

Thatcher Group, Inc. 2025-2026 Benefit Guide

Helping you make informed choices about your employee benefits.



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IMPORTANT:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices about your prescription drug coverage. Please see page 37 for more details.

This document is an outline of the coverage provided under your employer’s benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the “plan documents”). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer’s benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Benefits Overview

Thatcher Group, Inc. recognizes that each employee’s success is our success. We aim to attract, develop and retain the best employees. Empowering the individual and the team is an essential element of our culture. It is the company’s responsibility to provide meaningful work in a safe, respectful and stable environment. We provide opportunities with commensurate reward and recognition. Providing competitive benefits is an essential part of taking care of our employees. We offer the following benefits to all full-time employees working at least 30 hours per week.

Benefits Offered

- » Medical and Rx
- » Telemedicine
- » Health Savings Account (HSA)
- » Flexible Spending Account (FSA)
- » Voluntary Dental
- » Vision
- » Life and Accidental Death & Dismemberment (AD&D)
- » Voluntary Life and AD&D
- » Short-Term Disability
- » Long-Term Disability
- » Accident
- » Critical Illness
- » Hospital Indemnity
- » EAP
- » 401 k

Eligibility

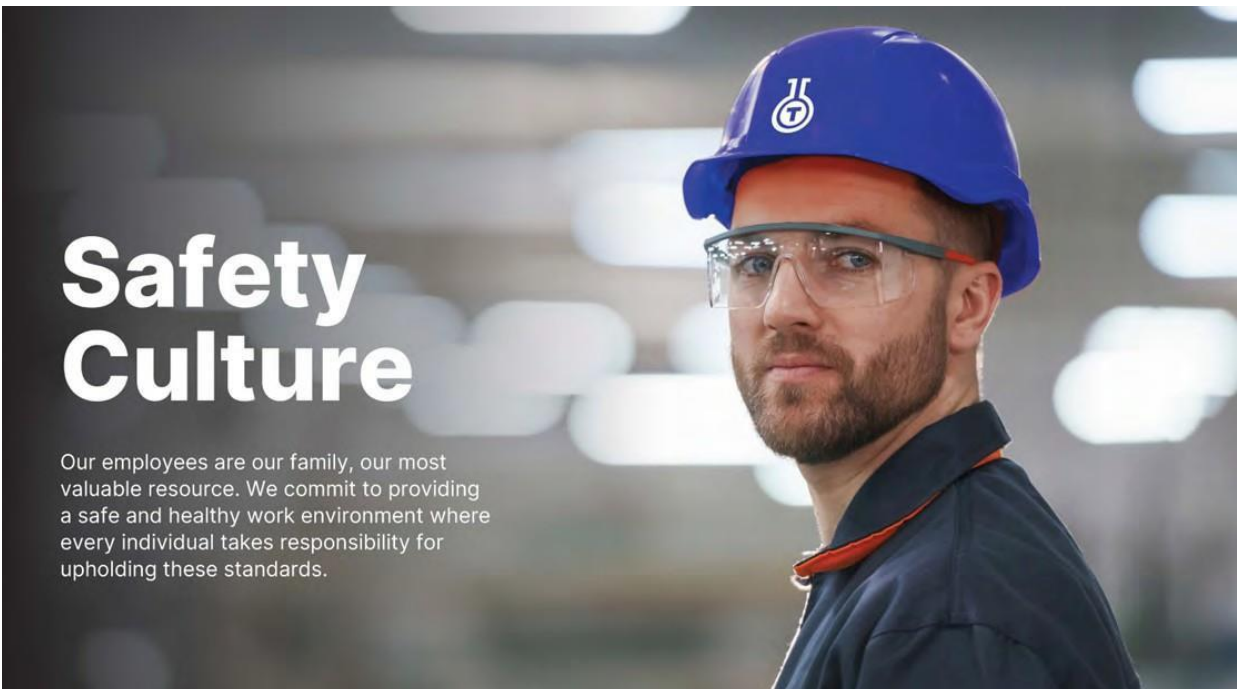
You and your dependents are eligible for Thatcher Group, Inc. benefits on the first of the month following your date of hire.

Eligible dependents are your spouse, children under age 26, or disabled dependents of any age. Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.

Qualifying Events

Qualifying events are life changes approved by the IRS to allow adjustments to your insurance coverage outside of Thatcher Group’s annual open enrollment. Common qualifying events include:

- » Marriage, Divorce, or legal separation
- » Addition of a dependent child through birth, adoption, or a change in legal custody
- » Death of a spouse or dependent
- » Losing or gaining coverage under another group plan
- » Losing or gaining coverage through Medicaid or Medicare
- » Receiving a qualified medical child support order (QMCSO)
- » Change to hours worked required for benefit eligibility





A UnitedHealthcare Company



Medical Benefits

Administered by UMR | www.umar.com | 800.826.9781

Thatcher Group, Inc. offers a choice between two High Deductible Health Plans (HDHP) and one Traditional PPO plan through UMR. HDHP plans require members to meet their deductible before services are covered, with the exception of preventive care. These plans allow you to make pre-tax contributions to a Health Savings Account (HSA).

