YOUR BENEFITS, BUILT AROUND YOU.

2027 Beck Benefits Guide

At The Beck Group, we are dedicated to supporting all aspects of your well-being, both at work and at home, and your benefits are a big part of that.

We are committed to creating a culture that prioritizes the well-being of our employees and their families by providing a comprehensive and competitive benefits package.

As always, we encourage you to prioritize your well-being by focusing on preventive care and the tools and resources available to help you live your best life.

Before making your benefit elections, take time to review this guide so you can make informed decisions about which plans are the right fit for you and your family. Remember to choose carefully, as the elections you make during Annual Enrollment cannot be changed until the following year unless you experience a qualifying life event.

Thank you for all that you do.

FRED PERPALL
Chief Executive Officer

Welcome to Your 2027 Benefits Guide

Use this Benefits Guide to learn about your benefit plan options.

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Meet Your Benefits Team

We all work together to make Beck a success, and our commitment to our employees extends to the benefits and resources available to support you. This guide is designed to help you understand and make the most of your benefits. As you review your options, know that your Benefits Team is here to answer questions and help you make informed decisions for you and your family.

ELIZABETH HAYNIE
Sr. Manager, Benefits & Wellbeing

PAULINA GUZMAN
Benefits Specialist

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.

Eligibility & Dependents

Beck offers a variety of benefits to support you and your family's needs. Choose options that cover what's important to your unique lifestyle.

ELIGIBILITY

If you are a biweekly employee who is regularly scheduled to work at least 30 hours per week, you are eligible to participate in the **medical, dental, vision, life and disability plans, and additional benefits**.

WHEN DOES COVERAGE BEGIN?

Medical, Dental & Vision: Effective on your date of hire. Premium payments begin accruing on your date of hire.

Life Insurance: Effective after 30 days of employment.

Accident, Critical Illness, Hospital Indemnity & Retirement Benefits: Effective on the first of the month following 30 days of employment.

Short-Term & Long-Term Disability: Effective after 90 days of employment.

Making Changes: You will not be able to change your benefits until the next enrollment period unless you experience a Qualifying Life Event.

ELIGIBLE DEPENDENTS

Dependents eligible for coverage in Beck's benefits plans include:

- Your legal spouse
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom legal guardianship has been awarded to you or your spouse)
- Dependent children 26 or more years old, unmarried and incapable of self-sustaining employment due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return (periodic certification may be required)

DEPENDENT VERIFICATION

Verification of dependent eligibility is required upon enrollment.

You have 31 days from your hire date to provide dependent verification. Failure to do so will result in termination of dependent benefits retro to your hire date. You will upload your dependent verification documents into Workday.

Examples of acceptable documents include marriage license or certificate, tax returns showing spouse information, and child birth certificates. If you have questions about this verification or are having trouble locating your documents, please contact the Beck Benefits Team ASAP.

Preparing for Enrollment

As a committed partner in your health, Beck absorbs a significant amount of your benefit costs. Your contributions for medical, dental and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Please note that employee contributions vary depending on level of coverage. Typically, the more coverage you have, the higher your portion.

You have 31 days from your hire date to submit your benefit elections online. Failure to submit within 31 days will result in automatic decline of all employee-paid benefit plans.

1. **STEP ONE: LOG IN TO WORKDAY**
   You can access Workday 24/7 from the Beck Portal > Workday. Log in to review benefit information and start your enrollment.

2. **STEP TWO: UPDATE PERSONAL INFORMATION**
   Ensure your address is correct, update emergency contacts and add your personal and spouse emails to enhance Beck's ability to notify you of important changes and keep you up to date.

3. **STEP THREE: REVIEW HEALTH NEEDS FOR YOU AND YOUR FAMILY**
   Think about upcoming healthcare needs, regular prescriptions you take and how often you visit doctors/specialists. Your healthcare utilization may help you determine which benefits are the best fit for you.

4. **STEP FOUR: REVIEW MEDICAL PLAN DETAILS**
   Take a look at plan details such as premium costs, deductibles, and out-of-pocket maximums to ensure you understand the benefits you will receive.

5. **STEP FIVE: CONSIDER YOUR HSA OR FSA**
   An HSA or FSA can help cover healthcare costs including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with reducing your taxable income and achieving your long-term financial goals.

6. **STEP SIX: UPLOAD DEPENDENT DOCUMENTATION**
   Upload supporting documentation for your dependents. This is required in order for them to receive benefits — including the Beck-paid spouse/child life insurance.

ENROLL EARLY!

Don't wait until the last minute! Submitting your benefit elections online as soon as you determine your plan choices will help avoid "catch-up" premium deductions on your paycheck.

KEEP YOUR SPOUSE INFORMED. The Beck Benefits Hub website was designed for spouses, with no login required. It's the home base for Beck benefits information and resources. Visit the link below or scan the QR code to get started.

beckgroupbenefits.com

When Life Changes, So Can Your Benefits!

WHAT ARE QUALIFYING LIFE EVENTS?

Most people know you can change your benefits when you start a new job or during Open Enrollment, but did you know that changes in your life may permit you to update your coverage at other points in the year? Qualifying Life Events (QLEs) determined by the IRS could allow you to enroll in health insurance or change your elections outside of Beck's annual Open Enrollment period.

COMMON QUALIFYING EVENTS INCLUDE:

- **Marital status changes** including marriage, divorce or legal separation
- **Dependent changes** through birth, adoption or loss of dependent status
- **Spouse employment changes** resulting in a gain or loss of coverage
- **Employment status changes** between full-time and part-time employment
- **Medicare or Medicaid eligibility** that affects your coverage options
- **Marketplace eligibility** that affects your coverage options
- **Address or location changes** that affect coverage eligibility

SOME LESSER-KNOWN QUALIFYING EVENTS MAY INCLUDE:

- Turning 26 and losing coverage through a parent's plan
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

WHEN A QUALIFYING LIFE EVENT OCCURS

When a Qualifying Life Event occurs, don't miss the opportunity to update your benefits! **You have 31 days from the event date to submit supporting documentation and submit changes to your coverage.** Keep in mind your change in coverage must be consistent with your change in status.

Questions regarding specific life events and your ability to request changes should be directed to the Beck Benefits Team.

Beneficiaries

Don't forget to review your beneficiaries! Beneficiaries of your life insurance policy/policies can be updated at any time, but a life event is a great opportunity to review them. Keeping your beneficiary information current helps ensure your benefits are distributed according to your wishes.

Make any beneficiary changes in Workday and via T. Rowe Price.

Wellness Programs

We Care. Caring is one of Beck's core values, and that extends to helping you and your family live healthier, fuller lives. We're committed to offering resources that make it easier for you to thrive, both now and in the years ahead.

VITALITY

Whether you'd like to become more active, improve your diet or simply maintain a healthy lifestyle, Vitality can help! It's easy to get started, and you will earn rewards along the way. Vitality is provided to all benefits-eligible employees and spouses covered on Beck's medical plan.

The Vitality program serves as a customized guide, much like a road map, to help you on your journey towards wellness.

Through the Vitality program you can:

- Earn points for healthy activities and redeem them for rewards
- Track your physical activity with fitness devices or gym/studio check-ins
- Set personalized health goals
- Qualify for up to $350 in reimbursement towards gym/workout memberships
- Engage in online education sessions and health assessments

As you complete healthy activities and goals you will earn Vitality Points™ while also earning Vitality Bucks®. Use your Vitality Bucks® to reward yourself for all your hard work, and redeem them for gift cards or fitness devices from retailers like: Amazon, iTunes, Nike, Polar, Garmin and Fitbit.

Visit Vitality at powerofvitality.com today to get started!

REAL APPEAL

Making small lifestyle improvements can bring you closer to being the best — the healthiest — you, you can be. You are not alone in improving your health, and sometimes you need the 1-to-1 support of a personal coach to start making changes. In addition to the tools and resources available to you through Vitality, Beck provides Real Appeal at no cost to employees and spouses covered on Beck's medical plan.

Real Appeal is a coach-based digital lifestyle change program that inspires healthy habits that last. Real Appeal combines the latest technology with ongoing coach support so you can make the changes that matter most — whether that's around eating, activity, sleep or stress. It's an approach shown to help participants lose weight, manage blood pressure, and reduce the risks of type 2 diabetes and heart disease.

Real Appeal features:

- Professional health coach
- Hundreds of on-demand fitness classes, nutrition tracking, meditations, and more
- Free digital smart scale and fitness bands mailed to your home
- Weekly online lessons to empower you
- Small group of participants to keep you engaged and motivated

See if Real Appeal is a good fit for you at realappeal.com.

CONFIDENTIALITY: The privacy and security of your personal information are extremely important to The Beck Group. Your personal health information is not shared with The Beck Group or UnitedHealthcare in an individually identifiable format. Health statistics Beck receives are aggregate. Personal health information is always treated privately and we take this very seriously.

Wellness Discounts on Medical Premiums

Just 5 numbers (blood pressure, HDL cholesterol, triglycerides, blood glucose and body mass index) account for more than 80% of preventable health conditions, and being aware of your current health status is important and could help you avoid serious health issues. To reward you for taking steps toward good health, you can qualify for a discount on your medical premiums.

Save thousands of dollars annually on your medical premium cost when you and your covered spouse complete the required steps by the annual deadline.

PARTICIPATION WELLNESS DISCOUNT

Get Rewarded for Taking Action

Complete a health screening to get a better understanding of your current overall health. The health screening consists of 25 health measures to give you a comprehensive look at your current health. The health screening can be done through our partnership with Quest Diagnostics lab or via health measures on file with your personal physician (as long as the results are dated within the acceptable range).

NOTE: the health screening completed through Quest Diagnostics is at no cost to you. There may be costs associated with completing the health screening with your personal physician. Please contact the Beck Benefits Team for more information.

If it is unreasonably difficult for you and/or your eligible spouse to complete a health screening due to a medical condition, please contact the Beck Benefits Team at BeWell@beckgroup.com to discuss alternatives.

For additional wellness discount information and eligibility period dates, please contact the Beck Benefits Team.

HEALTH RESULTS DISCOUNT

Get Rewarded For Your Good Health

By maintaining or improving your health measures, you have an opportunity to earn a deeper discount on your medical premiums.

Your first year health screening forms your baseline health measures and will be what your second year health measures are compared to. You will earn the health results discount if your second year health screening shows at least 3 of the following 5 measures in a healthy range, or, improvement of at least 5% compared to your baseline measures.

- Blood Pressure
- Triglycerides
- HDL Cholesterol
- Blood Glucose or A1C
- Body Mass Index or Waist Circumference

Your second year of completing a health screening marks your eligibility for earning the Health Results Wellness Discount.

If you do not complete your first year health screening, you will not have a first-year baseline for comparison and will not be eligible for the Health Results Wellness Discount.

If you think you may be unable to meet the healthy range for a particular measure (ex. pregnancy, family history, etc.), you may qualify for an alternative. For more information, please contact BeWell@beckgroup.com.

HOW MUCH CAN YOU SAVE?

MEDICAL TIER ENROLLMENT	PARTICIPATION WELLNESS DISCOUNT	HEALTH RESULTS WELLNESS DISCOUNT
EMPLOYEE ONLY	Up to $1,612	Up to $2,470
EMPLOYEE + CHILD(REN)	Up to $1,612	Up to $2,470
EMPLOYEE + SPOUSE	Up to $3,250	Up to $4,914
EMPLOYEE + FAMILY	Up to $3,250	Up to $4,914

Note: Savings shown annually over 26 pay periods

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Tobacco/Nicotine Cessation Program

Because of the risks to your health, and the potential for significant health improvement by quitting, Beck is pleased to offer the Quit for Life tobacco/nicotine cessation program from UnitedHealthcare to all employees and spouses covered on Beck's medical plan.

PROGRAM HIGHLIGHTS

- **Support from a Quit Coach:** Five (5) scheduled calls with a coach, plus unlimited additional calls for support if you need it. The Quit Coaches will help you create a realistic quit plan, offer quit tips, discuss ways to overcome cravings and provide motivation. Quit Coaches have specialty degrees, previous experience in cessation programs and are multilingual.
- **Quit-Tobacco Medications:** Quit Coaches will help you decide if prescription or over-the-counter medications are a right fit for you, and they can arrange FREE nicotine-replacement therapy (like patches or gum).
- **Quit Guide:** Receive a comprehensive booklet that breaks down the 5 steps to quitting.
- **Text Messages:** Get timely tips, reminders and motivation to help you control cravings and stay on track.
- **Members-Only Website:** You will have exclusive online access to track your progress and connect with others trying to quit.

The Quit for Life program is available at any time to all Beck employees and spouses covered on Beck's medical plan as a resource to use should they wish to quit tobacco/nicotine.

ENROLL ONLINE

- Visit quitnow.net and click "Get Started."
- Fill in the responses on the Program Check page: "The Beck Group" and "My Insurance is not listed."
- Click "Continue with employer" on the next page.
- Enter your name, DOB, and email address.
- On the next page, enter your medical ID number (shown on your medical ID card) + Beck's Group Number (Surest plan: 78800604; HSA plan: 705241).
- Create your password and get started.

ENROLL BY PHONE

- Call 866-QUIT-4-LIFE
- Be prepared with your Subscriber ID and Policy Number (see above)

TOBACCO/NICOTINE SURCHARGE

To encourage tobacco/nicotine users to take the first step in quitting, a tobacco/nicotine surcharge will be applied to employees and spouses enrolled in the Beck's medical plan who meet the definition of tobacco/nicotine user.

The tobacco/nicotine surcharge can be avoided if the tobacco/nicotine user(s) complete all 5 calls in the Quit for Life cessation program by the annual deadline.

Proof of quitting tobacco/nicotine is not required in order to avoid the surcharge. If you are a new hire, you are given a grace period without the surcharge until the next available annual deadline (for surcharge application the following year).

The tobacco/nicotine surcharge is $30 per pay period and will be applied starting the first pay period of the year following the annual deadline.

During annual Benefits Open Enrollment, employees are asked to identify if they, or their spouse enrolled in medical, meet the tobacco/nicotine user definition and sign an affidavit attesting to the truthfulness of the tobacco/nicotine election. Tobacco/nicotine users who have completed the Quit for Life program by the stated deadline will avoid the tobacco/nicotine surcharge the following plan year.

