shiftkey

2027

EMPLOYEE BENEFITS GUIDE







What's Inside



IMPORTANT CONTACTS 3

WELCOME TO YOUR BENEFITS 4

ELIGIBILITY 5
- Holmes Murphy Benefit Advocacy Service
- Changing Benefits After Enrollment
- Qualified Life Events

MEDICAL PLANS 7
- Medical Plan Comparison
- Pharmacy Plan Comparison
- Options for Care
- Telemedicine
- Cigna Programs

FUNDING ACCOUNTS 13
- Health Savings Account (HSA)
- Flexible Spending Accounts (FSA)
- FSAs vs. HSAs
- Using Funds

DENTAL PLAN 16
- Base Plan
- Buy-Up Plan

VISION PLAN 17
- Vision Plan

LIFE INSURANCE 18
- Basic Life
- Accidental Death and Dismemberment (AD&D)
- Voluntary Life

DISABILITY INSURANCE 19
- Short-Term Disability (STD)
- Long-Term Disability (LTD)

SUPPLEMENTAL MEDICAL 20
- Accident
- Critical Illness
- Hospital Indemnity

FOCUS ON WELLBEING 22
- Employee Assistance Program
- Financial Wellness
- Travel Assistance
- Bereavement Support Services
- Pet Insurance

BI-WEEKLY CONTRIBUTIONS 27

REQUIRED NOTICES 28

IMPORTANT CONTACTS

Coverage	Contact	Website	Phone
Medical/Prescription Cigna OneGuide (for medical plan enrollees)	Cigna Group #00634554	mycigna.com	866-494-2111
MDLive (for medical plan enrollees)	Cigna/MDLive	mycigna.com	888-726-3171
Dental (inc'l virtual care)	Cigna Group #00634554	mycigna.com	800-244-6224
Vision	EyeMed	eyemed.com	866-800-5457
Flexible Spending Accounts (FSA)	Navia Benefits	customerservice@naviabenefits.com	425-452-3500
Health Savings Account (HSA)	HSABank	hsabank.com	800-357-6246
Accident Insurance	Lincoln	lincolnfinancial.com	800-423-2765
Critical Illness Insurance	Lincoln	lincolnfinancial.com	800-423-2765
Hospital Indemnity Insurance	Lincoln	lincolnfinancial.com	800-423-2765
Life and AD&D	Lincoln	lincolnfinancial.com	800-423-2765
Disability Insurance	Lincoln	lincolnfinancial.com	800-423-2765
Total Pet Plan	Wishbone	wishbone.pet	800-891-2565
Employee Assistance Program	Ulliance Group Code: ShiftKey/Irving	lifeadvisor.com	800-448-8326 877-231-1492
TravelConnect	On Call International	MyOnCallPortal.com **(Group ID: LFGTravel123)**	866-525-1955
Financial Wellness	Northstar	northstarmoney.com/advisors support@northstarmoney.com	N/A
Discount Program	Perkspot	avantperks.perkspot.com	N/A
Holmes Murphy Benefit Specialist	Maria Martinez	mmartinez@holmesmurphy.com	214-265-6332
ShiftKey Talent Team	ShiftKey	benefits@shiftkey.com	214-257-8686

In this guide, we use the term company to refer to ShiftKey, LLC. This guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by ShiftKey, LLC. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Welcome

TO YOUR 2027 BENEFITS GUIDE

We are pleased to provide you with a wide range of competitive benefits that are a vital part of your total compensation. You have the flexibility to select from a full range of benefits to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement. This guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family, and be sure to act before the enrollment deadline.



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



Eligibility

If you regularly work at least 30 hours per week, you are eligible for benefits. Most of your benefits are effective on your date of hire. You may also enroll your eligible dependents for coverage. Eligible dependents could be:

- Your legal spouse or qualified domestic partner
- Children under the age of 26, regardless of student, dependency or marital status
- Children who are past the age of 26 and are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

Changing Benefits After Enrollment

During the year, you cannot make changes to your benefits unless you have a Qualified Life Event. If you do not make changes to your benefits within 30 days of the Qualified Life Event, you will have to wait until the next annual Open Enrollment period to make changes (unless you experience another Qualified Life Event).

Qualified Life Event		Documentation Needed
Change in Marital Status	• Marriage • Divorce/Legal Separation • Death	• Copy of marriage certificate • Copy of divorce decree • Copy of death certificate
Change in Number of Dependents	• Birth or adoption • Step-child • Death	• Copy of birth certificate or copy of legal adoption papers • Copy of birth certificate plus a copy of the marriage certificate between employee and spouse • Copy of death certificate
Change in Employment	• Change in your eligibility status (i.e., full-time to part-time) • Change in spouse's benefits or employment status	• Notification of increase or reduction of hours that changes coverage status • Notification of spouse's employment status that results in a loss or gain of coverage





Holmes Murphy Benefit Advocacy Service

As an employee of ShiftKey, you have access to Holmes Murphy's Benefits Specialist, Maria Martinez, who is available to you and your dependents to help assist you in your benefits-related questions. Simply call or email and Maria will be available to help you. If she doesn't have an immediate answer, she will research it and get back to you in a timely manner without you waiting on hold. How easy is that?

Some of these questions may be:

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



HELP WHEN YOU NEED IT

Benefits can be confusing, that's why you can contact your dedicated benefits analysts from Holmes Murphy.



YOUR DEDICATED BENEFITS SPECIALIST

Maria Martinez
mmartinez@holmesmurphy.com
Direct: **214-265-6332**
Fax: **800-882-5949**
Available Monday - Friday, 8 a.m. to 5 p.m. CT

PROTECTION YOU NEED

Our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens.

Medical Plans



Medical insurance is essential to your well-being. ShiftKey offers all benefits-eligible employees a choice of three plan options through Cigna.