Utah employees will access the UMR Options PPO network while employees located outside of Utah will access the UMR Choice Plus network. To search for providers, go to www.umar.com and select "Find a Provider."

UTAH EMPLOYEES	Untied Healthcare Options PPO \$1,500 Traditional Plan	
	In-Network	Out-of-Network
Annual Deductible Per Calendar Year	\$1,500 Single / \$3,000 Family	\$2,000 Single / \$3,500 Family
Annual Out-of-Pocket Maximum (includes deductible)	\$3,000 Single / \$5,000 Family	\$3,500 Single / \$6,500 Family
Coinsurance	20%	40%
Doctor's Office		
Primary Care Office Visit	\$30 copay	40% AD
Specialist Office Visit	\$50 copay	40% AD
Urgent Care	\$75 copay	40% AD
Teladoc Services	Covered 100%	
Preventive Visits (routine exams, x-rays / tests, immunizations, well baby care and mammograms)	Covered 100%	40% AD
Hospital Services		
Emergency (copay waived if admitted)	\$300 copay	\$300 copay
Inpatient, Outpatient, etc.	20% AD	40% AD
Prescription Drugs		
Retail (Tier I / II / III) Specialty Mail Order (Tier I / II / III)	\$10 / \$35 / \$60 copay \$100 copay \$25 / \$87.50 / \$150 copay	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.

AD = After deductible



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Medical Benefits

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UTAH EMPLOYEES	United Healthcare Options PPO UMR HDHP \$2,500		United Healthcare Options PPO UMR HDHP \$5,000	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Per Calendar Year	\$2,500 Single / \$5,000 Family	\$3,000 Single / \$5,500 Family	\$5,000 Single / \$10,000 Family	\$5,500 Single / \$10,500 Family
Annual Out-of-Pocket Maximum (includes deductible)	\$4,000 Single / \$7,000 Family	\$4,500 Single / \$7,500 Family	\$7,000 Single / \$12,000 Family*	\$7,500 Single / \$12,500 Family**
Coinsurance	20%	40%	20%	40%
Doctor's Office				
Primary Care Office Visit	20% AD	40% AD	20% AD	40% AD
Specialist Office Visit (including Urgent Care)	20% AD	40% AD	20% AD	40% AD
Teladoc Services	Covered 100%	Not covered	Covered 100%	Not covered
Preventive Visits (routine exams, x-rays / tests, immunizations, well baby care and mammograms)	Covered 100%	40% AD	Covered 100%	40% AD
Hospital Services				
Emergency	20% AD	20% AD	20% AD	20% AD
Inpatient, Outpatient, etc.	20% AD	40% AD	20% AD	40% AD
Prescription Drugs				
Brand and Generic Drugs (retail and mail order benefits available)	20% AD	If you use a Non- Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.	20% AD	If you use a Non- Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.

AD = After deductible

*(\$8,550 Maximum amount that any one person will satisfy towards the annual family out-of-pocket);

**(\$8,550 Maximum amount that any one person will satisfy towards the annual family out-of-pocket)

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial.

The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

Non-Utah employees may take advantage of the Choice Plus Network listed below. To search for providers, go to www.umar.com and select Find a Provider. HDHP plans require members to meet a deductible before services are covered with the exception of preventive services. These plans allow you to make pre-tax contributions to a Health Savings Account (HSA).

NON-UTAH EMPLOYEES	Untied Healthcare Options Choice Plus \$1,500 Traditional Plan	
	In-Network	Out-of-Network
Annual Deductible Per Calendar Year	\$1,500 Single / \$3,000 Family	\$2,000 Single / \$3,500 Family
Annual Out-of-Pocket Maximum (includes deductible)	\$3,000 Single / \$5,000 Family	\$3,500 Single / \$6,500 Family
Coinsurance	20%	40%
Doctor's Office		
Primary Care Office Visit	\$30 copay	40% AD
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Retail (Tier I / II / III) Specialty Mail order (Tier I / II / III)	\$10 / \$35 / \$60 copay \$100 copay \$25 / \$87.50 / \$150 copay	If you use a Non-Network Pharmacy, you are responsible for payment upfront. You may be reimbursed based on the lowest contracted amount, minus any applicable deductible or copayment amount.

AD = After deductible



NON-UTAH EMPLOYEES	United Healthcare Options Choice Plus UMR HDHP \$2,500		United Healthcare Options Choice Plus UMR HDHP \$5,000	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible Per Calendar Year	\$2,500 Single / \$5,000 Family	\$3,000 Single / \$5,500 Family	\$5,000 Single / \$10,000 Family	\$5,500 Single / \$10,500 Family
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The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.