Tobacco/Nicotine User Definition: Someone who has used tobacco/nicotine products* on average four times or more per week within the last six months, regardless of the location (this includes company events, socially, at home, etc.)

*Tobacco/nicotine products include cigarettes, cigars, smokeless tobacco, chewing tobacco, hookahs, vapor pipes, pipes and e-cigarettes.

Medical Benefits

Medical benefits are provided through UnitedHealthcare and Surest. Choose the plan that works best for your life. Consider the premiums, out-of-pocket costs and claim cost experience for each plan. Keep in mind your choice is effective for the entire 2027 plan year unless you have a Qualifying Life Event.

MEDICAL PREMIUMS

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your biweekly contributions. For information on how to achieve the wellness rates, review the Wellness Programs & Discounts section of this guide.

BIWEEKLY CONTRIBUTIONS

		EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
HEALTH SAVINGS ACCOUNT MEDICAL PLAN	HEALTH RESULTS WELLNESS RATE	$18	$125	$139	$186
	PARTICIPATION WELLNESS RATE	$51	$189	$172	$250
	NON-WELLNESS RATE	$113	$314	$234	$375
SUREST MEDICAL PLAN	HEALTH RESULTS RATE DISCOUNT	$59	$227	$220	$313
	PARTICIPATION WELLNESS RATE	$92	$291	$253	$377
	NON-WELLNESS RATE	$154	$416	$315	$502

HOW TO FIND A PROVIDER

If you are enrolled in the Health Savings Account Medical Plan, visit myuhc.com and log in to your account or call Customer Care at 866-844-4864 for a current list of UnitedHealthcare network providers. You can also download the UnitedHealthcare app. If you are enrolled in the Surest Medical Plan, the provider network is the same as the UnitedHealthcare network. You can search providers and costs by visiting benefits.surest.com or calling Customer Care at 866-683-6440 for assistance. You can also search providers and costs in the Surest app.

NO-COST PREVENTIVE CARE.

Most preventive care offered by an in-network physician is covered at 100% on both plans.

Medical Plan Summary

This chart summarizes the 2027 medical coverage provided by UnitedHealthcare and Surest. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	HEALTH SAVINGS MEDICAL PLAN		SUREST MEDICAL PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE				
INDIVIDUAL	$2,500†	$8,000	None	None
FAMILY	$5,000	$16,000	None	None
ANNUAL OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)				
INDIVIDUAL	$5,000	$20,000	$5,500	$11,000
FAMILY	$10,000	$40,000	$11,000	$22,000
COPAYS/COINSURANCE				
PREVENTIVE CARE	100%	Not covered	100%	$205
PRIMARY CARE	80%*	60%*	$25-$135	$220
SPECIALIST SERVICES	80%*	60%*	$25-$135	$220
MENTAL HEALTH CARE	100%*	60%*	$25-$135	$390 copay
URGENT CARE	80%*	60%*	$80 copay	$210 copay
DIAGNOSTIC CARE	80%*	60%*	$0 copay	$0 copay
EMERGENCY ROOM	80%*	80%*	$900 copay	$900 copay

* After deductible is met
† Applies to Employee Only tier coverage only

Surest Medical Plan Deductible & Out-of-Pocket Max: The Surest Medical Plan does **not have** deductibles to meet or coinsurance to calculate. You pay flat copay rates for all services covered on the plan. The copays count toward your out-of-pocket max. Once you meet your out-of-pocket max, the plan will pay 100% of your claim costs for the rest of the plan year. Be sure to register your Surest account and download the app to check costs up front and avoid surprises.

Health Savings Account Medical Plan Deductible and Out-of-Pocket Max: The HSA Medical Plan family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan. The out-of-pocket maximum works differently — once a participant meets the individual out-of-pocket max amount, 100% of their claim costs are paid by the plan for the rest of the plan year.

OUR PLANS ARE SELF-INSURED

Our medical and Rx plans are self-insured, which means that Beck bears the financial risk of the plan and pays any claim cost not paid by you. Rather than paying insurance premiums to an insurance carrier as with fully insured plans, the company pays fixed costs for using the insurance carrier's network of physicians and variable costs for the members' claims. Self-insured plans allow for more control and freedom in plan design. Together, Beck and employees share the cost for healthcare.

Being a smart consumer of our healthcare (ex. using in-network providers, comparing prescription costs, evaluating treatment options, advocating for yourself by asking your doctor questions and engaging in Beck's wellness programs) can help to manage claim costs for you personally and for Beck.

Preventive Care

Both of Beck's medical plans cover a set of preventive services — at no cost to you!

Screenings, check-ups and vaccines that are deemed to be preventive care per UnitedHealthcare based on your age and gender are paid at 100%. Preventive care is an important part of managing your health and being aware of potential medical issues. Keep up to date with your primary care physician to save time and money and keep yourself healthier in the long run. Visit uhc.com/health-and-wellness/preventive-care and enter your age and gender to determine your covered preventive care and print a list of services for discussion with your physician.

Some preventive services that may be covered include:*

- **Annual wellness services** including checkups, physicals and immunizations
- **Health screenings** for blood pressure, cancer, depression, obesity and diabetes
- **Pediatric screenings** for hearing, vision, obesity and developmental disorders
- **Maternity support** including anemia screenings, breastfeeding support and breast pumps
- **Iron supplements** for at-risk children ages 6 to 12 months

ANNUAL CANCER SCREENINGS

Getting regularly screened for cancer is important and cost shouldn't prevent you from getting screened. Both of Beck's medical plans cover one cancer screening with an in-network provider each year at no-cost to you. This includes mammogram, colonoscopy (regardless of prior findings), prostate & cervical cancer screenings.

* Take advantage of these covered services. However, remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. This means if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs.

How to Pick a Plan

Which plan is right for you? When deciding, consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

HOW DOES IT WORK?

The Health Savings Account Plan:

- You'll pay less in premiums out of your paycheck.
- You'll pay for the full in-network cost of non-preventive medical services until you reach your deductible.
- You can also use a Health Savings Account in conjunction, which provides a safety net for unexpected medical costs and tax advantages.
- If you expect to mostly use preventive care (which is covered), this plan may be for you.

The Surest Plan:

- You'll pay more in premiums out of your paycheck.
- You're able to choose from the UnitedHealthcare network of providers who offer a fixed copay for services.
- If you expect to need more medical care this year or you have a chronic illness, this plan may be the right choice for you for ease of use and spreading costs out more evenly.

Cancer Support

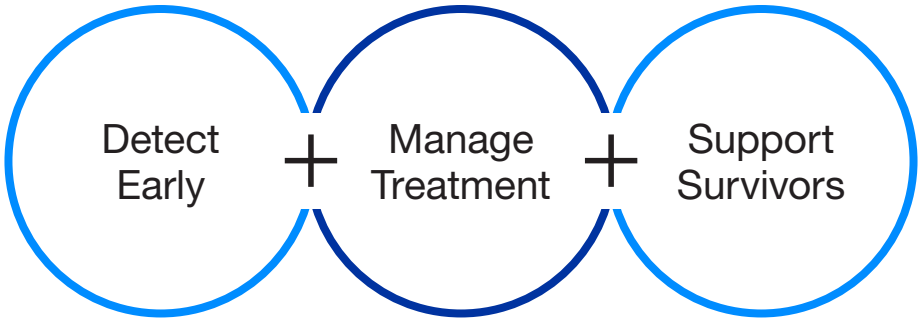
NEW BENEFIT FOR 2027

Cancer care and support for every step. Beginning in January 2027, employees will have access to Color, a new benefit that simplifies cancer screening, treatment support, and ongoing care. Whether you're focused on prevention, navigating a diagnosis, or supporting a loved one with cancer, Color is here to support you every step of the way.

SUPPORT THROUGHOUT THE CANCER JOURNEY

Color provides personalized guidance and resources for prevention, treatment, and survivorship, including:

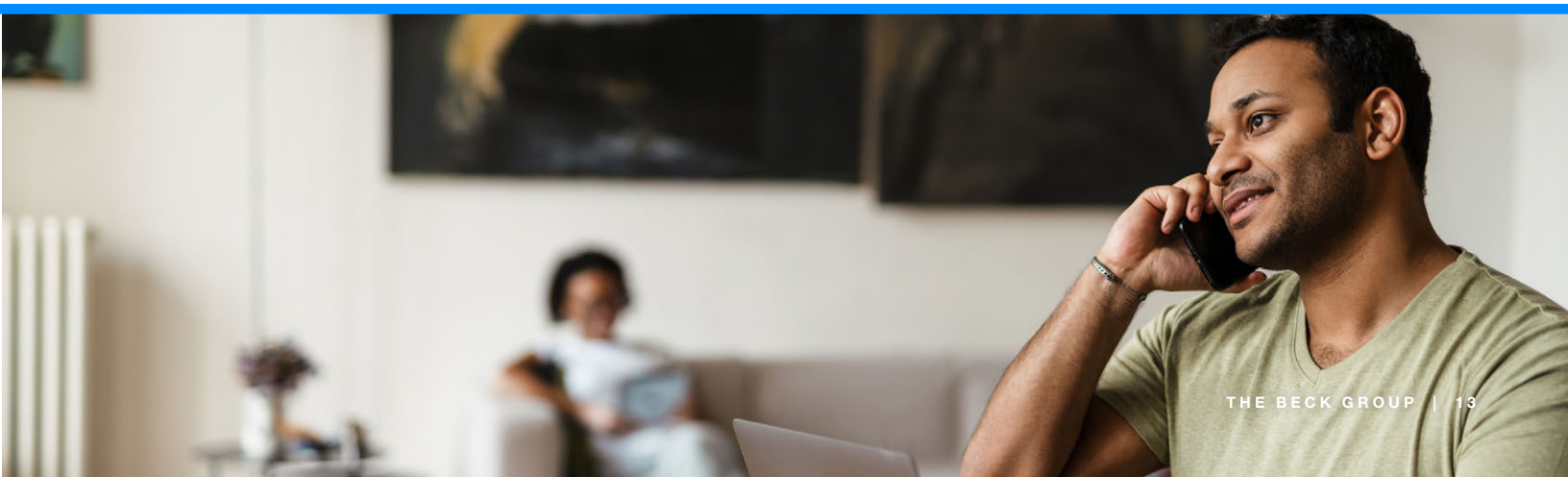
- **At-home cancer screenings:** Access free at-home screenings for colon, cervical, prostate, and skin cancer, along with genetic testing and counseling for individuals at higher risk.
- **Help scheduling screenings:** Get assistance finding a provider and scheduling in-person screenings, including mammograms and colonoscopies.
- **Care and treatment guidance:** Receive 24/7 symptom and prescription support, second opinions, clinical trial guidance, and access to Color's expert oncology network.
- **A dedicated care team:** Connect with oncologists, nurses, dietitians, genetic counselors, and advocates seven days a week.
- **Peer support:** Join dedicated support groups for patients, survivors, and those supporting someone with cancer. Groups are led by coaches trained in the emotional impact of cancer.



SUPPORT WHEN YOU NEED IT MOST

Color can help whether you are:

- Taking steps to prevent or detect cancer early
- Navigating a new or existing diagnosis
- Managing treatment or symptoms
- Moving forward after treatment
- Supporting a family member or loved one
- To get started, visit color.com/beckgroup



Pharmacy Benefits

PRESCRIPTION DRUG COVERAGE FOR MEDICAL PLANS

Our Prescription Drug Program is coordinated through OptumRx via UnitedHealthcare. That means you will only have one ID card for both medical care and prescriptions. Your cost for prescriptions is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, or Non-Preferred.

	HEALTH SAVINGS MEDICAL PLAN		SUREST MEDICAL PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY)				
GENERIC	80%*	60%*	$20 copay	Not covered
PREFERRED	80%*	60%*	$60 copay	Not covered
NON-PREFERRED	80%*	60%*	$120 copay	Not covered
MAIL ORDER RX (90-DAY SUPPLY)				
GENERIC	80%*	Not covered	$50 copay	Not covered
PREFERRED	80%*	Not covered	$150 copay	Not covered
NON-PREFERRED	80%*	Not covered	$300 copay	Not covered

* After deductible is met

GENERIC DRUGS

Looking to save money on medication costs? You've most likely heard that generic prescription drugs are a more affordable option, so here's the skinny: **Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety and strength.**

Because they are the same medicine, generic drugs are just as effective as brand-name drugs and undergo the same rigid FDA standards. But on average, **a generic version costs 80% to 85% less than the brand-name equivalent**.

MAIL ORDER PRESCRIPTION BENEFITS

Another way to increase your health plan value is the management of your monthly and ongoing medications, like those for high blood pressure or diabetes. Do your research and check to see if mail ordering your prescriptions can work for you and save you money.

PRICE CHECK

Checking the cost of your medication before you visit the pharmacy can help you stay informed and avoid unexpected costs.

Compare medication costs before filling a prescription. Log in to your medical plan account to view prescription pricing and compare medication costs at participating pharmacies near you.