PARTS OF YOUR MEDICAL PLAN

Three plan options available to you through **Cigna**, are all offered through the Cigna Open Access Plus (OAP) network. The plans do have out-of-network benefits, but you will pay less if you stay in-network.

Annual deductible amount - The amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay.

Out-of-pocket maximums (OOPM) - The most you will pay each year for eligible network services including prescriptions. After you reach your out-of-pocket maximum, the plan picks up the full cost of the covered medical care for the remainder of the year.

Copays - A copay is a fixed amount you pay for a health care service. Copays do not count toward your deductible but do count toward your annual out-of-pocket maximum.

Coinsurance - Once you've met your deductible, you and the plan share the cost of care, called coinsurance. For example, you pay 20% for services and the plan will pay 80% of the cost until you have reached your out-of-pocket maximum.

Embedded Deductible/OOPM - An embedded deductible or out-of-pocket maximum is a feature where individual members of a family plan each have their own deductible or out-of-pocket limit, and once any member meets their individual limit, the plan begins to cover expenses for that member even if the overall family limit hasn't been reached.



MEDICAL PLAN COMPARISON

	Value HDHP Plan (Employee's Costs)		Plus HDHP Plan (Employee's Costs)		OAP Buy-Up PPO Plan (Employee's Costs)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-Of-Network
Calendar Year Deductible (Embedded)						
Individual	$4,500	$10,000	$3,500	$6,000	$750	$2,500
Family	$9,000	$20,000	$8,400	$18,000	$1,500	$7,500
Calendar Year Out-of-Pocket Maximum (Embedded; Includes Deductible)						
Individual	$4,500	$20,000	$3,500	$6,000	$1,250	$28,000
Family	$9,000	$40,000	$8,400	$18,000	$3,750	$56,000
Coinsurance/Copays						
Preventive Care	$0	30% coinsurance*	0%	30% coinsurance*	$0	40% coinsurance*
Primary Care Physician	0% coinsurance*	30% coinsurance*	0% coinsurance*	30% coinsurance*	$25 copay	40% coinsurance*
Specialist	0% coinsurance*	30% coinsurance*	0% coinsurance*	30% coinsurance*	$45 copay	40% coinsurance*
Urgent Care	0% coinsurance*	0% coinsurance*	0% coinsurance*	0% coinsurance*	$25 copay	$25 copay
Emergency Room	0% coinsurance*	0% coinsurance*	0% coinsurance*	0% coinsurance*	$400 copay	$400 copay
Inpatient and Outpatient	0% coinsurance*	30% coinsurance*	0%	30%	0% coinsurance*	40% coinsurance*

*After deductible

NETWORK PROVIDER/FACILITY SEARCH

Make sure that your provider or facility is in-network. To locate a network provider, follow the steps below or call 866-494-2111. Visit **mycigna.com**, select "Find a Doctor" at the top of the screen. Then, under "Not a Cigna customer yet?" select "Plans through your employer or school." If you're already a Cigna customer, login to **mycigna.com** or the myCigna app to search your current network.

Member Service Portal

Your medical carrier's member portal is your access to secure, personalized services with interactive health tools built around you, your benefits, and your health. Access via **mycigna.com**.

Once you are registered, your personal health information will be available to you 24/7, including:

- Finding care
- Managing prescriptions
- Managing claims
- Staying healthy
- Getting coverage and cost details

Need your health data on the run? Download your free carrier app from the App Store or Google Play. Use your mobile device to search for doctors, hospitals and more! Just search myCigna.

PHARMACY PLAN

When you enroll in medical coverage, you will also receive prescription benefits through **Cigna**. Here you can see the basics, but be sure to check the formulary for a full list of the prescriptions that are covered by the plan. Remember, you can always ask your doctor about lower-cost alternatives. Generic drugs tend to be less expensive than brand-name drugs, so keep that in mind when shopping around.

Certain preventive and generic drugs are covered at 100%, no cost to you, when you use an in-network pharmacy.

Items that could be considered preventive include, but are not limited to:

- Asthma
- Cholesterol Lowering
- Depression
- Diabetes (including diabetic supplies and continuous glucose monitor supplies)
- Heart Disease and Stroke
- High Blood Pressure
- Osteoporosis
- Prenatal Vitamins
- Prescription Vitamins

	Value HDHP Plan (Employee's Costs)		Plus HDHP Plan (Employee's Costs)		OAP Buy-Up PPO Plan (Employee's Costs)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-Of-Network
Retail Pharmacy (30-Day Supply)						
Generic (Tier 1)	0% coinsurance*	0% coinsurance*	0% coinsurance*	0% coinsurance*	$10 copay	50% coinsurance*
Preferred (Tier 2)	0% coinsurance*	0% coinsurance*	0% coinsurance*	0% coinsurance*	$35 copay	50% coinsurance*
Non-Preferred (Tier 3)	0% coinsurance*	0% coinsurance*	0% coinsurance*	0% coinsurance*	$75 copay	50% coinsurance*
Preferred Specialty (Tier 4)	0% coinsurance*	0% coinsurance*	0% coinsurance*	0% coinsurance*	$150 copay	50% coinsurance*
Mail Order Pharmacy (90-Day Supply)						
Generic (Tier 1)	0% coinsurance*	0% coinsurance*	0% coinsurance*	0% coinsurance*	$30 copay	50% coinsurance*
Preferred (Tier 2)	0% coinsurance*	0% coinsurance*	0% coinsurance*	0% coinsurance*	$105 copay	50% coinsurance*
Non-Preferred (Tier 3)	0% coinsurance*	0% coinsurance*	0% coinsurance*	0% coinsurance*	$225 copay	50% coinsurance*
Preferred Specialty (Tier 4)	Not Covered	Not Covered	Not Covered	Not Covered	$450 copay	Not Covered

Bi-Weekly Employee Medical Rates	Value HDHP Plan	Plus HDHP Plan	OAP Buy-Up PPO Plan
Employee	$55.00	$111.00	$138.00
Employee + Spouse	$196.00	$282.00	$362.00
Employee + Child(ren)	$178.00	$254.00	$328.00
Family	$282.00	$402.00	$519.00

Options for Care

You have many options for how and where you can receive care through your Cigna medical plan. But which one is best for your situation? Use the chart below to help you decide and see the page for service costs.