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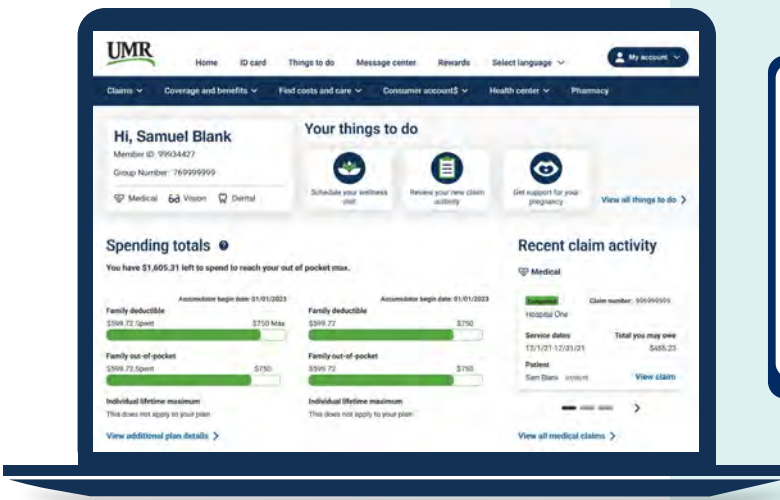
Make umr.com your first stop

You want managing your health care to be fast and easy, right? You got it. At **umr.com**, you'll find everything you want to know – and need to do – as soon as you sign in.

No hassles. No waiting. Just the answers you're looking for anytime, night or day!

The UMR app is another way we're reimagining health care to work for you.

We have a smarter, simpler, faster way to manage your health care benefits, right from the palm of your hand.



(Fictionalized data)



Download the UMR app today!

Scan the QR code to the left or visit your app store to get started.



Sign in now to:

- View **Things to do**, your personalized benefits to-do list
- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and your treatment options
- Access tools and trusted resources to help you live a healthier life

With just a tap, you can:

- Access your digital ID card
- View your plan details on-demand – anytime, anywhere
- Find out if there is a copay for your upcoming appointment
- Chat, call or message UMR's member support team

Note: The images shown reflect available features within our desktop site. These features may or may not be available to all users, depending on your individual and/or company benefits.

You don't need a Ph.D. to understand your benefits

We've made it easy to find the top things people want to know. Select **Coverage and benefits** from the blue secondary navigation to find out:

- What health care services are covered?
- What's the cost difference between an in-network and out-of-network service?
- What's your deductible, and are you close to reaching it?
- Is there a copayment for your office visit? If so, how much?

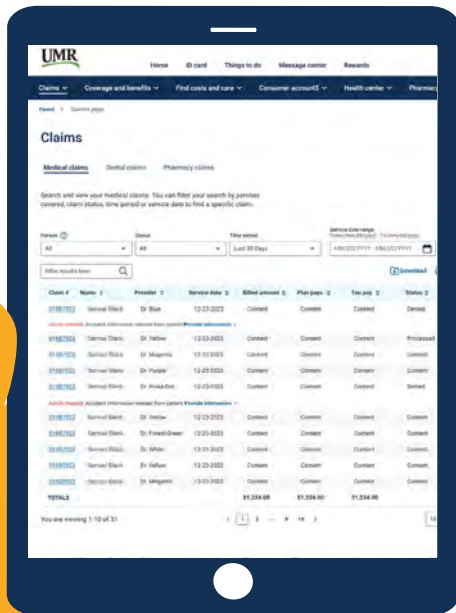
Buried in paperwork? A single click lets you track all your claims

With the **Claims** menu option, check in at your convenience to see if a claim has been processed and what you might owe. To get more details on a specific claim, select the **Claim #** or the **EOB** link on the same row as the claim. This will tell you the type of services provided, the amount billed and the amount paid, if any, and whether there's any action that needs to be taken before the claim can be processed.

You can choose to receive a secure email any time you have a new EOB. If you're not ready to give up paper completely, you can print out copies from the **Claims** dashboard.

Don't be surprised by unexpected costs

Under the **Find costs and care** menu option, you can find in-network doctors near you and get a better idea of what you'll pay with the **Health cost estimator** tool.



(Fictionalized data)

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This content is provided for information only and is not to be considered medical advice. All decisions about medical care should be made by the doctor and patient. Always refer to the plan document for specific benefit coverage or call the toll-free member phone number on the back of your health plan ID card. UMR operates in accordance with medical privacy standards established by applicable federal and state laws. The screen shots shown are for illustrative purposes and use fictional data only.



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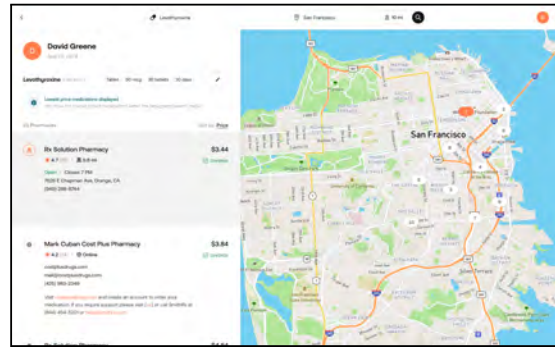
Member Portal Overview

The SmithRx Member Portal is where you can find your pharmacy benefits resources all in one place. Find key plan info, ID cards, history of prescriptions, notifications on prior authorizations (if applicable), plan usage, and support.