Health Savings Medical Plan

- Website: myuhc.com
- **Scan the QR code** to download the UHC app

Surest Medical Plan

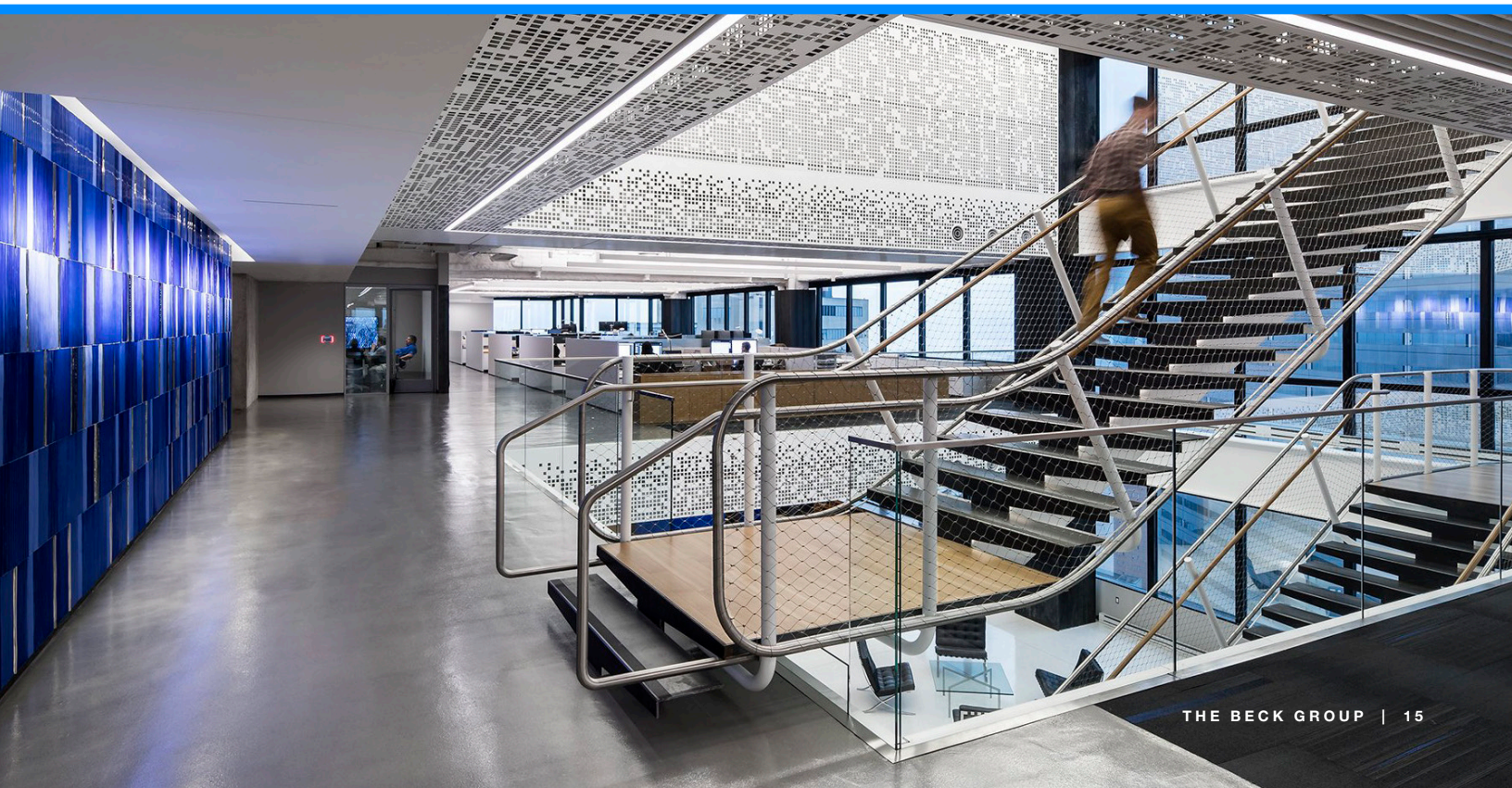
- Website: benefits.surest.com
- **Scan the QR code** to download the Surest app

COMPARE COSTS BEFORE YOU FILL! Websites/apps such as GoodRx and RxSaver let you find discounts on prescriptions (often most helpful with expensive or brand prescriptions). If you use these discounts, make sure to check the price against the cost through your insurance to get the best deal. Note that these discounts can't be combined with your benefit plan's coverage. As a result, if you choose to use a discount card from websites/apps such as GoodRx or RxSaver, the amount you pay will not count toward your deductible or out-of-pocket maximum under the benefit plan.

Managing Medical Costs

KNOW BEFORE YOU GO: PAYING FOR SERVICES

DEDUCTIBLE: You pay first	The amount you pay for covered services and prescriptions before the plan begins paying its share. **Applies to services and prescriptions on the HSA Medical Plan only.**	**YOU PAY 100%** Before deductible is met
COPAY: Set dollar amount	A set amount you pay for covered services and prescriptions when you receive care, and the plan pays the rest. **Applies to services and prescriptions on the Surest Medical Plan only.**	**YOU PAY A SET AMOUNT** Plan pays the rest
COINSURANCE: You share the cost	After meeting your deductible, you pay a percentage of the cost and the plan pays the rest. **Applies to services and prescriptions on the HSA Medical Plan only.**	**IN-NETWORK: YOU PAY 20% // PLAN PAYS 80%** After deductible is met, until out-of-pocket maximum is met
OUT-OF-POCKET MAXIMUM: Maximum you'll pay	The most you'll pay during the plan year. After you reach it, the plan pays 100% of covered costs.	**PLAN PAYS 100% THROUGH END OF PLAN YEAR** Once out-of-pocket maximum is met



RISING COSTS OF HEALTHCARE

The cost of healthcare in the U.S. has been steadily growing each year. Why? Some of the factors include escalating prescription drug costs, increased demand for care (resulting in higher prices for premiums and prescription drugs) and new expensive medical technology. The Beck Group wants to help keep you healthy, so we do what we can to keep your healthcare costs reasonable. Make sure you're informed about your options so you can make the best healthcare choices for you and your family. Placing an importance on preventive care, making healthy choices, and managing costs will help keep your health—and wallet—in control in the long run.

HEALTHCARE COST TOOLS

Your healthcare spending is in your control. There are many provider choices and varying costs for services. Prices for medications can vary greatly from generic to brand or specialty, and can even vary by pharmacy. How do you decide where to go? Healthcare cost transparency tools are online services available through UnitedHealthcare and Surest that allow consumers to compare costs for medical services, from prescriptions to major surgeries, to make choices easier. Visit myuhc.com (HSA Medical Plan) or benefits.surest.com (Surest Medical Plan) and log in to your account to search for costs before receiving care.

- **HSA Medical Plan (UnitedHealthcare):** Log in to myuhc.com and navigate to "Find Care", then select the type of visit or service you are looking for. Choose a provider and click on the "cost" tab of their profile to view the cost of their care. To price medications, navigate to "Pharmacies & Prescription" at the top, then select "Drug Pricing."

- **Surest Medical Plan:** Log in to benefits.surest.com and simply enter the type of care, condition or prescription you are looking for in order to review options and costs. You can also use the "quick search" buttons.

IN-NETWORK & OUT-OF-NETWORK

The term "in-network" refers to a group of doctors, hospitals and clinics that have negotiated rates with UnitedHealthcare. You will receive the greatest cost efficiency by visiting in-network providers. You may search for in-network providers, pharmacies & facilities at myuhc.com (HSA Medical Plan) or benefits.surest.com (Surest Medical Plan). When visiting a provider for the first time, it's also recommended that you ask "are you in-network for UnitedHealthcare/Surest?". We recognize there may be times when you have no choice but to use an out-of-network provider. If it is a true emergency, a trip to the ER is always covered at in-network rates.

COST INFORMATION ON THE GO

Download the UnitedHealthcare App (HSA Medical Plan) or the Surest app (Surest Medical Plan) to gain access to all the helpful tools from the UnitedHealthcare or Surest websites on the go! You can also view/print your medical ID card!

TIPS FOR CONTROLLING YOUR COSTS

1. Check network status of your provider before your visit.
2. If your provider refers you to another physician or treatment center (ex. MRI), use your app to check network status and compare costs before you go.
3. Price medications your physician prescribes before you leave their office. This gives you the opportunity to ask about an alternative if the cost is too high.
4. Always ask your provider to review all your treatment options and ensure you're comfortable with your care plan.
5. Consider getting a second opinion through 2ndMD, a free service for Beck medical plan enrollees, before scheduling surgery. Visit 2nd.md to learn more.

Know Before You Go!

The cost of an MRI can vary between $300 and $3,000 — even in-network. Use UnitedHealthcare's or Surest's cost estimator to shop costs before you get care.

Where To Go For Care

KNOW BEFORE YOU GO

Not all care costs the same—knowing where to go can help you avoid paying more than you need to. Choosing the right care option can save you money and keep our health plan costs down for everyone. Use this guide to find the best option for your situation and get the care you need, when you need it.

	PRIMARY CARE	VIRTUAL PRIMARY CARE	URGENT CARE	EMERGENCY ROOM
BEST FOR	Routine care	Minor illnesses from home	Non-emergency injuries	Life-threatening emergencies
CARE PROVIDED*	• Routine checkups • Immunizations • Preventive services • General health management	• Cold & flu symptoms • Allergies • Bronchitis • Urinary tract infection • Sinus problems	• Strains, sprains • Minor broken bones (e.g., finger) • Minor infections • Minor burns • X-rays	• Heavy bleeding • Chest pain • Major burns • Spinal injuries • Severe head injury • Broken bones
COST**	Often requires a copay and/or coinsurance	$0 copay – Surest $0 copay – HSA Medical Plan	Often requires a higher copay/cost than an office visit	Often requires a much higher copay/cost than an office visit
APPOINTMENT NEEDED?	Usually	No	No	No
WAIT TIME**	Scheduled	Usually immediate	Moderate	Often longest

* This is a sample list of services and may not be all-inclusive.
** Costs and time information represent averages only and are not tied to a specific condition or treatment.

Do Your Homework!

What may seem like an urgent care center could actually be a standalone ER. **These newer facilities come with a higher price tag,** so ask for clarification if the word “emergency” appears in the company name.

Mental Wellbeing Benefits

MEDICAL PLAN BENEFITS

Behavioral health benefits, such as mental health and substance misuse benefits, are available for employees and family members enrolled in Beck's medical plan. The cost for an office visit with a mental health provider depends on the medical plan you are enrolled in.

- **Surest Medical Plan:** $25 copay (in-network)
- **HSA Medical Plan:** $0 after annual plan deductible is met (in-network). Provider office visit costs will vary. Log in to myuhc.com to check provider costs.

To locate an in-network behavioral health provider:

- **Surest plan members:** log in to benefits.surest.com, click on "Find Care" and search for "Behavioral Health Therapy."
- **HSA plan members:** log in to myuhc.com and click on "Find Care & Costs" and then "Behavioral Care Providers."

IMPORTANT! When using out-of-network providers, pre-authorization is required prior to receiving mental health benefits. Failure to do so will result in a reduction of benefit coverage. Call the number on the back of your medical ID card and ask to speak with someone about pre-authorization for out-of-network mental health providers.

VIRTUAL CARE FOR MENTAL HEALTH

If you are struggling with issues like stress, depression, anxiety or just want to talk to someone, you can reach a therapist or psychologist from the comfort of your own home. A virtual visit lets you see and talk to a therapist or psychologist from your mobile device or computer without an appointment. You can elect to meet right away or at a later time. If you find a therapist you like, you can set up recurring appointments with them.

For more information on virtual visits, refer to the Virtual Visits section of this guide.

TALKSPACE

Talkspace is an in-network provider on both Beck medical plans. You will be matched with your own licensed, verified and background-checked therapist. Schedule regular times to talk, send unlimited messages, or set up a video chat. Rates are paid weekly. Couples and teen therapists available.

- **Surest Medical Plan:** $25 copay
- **HSA Medical Plan:** $0 after annual plan deductible is met

Visit talkspace.com and select Optum for insurance.

GALILEO HEALTH

Galileo Health connects you licensed clinicians by phone or video — no waiting room, no referral needed. It's your go-to medical practice for just about any condition or concern, including mental health support.

- **Surest Medical Plan:** $0 copay
- **HSA Medical Plan:** $0 cost (no deductible needed)

To get started, log in to your UnitedHealthcare or Surest account, click on Find Care > Virtual Care/Visit > Virtual Primary Care.

CALM HEALTH

Employees and spouses enrolled in Beck's medical plans have free access to Calm Health. The Calm Health app brings you a library of support — including mindfulness content and programs created by psychologists — for a variety of health experiences and life stages.

- Find tools, music and sounds to help you meditate and improve focus
- Join self-guided self-care programs, and track your progress along the way
- Access support to help you strengthen your mind-body connection and wellbeing

To get started, scan the QR code for the medical plan in which you are enrolled and follow the prompts to access Calm Health. Contact BeWell@beckgroup.com if you have issues setting up your Calm Health account.

HSA Medical Plan

Surest Medical Plan

Support for Your Mental Wellbeing

Beck's BeWell benefit, offered through Magellan, provides free support to you and your entire household. Take advantage of these support services.

BETTERHELP

Mental health affects every aspect of our lives, and it's important to pay attention to your wellbeing. Through Beck's BeWell benefit, in partnership with Magellan, you have access to confidential virtual therapy, provided by BetterHelp. You have 8 free sessions per issue, per year. Counseling is available for your entire household — individuals, couples, and teens (with parental consent and in accordance with applicable law and clinical appropriateness).

You can choose from one of four modalities:

- Text messaging exchange over a week
- Live phone session
- Live video session
- Live chat session

You can also toggle between modalities while in therapy. For example, you can choose to chat with a therapist online one week and schedule a video session the next week.

Go to BetterHelp.com/Magellan and click on "Get Started." (Employer Name: The Beck Group).

COUNSELING & WELLBEING COACHING

No matter where you are on your journey, there are times when a little help can go a long way toward achieving your goals. From checking off daily tasks to working on more complex issues, Beck's partnership with Magellan offers you counseling & life coach services to help make your life a little easier.

Key features:

- Provided at no cost to you and the members of your entire household
- Up to 8 counseling sessions per issue, per year
- Up to 6 wellbeing coaching sessions per year
- Completely confidential service provided by a third party

Counseling:

Access a nationwide network of licensed counselors for support with challenges such as stress, anxiety, grief, substance misuse, relationships, parenting, and more. Counseling is confidential and available in-person, by text message, chat, phone, or video conference.

Wellbeing Coaching:

Define and reach your goals with the support of a coach. Coaches can help with personal improvement, healthy eating, weight loss, and more. Coaches are available by phone or video.

Visit member.magellanhealthcare.com to browse all of the services available (Organization Name: The Beck Group).

Virtual Care

Whether you're dealing with a sudden illness, managing an ongoing health concern, or simply have a health question, Beck's virtual care resources connect you with a provider quickly. Get the care you need, wherever you are.

GETTING STARTED WITH GALILEO

Galileo is Beck's virtual care provider. Get unlimited, 24/7 access to care through the Galileo mobile app. Whether you need help with a sudden illness, ongoing care, or everyday health questions, Galileo's team of providers is available anytime, anywhere.

What It Costs:

Cost depends on the medical plan you choose:

- $0 copay for virtual primary care/urgent care and virtual behavioral health services on both medical plans.
- $0 to $135 copay for specialist visits and consultations on both medical plans.