Care Center	What Is It?	What Can They Treat?
Nurse Line	• Staffed by registered nurses • Resource for guidance during natural catastrophes or health outbreaks • Available 24/7/365 days a year at NO COST	• Answer general questions like, "How long should I ice my sprained ankle?" • Give advice/referrals of where to go for treatment (e.g., ER or primary care doctor)
Telemedicine/Virtual Visits	• Convenient, low-cost option for treating common, non-urgent health concerns • A doctor will diagnose the issue over the phone and write a prescription, if necessary • Available 24/7/365 days a year, by web, phone or mobile app	• Minor illnesses & infections • Cold and flu symptoms • Bronchitis • Allergies • Mental health • Headaches/migraines • And more...
Doctor's Office	• Routine care or treatment for a current health issue • Your primary doctor knows you and your health history • To manage your medications • To refer you to a specialist • Normally available Monday-Friday; check with your provider for actual office hours	• Routine checkups • Preventive services • Immunizations • Minor injuries, such as sprains • Illnesses • Manage your general health and chronic conditions
Urgent Care Clinic	• Treatment of non-life-threatening injuries or illnesses • Staffed by qualified physicians • Generally open nights and weekends; some open 24/7	• Cold and flu symptoms • Minor accidents or falls • Minor sprains or fractures • Minor cuts and burns • Vomiting, diarrhea
Emergency Room	• Immediate treatment for serious, life-threatening conditions • Ready to treat any critical situation • Can be hospital-based or freestanding • Available 24/7/365 days a year	• Chest pain • Difficulty breathing • Severe abdominal pain • Broken bones • Head injuries • Uncontrolled bleeding • Seizures • Coughing, or vomiting blood

Virtual Visits

Access MDLive:
888-726-3171
mycigna.com

Or access on the myCigna app

Find a Doctor/Facility

Access Cigna One Guide:
866-494-2111
mycigna.com

Or access on the myCigna app

Telemedicine

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

REGISTER TODAY SO YOU ARE READY WHEN YOU NEED CARE



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

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

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

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

Avoid costly copays and deductibles associated with the emergency room and urgent care clinics.

USING TELEMEDICINE IS AS EASY AS ONE, TWO, THREE

Register Now
Setting up your secure account takes only minutes.
Visit **mycigna.com** and click on "Login/ Register>Start Registration"
Or call **888-726-3171**

Request a Visit
You can have a doctor visit right away or schedule an appointment all by phone or computer

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

Cigna Programs

We are excited to share several programs that Cigna offers to all members enrolled in our medical plan at NO COST TO YOU! Please see below for important information on how to participate in these free programs. Please contact the benefits team with any questions at **benefits@shiftkey.com.**

Let's face it, understanding and using your health plan isn't always easy. Well, not to worry. Your **Cigna One Guide®** team is ready and waiting to help. It's their highest level of personal support available. This program is available using click-to-chat on **mycigna.com** or by calling 866-494-2111. They will help you find the right care, understand your plan, and save money!

Cigna's **RecoveryOne** program provides personalized support for musculoskeletal health, including recovery from injuries and surgeries. With access to expert guidance, digital tools, and tailored exercise plans, you can manage pain, improve mobility, and speed up your recovery—all from the comfort of your home. Take control of your physical health with Cigna's RecoveryOne program and get back to feeling your best. Learn more at **recoveryone.com/cigna**.

Omada is a personalized diabetes and/or heart disease management program that combines tools and support to help you make changes that last—whether that's around eating, activity, sleeping, or stress. When you join the program, you'll get your own professional health coach, connected health devices, weekly online lessons, and a small peer group. If you or your adult family members are enrolled in the Cigna health plan and are at risk for type 2 diabetes or heart disease or living with high blood pressure, the Omada program is included in your benefits. For more details and registration instructions, visit **omadahealth.com/success-stories**.

Cigna's **Medication Pricing** program helps you find the most cost-effective options for your prescriptions. Easily compare prices at different pharmacies, discover generic alternatives, and get access to discounts and savings. This program empowers you to make informed decisions and manage your medication costs effectively. Take advantage of Cigna's Medication Pricing program to ensure you get the best value for your prescriptions. Access the tool at **mycigna.com**!



Funding Accounts

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is a personal savings account you can use to pay for qualified out-of-pocket medical expenses with pretax dollars — now or in the future. Our HSAs are managed by **HSA Bank**. Once you're enrolled in the HSA, you'll receive a debit card to help manage your HSA reimbursements. Your HSA can also be used for your expenses and those of your spouse and dependents, even if they are not covered by the HDHP medical plan. ShiftKey partners with HSA Bank to offer HSAs to HDHP enrollees.

Eligibility

You must be enrolled in the High Deductible Health Plan.

Contributions

ShiftKey contributes:

- Employee Only: $600 for Value plan, $600 for Plus plan
- Family: $2,000 for Value plan, $1,200 for Plus plan

You contribute on a pretax basis and can change how much you contribute from each paycheck up to the annual IRS maximum of $4,500 if you enroll only yourself or $9,000 if you enroll in family coverage. You can make an additional catch-up contribution of $1,000 if you are age 55 or older by 12/31/2027.

Eligible Expenses

You may use your HSA funds to cover eligible medical, dental, vision and prescription drug expenses incurred by you and your eligible family members.

Using Your Account

Use the debit card linked to your HSA to cover eligible expenses or pay for expenses out of your own pocket and save your HSA money for future health care expenses.