Access the member portal at member.mysmithrx.com

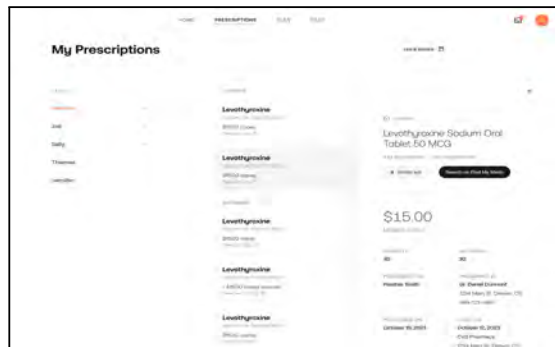
Find My Meds

Search for a medication by city or zip code and see cost estimations based on your benefits for pharmacies near you. Easily find pharmacy contact information so you can plan your fill.



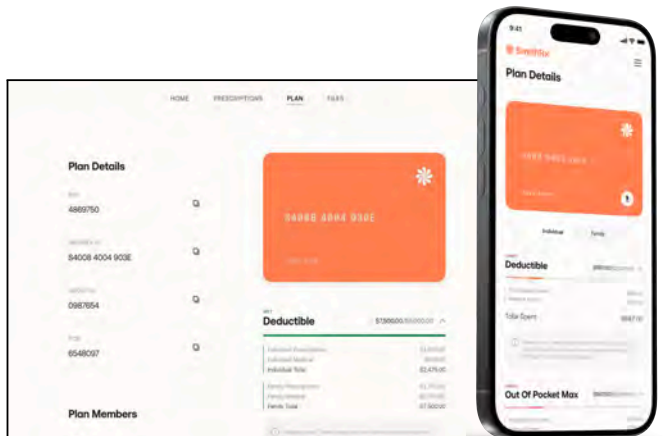
Prescriptions

Find a full history of prescriptions you've filled in the Prescription section. View the drug name, quantity, and strength, date of fill, prescriber details, and the copay amount.



Member ID & Plan Information

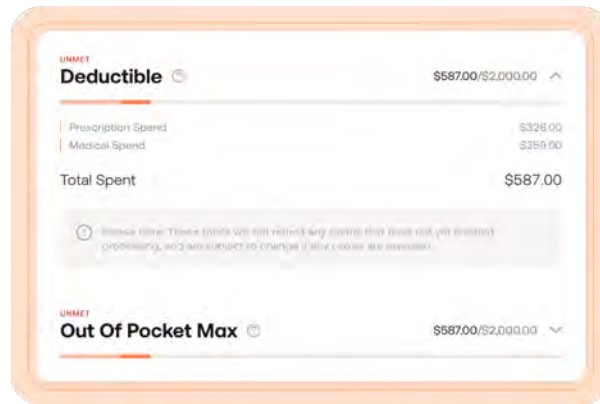
Access your ID card and plan details in the Plan section of the member portal. You can copy card ID values and paste them directly into forms. Keep your Member Card handy adding it to Google or Apple wallets on your mobile device.





Plan Details: Plan Usage Tracker and Summary of Benefits

Under the “Plan” section, view your plan usage and summary of benefits. This includes the total spending against your plan deductible and out-of-pocket limits, total spend breakdown, and plan coverage details.



Notification Center

The Notification Center keeps you informed with important updates about your prescriptions. An orange circle indicates you have a new message. Click the notification to open the message.



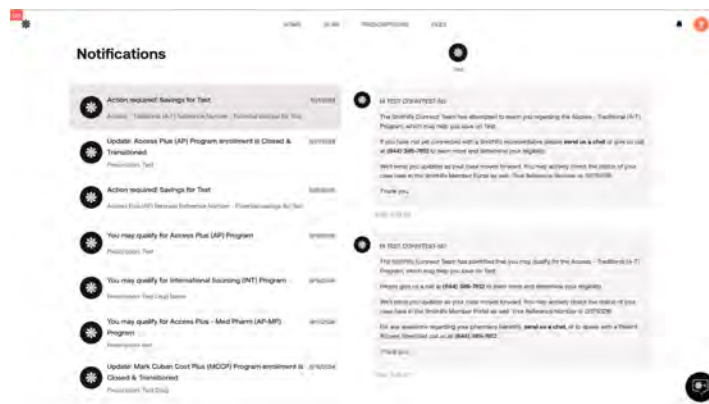
Prior Authorization (PA) Notifications

Some medications require your doctor's approval before it can be filled. This approval is called prior authorization (PA). If a PA has been started for your medication, you'll receive updates by email, text, and in the Member Portal. You can view the status and any instructions in the Portal's Notification Center.



Medication Savings Alerts

If savings are available for your medication, you'll receive alerts by email, text, and in the Member Portal. You can view savings options and instructions in the Portal's Notification Center.