Use Galileo When:

- Your doctor is not available
- You need care after hours
- You become ill while traveling
- You have a health question and want guidance
- You need support managing an ongoing condition
- You want to avoid an unnecessary trip to the doctor's office
- You need care for a new illness or injury
- You have questions about women's health or preventive care
- You want to establish or connect with a primary care provider

HOW GALILEO WORKS

Download the Galileo app and create your account. You can message providers, receive treatment recommendations, manage chronic conditions, and access care whenever and wherever you need it, all from one place.

Good For:

- Bladder infection/urinary tract infection
- Cold/flu or stomach ache
- Pink eye or rash
- Sore throat or bronchitis
- Back, joint or muscle pain
- Post-partum depression
- Trauma and/or loss
- Depression, anxiety and/or stress
- Ongoing condition management
- Acne treatment
- Hair loss treatment
- Birth control and contraceptive care
- Stomach bug/gastroenteritis

Not Good For:

- Anything requiring an exam or test
- Complex or chronic conditions
- Injuries requiring bandaging or sprains/broken bones
- Emergency care

SIGN UP TODAY!

Scan the QR code to download the Galileo app and create your account. Access virtual care anytime, anywhere.

galileo

Sword Health

Virtual support for back, joint, and muscle pain or pelvic floor health. Sword Health is a no-cost digital MSK program that helps prevent and treat pain from home. Personalized exercise plans, motion-tracking technology, and clinician support can improve mobility, reduce pain, and support long-term recovery.

Access Sword Health through your UnitedHealthcare or Surest account.

Dental Benefits

Brushing your teeth and flossing are great, but don't forget to visit the dentist too! Beck offers affordable plan options for routine care and beyond. Coverage is available from Cigna Dental.

NETWORK DENTISTS

If you use an out-of-network dentist, your out-of-pocket costs may be higher. Out-of-network services are reimbursed based on Cigna's Maximum Reimbursable Charge (MRC). The MRC is calculated at the 90th percentile of provider allowed amounts in the geographic area. An out-of-network dentist may balance bill you for charges above the MRC. Beck's dental plan uses Cigna Total DPPO network. To find a network dentist, visit Cigna Dental at hcpdirectory.cigna.com.

Prevent surprise bills and confirm the network status of your provider before getting care by asking them "Are you in-network with Cigna's Total DPPO Network?".

DENTAL PREMIUMS

Premium contributions for dental are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your biweekly premium.

DENTAL PLAN SUMMARY

The chart below summarizes the 2027 dental benefits available through Cigna Dental. In-network providers offer the highest level of coverage, allowing you to get the most value from your benefits. Covered services include preventive care, basic and major services, and orthodontia.

	CIGNA DENTAL PLAN	
BIWEEKLY CONTRIBUTIONS		
EMPLOYEE ONLY	$16	
EMPLOYEE + SPOUSE	$27	
EMPLOYEE + CHILD(REN)	$25	
EMPLOYEE + FAMILY	$42	
	IN-NETWORK	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE		
INDIVIDUAL	$50	$50
FAMILY	$150	$150
ANNUAL MAXIMUM		
PER PERSON	$2,000	$2,000
COVERED SERVICES		
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers, Panoramic X-rays	100% In-network	100% of MRC*
BASIC SERVICES Full Mouth X-rays, Fillings, Oral Surgery, Simple Extractions	80% after deductible	80% of MRC* after deductible
MAJOR SERVICES Complex Extractions, Denture Adjustments and Repairs, Root Canal Therapy, Periodontics, Crowns, Dentures, Bridges	50% after deductible	50% of MRC* after deductible
ORTHODONTICS Dependent Child(ren) and Adults	50%; no deductible	50% of MRC*; no deductible; subject to lifetime maximum
ORTHODONTIC LIFETIME MAXIMUM	$2,000	$2,000

*Out-of-network reimbursement is based on Cigna's Maximum Reimbursable Charge (MRC). You may be responsible for charges above the MRC.

Vision Benefits

Don't wear glasses? Even **you** shouldn't skip an annual eye exam! Beck provides you and your family access to quality vision care with a comprehensive vision benefit through EyeMed.

EYEMED VISION PLAN

BIWEEKLY CONTRIBUTIONS	
EMPLOYEE ONLY	$4.04
EMPLOYEE + SPOUSE	$7.67
EMPLOYEE + CHILD(REN)	$8.07
EMPLOYEE + FAMILY	$11.87

	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
EXAMS			
COPAY	$0 copay	Reimbursed up to $40	Once every calendar year
RETINAL IMAGING	$0 copay	Reimbursed up to $20	
LENSES			
SINGLE VISION	$25 copay	Reimbursed up to $30	Once every calendar year
BIFOCAL	$25 copay	Reimbursed up to $50	
TRIFOCAL	$25 copay	Reimbursed up to $70	
LENTICULAR	$25 copay	Reimbursed up to $70	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING & EVALUATION*	Standard: $55 copay; Premium: 10% off retail price	Not covered	Once every calendar year
ELECTIVE	$200 allowance; 15% off balance Once every calendar year over $200	Reimbursed up to $150	
MEDICALLY NECESSARY	100%	Reimbursed up to $300	
FRAMES			
COPAY	$0 copay	Reimbursed up to $40	Once every calendar year
ALLOWANCE	$200 allowance; 20% discount on remaining balance; 40% off purchase of additional complete pair(s) of prescription eyeglasses	Reimbursed up to $105	

*Fitting and Evaluation fee applied to contact lens allowance.

SHOP ONLINE

Visit glasses.com to shop thousands of name-brand frames and use the virtual try-on tool to see how styles look from any angle. Upload a picture of your prescription and visit any LensCrafters location for adjustments as needed. Glasses.com is in-network with EyeMed.

DISCOUNTS ON HEARING AIDS

Through EyeMed's partnership with Amplifon, you get 40% off hearing exams, discounted pricing on hearing aids, low price guarantees, 60-day hearing aid trial, free batteries for 2 years and a 3-year warranty, plus loss and damage coverage.

PRESCRIPTION SAFETY GLASSES: Get prescription safety glasses at a discounted price and up to $85.00 paid by Beck. Enrollment in Beck's vision plan is **NOT** required. Contact BeWell@beckgroup.com for details.

Health Savings Account

Your Health Savings Account (HSA) can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered on your medical plan. If you are not currently enrolled in Beck's HSA Medical Plan but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

Optum will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors visits, eye exams, prescriptions, laser eye surgery, menstrual products, over-the-counter medications, and more. Visit IRS Publication 502 on irs.gov for a complete list.

Paycheck Contributions (Pre-tax)

Employer Contributions (Pre-tax)

HSA

Tax-free Payments
(for qualified medical expenses)

Unused funds roll over annually

ELIGIBILITY

You are eligible to contribute to an HSA through Beck if:

- You are enrolled in Beck's Health Savings Account Medical Plan
- Your spouse does not have a Health Care Flexible Spending Account or Health Reimbursement Arrangement
- You are not eligible to be claimed as a dependent on someone else's tax return
- You are not enrolled in TRICARE or Medicare
- You are not turning 65 or older this year
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care (service-related care is not taken into consideration)

YOUR MONEY. YOUR ACCOUNT.

Your HSA is a personal bank account that you own and administer. It's up to you how much you contribute, when to use the money for eligible expenses, and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year-over-year to use in retirement. HSA funds are also portable if you change jobs. There are no vesting requirements or forfeiture provisions.

Because this is a personal account, it is your responsibility to ensure that healthcare costs paid with this account are eligible per the IRS. The amount you have available to spend with your debit card is equal to the fund balance in your account. If you don't have enough available funds in your account, you may use another method of payment and reimburse yourself at a later date, once enough funds have been added.

Optum will issue you a debit card, giving you direct access to your account balance. Use your debit card to pay for eligible expenses.

HOW TO ENROLL

To enroll in the company-sponsored HSA, you must elect the HSA Medical Plan with Beck. When making your benefit elections, **you must also enroll in Optum's HSA bank account**. You can elect to contribute money on a pre-tax basis or set the contribution amount to $0 — you will still receive Beck's contribution. You may change your contribution amount at any time throughout the year to reflect changes in your financial or healthcare needs.

If you don't have an existing HSA bank account with Optum Bank, Beck will set one up for you. If you already have an account with Optum Bank, that existing account will be utilized.

PLAN. SPEND. SAVE.

Contributions to an HSA can be made through payroll deductions on a pre-tax basis (account must be with Optum Bank in order to set up payroll contributions and receive Beck's contribution). **The money in this account (including interest and investment earnings) grows tax-free.** When the funds are used for qualified medical expenses, they are spent tax-free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

HSA FUNDING LIMITS

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2027, contributions (which include any employer contribution) are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$4,500
FAMILY	$9,000
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

Beck provides a one-time lump-sum contribution to your HSA based on the quarter in which coverage becomes effective. You do not have to contribute your own money to receive Beck's contribution.

The contribution is deposited directly into your HSA and can be used immediately for eligible expenses or saved for future healthcare needs.

BECK HSA CONTRIBUTION SCHEDULE*				
	JAN 1 – MAR 31	APR 1 – JUNE 30	JULY 1 – SEPT 30	OCT – DEC 1**
EMPLOYEE ONLY COVERAGE	$750	$625	$500	$375
EMPLOYEE + S/C/F COVERAGE	$1,500	$1,250	$1,000	$750

*If you are turning 65 this year, you are not eligible to participate in Beck's HSA bank account.

**If hired after Dec. 1, you are not able to participate in the Beck HSA until 1/1 of the following year.

HSA contributions in excess of the IRS annual contribution limits ($4,500 for individual coverage and $9,000 for family coverage for 2027) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed from your HSA.
- Leave the excess contributions in your HSA and pay 6% excise tax on excess contributions. Next year consider contributing less than the annual limit to your HSA to make up for the excess contribution during the previous year.

SAVE MORE WHEN YOU CAN! It's up to you how much to contribute to your HSA and you can adjust your contribution amount any time throughout the year. Buying a new house or sending a kid to college? You can contribute less this year. Paid off your student loans or found out your child needs braces? Stash the annual max in your account.

Flexible Spending Accounts

Flex your spending power! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket healthcare or childcare expenses. Both FSAs offered by Beck are administered by UnitedHealthcare.

GENERAL RULES AND RESTRICTIONS

The IRS has the following rules and restrictions for Healthcare and Dependent Care FSAs:

- Expenses must be incurred during the 2027 plan year
- Dollars cannot be transferred between FSAs
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time
- You must "use it or lose it" — any unused funds will be forfeited
- You cannot change your FSA election in the middle of the plan year unless you experience a Qualifying Life Event
- Those considered highly compensated employees (family gross earnings were $160,000 or more last year) may have different FSA contribution limits. Visit irs.gov for more information
- To participate in a Dependent Care FSA, both parents must be working or looking for work. For information about working status and how it impacts participation in this benefit and the amount you can contribute, visit irs.gov

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

You can contribute up to $3,400 annually for qualified healthcare expenses (deductibles, copays, and coinsurance) with pre-tax dollars, helping reduce your taxable income while increasing your take-home pay. To participate in the Health Care FSA, you must either be enrolled in the Surest Medical Plan or have waived medical coverage.

USING FSA FUNDS

You may use your issued FSA debit card to pay for eligible expenses (Healthcare and/or Dependent Care — one card for both accounts).

You can use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction may be denied, and you can pay out-of-pocket and submit for reimbursement of eligible expenses.

If you incur an eligible expense and you do not use your debit card, submit a claim form along with the required documentation. You can log in to myuhc.com to view your FSA balance and submit claims online. If you have questions about your FSA account or reimbursements, you may call UHC. Always retain a receipt for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Without proof that an expense was valid, your card could be turned off and your expense deemed taxable.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

In addition to the Health Care FSA, you may opt to participate in the Dependent Care FSA — whether or not you elect any other benefits. You can set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the available funds in your account at the time of reimbursement request or card swipe.

You can enroll in the Dependent Care FSA regardless of your medical plan enrollment. Be sure you have qualifying expenses before you enroll.

- With the Dependent Care FSA, you can set aside up to $7,500 to pay for child or elder care expenses on a pre-tax basis
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the principal place of residence as the employee for more than half the year may be a qualifying individual
- Expenses are reimbursable if the provider is not your dependent
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed

This account covers dependent daycare expenses that are necessary for you and your spouse to work or attend school full time. Examples of eligible dependent care expenses include:

- In-Home Baby-Sitting Services (not provided by a tax dependent)
- Care of a Preschool Child by a Licensed Nursery or Daycare Provider
- Before and After-School Care
- Day Camp
- In-House Dependent Daycare

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Use It or Lose It: Plan Your FSA Carefully

The funds in Healthcare and Dependent Care FSAs do not roll over into the next year. If you don't spend your funds, you will forfeit them. Carefully evaluate your expected out-of-pocket costs when determining how much you want to elect to contribute to these accounts for the year.

FSA vs. HSA

OWNERSHIP	FSA	Your employer owns your FSA. If you leave your employer, you lose access to the account unless you continue participation through COBRA.
	HSA	You own your HSA. It is a savings account in your name and you always have access to the funds, even if you change jobs.
ELIGIBILITY & ENROLLMENT	FSA	You can elect an FSA even if you waive medical coverage. You cannot be enrolled in both a Healthcare FSA and the HSA Medical Plan or an HSA. You may enroll in Dependent Care FSA regardless of your medical plan enrollment.
	HSA	You must be enrolled in Beck's HSA Medical Plan to be eligible to contribute money to your HSA. You cannot be covered by a spouse's non-high deductible plan or eligible for a spouse's FSA or enrolled in Medicare or TRICARE.
TAXATION	FSA	Contributions are tax-free via payroll deduction. The funds spent, however, are not tax-free.
	HSA	For Federal tax purposes, the money in the account is "triple tax-free," meaning: 1. Contributions are tax-free. 2. The account grows tax-free. 3. Funds are spent tax-free (if used for qualified expenses).
CONTRIBUTIONS	FSA	You can contribute up to $3,400 in 2027 to an FSA. You cannot make changes to your contribution during the plan year without a Qualifying Life Event.
	HSA	The contribution limit for 2027 is $4,500 for individuals and $9,000 for families. This amount includes Beck's contribution. If you are 55 or older, you may make a "catch-up" contribution of $1,000 per year. Beck will contribute an amount based on your medical tier and the effective date of your enrollment (see Health Savings Account section of this guide). You can change your contribution at any time during the plan year.
PAYMENT	FSA	Beck's plan includes an FSA debit card to pay for eligible expenses. If you don't have your debit card with you, you'll pay out-of-pocket and submit your receipts for reimbursement. One card is issued for both Healthcare and Dependent Care FSAs, and it can be used for both accounts.
	HSA	Beck's plan includes an HSA debit card to pay for qualified expenses directly. You can also use online bill payment services through Optum.
ROLLOVER OR GRACE PERIOD	FSA	You must use the money in the account by end of the plan year. You may submit expenses through March 31 of the following year, but the cost must have been incurred in the prior plan year. Any funds unclaimed as of March 31 will be forfeited.
	HSA	The money in the account rolls over from year to year. Funds are always yours and may be used for future qualified expenses — even in retirement years.
QUALIFIED EXPENSES	FSA	Healthcare services like physician visits, hospital services, prescriptions, dental care and vision care. Dependent care services like preschool, day camp or before/after school programs. A full listing of eligible expenses is available at irs.gov. UnitedHealthcare may request supporting documentation for an expense paid with your FSA funds.
	HSA	Physician visits, hospital services, prescriptions, dental care, vision care, Medicare Part D plans, COBRA premiums and long-term care premiums. A full listing of eligible expenses is available at irs.gov.