Your HSA is Always Yours — No Matter What

One of the best features of an HSA is that any money left in your HSA account at the end of the year rolls over so you can use it next year or sometime in the future. And if you leave the Company or retire, your HSA goes with you so you can continue to pay for or save for future eligible health care expenses.

FLEXIBLE SPENDING ACCOUNT (FSA)

Flexible Spending Accounts (FSAs) allow you to pay for eligible expenses using tax-free dollars. Our FSAs are managed by **Navia Benefits**. Important: There is a "use-it-or-lose-it" rule imposed by the IRS. If you do not spend all the money in Health Care, Limited Purpose or Dependent Care FSA by March 31 of the following year for expenses incurred from January 1 – December 31, unused dollars will be forfeited per IRS regulations for pretax contributions.

Health Care FSA	Limited Purpose FSA	Dependent Care FSA
• For employees enrolled in the Cigna OAP Buy-Up PPO Plan or another non-HSA medical plan.	• For employees enrolled in the Value HDHP or Plus HDHP Plans or any other HSA-qualified. medical plan.	• For employees enrolled in any of the Cigna medical plans.
• Contribute up to $3,500 per year, pretax, to pay for eligible medical, prescription, dental and vision expenses. • Employees will have 90 days after the 2027 plan year ends to claim unused balances, then $700 will rollover from your unused 2027 balance into 2028 (all other remaining funds will be forfeited at the end of the run out period due to the IRS "use-it-or-lose-it" rule).	• Those enrolled in the HDHP can contribute up to $3,500 per year, pretax, to pay for eligible vision and dental expenses. • Employees will have 90 days after the 2027 plan year ends to claim unused balances, then $700 will rollover from your unused 2027 balance into 2028 (all other remaining funds will be forfeited at the end of the run out period due to the IRS "use-it-or-lose-it" rule).	• Contribute up to $7,500 per year, pretax, ($3,750 if married and filing separate tax returns) to pay for day care expenses associated with caring for elder or child dependents that are necessary for you. • You cannot use your Health Care or Limited Purpose FSA to pay for dependent care expenses. • Employees will have 90 days after the 2027 plan year ends to claim unused balances, then any unused funds will be forfeited under IRS "use-it-or-lose-it" rule.

How an FSA works:

• Choose a specific amount of money to contribute each pay period, pretax, to one or both accounts during the year.

• The amount is automatically deducted from your pay at the same level each pay period.

  • You have immediate access to the full annual elected amount in your Health Care FSA or Limited Purpose FSA as of January 1.

  • You will only be able to access available funds in your Dependent Care FSA, not "future" funds.

• As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

Save your receipts! You may be required to produce them during a plan year audit as required by the IRS.

FSA AND HSA COMPARISON		
	Health Care FSA & Limited Purpose FSA	HSA
Stands for	Flexible Spending Account	Health Savings Account
What is it?	A benefit plan sponsored by an employer to reimburse qualified health care expenses to participating employees. ShiftKey offers **Limited Purpose** and **Health Care** FSAs.	Account offered in conjunction with a high-deductible health plan that reimburses the employee for qualified health care expenses.
Who is eligible?	At ShiftKey, employees who elect the ShiftKey PPO plan are eligible to participate.	Employees enrolled in a high deductible health plan (HDHP) who do not have any other non-HDHP health plan, including coverage under Medicare, a spouse's health plan or Flexible Spending Account (FSA).
Contribution limits	**Health Care FSA:** Projected amount of $3,500 for 2027 **Limited Purpose & Health Care FSA:** Projected amount of $3,500 for 2027	Single coverage: $4,500 Family coverage: $9,000
Who owns the account?	Employer	You
Contributions subject to income tax?	No	No
Does interest accrue?	No	Yes
Contributions	Money is deducted (pretax) from your salary every pay period. Additional individual contributions are NOT allowed, except for at time of QLE.	Money is deducted (pretax) from your salary every pay period. Additional individual contributions up to the maximum contribution amount ARE allowed.
Disbursement of funds	ShiftKey pre-funds the entire annual contribution that you elect.	Only funds paid in by you or your employer, on a per period basis, are available for health care expenses.
Catch-up contribution	No	Yes. Employees aged 55 to 65 may contribute up to $1,000 more to their account per year.
Portability and forfeiture	You lose any unspent money when employment is terminated.	This account is portable. HSA balance is not forfeited when you change employers or health plans.
Expiration	Carry over up to a projected amount of $700 to the next plan year. Unused funds over this amount will be forfeited.	Your funds never expire.
Balance carry over (or rollover)	No. "use-it-or-lose-it" provision applies.	Yes. Unused funds are carried over to the following year.
Can I change my contribution?	Only for Qualifying Life Events, such as a marriage, divorce, birth, or during Open Enrollment.	Yes, on a monthly basis.
Eligible medical expenses	Qualifying medical expenses are those specified in the plan, e.g., copays, coinsurance, deductible, prescription drugs, braces, dental and eye care expenses.	Qualified medical expenses defined under Internal Revenue Code 213(d), except for amounts distributed to pay health insurance premiums. HSAs can be used to pay premiums for Temporary Continuation of Coverage, Long Term Care and health insurance for retirees.
Non-medical expenses	FSA funds cannot be used for non-medical expenses.	HSA funds can be used for non-health care distributions but are included in gross income and subject to a 10% penalty if under age 65.
Proof of expenses required?	Yes	No. However, you should be prepared to substantiate to the IRS that the expense has been incurred, the amount of the expense, and its eligibility.

Dental Plan

ShiftKey offers two dental plans through **Cigna** and uses the Cigna network of providers. Taking care of your oral health is not a luxury; it is a necessity to long-term optimal health. With a focus on prevention, early diagnosis and treatment, Dental insurance can greatly reduce your costs when it comes to restorative and emergency procedures. Preventive services are covered at no cost to you and include routine exams and cleanings. You will pay only a small deductible and coinsurance for basic and major services.