Health Savings Account

Administered by HealthEquity | www.healthequity.com | 866.346.5800

HealthEquity®

When you enroll in the High Deductible Health Plan, you are allowed to open a Health Savings Account (HSA). This allows you to put money away tax free through payroll deductions, let it accrue interest tax free, and then use it for qualified medical, dental and vision expenses tax free.

What is an HSA?

With an HSA you own the account and it is fully portable. Balances roll over year after year, growing tax free. You never lose your contributions to your HSA, unlike other health accounts, such as a flexible spending account (FSA). Even if you change jobs, health plans, or retire, you keep your HSA.

HSA's can be used to pay for eligible medical, dental and vision expenses for you, your spouse, and any family member who qualifies as a tax dependent. (See IRS Publications 969 for a list of eligible expenses). This includes things like pre-deductible medical expenses and prescription costs

Who is Eligible for an HSA?

Anyone meeting the following requirements is eligible for an HSA.

- » Be enrolled in a qualified high deductible health plan.
- » Have no other health coverage except what is permitted by the IRS (see IRS Publication 969).
- » Not be enrolled in Medicare.
- » Not be claimed as a dependent on someone else's tax return.

Yearly HSA Contribution Limit

Individual HSA: \$4,300* for 2025; \$4,400* for 2026

Family HSA: \$8,550* for 2025; \$8,750* for 2026

*A \$1,000 additional catch up contribution is allowed for account holder's age 55+

Benefits of an HSA

- » Pay for qualified medical, dental and vision expenses with tax-free dollars.
- » Lower health insurance premiums with an HSA qualified health plan.
- » Keep your contributions year after year and watch your balance grow. There is no "use it or lose it." It is yours.
- » Invest your balance over the threshold amount to grow your HSA further.

Here is How an HSA works

1. You decide the annual amount you want to contribute to your HSA; not to exceed the yearly IRS limits.
2. Your contributions are deducted from each paycheck pretax, and deposited into your HSA.
3. You can pay for eligible medical, dental and vision expenses with your HSA debit card. You may also pay the provider directly through your HealthEquity online account, or you can request a reimbursement if you paid out-of-pocket and did not use your HSA debit card.



Common Eligible Expenses Include:

- » Over the counter medications
- » Contact lenses and solutions
- » Dental treatments
- » Doctor's office visits and copays
- » Prescriptions
- » Eyeglasses
- » Feminine hygiene products
- » Flu shots
- » Hearing aids
- » Laser eye surgery
- » Orthotic inserts
- » Personal protective equipment (like masks and hand sanitizer)

(For a full list see IRS Publications 969)



Flexible Spending Account

Administered by HealthEquity | www.healthequity.com | 866.346.5800

A Flexible Spending Account (FSA) provides you the opportunity to pay for health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next plan year, you can lower your taxable income.

Flexible Spending Accounts are convenient and easy to use. With a little up-front planning, you can enjoy significant tax savings, while paying for a wide assortment of out-of-pocket health care and dependent care expenses.

How it Works

Each plan year you designate an annual election to be deposited into your health care and/or dependent care accounts. Your annual election will be divided by the number of pay periods in the plan year and deducted equally from each paycheck on a pre-tax basis. For health care expenses, you have immediate access to the total amount you elected to contribute for the plan year. With the dependent care, you have access to the amount at the time you request reimbursement.

Yearly FSA Contribution Limits:

Healthcare FSA: \$3,300* for 2025

Limited Purpose FSA: \$3,300* for 2025

Dependent Care FSA: \$5,000* for 2025

*FSA limits are subject to change for 2026

Things to Consider

- » Be conservative when estimating your annual election amount. The IRS has a strict “use it or lose it” rule. If there is a balance in your account after the end of the grace period you will forfeit any funds left in your account from that plan year.
- » The health care and dependent care FSA's are two separate accounts and funds cannot be transferred between accounts.
- » The Dependent Care FSA cannot be used for dependent's medical expenses.
- » You cannot stop or change your FSA contribution amount during the year unless you have a qualified change in family status.
- » Expenses reimbursed through an FSA cannot be used as a deduction or credit on your federal income taxes.
- » You cannot be enrolled in an HSA and a full FSA during the same tax year, this includes a spouse's FSA and or HSA.

Limited Purpose FSA

- » LPFSA can only be used for eligible dental and vision expenses and is only available to those enrolled on the HDHP.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account enables you to pay for work-related dependent day care costs with pre-tax dollars. Available regardless of enrollment in the FSA or HSA.



Get ready for the next level of care

Introducing your new
virtual care benefit.



Your care options with Primary360 include:

Coming soon 10/1/2025

Primary Care

Manage your overall health—body and mind—with a U.S. board-certified primary care provider and care team. From routine checkups to ongoing care, visits are easy to schedule when it's convenient for you.

- Checkups and preventive care
- Prescriptions
- Lab orders and screenings
- Referrals to in-person (and in-network) specialists
- Support for chronic conditions

Coming soon 10/1/2025

Mental Health

Have real conversations and see progress with a therapist of your choice. Available 7 days a week from the privacy of your own home.