Family Planning & Beyond

Beck's core value of caring includes supporting our people and their growing families. We hope these resources and benefits provide you with the support and care you need as your family grows. For more detailed information on these benefits and others, review Beck's Family Planning & Leave Guide.

MAVEN: SUPPORT DESIGNED FOR YOU AND YOUR FAMILY

No matter where you are on your reproductive and family health journey, Maven and Fertility Solutions Plus are here. Get free 24/7 virtual access to top-rated providers via video appointments, messaging, and classes — all from the comfort of your home — and clinical care from experienced fertility nurses. **Beck is pleased to offer all of Maven's support programs at no cost to employees and spouses enrolled in Beck's medical plan.**

Your membership includes:

- A personal Care Advocate who serves as a trusted guide to help you navigate the platform and connect you with providers.
- On-demand video chat and messaging with doctors, nurses, and coaches across 35+ specialties, including fertility, mental health, and pediatrics.
- Provider-led virtual classes and vetted articles — tailored to your journey.

Get personalized support for every step of your journey. Enroll in Maven at any stage! To sign up and access these resources, visit: mavenclinic.com/join/getsupport.

Fertility & Family Building

You have unlimited access to an experienced fertility nurse who can provide information about treatment options and help find fertility centers of excellence to get care. Get financial and personal support for:

- Preconception
- Fertility preservation
- IUI & IVF
- Male fertility
- Mental health

Maternity & Newborn Care

Maven OB-GYNs can answer questions you have in between your in-person visits and help you navigate your symptoms. Maven pediatricians can answer questions about newborn weight, mystery rashes, and starting solids (and yes, they're available even at 2am!). Get support for things like:

- Pregnancy
- Birth planning
- Infant Sleep
- Lactation Consultants
- Return-to-work coaching
- Miscarriage & loss

Parenting & Pediatrics

Being a parent is the hardest and best job you will ever have. Maven pediatric specialists are here to support you! They can help with:

- Parent coaching
- Special needs support
- Childcare navigation
- Behavioral support
- 24/7 pediatric care and specialties

Menopause & Midlife Health

Menopause can bring on physical and mental health changes and challenges. Maven is here to help support you through your entire journey. You have free access to:

- 24/7 connection to specialists, including OB-GYNs, mental health specialists, urologists, nutritionists, career coaches, and more
- Gender-inclusive care, including prescription support and education for hormonal health (such as HRT and Low-T)
- Clinically-backed content and classes
- Communities to reduce isolation and empower you

FREE BREAST PUMP

Moms-to-be on Beck's medical plan are eligible to receive a free breast pump. To order, visit aeroflowbreastpumps.com.

Select insurance company "UnitedHealthcare", add your item to the cart and checkout.

ADOPTION ASSISTANCE PROGRAM

As a company who cares about their employees, we recognize that employees choose to build their families in many ways. In an effort to support employees who are adoptive parents, we are pleased to offer Adoption Assistance to full-time employees who have worked for Beck at least one year.

Adoption benefits are available to eligible employees adopting a child under 18 years of age, with a reimbursement of up to $5,000 for each child (maximum benefit of $10,000). In addition to financial reimbursement, Beck provides 2 weeks of paid leave to employees after the placement of their child. For more information, contact the Beck Benefits Team.

PAID FAMILY LEAVE

Family is important to Beck, and supporting the growing families of our people is why we offer family leave benefits, paid at 100% of your salary. After the birth of a baby, mothers are eligible for 10 weeks of short-term disability leave (after 90 days of employment) and two weeks of paid family leave (12 weeks total), and partners are eligible for two weeks of paid family leave (can be used all at once or in 5-day increments within three months of the baby's birth).

For details on family leave and other benefits and resources available to you, review the Beck Family Planning & Leave Guide on the Beck Portal under:

Departments > HR > BeWell Website > Health Benefits

If you are based in Colorado, you may be required to apply for FAMLI leave in addition to Beck leave, which would run concurrently with your Beck leave. For more information, please contact the Beck Benefits Team at BeWell@beckgroup.com.

Adding Baby to Insurance

If you plan to add your newborn to Beck's medical plan, **you have 31 days from their birth date to do so.** Contact the Beck Benefits Team or review the Family Planning & Leave Guide as soon as possible for enrollment details.

After the 31-day deadline passes, you are not able to add your baby to your insurance coverage until the next annual open enrollment period.

Supplemental Health Benefits

Beck offers several ways for you to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for you and your dependents and is offered at discounted group rates.

ACCIDENT COVERAGE

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident coverage, available through Unum, provides benefits for you and your covered family members if you have expenses related to an accident that occurs outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help you pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits under this plan are payable to you, to use as you wish.

BE WELL (WELLNESS) BENEFIT

Every year, each family member who has Accident coverage can also receive $50 for getting a covered screening test such as an annual exam (including Beck's health screening, sports physicals and well-child visits), screenings for cancer including pap smear and colonoscopy, cardiovascular function screenings, cholesterol and diabetes screenings, chest x-ray, mammogram, and immunizations including HPV, MMR, tetanus and influenza.

BIWEEKLY CONTRIBUTIONS	BASE PLAN	PLUS PLAN
EMPLOYEE ONLY	$5.43	$9.02
EMPLOYEE + SPOUSE	$9.59	$15.88
EMPLOYEE + CHILD(REN)	$12.26	$21.84
EMPLOYEE + FAMILY	$16.42	$28.70

SUMMARY OF BENEFITS*	BASE PLAN	PLUS PLAN
HOSPITAL ADMISSION	$1,500	$2,000
HOSPITAL ADMISSION – HOSPITAL ICU	$1,500	$2,000
DAILY STAY (Per day up to 365 days for a covered accident)	$200	$300
DAILY STAY – HOSPITAL ICU (Per day up to 15 days for a covered accident)	$200	$300
DISLOCATIONS & FRACTURES	Up to $3,500	Up to $5,500
AMBULANCE	Ground: $200 / Air: $2,000	Ground: $200 / Air: $2,000
TREATMENT EMERGENCY ROOM	$150	$250
TREATMENT IN A PHYSICIAN'S OFFICE OR URGENT CARE FACILITY	$75	$150
PHYSICIAN FOLLOW-UP VISITS (Maximum 2 Visits)	$50 (Maximum 2 Visits)	$50 (Maximum 2 Visits)
THERAPY SERVICES (Chiro, speech, physical therapy, occupational)	$15 (Maximum 15 Days)	$15 (Maximum 15 Days)
MEDICAL IMAGING TIER 1 (X-rays or ultrasound)	$100	$200
MEDICAL IMAGING TIER 2 (Bone Scan, CAT, CT, EEG, MR, MRA, or MRI)	$200	$400
BURNS	Up to $7,500	Up to $15,000
OUTPATIENT SURGICAL FACILITY	$200	$400
CONCUSSION	$200	$200
COMA	$10,000	$10,000
GENERAL SURGERY (Abdominal, thoracic or cranial)	$1,000	$2,000
GENERAL SURGERY (Exploratory)	$100	$200

*This list is a summary. Refer to plan documents for a comprehensive list of covered benefits.

CRITICAL ILLNESS COVERAGE

Critical Illness insurance through Unum helps offset the financial effects of a catastrophic illness by paying a lump-sum benefit when you or a covered dependent is diagnosed with a covered illness. The benefit amount you receive is based on the amount of coverage in force, the illness diagnosed, and all other terms and provisions of the policy. You can use this money however you like; for example: to help pay your medical insurance deductible, lost wages, childcare, travel, home health care costs or any of your regular household expenses.

COVERED BENEFITS	
The below benefits are payable at 100% of your selected coverage amount:	
Amyotrophic Lateral Sclerosis (ALS)	Invasive Cancer (including all Breast Cancer)
Benign Brain Tumor	Loss of Hearing
Cerebral Palsy	Loss of Sight
Cleft Lip or Palate	Loss of Speech
Coma	Major Organ Failure Requiring Transplant
Cystic Fibrosis	Multiple Sclerosis
Dementia (including Alzheimer's Disease)	Occupational Human Immunodeficiency Virus (HIV) or Hepatitis
Down Syndrome	Parkinson's Disease
End Stage Renal (Kidney) Failure	Permanent Paralysis
Functional Loss	Spina Bifida
Heart Attack (Myocardial Infarction)	Stroke

Plan Highlights

- Guaranteed issue coverage (no medical questions)
- Benefits are payable based on the date of the covered event occurring or the date of diagnosis. Illnesses or occurrences prior to the effective date of coverage will not be payable events
- Every year, through the Be Well (Wellness) Benefit, each family member covered under the Critical Illness plan can receive $50-$100 (depending on coverage tier) for getting a covered screening test such as an annual exam (including Beck's health screening, sports physicals and well-child visits), screenings for cancer including pap smear and colonoscopy, cardiovascular function screenings, cholesterol and diabetes screenings, chest x-ray, mammogram, and immunizations including HPV, MMR, tetanus and influenza.
- Coverage Amounts:
  - Employee: $10,000, $20,000 or $30,000
  - Spouse: 100% of Employee Coverage Amount
  - Children: 100% of Employee Coverage Amount for NO ADDITIONAL COST

The below benefits are payable at 100% of your selected coverage amount:	
Coronary Artery Disease: Major – 50% / Minor – 10%	Non-Invasive Cancer – $25%
Infectious Disease – 25%	Skin Cancer – $500

Note: This is a summary. Refer to plan document for details including definitions, plan exclusions and limitations.

BIWEEKLY CONTRIBUTIONS	$10,000 BENEFIT ($50 BE WELL)		$20,000 BENEFIT ($75 BE WELL)		$30,000 BENEFIT ($100 BE WELL)	
RATES BASED ON CURRENT AGE	EMPLOYEE ONLY OR EMPLOYEE + CHILD(REN)	EMPLOYEE + SPOUSE OR EMPLOYEE + FAMILY	EMPLOYEE ONLY OR EMPLOYEE + CHILD(REN)	EMPLOYEE + SPOUSE OR EMPLOYEE + FAMILY	EMPLOYEE ONLY OR EMPLOYEE + CHILD(REN)	EMPLOYEE + SPOUSE OR EMPLOYEE + FAMILY
Age <25	$1.73	$3.45	$3.45	$6.90	$5.18	$10.36
25–29	$2.10	$4.19	$4.19	$8.38	$6.29	$12.57
30–34	$2.70	$5.39	$5.39	$10.78	$8.09	$16.17
35–39	$3.39	$6.78	$6.78	$13.55	$10.16	$20.33
40–44	$4.68	$9.36	$9.36	$18.72	$14.04	$28.08
45–49	$6.71	$13.42	$13.42	$26.84	$20.13	$40.26
50–54	$10.17	$20.34	$20.34	$40.69	$30.52	$61.03
55–59	$14.28	$28.56	$28.56	$57.12	$42.84	$85.68
60–64	$20.56	$41.11	$41.11	$82.23	$61.67	$123.34
65–69	$29.97	$59.94	$59.94	$119.89	$89.92	$179.83
70–74	$44.10	$88.19	$88.19	$176.38	$132.29	$264.57
75–79	$60.57	$121.14	$121.14	$242.29	$181.72	$363.43
80–84	$82.59	$165.18	$165.18	$330.35	$247.76	$495.53
85+	$128.70	$257.39	$257.39	$514.78	$386.09	$772.17

HOSPITAL INDEMNITY COVERAGE

Hospital Indemnity Coverage through Unum pays cash benefits directly to you if you have a covered stay in a hospital or intensive care unit. You can use the benefits from this policy to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging, or everyday expenses such as groceries and utilities. Pregnancy is not considered a pre-existing condition for this benefit, so you are able to enroll in this coverage if you are currently pregnant.

- Guaranteed issue coverage (no medical questions)
- Coverage not applicable for emergency room treatment, outpatient treatment, or a confinement of less than 20 hours

SUMMARY OF BENEFITS*	BASE PLAN	PLUS PLAN
HOSPITAL ADMISSION	$500 per insured per calendar year	$1,000 per insured per calendar year
DAILY HOSPITAL CONFINEMENT	$200 per day, to a maximum of 60 days per calendar year	$200 per day, to a maximum of 60 days per calendar year
HOSPITAL INTENSIVE CARE UNIT CONFINEMENT	$500 per day, to a maximum of 15 days per calendar year	$500 per day, to a maximum of 15 days per calendar year

*This is a summary. Refer to plan documents for details.

BIWEEKLY CONTRIBUTIONS	BASE PLAN	PLUS PLAN
EMPLOYEE ONLY	$6.73	$8.80
EMPLOYEE + SPOUSE	$15.98	$21.39
EMPLOYEE + CHILD(REN)	$9.67	$12.55
EMPLOYEE + FAMILY	$18.92	$25.14

Well Child Benefit

Both Hospital Indemnity plans include a Well Child Benefit that gives you $100, for up to four (4) well child doctor visits (regular well child exams, not sick visits) within the first year of birth — $400 total in cash benefit. The initial Well Child payment of $100 will be included in your hospital stay payment. You will submit for the remaining three (3) Well Child visit claims as they occur — the visits must be at least 30 days apart.

Life Insurance

Discussing what might happen to your family if you were not around to provide for them isn't always the easiest conversation, but it is necessary. Survivor benefits provide financial assistance in an absence, and can help you plan for the unexpected.