When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than your expected share of the bill. Please visit **mycigna.com** or call 800-244-6224 to find an in-network provider. Please refer to the Summary Plan Description for complete plan details.

Cigna also offers their 24/7 Dental Virtual Care program. This program connects you with a licensed dentist who, through a video call, can help address urgent dental situations like toothaches, infection, swelling, and can also prescribe medications to be filled at your local pharmacy, if necessary. Please visit **mycigna.com** to learn more.

	Cigna Base Dental Plan		Cigna Buy-Up Dental Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
Waived for Preventive Care?	Yes	Yes	Yes	Yes
Annual Maximum				
Per Person/Family	$1,500	$1,500	$1,500	$1,500
Preventive *	100%	100%	100%	100%
Basic	80%	80%	100%	100%
Major	50%	50%	60%	60%
Orthodontia				
Benefit Percentage	Not covered	Not covered	50%	50%
Adults and Children	Not covered	Not covered	Yes	Yes
Lifetime Maximum	Not covered	Not covered	$1,500	$1,500

*NOTE: Preventive benefits do NOT count toward your annual maximum. Your annual maximum will increase by $100 in 2027 if you had a Preventive service in 2026.

Bi-Weekly Employee Dental Rates	Cigna Base Dental Plan	Cigna Buy-Up Dental Plan
Employee	$3.00	$5.00
Employee + Spouse	$10.00	$14.00
Employee + Child(ren)	$12.00	$18.00
Employee + Family	$18.00	$27.00

Vision Plan

Healthy eyes and clear vision are an important part of your overall health and quality of life. ShiftKey partners with **EyeMed** to offer vision coverage through the EyeMed network.

You may enroll yourself and your eligible dependents or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect vision coverage or cover the same dependents under medical and vision.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

Please visit **eyemed.com** or call 866-800-5457 to find an in-network provider. Please refer to the Summary Plan Description for complete plan details.

	EyeMed Vision Plan	
	In-Network	Out-Of-Network Reimbursement
Copay		
Routine Exams (every 12 months)	$10 copay	
Materials Copay	$25 copay	
Frames (every 12 months)		
Frames	$150 allowance plus 20% off additional balance	Up to $70
Lenses (every 12 months - in lieu of contacts)		
Single Vision	100%	Up to $30
Bifocal	100%	Up to $50
Trifocal	100%	Up to $70
Lenticular	100%	Up to $70
Contacts (in lieu of lenses)		
Fit and Follow-Up Exams	Member cost up to $40	No benefit
Elective	$150 allowance	Up to $120
Medically Necessary	100%	Up to $210

Bi-Weekly Employee Vision Rates	EyeMed Vision Plan
Employee	$1.00
Employee + Spouse	$2.00
Employee + Child(ren)	$2.00
Employee + Family	$4.00

Life and AD&D

BASIC LIFE AND AD&D

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

ShiftKey provides employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance through Lincoln. This benefit is provided at no cost to you.

Basic Life and AD&D Insurance - For You		
Coverage Level	Coverage Amount	Evidence of Insurability (EOI) Proof of Good Health
Life and AD&D	1 times your basic annual earnings to a maximum of $250,000.*	None

*This benefit reduces to 65% at age 65 and reduces to 50% at age 70.

Imputed Income

Under current tax laws, imputed income is the value of your Basic Life Insurance that exceeds $50,000, and is subject to federal income, Social Security, and state income taxes. If applicable, the premium for this employer-paid benefit that is above $50,000 will be included in your paycheck and shown on your W-2 statement.

VOLUNTARY LIFE AND AD&D

In addition to the employer-paid Basic Life and AD&D coverage, you have the option to purchase supplemental voluntary life insurance through Lincoln for yourself and your eligible dependents.

During your initial enrollment opportunity, you may elect up to the Guarantee Issue (GI) amount of Voluntary Life for yourself and your eligible dependents without providing an Evidence of Insurability (EOI). If you elect over the GI amount, you will be required to complete an Evidence of Insurability (EOI).

Life and AD&D Insurance - For You and Your Dependents		
Coverage Level	Coverage Amount	Evidence of Insurability (EOI) Proof of Good Health
Employee Only	Increments of $10,000 not to exceed 5 times to your salary or $500,000.	Required if electing coverage equal to or greater than 5 times base annual pay or $500,000, whichever is less earnings.
Spouse	Increments of $5,000 up to $250,000 – not to exceed 50% of employee coverage.	Required for amounts equal to or greater than $250,000.
Child(ren)	Increments of $500 for birth to 14 days. $10,000 for children 14 days to age 26.	None

Important Reminder

You MUST designate a beneficiary for your Life and AD&D insurance when you become eligible for coverage or upon enrollment. This will ensure your assets are distributed according to your wishes.

Disability

Disability insurance can keep you financially stable should you experience a qualifying disability and be unable to work. It can help provide a sense of security, knowing that if the unexpected should happen, you'll still receive a monthly income. A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training, or experience.

ShiftKey provides employees with Short-Term Disability (STD) and Long-Term Disability (LTD) insurance through **Lincoln Financial** at no cost to you (note the additional voluntary STD option below).

Short-Term Disability Benefits-at-Glance	
Coverage (ShiftKey Paid)	60% of your weekly earnings to a $2,000 maximum for 12 weeks.
Voluntary Option (Employee-Paid)	67% of your weekly earnings to a $3,000 maximum for 12 weeks.
When Payment Begins	Payment begins after 7 days of approved disability.