- Anxiety and depression
- Sleep issues
- Relationship conflicts
- Trauma and PTSD
- Medication management



Coming soon 10/1/2025

Expert Medical Opinion

Need a second opinion? We've got you. Get assurance and advice on a diagnosis, treatment or surgery from leading experts in over 450 specialties.

- Joint pain
- Chronic conditions
- Back issues
- Cancer
- Surgery
- Heart disease
- And more

Schedule a visit today and get peace of mind

Visit TeladocHealth.com | Call 1-800-835-2362 | Download the app  | 



Voluntary Dental Benefits

Administered by Delta Dental | deltadentalins.com | 800.521.2651

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Thatcher Group dental plan through Delta Dental.

This plan offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and reduce you out-of-pocket costs if you choose a dentist who participates in the Delta Dental PPO network. For more information, visit deltadentalins.com.

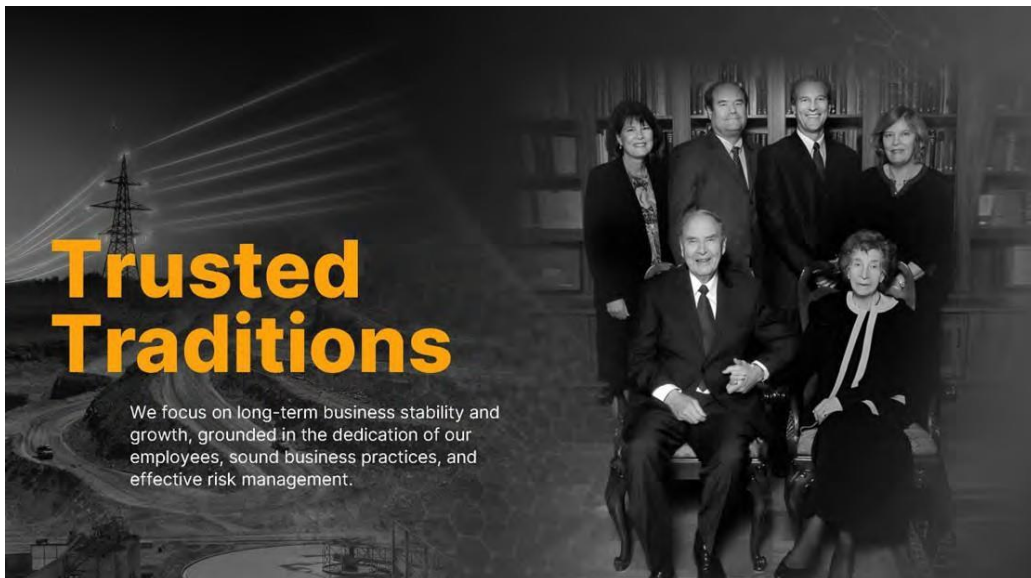
The following is a brief outline of your dental coverage.

Services	PPO and Premier Dentists**	Non-Delta Dental Dentists**
Provider Network	Dental PPO Network	
Calendar Year Deductible	\$50 Per Person / \$150 Per Family	\$50 Per Person / \$150 Per Family
Calendar Year Benefit Maximum	\$1,500 Per Person per Calendar Year	\$1,500 Per Person per Calendar Year
Preventive Dental Services (exams, cleanings, x-rays and sealants)	Covered 100%	Covered 100%
Basic Dental Services (fillings, space maintainers, simple extractions, posterior composites and denture repair/reline/rebase)	Covered 80% AD	Covered 80% AD
Major Dental Services (crowns, inlays, onlays and cast restorations)	Covered 50% AD	Covered 50% AD
Orthodontia Services (adults and dependent children)	Covered 50% to \$1,500 lifetime maximum	Covered 50% to \$1,500 lifetime maximum

AD = After Deductible

*Limitations may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

**Reimbursement is based on PPO dentists, Premier contracted fees for Premier dentists and program allowance for non Dental dentists.





Keep smiling

Delta Dental PPO™



Stay in network to save

Visit a dentist in the PPO¹ network to maximize your savings.² These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.³ Find a PPO dentist at deltadentalins.com.

If you can't find a PPO dentist, consider a Delta Dental Premier[®] dentist. These dentists have agreed to set fees and offer another opportunity to save.

Set up an online account

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at deltadentalins.com.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or Social Security number. If your family members are covered under your plan, they'll need to

provide your information. Prefer to have an ID card? Simply log in to your account to view or print your card.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim — we'll handle the rest.

Understand transition of care

Generally, multi-stage procedures are covered under your current plan only if treatment began after your plan's effective date of coverage.⁴ Log in to your online account to find this date.

Get LASIK and hearing aid discounts

With access to QualSight and Amplifon Hearing Health Care⁵, you can receive significant savings on LASIK procedures and hearing aids. To take advantage of these discounts, call QualSight at **855-248-2020** and Amplifon at **888-779-1429**.

Save with a PPO dentist



PPO



PREMIER



NON-DELTA DENTAL

¹ In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan

² You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

³ You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

⁴ Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

⁵ Vision corrective services and Amplifon's hearing health care services are not insured benefits. Delta Dental makes the vision corrective services program and hearing health care services program available to you to provide access to the preferred pricing for LASIK surgery and for hearing aids and other hearing health services.