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

Life and AD&D benefits are essential to the financial security of you and your family. As such, it is important to understand how your Plan works and what benefits you will receive.

Basic Life and AD&D benefits are provided by Beck at no cost to you, which guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an employee's benefits after death.

As a full-time employee, you automatically receive Basic Life and AD&D insurance even if you elect to waive other coverage. Basic Life and AD&D coverage is through Unum and begins 30 days after your hire date.

Your Basic Life and AD&D insurance benefit is 2x annual salary, rounded to the next higher multiple of $1,000, up to $1,000,000. As a new hire, there is no medical underwriting required for benefit volumes up to $500,000. If your coverage is above that, you will need to submit a medical questionnaire to Unum for approval.

BASIC DEPENDENT LIFE

Beck provides Basic Life and AD&D coverage of $10,000 for spouse and $5,000 for each child. This coverage is provided at no cost and you will automatically receive it even if you waive all other benefit coverage.

BENEFICIARY DESIGNATION

A beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under group Life and AD&D offered by Beck. Benefits for a dependent's death are payable to you.

You can designate your beneficiaries in Workday. It is important that your beneficiary designation is clear so there is no question as to your intentions. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies), please indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in percentages.

For example:

PRIMARY	CONTINGENT
Mary J. Doe, Wife (34%) Jane Doe, Daughter (33%) John Doe, Son (33%)	Joseph W. Doe, Son (50%) Jane Doe, Daughter (50%) OR Estate of the Insured (100%)

If you need assistance, contact your Benefits Team or your own legal counsel.

SUPPLEMENTAL LIFE AND AD&D INSURANCE

In addition to the Basic coverage provided by Beck, benefit eligible employees may purchase Supplemental Life and AD&D insurance for themselves. Premiums are paid through post-tax payroll deductions. Your cost automatically adjusts each year at our annual renewal to reflect the age-graded rates.

Some benefit levels require Evidence of Insurability (EOI) prior to approval — thresholds shown in the table below. Evidence of Insurability is a short medical questionnaire that you will complete and return to Unum. Once Unum processes and approves your EOI, they will notify Beck to update your coverage and premium cost.

SUPPLEMENTAL LIFE AND AD&D INSURANCE

BASIC LIFE/AD&D	
COVERAGE AMOUNT	2x annual salary, rounded to the next higher multiple of $1,000
WHO PAYS	Beck pays full cost
BENEFITS PAYABLE	The Life benefit pays if you die while covered under the Plan. The AD&D benefit pays in addition if loss of your life is due to an accident. The AD&D benefit will also pay a partial amount if you lose a limb or suffer paralysis in an accident.
MAXIMUM BENEFIT	Up to $1,000,000
EVIDENCE OF INSURABILITY (EOI)	Benefit amount over $500,000 will require medical underwriting to Unum
BASIC DEPENDENT LIFE/AD&D	
COVERAGE AMOUNT	$10,000 for spouse and $5,000 for each child (up to the age of 26)
WHO PAYS	Beck pays full cost
BENEFITS PAYABLE	If your dependent dies while covered under the Plan
EVIDENCE OF INSURABILITY (EOI)	N/A
SUPPLEMENTAL EMPLOYEE LIFE	
COVERAGE AMOUNT	1x or 2x annual salary, rounded to the next higher multiple of $1,000
WHO PAYS	You pay full cost
BENEFITS PAYABLE	The Life benefit pays if you die while covered under the Plan. The AD&D benefit pays in addition if loss of your life is due to an accident. The AD&D benefit will also pay a partial amount if you lose a limb or suffer paralysis in an accident.
MAXIMUM BENEFIT	Not to exceed 2x annual earnings or $1,000,000
EVIDENCE OF INSURABILITY (EOI)	Required for the amount over $450,000 or if you choose to increase your election or enroll after your new hire enrollment period.
SUPPLEMENTAL SPOUSE LIFE	
COVERAGE AMOUNT	$1,000 increments
WHO PAYS	You pay full cost
BENEFITS PAYABLE	The Life benefit pays if your spouse dies while covered under the Plan. The AD&D benefit pays in addition if loss of your spouse's life is due to an accident. The AD&D benefit will also pay a partial amount if your spouse loses a limb or suffers paralysis in an accident.
MAXIMUM BENEFIT	50% of employee life amount up to $500,000
EVIDENCE OF INSURABILITY (EOI)	Required for the amount over $25,000 or if you chose to increase your election or enroll after your new hire period.
SUPPLEMENTAL CHILD LIFE	
COVERAGE AMOUNT	$5,000 or $10,000
WHO PAYS	You pay full cost
BENEFITS PAYABLE	The Life benefit pays if your child dies while covered under the Plan. The AD&D benefit pays in addition if loss of your child's life is due to an accident. The AD&D benefit will also pay a partial amount if your child loses a limb or suffers paralysis in an accident.
MAXIMUM BENEFIT	$10,000
EVIDENCE OF INSURABILITY (EOI)	Required if you elect coverage for your dependent child after your new hire enrollment period.

Basic and supplemental life insurance for both you and your spouse will be reduced to 67% of your original benefit when you reach age 70. If you are electing coverage for the first time at age 70 or above, your benefit amount will be reduced to 67% of your benefit election. There will be no further age-related reductions.

VOLUNTARY LIFE INSURANCE

RATES/$1,000 (MONTHLY)

EMPLOYEE AGE (AS OF 01/01/2027)	EMPLOYEE	SPOUSE RATE BASED ON EMPLOYEE AGE
<25	$0.092	$0.092
25-30	$0.078	$0.078
30-35	$0.078	$0.078
35-40	$0.081	$0.081
40-45	$0.105	$0.105
45-50	$0.148	$0.148
50-55	$0.237	$0.237
55-60	$0.380	$0.380
60-65	$0.589	$0.589
65-70	$1.554	$1.554
70+	$2.776	$2.776

VOLUNTARY AD&D INSURANCE

PREMIUM RATES – $1,000 MONTHLY

Employee	$0.025
Spouse	$0.025
Child	$0.025

VOLUNTARY CHILD LIFE INSURANCE

PREMIUM RATES – $1,000 MONTHLY

$0.200

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

Coverage Amount ÷ 1,000 = Coverage Units x Age-Based Rate = Monthly Premium

(from rate table)

(for biweekly cost, multiply by 12 and divide by 26)

Example: An employee age 55-60 electing $150,000 of coverage would pay $68.25 per month.

$150,000 ÷ 1,000 = **150** × $0.455 = **$68.25**

WHOLE LIFE INSURANCE WITH LONG-TERM CARE (LTC) RIDER

Life is unpredictable. Group Whole Life with an Accelerated Death Benefit for Long-Term Care with Restoration or Benefits Rider can help you prepare for the unexpected by providing financial security for life and its uncertainties. Enrollment in this benefit is offered once a year during annual Benefits Open Enrollment.

The first time you are offered this benefit, you can enroll without medical questions.* If you wait to enroll at a later date, evidence of insurability will apply and coverage may be declined.

Check out the policy benefits and highlights below.

POLICY FEATURE	HOW IT WORKS
DEATH BENEFIT	Pays a lump-sum cash benefit when the insured dies; or Maturity Benefit that pays a lump-sum cash benefit if the insured is still living at age 121.
ACCELERATED DEATH BENEFIT FOR TERMINAL ILLNESS	Pays an advance of the death benefit up to 75% of the face amount when diagnosed terminally ill.
ACCELERATED DEATH BENEFIT FOR LONGTERM CARE WITH RESTORATION OF BENEFITS	Pays a monthly advance of 4% of the death benefit for up to 25 months while receiving qualified LTC services. The restoration benefit restores the death benefit and cash value to the pre-acceleration amounts.

Plan Highlights:

- Your rates lock in at your current age and do not increase as you age.
- Coverage is portable, which means you can take this plan with you if you no longer work for the company.
- You choose the level of coverage that is right for you.
- Rates are based on your age and coverage amount
- Certain benefit restrictions apply for enrollments after age 64.
- **This guide is a summary.** Please refer to the plan documents for a complete description of coverage, limitations, and exclusions.

COVERAGE AMOUNTS	GUARANTEE ISSUE* (NO MEDICAL QUESTIONS)	MAXIMUM BENEFIT AMOUNT
EMPLOYEE ONLY	$100,000	$250,000
WORKING SPOUSE	$50,000	$150,000
CHILD(REN)	$20,000	$50,000

*Although Guarantee Issue or Simplified Issue may be available, all exclusions and limitations will still apply to coverage issued.

Disability Leave

Protecting yourself in the case of an unfortunate debilitating injury and planning for the care you will need in the future is important. This insurance protects a portion of your income until you can return to work or reach retirement, and provides security should you need extended care in the future.

SHORT-TERM DISABILITY LEAVE

If you are a full-time biweekly employee and require at least five (5) consecutive business days of time off due to a medical condition that prevents you from performing your job, you may be eligible for payment under the Short-Term Disability leave program in the form of salary continuation. Short-Term Disability benefits are active 90 days after date of hire. While on Short-Term Disability leave, you will be paid 100% of your regular salary through normal payroll processing. Holidays, which fall within any paid Short-Term Disability leave will be processed as part of your leave and the holiday hours will be forfeited.

Unum administers Beck's Short-Term Disability claims. Until required forms and documentation are received by Unum, any leave will be logged as PTO. Short-Term Disability leave will begin per the start date provided by your physician. Failure to provide proper medical certification by the deadline communicated to you by a Unum representative may result in the denial of your Short-Term Disability benefit.

Employees on Short-Term Disability leave are expected to return to work as soon as they are physically able to perform the duties of their position. Unum will advise if certification from your physician is needed to confirm the return to work date.

If you are based in Colorado, you may be required to apply for FAMLI leave in addition to Beck leave, which would run concurrently with your Beck leave.

LONG-TERM DISABILITY (LTD) INSURANCE

Long-Term Disability (LTD) insurance protects a portion of your income if you become partially or totally disabled for a long period of time. Beck provides a Basic LTD insurance benefit at no cost to you that replaces 60% of your income, up to a maximum of $25,000 per month, with a minimum monthly benefit of the greater of $100 or 10% of your gross disability payment.

You are automatically enrolled in the company-provided Basic LTD insurance after 90 days of employment. You must be disabled for at least 90 days before you can receive the LTD insurance benefit payment.

Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner. Please refer to your Summary Plan Description for details or contact your Benefits Team for specific benefits.

The Basic LTD policy provides a Spousal LTD benefit of $2,000 per month, with a maximum benefit period of 2 years. Your spouse must be disabled for at least 60 days before he/she can receive the LTD insurance benefit payment.

During the annual Open Enrollment, you may be eligible to purchase additional coverage or increase existing coverage. Unum will reach out to you directly during the enrollment period with the options available to you.

NEED TO TAKE A LEAVE?

See "How to Apply for Leave" on the next page. Please also inform BeWell@beckgroup.com.

UNPAID FAMILY AND MEDICAL LEAVE

In accordance with the Family and Medical Leave Act ("FMLA"), Beck provides up to 12 weeks of unpaid leave (or 26 weeks in the case of an Armed Forces member family leave) to eligible employees. Employees who: (1) have worked for the company for at least 12 months (not necessarily consecutively); and (2) have worked 1,250 hours for the company within the past 12 months, may take up to 12 weeks of unpaid leave during any 12-month period for any of the following reasons:

- Birth of a child of the employee and in order to care for the child within first year following birth.
- Placement of a child with the employee for adoption or foster care within first year of placement.
- Care of the spouse, or a child, or parent of the employee, if such family member has a serious health condition.
- A serious health condition that makes the employee unable to perform the functions of his or her position.
- Because of any qualifying exigency (as the secretary of Labor shall, by regulation, determine) arising out of the fact that the spouse, or a son, daughter or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

For more information on FMLA, please refer to the Beck Employee Handbook.

HOW TO APPLY FOR LEAVE

1. Contact Unum at 866-779-1054 or submit your claim online at unum.com.
2. Follow the claim submission instructions.
3. Unum will communicate the required documentation and facilitate processing of your leave request.

Before You Apply For Leave

- Unum administers Beck's FMLA claims.
- Leave will be logged as PTO until required documentation is received.
- Contact BeWell@beckgroup.com if you need to initiate FMLA.
- Colorado employees may be required to apply for FAMLI leave in addition to Beck leave, which would run concurrently with your Beck leave.

Retirement

Whether you're just starting out in your career or you've been in the workforce for years, it's always a good time to plan for retirement. Taking advantage of your employer-sponsored retirement plan and any available matching contributions can help you build a stronger financial future.

RETIREMENT PLANNING

It's never too early — or too late — to start planning for your retirement. Making contributions to a 401(k) account is the first step toward achieving financial security later in life. The Beck Group Retirement Savings Plan provides you with the tools and flexibility you need to retire comfortably and securely.

Eligible employees can invest for retirement while receiving certain tax advantages. The Beck Group Retirement Savings Plan is a savings plan with provisions that allow you to make pre-tax contributions (made before taxes are taken out of your paycheck) and/or Roth contributions (made with money that has already been taxed). Beck will make a matching contribution of 100%, up to the first 6% of an employee's contributions (up to IRS limits).

Employees are auto enrolled into the retirement plan with a 6% contribution to take full advantage of Beck's match. Once you hit the contribution limit, both your contributions and Beck matching contributions will stop.

Pre-tax and Roth contribution sources are eligible for Beck matching contributions. After-tax and catch-up contribution sources are not eligible for Beck matching contributions. Administrative and record-keeping services for this Plan are provided by T. Rowe Price.

PLAN AT A GLANCE	
PLAN NAME	The Beck Group Retirement Savings Plan
RECORD KEEPER	T. Rowe Price
WEBSITE	rps.troweprice.com
ELIGIBILITY	First of the month following 30 days from hire date

WHAT IS A 401(K)?

This employer-sponsored retirement account can help build and create choices for your future self by saving money — tax-free — from your paycheck. Due to the value of compounding interest, the sooner you participate in a 401(k), the better.

Eligible employees can invest for retirement while receiving certain tax advantages. You are eligible to begin making contributions into the plan on the 1st of the month following 30 days of employment.