Long-Term Disability Benefits-at-Glance	
Coverage	60% of your pre-disability earnings up to a maximum benefit of $10,000 per month until you recover or reach your Social Security Normal Retirement Age, whichever is sooner.
When Payment Begins	Payment begins after 90 days of approved disability.
Benefit Limitations	Mental/Nervous: 24 months Substance Abuse: 24 months

HOW STD AND LTD WORK TOGETHER

Available PTO, Sick Time, or Paid Parental Leave may be used until STD begins. → After 7 days of sickness or injury, approved STD pays a portion of your income. → After 13 weeks, LTD begins if approved.

Supplemental Medical

Just as it sounds, Supplemental Medical plans can help you pay for costs you may incur after an accidental injury, illness, or hospitalization. These plans are offered through **Lincoln Financial** and are 100% voluntary.

ACCIDENT INSURANCE

Accident insurance pays out a lump sum if you become injured because of an accident. It allows you to claim benefits even if the injuries you incur do not keep you out of work. Accident insurance may also complement health insurance if an accident causes you to have medical expenses that your health insurance doesn't cover.

Accident insurance covers qualifying injuries, which might include a broken limb, loss of a limb, burns, lacerations, or paralysis. In the event of your accidental death, accident insurance pays out money to your designated beneficiary. While health insurance companies pay your provider or facility, accident insurance pays you directly.

Bi-Weekly Employee Accident Rates	
Employee	$4.41
Employee & Spouse	$6.72
Employee & Child(ren)	$8.18
Family	$10.70

Health Assessment Benefit

There is a $50 annual benefit per member per year for having one health screening test performed (see plan document for list of eligible screenings).

How Accident Insurance Works

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

A set amount is payable based on the injury you suffer and the treatment you receive.

- Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit.
- Coverage is available for you, your spouse, and eligible dependent children.
- You do not need to answer medical questions or have a physical exam to get basic coverage.
- Accident insurance covers injuries that happen on the job or off the job — unlike workers' compensation, which only covers on-the-job injuries.
- Benefit payments are not reduced by any other insurance you may have with other companies.



CRITICAL ILLNESS INSURANCE

If you suffer from a serious illness, such as cancer, stroke, or a heart attack, medical insurance may not provide the coverage you need. Critical Illness insurance will ease the financial strain and help you focus on recovery.

How Will a Critical Illness Claim Get Paid?

If you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum.

The payment will go directly to you instead of to a medical provider. The payment you receive can be used for many things including:

- Child care costs
- Medical expenses
- Travel expenses for you and your family
- Lost wages from missed time at work
- Living expenses
- And more

You can purchase increments of $10,000 to a maximum of $30,000 for yourself and your spouse. Child(ren) are eligible for up to 50% of employee coverage.

Consider the following advantages of this critical illness coverage offering:

- A set amount of money is paid directly to you to be used however you choose
- You can insure your spouse and children
- There are no health questions to answer
- The policy is portable, so if you leave ShiftKey, you can take the policy with you
- Health Screening Benefit — $50

Covered conditions include:

- Heart Attack
- Coronary Artery Bypass Graft
- Non-Invasive Cancer
- Kidney Failure
- Major Organ Transplant
- Stroke
- Alzheimer's Disease

Please visit Workday to see your personalized bi-weekly premium amounts.

Health Assessment Benefit

There is a $50 annual benefit per member per year for having one health screening test performed (see plan document for list of eligible screenings).



HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity insurance is a Supplemental Insurance plan designed to pay for the costs of a hospital admission that may not be covered by other insurance.

How Does Hospital Indemnity Insurance Work?

If you are admitted to the hospital for an injury or illness, your Hospital Indemnity plan makes cash payments to you to pay for costs not covered by your health insurance, health insurance deductibles, copays and coinsurance, child care expenses while you are in the hospital, or cost of- living expenses as you recover.

Other advantages of hospital insurance are:

- There are no health questions to answer
- You can cover your spouse and children
- The policy is portable, so if you leave ShiftKey, you can take the policy with you
- This Hospital Indemnity policy is compatible with your HSA

Hospital Indemnity Insurance Benefit Examples:	
Hospital Admission	
Initial Hospital Admission	$1,000
Initial Intensive Care Admission	$2,000
Hospital Confinement	
Hospital Confinement	$200 per day up to 30 days

Bi-Weekly Employee Hospital Indemnity Rates	
Employee	$9.58
Employee & Spouse	$18.35
Employee & Child(ren)	$13.67
Family	$22.16

Employee Assistance Program

You automatically have access to the Employee Assistance Program (EAP) through **Ulliance.** This program provides professional, confidential telephonic or face-to-face counseling services to you and your household members at no cost. The EAP can help you resolve personal issues and problems before they affect your health, relationships and work performance.

This program is available 24 hours a day, 365 days a year for confidential counseling, referral, and followup services for issues such as:

- Stress
- Marital or family problems
- Anxiety and depression
- Substance abuse (alcohol and/or drugs)
- Financial issues
- Child care issues - including identifying schools, day care, tutors and more
- Aging parents
- Pet care
- Maintenance and repair providers
- Community volunteer opportunities

800-448-8326
LifeAdvisor.com

Group code:
ShiftKey
Location: **Irving**

It's important to note that all EAP conversations are voluntary and strictly confidential. If you and your counselor determine that additional assistance is needed, you'll be referred to the most appropriate and affordable resource available. Although you're responsible for the cost of referrals, these costs are often covered under your medical plan.



Financial Wellness - Northstar

As a ShiftKey employee, you are eligible to receive personalized financial guidance from Northstar. They are a financial planning tool that takes a personal approach to reaching your goals, including:

- Working 1-on-1 with a personal financial advisor (CFP)
- Receiving a personalized step-by-step financial plan
- Setting achievable goals with personal finance tools
- Getting enrollment decision support with benefits tools
- Adjusting your plan as your life goals change

HOW IT WORKS:

Answer five questions, then get paired with a Northstar Advisor to get started right away.

→

Talk about what matters most - your financial priorities, concerns, and goals with your Northstar Advisor.