West Virginia: Learn about our commitment to providing access to a quality dentist network at deltadentalins.com/about/legal/index-enrollee.html.



A UnitedHealthcare Company



Vision Benefits

Administered by UMR | www.umar.com | 800.826.9781

All employees enrolled in the medical plan will automatically be enrolled in the Vision plan with UMR. The Vision benefit is provided to you at no cost as long as you are enrolled on one of the medical plans with UMR.

Benefits	Member Cost
Eye Exam Routine/Eye Refraction	\$0 copay / \$10 copay
Eyeglass Lenses & Frames	\$150 allowance
Elective Contacts (in Lieu of eyeglass lenses and frames benefit)	\$150 allowance
Frequency Exams, Lenses, Frames, Contacts (in lieu of lenses)	Once in the calendar year

How your vision coverage works:

Your UMR vision coverage offers you the convenience of choosing any vision provider without network restrictions.

All you need to do is choose a vision provider and present your medical identifications card. Be sure to tell the provider that UMR Vision does not use a network.

The provider can then call the number on your ID card to obtain your vision benefits. A UMR customer service representative can answer any additional questions when the provider is verifying your benefits.

Submitting your vision claims for payment:

You can go to the umar.com member location and select I need to... Find a form. Select the Medical Claim Form (EZ Claim) and follow the instructions to complete and submit the form by email, fax or standard mail.

You can also print the form and take it with you on your vision visit. The form includes instructions and the same multiple delivery options your vision provider can use to get your claim submitted and processed.





Life and Accidental Death & Dismemberment Insurance



Insured by Guardian | [Guardianlife.com](https://www.guardianlife.com) | 888.600.1600

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump-sum payment if you pass away while employed by Thatcher Group. Thatcher Group provides basic life insurance at no cost to you in the amount of 1x your salary, up to \$250,000.

Whether it's used to fund a child's education or pay off a mortgage, a life insurance policy can help offset financial burdens during a difficult time. Additional coverage may be purchased through the Voluntary Life and AD&D plan.

*Coverage will be reduced as you age – by 35% at age 65 and 50% at age 70.

Accidental Death & Dismemberment (AD&D) Insurance

Accidental Death & Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or pass away in an accident. Thatcher Group provides AD&D coverage at no cost to you in the amount of 1x your salary, up to \$250,000. This coverage is in addition to your employer- paid life insurance described above.



Voluntary Life and AD&D Insurance

Insured by Guardian | [Guardianlife.com](https://www.guardianlife.com) | 888.600.1600

You may purchase Life and AD&D insurance in addition to the company-provided coverage. You may also purchase Life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage (up to \$250,000 and up to \$50,000 for your spouse) without answering medical questions if you enroll when you are first eligible.

Employee— Coverage available in \$10,000 increments up to a maximum of \$500,000

Spouse— Coverage available in \$5,000 increments up to \$150,000, not to exceed 100% of Employee's amount

Children— \$20,000, not to exceed 100% of Employee's amount

*Coverage will be reduced as you age- by 35% at age 65 and 50% at age 70.

Innovative Excellence

As a learning organization, we stay adaptable and proactively pursue excellence. We seek ways to constantly improve our skills, knowledge, and practices to deliver the best outcomes for customers and colleagues alike.



Disability Insurance

Insured by Guardian | Guardianlife.com | 888.600.1600



Thatcher Group, Inc. also provides disability insurance through Guardian. Disability insurance can help to replace a portion of your income when you are unable to work. For many people, unplanned time away from work can make it difficult to manage household costs. If you are unable to work due to a covered injury, illness, or even childbirth. Disability Insurance can provide an ongoing benefit to help keep your finances stable.

	How it Works	Who Pays for the Benefit
Short-term Disability	You receive 60% of your income up to \$2,500 per week. Benefits begin on the 8th calendar day from the covered accident and sickness and continue for up to 12 weeks.	Thatcher
Long-term Disability	You receive 60% of your income up to \$15,000 per month. Benefits begin after 90 calendar days of absence from work and continue until you reach the Social Security normal retirement age.	Thatcher



Voluntary Benefits

While you can't predict life's unexpected events, you can plan for them by choosing benefits that help protect what's important to you.

Accident

Administered by Guardian

The Accident plan provides cash payments directly to you to help cover out-of-pocket costs, such as deductibles or coinsurance. The full schedule of benefits payable for accidental injuries include initial/follow-up treatment, ambulance trips, medical imaging, surgeries, concussion, dislocations and fractures, hospital stays, AD&D, and health screening benefits. It is important to note this benefit is for off the job accidents only. Some benefits are payable once per covered accident, while others are once per plan year. See Benefit Summary for detailed information and schedule of benefits and exclusions.