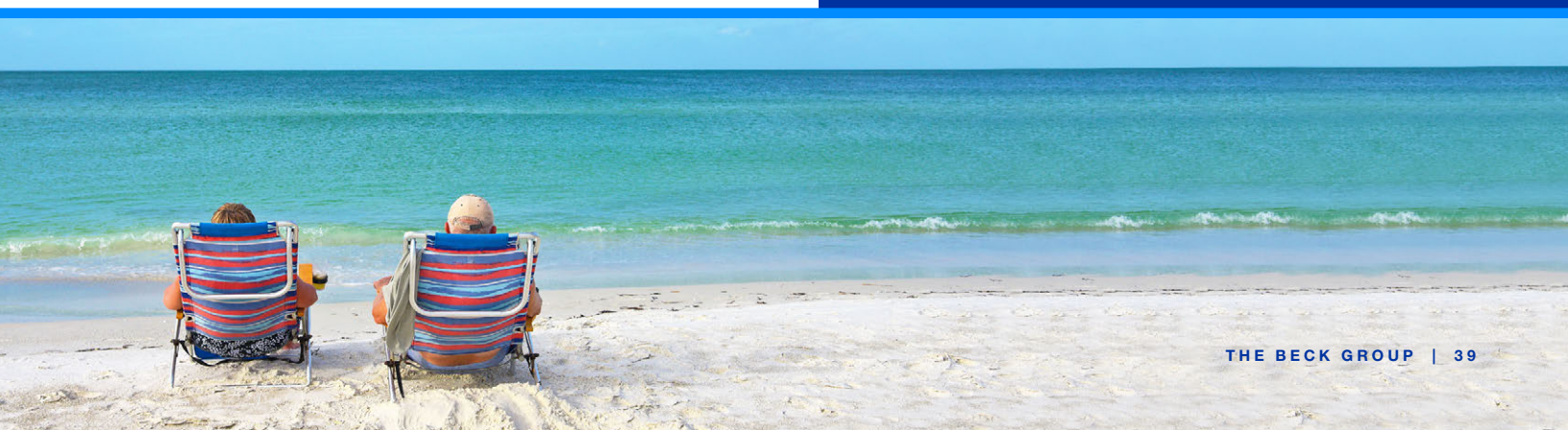
PRE-TAX VS. ROTH 401(K):

What's the difference? If you contribute to your 401(k) pre-tax, your contributions will be taken out before taxes each pay period. However, you'll have to pay taxes on the funds when you withdraw them during retirement.

If you choose the available Roth 401(k), contributions will be deducted from your paycheck after taxes — so you won't pay taxes when you withdraw during retirement. Once you retire, you might be in a higher tax bracket, so contributing after taxes now could save you money in the long run.

Retirement Planning Tip

When you retire, you'll need at least 70% of your pre-retirement earnings to maintain your standard of living. Social Security retirement benefits typically replace only about 40%, so start building that nest egg now.



HOW MUCH SHOULD I BE SAVING?

Industry standards suggest saving, at a minimum, 12% to 15% of your income, inclusive of Beck's generous matching contribution. If you cannot afford to save that much right now, at least make sure to be saving up to the matching amount so you are not leaving free money behind.

CONSOLIDATING YOUR RETIREMENT SAVINGS

If you have an existing qualified retirement plan (pre-tax) with a previous employer, you may transfer those assets into the plan at any time. Contact T. Rowe Price at 800-922-9945 for details.

Regardless of which retirement account you choose or how much you contribute, it's important to think of it as a Long-Term strategy. Dipping into the account early will jeopardize the quality of your retirement and rack up penalties from the IRS.

VESTING

The term "vested" refers to how much of the employer contributions in your account that you can take with you if or when you leave Beck. With our vesting schedule, each year you'll own a greater percentage of the company's matching contributions. When you're fully vested, you'll own 100% of company match contributions. You always own and are fully vested in your own personal 401(k) contributions.

VESTING SCHEDULE

YEARS OF SERVICE	% VESTED	YEARS OF SERVICE	% VESTED
AFTER 1 YEAR	40%	AFTER 3 YEARS	90%
AFTER 2 YEARS	60%	AFTER 4 YEARS	100%

CONTRIBUTING TO THE PLAN

You are eligible to start making contributions into the Plan on the 1st of the month following 30 days of employment. All employees are auto enrolled in the Plan at a 6% contribution rate, which takes full advantage of Beck's matching contribution. The maximum annual employee contribution allowed is 100% of your compensation, but is subject to the IRS annual maximum allowable amount.

You may stop or change your contribution amount at any time by contacting T. Rowe Price at 800-922-9945 or online at rps.troweprice.com.

The deferred contribution limit set annually by the IRS is $24,500 for 2027.

CATCH-UP CONTRIBUTIONS

If you are age 50 or older this calendar year and you already contributed the maximum allowed to your 401(k) account, you may also make a "catch-up contribution." The maximum catch-up contribution is $8,000 for 2027 — for a combined total contribution allowance of $32,500.

ENHANCED CATCH-UP

Employees ages 60-63 can contribute an enhanced catch-up contribution that is the greater of $11,250.

CATCH-UP AS ROTH

Beginning January 1, 2026, catch-up contributions for employees earning more than $150,000 in FICA wages from the prior year must be made on a Roth (after-tax) basis. Employees at or below this income level may still choose between pre-tax and Roth catch-up contributions, depending on plan rules. With Roth contributions, taxes are paid up front, but withdrawals in retirement are generally tax-free.

CHANGING OR STOPPING YOUR CONTRIBUTIONS

You may change the amount of your contributions any time. All changes will become effective as soon as administratively feasible and will remain in effect until you modify them. You may also discontinue your contributions any time. Once you stop making contributions, you may start again at any time.

You may change your contributions by logging into rps.troweprice.com, via the T. Rowe Price app or by calling 800-922-9945.

INVESTING IN THE PLAN

You will be automatically invested in a T. Rowe Price Retirement Fund with the target date closest to the year you will turn 65. The Beck Group Retirement Savings Plan offers a selection of investment options for you to choose from. You may change your investment choices any time. For more details, refer to your 401(k) Enrollment Guide.

BENEFICIARY DESIGNATION

Don't forget to name your beneficiary. Your beneficiary for your 401(k) retirement account must be designated on the T. Rowe Price website at rps.troweprice.com.

DON'T MISS THE FULL MATCH! Once you hit the contribution limit, both your contributions and Beck matching contributions will stop. To take full advantage of Beck's matching contribution, be sure to spread your contributions out evenly over the full 26 pay periods in the year.

Financial Wellness Programs

Tell your money where to go and stop wondering where it went. The financial wellness resources offered by Beck will teach you how to take control of your money once and for all. We are pleased to offer these programs to you for free!

SMARTDOLLAR

Beck is proud to offer the SmartDollar program to you for free. SmartDollar is built for you at every stage of your financial journey, whether you're living paycheck to paycheck, paying off debt, building an emergency fund, or preparing for retirement. It uses the proven financial principles of Ramsey Solutions to help you break the paycheck-to-paycheck cycle and change your money habits so you can keep and grow your income instead of piling up consumer debt.

What You Get For Free:

- Budgeting tools: You get full access to the EveryDollar app with bank connectivity to plan every paycheck
- Financial courses: Access to go at your own pace financial courses, including Financial Peace University
- Tax and legal perks: Free state and federal tax filing through Ramsey SmartTax and free will preparation through Mama Bear Legal Forms
- Expert answers: Use the built-in AI tool to get fast answers to everyday money questions

Start taking control of your money today! Go to: smartdollar.com/enroll/trp_105535

TAKE CONTROL OF YOUR MONEY!
Small steps can lead to big results. SmartDollar provides practical tools to help you build a budget, reduce debt, grow savings, and plan confidently for the future.

DEDICATED FINANCIAL CONSULTANT

You have access to Beck's free dedicated financial consultant. Our experienced consultant has years of helping individuals improve their financial health and is versed in Beck's retirement and financial benefits. They can help you with everything from how to save for an upcoming trip, to paying off student loans to preparing for retirement. You will get personalized answers to questions like:

- Am I on-track for retirement?
- How much should I save for the future?
- How can I best manage my debt?
- Do I have the right insurance coverage?
- How should I invest?

Contact BeWell@beckgroup.com for how to schedule.

MONEY COACH

Beck's BeWell Program gives you and your entire household free access to experts that can assist you with your finances.

- Three 30-minute telephone consultations per topic per year, with an unbiased financial coach with an average of 22 years experience.
- Get support for debt and credit, spending and savings, maternity leave, large purchases, caring for parents and more.
- Invite your spouse or partner to join you.

Get started today! Call 800-523-5668 (TTY 711) or visit member.magellanhealthcare.com (enter The Beck Group into Find My Company).

SOFI AT WORK

A leading financial services provider that offers below market rates on student loan refinancing with flexible terms, personal loans, benefits for new home buyers, mortgage refinancing, 529 college savings resources, and more!

Student Loan Support

- Refinance/consolidate student loans
- Below-market rates + additional rate discount of 0.125%
- No fees or prepayment penalties
- Calculators, guides + more Home Buying/Refinancing
- Competitive rates and down payments as little as 3%
- Flexible mortgage options
- Close on time guarantee
- Vetted real estate agent network

Contact BeWell@beckgroup.com for how to schedule.

Personal Loan Options

- Consolidate debt into one low monthly payment
- Low fixed rate that won't change
- No origination fees, late fees, or prepayment fees

Single-Sign-On (SSO) via T. Rowe Price

- Log in to your T. Rowe Price account at troweprice.com/workplace/en/login.html
- Click on "Plan & Learn" > "Student Loan Center" > then the blue button "Access Your Benefit"
- You will be taken to the SoFi website to create your account (one-time setup)
- After creating your account, future access will be available through your T. Rowe Price account via single sign-on

WAYSAVER SAVINGS ACCOUNT

Waysaver, the new savings program from T. Rowe Price, can help you build your savings to prepare for unexpected costs or a large planned expense. Waysaver estimates what you can afford based on your current spending habits — so you may not need to change your spending habits. Waysaver is available to you for free.

Experience the Smarter Way to Save

- **Simple.** Just download the app, link your checking account, and start saving today.
- **Intuitive.** Waysaver estimates how much to save and when, based on your cashflow patterns.
- **Convenient.** It builds your savings automatically, in manageable daily amounts.
- **Secure.** Breathe easy with the security you'd expect from your trusted retirement experts.
- **Rewarding.** Benefit from the high-yield interest offered by this account to build your savings faster.

Ready to save smarter? Learn more about Waysaver at troweprice.com/workplace/en/waysaver

Financial Wellness at No Cost to You

Take advantage of programs designed to help you:

- Pay down debt
- Build savings
- Buy a home
- Plan for the future

Additional Benefits

The Beck Group knows the value of supporting employees both at work and at home. That's why we offer additional benefits to help you protect what matters most. From legal assistance and pet insurance to resources that support your overall well-being, these programs are designed to help you protect what matters most.

LEGAL SERVICES

As part of Beck's BeWell Benefit, you have legal services and discounts available to you through Magellan. Visit your BeWell Benefit at 800-523-5668 (TTY 711) or visit member.magellanhealthcare.com to take advantage of the benefits below.

- Free 60 minute consultation (per issue) with an Attorney* in person or by phone. Consultations are helpful when dealing with divorce, family matters, real estate and consumer credit concerns.
- Preferential discount on hourly fees for attorney services after the initial 60-minute consultation.
- 25% discount for standard legal services (Civil and consumer rights, Personal property, Taxes and audits)
- 25% discount for estate planning (wills, trusts and powers of attorney)
- 35% discount for family law (divorce, juvenile court proceedings, elder care)
- Discounted document preparation services include:
  - Single Will Package: $99.00
  - Couples Will Package: $179.00
  - Minor's or Special Needs Trust: $249.00
  - Individual Estate Protection: $649.00
  - Protection of Couples' Estate: $999.00
- An online legal library with educational contents, articles, and definitions on topics ranging from divorce and child custody to estate planning and wills.
  - Other resources include self-serve access to instantly create state-specific forms.

PET INSURANCE

At Beck we value our fur-family members and know that looking after their health & wellness is important. We have partnered with ASPCA to help you do just that.

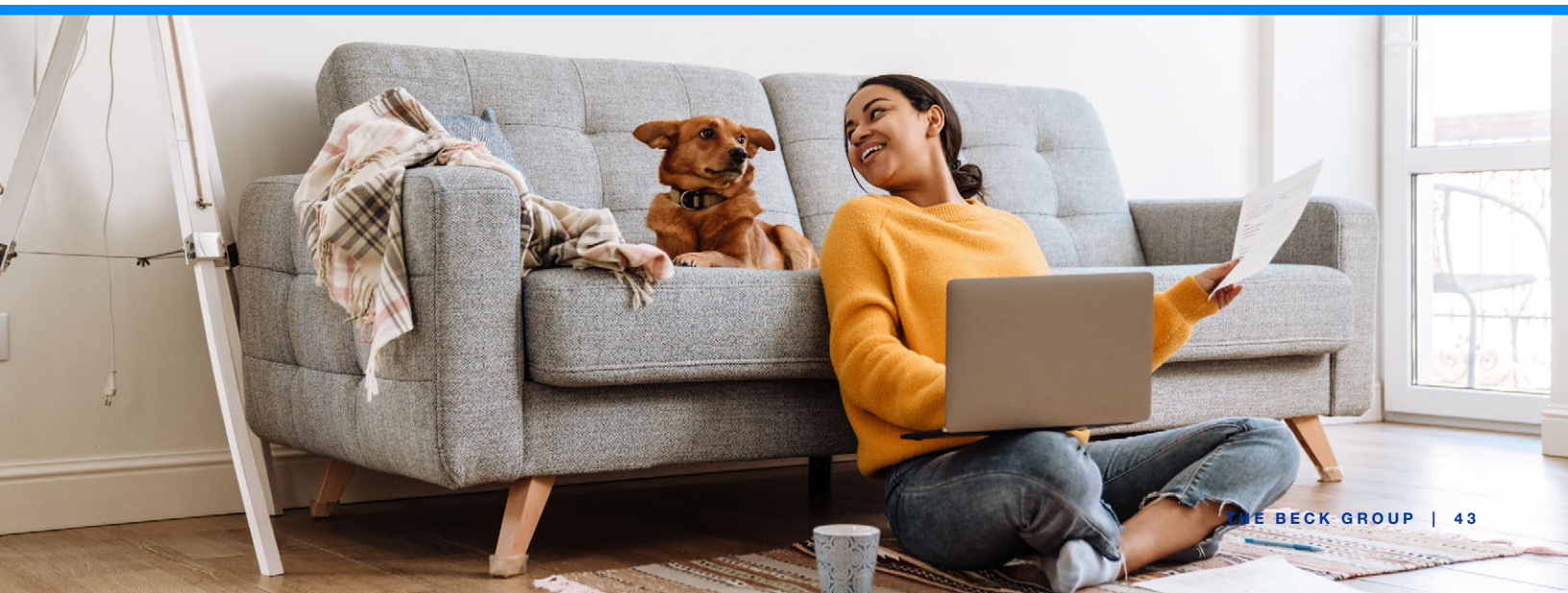
With the ASPCA® Pet Health Insurance program, it's easier to get your pet the care they need and deserve. You will get coverage that is easy to use, up to 90% cash back on vet bills, and up to a 10% discount on your premium.