→

Receive a custom action plan within minutes from your Northstar Advisor.

Ready to get started?

Scan the QR code or visit northstarmoney.com/activate and use your ShiftKey email address to activate your account.

Additional Benefits

TRAVEL ASSISTANCE

24-Hour Travel Connect provides a comprehensive range of information, referral, coordination and arrangement services designed to respond to most medical care situations and many other emergencies you may encounter when you travel. On Call also offers pre-trip assistance including passport/visa requirements, foreign currency and weather information.

When traveling more than 100 miles from home or in a foreign country, On Call offers you and your dependents the following services:

COVERAGE HIGHLIGHTS

- Replacement of lost or stolen travel documents
- Nurse help line, available 24 hours a day, seven days a week
- Emergency medical evacuations
- Evacuations for natural disasters and political emergencies
- Transportation of remains
- Return of children and pets to their home following a medical emergency

SAFETY SERVICES

If employees find themselves at the site of a natural disaster or political upheaval, TravelConnect will coordinate and provide:

- Evacuation to the nearest safe haven location
- Lodging at the safe haven location
- Travel arrangements home

MEDICAL ASSISTANCE

In the event of a medical emergency, you can use TravelConnect to speak with an assistance coordinator for:

- Worldwide medical, dental, and pharmacy referrals
- Treatment monitoring
- Hospital payment facilitation
- Relay of insurance and medical information
- Medical record requests
- Evacuation from a medical facility that cannot provide adequate treatment to one that can, and transportation home after treatment and stabilization
- Transportation to join a hospitalized member traveling alone
- Transportation, with an escort if needed, for unattended minor children and pets to their home
- Transportation of remains if a traveler passes away

TRAVEL SERVICES

TravelConnect also provides assistance throughout the entire travel process, from the planning stages until the return home.

Before the trip, we deliver:

- Travel and health information, including visa and vaccination requirements
- Security intelligence to help your employees travel safely and wisely
- Destination information, including weather conditions and currency

During the trip, we offer:

- Help with lost passports, tickets, and credit cards
- Translation services
- Emergency travel fund assistance
- Legal referrals
- Emergency messaging forwarding
- Identity recovery assistance

HOW IT WORKS:

At any time before or during a trip, you may contact On Call for emergency assistance services. It is recommended that you keep a copy of this summary with your travel documents. Simply detach the wallet card below to ensure convenient access to the On Call phone numbers.

To access TravelConnect, go to MyOnCallPortal.com and enter Group ID: **LFGTravel123**.

You may also call toll-free from the U.S. or Canada 866-525-1955. or collect from anywhere in the world 603-328-1955, or email mail@OnCallInternational.com.

BEREAVEMENT SUPPORT SERVICES

Lincoln provides **Empathy** for confidential and professional support services to all covered employees and family members to cope with the loss of a loved one — at no extra cost.

What beneficiaries will get with Empathy

HUMAN COMPASSION SURCHARGED BY TECHNOLOGY

Funeral planning
Comprehensive funeral assistance and obituary writing support to help beneficiaries honor their loved ones.

On-demand Care Team
Dedicated human support from Empathy's expert Care Managers.

Probate and estate guidance
Resources and guidance to help navigate probate and settle the estate.

Grief support
A collection of meditations, tools and resources for processing and coping with grief.

Time-saving tools
Digital solutions that simplify administrative responsibilities and streamline manual tasks.

Visit **empathy.com** for more information

PERKSPOT DISCOUNT PROGRAM

ShiftKey partners with **PerkSpot**, a one-stop-shop for exclusive discounts at many of your favorite national and local merchants! PerkSpot is completely free, and optimized for use on any device: desktops, tablets, and phones. Enjoy access to thousands of discounts in dozens of categories, updated daily.

Sign up or log in at **avantperks.perkspot.com**. Follow the onscreen instructions to make an account with your work email address. Opt into the weekly PerkSpot Discount Program email to find out about new offers and special promotions. Each week's email features both new and popular deals, as well as seasonal and thematic groupings of offers.

Once logged into PerkSpot Discount Program, browse your discounts in a number of ways. Peruse the "Everyday Savings" and "Popular Savings" sections for an array of in-demand deals from across different categories.

Discover discounts in your neighborhood with PerkSpot Discount Program's streamlined Local Map. Filter your map results by categories like restaurants, health and fitness, retail, and more!

Don't see the retailer or product you want? You can always request a merchant through your PerkSpot Discount Program account, and our negotiating experts will work to get it for you.

Wishbone Total Pet

Total Pet Plan from **Wishbone** is a pet care bundle helping you save on everything your pet needs for less than 40 cents a day. There are no exclusions — even pets with pre-existing conditions are covered. Combining the best in pet care, Total Pet Plan members get access to:

- Up to 40% off and free shipping on all orders from **PetCareRx.com**, including medications, food, toys, treats, and more
- Same-day pickup for human-grade prescriptions at participating pharmacies such as CVS, Walmart, and other CVS Caremark pharmacies
- Instant 25% savings on all in-house medical services at participating veterinarians; easy-to-use with no claim forms or deductibles
- 24/7 access to licensed US-based veterinarians for questions regarding your pet's health and behavior
- Durable ID tag and 24-hour lost pet recovery help line to protect your pet if they go missing

Enroll for one, low rate today!

Bi-Weekly Employee Pet Insurance Rates	
One Pet	$5.42
Family Plan	$8.54

Frequently Asked Questions

Which pets can I enroll?
You can enroll any dog and cat in Total Pet Plan. There are no restrictions due to age, breed or health of your pet. Pet Assure Veterinary Discounts also cover exotic pets.

How do I access my Total Pet benefits?
After enrollment, you'll receive login credentials from Pet Benefit Solutions. Log in to your account at **wishbone.pet** to access all of your plan benefits.

Are there additional fees?
No, your membership cost gives you access to all of your benefits without any additional fees.

