164.512(f)).When responding to legal requests, we disclose only the information required and follow all conditions and limitations imposed by HIPAA. We can share health information about you in response to a court or administrative order, or in response to a subpoena. With respect to information related to substance use disorder program, 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 provided testimony about your information in any civil, administrative, criminal or legislative proceedings against you with 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 comp.
- 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 substance use disorder 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.

With respect to substance use disorder program we may use or disclose your information in order to:

Respond to management and financial audits and substance use disorder program evaluations

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.

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.

Report suspected child abuse and neglect or prevent or reduce crime

We will only report the information required by law. We may report to law enforcement when a patient commits or threatens to commit a crime within our program or against our staff.

Communicate within our program and with contractors

We may use and disclose your information within our health plan and with organizations that help us administer our program, including contractors and business associates who perform services for us. These disclosures occur only as permitted by HIPAA for health care operations.

OUR RESPONSIBILITIES

- We may use and disclose your protected health information as permitted or required by HIPAA and other applicable laws. Certain uses and disclosures require your written authorization.
- 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 in this notice 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.

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).

CHANGES TO THE TERMS OF THIS NOTICE

We are required to follow the terms of this notice that are currently in effect. 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.

MICHELLE'S LAW ENROLLMENT NOTICE

Pursuant to Michelle's Law, you are being provided with the following notice because the Arona Corporation group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of Arona Corporation's group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the Arona Corporation group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the Arona Corporation group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

The Arona Corporation group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

To obtain additional information, please contact: Amy Linn at 515-657-8256 or alinn@bernaucapital.com

WOMEN'S HEALTH AND CANCER RIGHTS ACT INITIAL NOTICE

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. For further cost and details, refer to the information provided in this guide on deductibles and coinsurance for each specific plan. If you would like more information on WHCRA benefits, call Wellmark at 800-524-9242.

NO SURPRISES 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 Wellmark at 800-524-9242.

Visit www.cms.gov/medical-bill-rights for more information about your rights under federal law or call 1-800-985-3059 to file a federal complaint.

PATIENT PROTECTION NOTICE

Wellmark generally requires the designation of a primary care provider for participants in the HMO plans. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Wellmark designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Wellmark at 800-524-9242.

For children, you may designate a pediatrician as the primary

care provider.

You do not need prior authorization from Wellmark or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Wellmark at 800-524-9242.

IMPORTANT NOTICE FROM ARONA CORPORATION 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 Arona Corporation 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. Arona Corporation has determined that the prescription drug coverage offered by Wellmark 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 Arona Corporation 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 Arona Corporation 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: Arona Corporation

Contact--Position/Office: Amy Linn, Director of Human Resources

Address: 1001 Grand Ave, West Des Moines, IA 50265

Phone Number: 515-225-9029

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	The AK Health Insurance Premium Payment Program: myakhipp.com Email: customerservice@myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx	866-251-4861
Arkansas Medicaid	http://myarhipp.com/	855-MyARHIPP (855-692-7447)
California Medicaid	HIPP Website: www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ Email: hipp@dhcs.ca.gov	Phone: 916-445-8322 Fax: 916-440-5676
Colorado Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	Health First Colorado Website: healthfirstcolorado.com CHP+: hcpf.colorado.gov/child-health-plan-plus Health Insurance Buy-In Program (HIBI): mycohibi.com	Health First Colorado: 800-221-3943 Relay 711 CHP+: 800-359-1991 Relay 711 HIBI: 855-692-6442
Florida Medicaid	Website: www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	877-357-3268
Georgia Medicaid	GA HIPP: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp GA CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	GA HIPP: 678-564-1162, press 1 GA CHIPRA: 678-564-1162, press 2
Illinois Medicaid	Illinois Medicaid Premium Assistance Information Medicaid applicaiton website: abe.illinois.gov HIPP Email: mhfs.boc.hipp@illinois.gov	217-524-8268
Indiana Medicaid	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	Family & Social Services: 800-403-0864 Member Services: 800-457-4584
Iowa Medicaid and CHIP (Hawki)	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid Hawki: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	Medicaid: 800-338-8366 Hawki: 800-257-8563 HIPP: 888-346-9562
Kansas Medicaid	Website: kancare.ks.gov	Medicaid: 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	Medicaid website: ldh.la.gov/healthy-louisiana Medicaid email: healthy@la.gov LaHIPP website: www.ldh.la.gov/lahipp LaHIPP email: La.HIPP@la.gov LaHIPP Mailing Address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084	Medicaid: 888-342-6207 LaHIPP Phone: 877-697-6703 LaHIPP Fax: 888-716-9787
Maine Medicaid	Enrollment: www.mymaineconnection.gov/benefits/s/?language=en_US Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY: Maine Relay: 711
Massachusetts Medicaid and CHIP	Website: www.mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 TTY: 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	Website: dphhs.mt.gov/MontanaHealthcarePrograms/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	Website: dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Phone: 603-271-5218 Toll Free HIPP: 800-852-3345, ext. 15218
New Jersey Medicaid and CHIP	Medicaid: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ CHIP: njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY: 711
New York Medicaid	www.health.ny.gov/health_care/medicaid	800-541-2831
North Carolina Medicaid	www.medicaid.ncdhhs.gov	919-855-4100
North Dakota Medicaid	www.hhs.nd.gov/healthcare	844-854-4825

Oklahoma Medicaid and CHIP	www.insureoklahoma.org	888-365-3742
Oregon Medicaid	www.healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania Medicaid and CHIP	Medicaid: www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: www.dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	www.eohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte Share Line)
South Carolina Medicaid	www.scdhhs.gov	888-549-0820
South Dakota Medicaid	www.dss.sd.gov	888-828-0059
Texas Medicaid	www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP Website: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion Website: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: 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	Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select HIPP Website: coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington Medicaid	www.hca.wa.gov	800-562-3022
West Virginia Medicaid and CHIP	bms.wv.gov/mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 855-MyWVHIPP (855-699-8447)
Wisconsin Medicaid and CHIP	www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming Medicaid	www.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

2027 BENEFITS GUIDE