Get your quote at: aspcapetinsurance.com/beck.

Protect What Matters Most

From legal support for life's unexpected moments to affordable care for your pets, these benefits provide extra peace of mind when you need it most.

*Legal advice on employment matters is excluded



IDENTITY THEFT RESOLUTION

Beck's BeWell Program provides education on how to prevent identity theft and guidance to help to restore your credit if you have an issue.

You and your household members receive one free 60-minute telephone consultation with a Fraud Resolution Specialist™ (FRS) per issue, per year. The FRS will answer your questions and give you the direction and tools you need to start resolving the fraud issues. You also have the option to purchase resolution services on a self-pay basis and have the company work under power of attorney until all issues are resolved.

Our program provides you with an ID Theft Emergency Response Kit and assists with:

- Completing and submitting a Uniform ID Theft Affidavit to the proper authorities, Credit Reporting Agencies and creditors
- Providing fraudulent account forms or letters to itemize each fraudulent occurrence
- Obtaining a free copy of your credit report
- Reporting fraudulent activity and notifying local and Federal authorities and creditor fraud departments
- Placing a fraud alert and/or credit freeze (if allowed by State law) on your credit file

Think you've been a victim of ID theft?

If you or any of your household members suspect that you have experienced identity theft, call 800-523-5668 (TTY711) or visit member.magellanhealthcare.com.

MEDICARE SUPPORT

You and your eligible family members have access to complimentary Medicare guidance through Senior Market Solutions. Whether you are approaching age 65, preparing for retirement, helping a Medicare-eligible spouse or dependent, or reviewing your current coverage, a licensed Medicare advisor can provide personalized support at no cost to you.

Your dedicated advisor can help you:

- Understand Medicare enrollment rules
- Compare plan options and costs
- Avoid potential late-enrollment penalties
- Select coverage that fits your healthcare and financial needs
- Navigate the enrollment process
- Receive ongoing support after enrollment

Take advantage of this no-cost resource to better understand your Medicare options and make informed coverage decisions.

TRAVEL ASSISTANCE

When traveling for business or personal reasons, in a foreign country or just 100 miles or more away from home, you and your family can count on getting help in the event of a medical emergency. Beck's emergency travel assistance is provided at no cost to you, and includes:

- Hospital admission guarantee
- Emergency medical evacuation
- Transportation for a friend or family member to join hospitalized patient
- Prescription replacement assistance
- Medical referrals to Western-trained, English-speaking medical providers
- Care and transport home of unattended minor children

For assistance anywhere in the world, contact Assist America at:

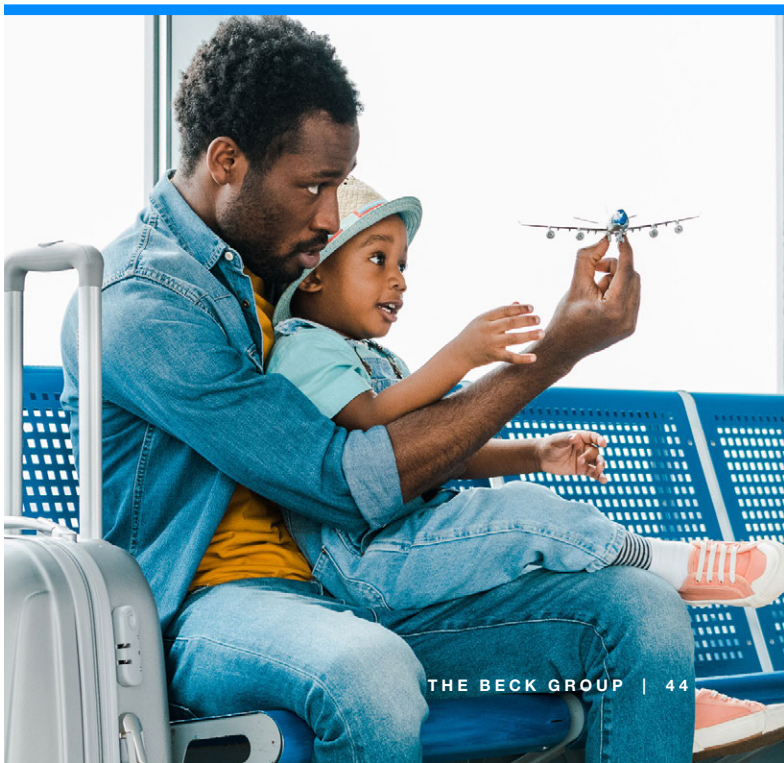
- Within the U.S.: 800-872-1414
- Outside the U.S.: (U.S. access code) +609-986-1234
- Via email: medservices@assistamerica.com

VISIT THE BECK DISCOUNT MARKETPLACE

Get instant access to Beck exclusive deals, limited-time offers, and savings perks on the products, services, and experiences you need and love. Shop offers from hotels, entertainment, food, fitness, electronics, and more!

- Quickly find the offers you want
- Save your favorites
- Find new curated offers every day

Access the Beck Discount Marketplace:
beckgroup.savings.beneplace.com/home



Contact Information

PLAN	CARRIER	PHONE	WEBSITE
Medical Plans	UnitedHealthcare*	866-844-4864	myuhc.com Group #: 705241
	Surest*	866-683-6440	benefits.surest.com Group #: 78800604
Flexible Spending Account (FSA)	UnitedHealthcare*	800-791-9361	myuhc.com
Accident, Critical Illness & Hospital Indemnity	Unum	800-635-5597	unum.com
Retirement	T. Rowe Price	800-922-9945	rps.troweprice.com
Whole Life + LTC	American Heritage Life*	800-521-3535	standard.com/ahl/mybenefits
Dental	Cigna Dental	800-244-6224	mycigna.com Policy #: 3346980
Financial Wellness	SmartDollar*	N/A	smartdollar.com Company Keyword: beckgroup
Life & AD&D	Unum	800-421-0344	unum.com Policy #: 571021
Vision	EyeMed	N/A	eyemed.com/en-us
Virtual Medicine & Mental Health Visits	Galileo*	855-462-7943	galileo.io
Disability	Unum	866-779-1054	unum.com Policy #: 571021
Legal Assistance	Magellan	800-523-5668 (TTY 711)	member.magellanhealthcare.com
Travel Assistance	Assist America	Within U.S.: 800-872-1414 Outside U.S.: +609-986-1234	assistamerica.com Reference number: 01-AA-UN-762490
Fertility, Pregnancy, Parenting & Menopause	Maven*	N/A	mavenclinic.com/join/getsupport
Wellness	Vitality	877-224-7117	powerofvitality.com
Health Coach	Real Appeal	N/A	realappeal.com
Health Savings Account (HSA)	Optum*	800-791-9361	myuhc.com
BeWell Benefit	Magellan	800-523-5668 (TTY 711)	member.magellanhealthcare.com
Beck Benefits Team	The Beck Group	N/A	BeWell@beckgroup.com

*Mobile app is available for on-the-go information.

Glossary

Balance Billing: When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance: Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay: The fixed amount, as determined by your insurance plan, you pay for healthcare services received.

Deductible: The amount you owe for healthcare services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB): A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs): A special taxfree account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," meaning that funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or a rollover into the next plan year.

- **Healthcare FSA:** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA:** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Healthcare Cost Transparency: Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA): A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in an HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, so if you change jobs your account goes with you.

High Deductible Health Plan (HDHP): A plan option that provides choice, flexibility and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, there are no copays and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

Network: group of physicians, hospitals and other healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network:** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network:** Providers that are not contracted with your insurance company. If you choose an out-of- network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating:** Providers that do not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment: The period set by the employer during which employees and dependents may enroll for coverage, make changes or decline coverage.

Out-of-Pocket Maximum: The most you pay during a policy period (usually a 12-month period) before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications: Medications available without a prescription.

Prescription Medications: Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty.

- **Preferred Drugs:** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs:** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs:** Prescription medications used to treat complex, chronic and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- **Prior Authorization:** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy:** The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable & Customary Allowance (R&C): Also known as the UCR (Usual, Customary, and Reasonable) amount. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount.

Summary of Benefits and Coverage (SBC): Mandated by healthcare reform, your insurance carrier provides you with a summary of your benefits and plan coverage.

Summary Plan Description (SPD): The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

Can I Save Money on my Health Insurance Premiums in the Marketplace?

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

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.1 2

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage**. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility.
To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596.
TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

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

[1] Indexed annually; see irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Special Enrollment Notice

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

Loss of Other Coverage

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

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

Marriage, Birth or Adoption

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

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

Medicaid or CHIP

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

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

For More Information or Assistance

To request special enrollment or obtain more information, please contact the Beck Benefits Team at BeWell@beckgroup.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 the beck benefits team at BeWell@beckgroup.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 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

Our Uses and Disclosures

We may use and share your information as we:

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

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.

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.

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 upon such request.

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting 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

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. For more information see: 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 may use or share your health information with health care providers or emergency personnel when needed to provide you with emergency treatment or to respond to a serious and immediate threat to your health or safety, even when you are unable to consent. This is allowed under HIPAA's rules for treatment and emergency disclosures.

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 Lawful Process
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.

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.

Respond to audits and program oversight
We may use and share your information for health oversight and health care operations. This includes sharing with government agencies that are authorized by law to conduct audits, inspections, and licensure activities, and with accrediting organizations to support accreditation, quality assessment and improvement, and program evaluation of our health plan. We share only the minimum necessary information as required by law.

Disclosure to Law Enforcement

We may disclose information to law enforcement if we believe, in good faith, that it is evidence of a crime that occurred on our premises, or to report certain crimes during a medical emergency that did not occur on our premises. In these situations, we will disclose only what the law allows in these situations.

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: hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

With Your Written Consent (42 CFR Part 2)

If you provide written consent, we may use or disclose your Substance Use Disorder (SUD) information in the following ways:

- To the person or organization you name in your consent. Part 2 allows you to decide who may receive your SUD information through a written consent.
- To prevent multiple enrollments in withdrawal management or maintenance treatment programs. Part 2 permits disclosures for this purpose when authorized by your consent or as otherwise allowed by law.
- To report prescribed SUD treatment medications to a state Prescription Drug Monitoring Program when required by law.
  Part 2 allows this type of disclosure only when a state statute mandates such reporting.

Additional Protections for SUD Information (42 CFR Part 2)
For records related to Substance Use Disorder (SUD) treatment, we will not disclose your information in any civil, criminal, administrative, or legislative proceeding without your written consent or a court order that meets the requirements of 42 CFR Part 2.

Respond to audits and program oversight
For Substance Use Disorder (SUD) records protected by 42 CFR Part 2, organizations performing audits or evaluations must agree in writing not to redisclose your information and must destroy or return identifying information when the audit or evaluation is complete.

Redisclosure Rules for Substance Use Disorder (SUD) Information
If you authorize us to disclose your SUD records to other health care providers or health plans for treatment, payment, or health care operations, those recipients may redisclose your information as permitted by the HIPAA Privacy Rule. However, your SUD information may *not* be used or disclosed in any civil, criminal, administrative, or legislative proceeding against you without your written consent or a court order that meets the requirements of 42 CFR Part 2.
We will include the required Part 2 notice prohibiting unauthorized redisclosure with every disclosure of SUD information.

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.

Date: 1/1/2027
Name of Entity/Sender: The Beck Group
Contact: Beck Benefits Team
Address: 1601 Elm St #2800, Dallas, TX 75201
Email Address: BeWell@beckgroup.com

Important Notice from The Beck 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 The Beck 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. **The Beck Group has determined that the prescription drug coverage offered by the Beck Group's 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 The Beck 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 The Beck 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 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 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: 1/1/2027
Name of Entity/Sender: The Beck Group
Contact--Position/Office: Beck Benefits Team
Address: 1601 Elm St #2800, Dallas, TX 75201
Email Address: BeWell@beckgroup.com

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; or
- 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 31 days after the qualifying event occurs. You must provide this notice to the Beck Benefits Teams at BeWell@beckgroup.com

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 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 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 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 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

Date: 1/1/2027
Name of Entity/Sender: The Beck Group
Contact--Position/Office: Beck Benefits Team
Address: 1601 Elm St #2800, Dallas, TX 75201
Email Address: BeWell@beckgroup.com

1. 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: HSA: $2,500 / $5,000, PPO: $5,500 / $11,000. If you would like more information on WHCRA benefits, email your plan administrator at BeWell@beckgroup.com.

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? Email your plan administrator at BeWell@beckgroup.com 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 United Healthcare at 866-844-4864.

Visit cms.gov/nosurprises 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 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 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 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 January 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	myarhipp.com/	855-MyARHIPP (855-692-7447)
California Medicaid	dhcs.ca.gov/ 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: in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	800-403-0864 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	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	Medicaid: ldh.la.gov/healthy-louisiana or email: healthy@la.gov LaHIPP: ldh.la.gov/lahipp or email: La.HIPP@la.gov	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/hipp	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

STATE	WEBSITE/EMAIL	PHONE
New Jersey Medicaid and CHIP	Medicaid: 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/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 Share Line)
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	Bureau for Medical Services 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 January 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Wellness Program Notices

Beck's Wellness Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive a premium incentive (refer to benefits guide for information on premium incentives). Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the premium incentive.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Beck Benefits Team at Bewell@beckgroup.com.

Protections from Disclosure of Medical Information

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

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) registered nurse, a doctor, or a health coach in order to provide you with services under the wellness program.

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Beck Benefits Team at BeWell@beckgroup.com.

Accommodations

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

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