Are there usage limitations?
No, all benefits have unlimited usage for the pets enrolled.

Wishbone Total Pet
wishbone.pet
help@wishbone.pet
800-887-5708



Bi-weekly Employee Contributions

Medical (Cigna)	Value HDHP Plan	Plus HDHP Plan	OAP Buy-UP Plan
Employee Only	$55.00	$111.00	$138.00
Employee + Spouse	$196.00	$282.00	$362.00
Employee + Child(ren)	$178.00	$254.00	$328.00
Family	$282.00	$402.00	$519.00

Dental (Cigna)	Base Plan	Buy-Up Plan
Employee Only	$3.00	$5.00
Employee + Spouse	$10.00	$14.00
Employee + Child(ren)	$12.00	$18.00
Family	$18.00	$27.00

Vision (EyeMed)	Bi-Weekly Rates
Employee Only	$1.00
Employee + Spouse	$2.00
Employee + Child(ren)	$2.00
Family	$4.00

Hospital Indemnity Insurance (Lincoln)	Bi-Weekly Rates
Employee Only	$9.58
Employee + Spouse	$18.35
Employee + Child(ren)	$13.67
Family	$22.16

Accident Insurance (Lincoln)	Bi-Weekly Rates
Employee Only	$4.41
Employee + Spouse	$6.72
Employee + Child(ren)	$8.18
Family	$10.70

Pet Insurance (Pet Benefits)	Bi-Weekly Rates
One Pet	$5.42
Family Plan	$8.54

Voluntary Life/AD&D (Lincoln)		
Age	Bi-Weekly Rates Per $1,000	
	Employee	Spouse
Under 25	$0.03	$0.04
25-29	$0.04	$0.05
30-34	$0.05	$0.06
35-39	$0.05	$0.08
40-44	$0.07	$0.12
45-49	$0.11	$0.18
50-54	$0.16	$0.30
55-59	$0.26	$0.42
60-64	$0.41	$0.63
65-69	$0.71	$1.05
70-74	$1.27	$1.84
75+	$2.57	$3.31
Child Rate	$0.11	

Critical Illness (Lincoln)		
Age	Bi-Weekly Rates Per $1,000	
	Employee	Spouse
0-29	$0.15	$0.12
30-39	$0.25	$0.20
40-49	$0.51	$0.46
50-59	$0.98	$0.94
60-69	$1.77	$1.73
70+	$3.92	$3.88

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 & 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 & 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 ShiftKey Benefits Team at **benefits@shiftkey.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.

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

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.

HIPAA 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 ShiftKey Benefits Team at **benefits@shiftkey.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 SHIFTKEY BENEFITS TEAM AT **benefits@shiftkey.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 **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

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

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

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

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

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

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

Example 1: 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: **https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html**

Help with public health and safety issues
We can share health information about you for certain situations such as:

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

For your medical emergencies
We 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: **www.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: ShiftKey, LLC
Contact: ShiftKey Benefits Team
Address: 5221 N O'Connor Blvd. Suite 1400
Email Address: **benefits@shiftkey.com**

Important Notice from ShiftKey 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 ShiftKey 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. ShiftKey has determined that the prescription drug coverage offered by ShiftKey'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 ShiftKey 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 ShiftKey changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: 1/1/2027
Name of Entity/Sender: ShiftKey, LLC
Contact: ShiftKey Benefits Team
Address: 5221 N O'Connor Blvd. Suite 1400
Email Address: **benefits@shiftkey.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 ShiftKey Benefits Team at benefits@shiftkey.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 **www.healthcare.gov**.

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

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

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

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

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

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

IF YOU HAVE QUESTIONS

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

1. Date: 1/1/2027
2. Name of Entity/Sender: ShiftKey, LLC
3. Contact: ShiftKey Benefits Team
4. Address: 5221 N O'Connor Blvd. Suite 1400
5. Email Address: **benefits@shiftkey.com**
6. **https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start**.

Women's Health and Cancer Rights Act

ENROLLMENT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, email your plan administrator at **benefits@shiftkey.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 **benefits@shiftkey.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 Cigna at 800-997-1654.

Visit **https://www.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 **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

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

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	**myalhipp.com**	855-692-5447
Alaska Medicaid	Premium Payment Program: **myakhipp.com** Medicaid Eligibility: **health.alaska.gov/dpa** Email: **customerservice@myakhipp.com**	866-251-4861
Arkansas Medicaid	**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 & 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/programs/third-party-liability/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 & 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 & 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: **www.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 & CHIP	**mass.gov/masshealth/pa** Email: **masspremassistance@accenture.com**	800-862-4840 TTY/Relay: 711
Minnesota Medicaid	**mn.gov/dhs/health-care-coverage**	800-657-3672
Missouri Medicaid	**dss.mo.gov/mhd/participants/pages/hipp.htm**	573-751-2005
Montana Medicaid	HIPP: **dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** HIPP Email: **HHSHIPPProgram@mt.gov**	800-694-3084

STATE	WEBSITE/EMAIL	PHONE
Nebraska Medicaid	ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: dhcfp.nv.gov	800-992-0900
New Hampshire Medicaid	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 800-852-3345, ext. 15218
New Jersey Medicaid	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 & CHIP	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 & CHIP	oklahoma.gov/ohca/insureoklahoma.html	888-365-3742
Oregon Medicaid	healthcare.oregon.gov/Pages/index.aspx	800-699-9075
Pennsylvania Medicaid & 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 & 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 & 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 & 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

STATE	WEBSITE/EMAIL	PHONE
Washington Medicaid	hca.wa.gov	800-562-3022
West Virginia Medicaid & CHIP	bms.wv.gov mywvhipp.com	Medicaid: 304-558-1700 CHIP: 855-699-8447
Wisconsin Medicaid & 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.



2027 Benefits Guide