Accident Insurance Benefit By Event	
Wellness Benefit	\$75 per year
Fractures	Up to \$6,000
Lacerations	Up to \$400
Dislocations	Up to \$5,000
Burns (2nd Degree / 3rd Degree)	\$500 - \$12,000
Joint Replacement (Hip / Knee / Shoulder)	\$2,500 / \$1,200 / \$1,250
Emergency Room Treatment	\$200
Concussion	\$200
Ambulance (Ground / Air)	\$200 / \$1,000

The above is for illustrative purposes only and is not a complete list of benefits payable. Refer to your certificate details, definitions, limitations and exclusions.

Critical Illness

Administered by Guardian

Critical illness insurance provides a lump-sum payment for an insured person diagnosed with any of the following critical illnesses while insurance is in effect for the insured person, after any applicable waiting period and subject to any pre-existing condition limitation: Cancer, Heart Attack, Stroke, Organ Transplant, Kidney Failure, and more. See Benefit Summary for detailed information and schedule of benefits and exclusions.

Elected Coverage	Benefit Amount
Employee Only	Lump sum benefit of \$10,000, \$20,000 or \$30,000
Spouse	Lump sum of \$10,000, \$20,000 or \$30,000
Child	50% of employee's lump sum benefit*

*Up to 100% of the employee benefit

Benefits			
All Eligible Employees			
Cancer and benign tumors		First Occurrence	Second Occurrence
Bone Marrow Failure		100%	100%
Invasive Cancer (Leukemia, Multiple Myeloma)		100%	100%
Skin Cancer		\$250	Not applicable
Heart disorders		First Occurrence	Second Occurrence
Coronary Artery Disease (Stents, Angioplasty, Thrombectomy)		10%	0%
Heart Attack		100%	100%
Lung and Vascular disorders		First Occurrence	Second Occurrence
Aneurysm		10%	0%
Pulmonary Embolism		30%	0%
Stroke - moderate		50%	50%
Additional disorders		First Occurrence	Second Occurrence
Kidney Failure		100%	100%
Major Organ Failure (Liver, Pancreas, Lungs)		100%	100%

Hospital Indemnity

Administered by Guardian

Hospital indemnity coverage eases the financial impact of an employee's hospitalization by providing a lump sum payment to help cover the costs associated with a hospital stay. Hospital indemnity coverage can be used to supplement medical insurance to help handle additional out-of-pocket costs that add up after a hospital stay. This can include copayments, coinsurance, deductibles, and incidental hospital expenses or other expenses such as transportation and lodging needs. See Benefit Summary for detailed information and schedule of benefits and exclusions.

Benefit Schedule	
Health Screenings	\$75 per year
Hospital / ICU Admission	\$1,500 per admission to a max of 2 admissions per year, per insured
Hospital / ICU Confinement	\$200 / \$400 per day to a max of 31 days per year, per insured

GuidanceResources®

Your Life. Your Work. Your Best.®

Your GuidanceResources® Program

Sometimes life can feel overwhelming. It doesn't have to. Your ComPsych® GuidanceResources® program provides confidential counseling, expert guidance and valuable resources to help you handle any of life's challenges, big or small.

Services:

Confidential Emotional Support

3 face-to-face or virtual sessions per person, per issue, per year

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work and Lifestyle Support

- Child, elder and pet care
- Moving and relocation
- Shelter and government assistance

Legal Guidance

- Divorce, adoption and family law
- Wills, trusts and estate planning
- Free consultation and discounted local representation

Financial Resources

- Retirement planning, taxes
- Relocation, mortgages, insurance
- Budgeting, debt, bankruptcy and more

Digital Support

- Connect to counseling, work-life support or other services
- Tap into an array of articles, podcasts, videos, slideshows
- Improve your skills with On-Demand trainings

Online Will Preparation

- Quickly and easily complete a will on your computer with EstateGuidance®
- Specify guardians, trustees and property division
- Provide funeral and burial instructions

Wellness Support

Flexible 3-5 coaching session model

- Make positive lifestyle changes with health coaching
- Improve your nutrition, exercise habits, weight loss efforts
- Get help with smoking cessation, back care, resiliency and more

Life is challenging. We can help.
Confidential 24/7 support.

COMPSYCH®
GuidanceResources® Worldwide

Guardian®



24/7 Live Assistance:
Call: (855) 239.0743
TRS: Dial 711



Online: guidanceresources.com
App: GuidanceNowSM
Web ID: Guardian

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ENROLL IN YOUR EMPLOYER PLAN TODAY

Simplifying your savings and investing experience

- ✓ A Roth option allows you to make after-tax contributions that may grow tax-free.**
- ✓ See a complete view of your overall retirement picture.
- ✓ Easily access your account and take action.
- ✓ Reduce your current taxable income with pretax contributions.
- ✓ Get real help from real people.

It's fast and easy to enroll

 **33 seconds¹**

Enrolling in your employer retirement plan is one of the simplest ways to save for retirement

¹ Based on enrollment data for period January 1, 2020 through December 31, 2020.

- 1 Go to your plan website and select *Register*.
- 2 Choose the *I do not have a PIN* tab.
- 3 Follow the prompts to create your username and password. Be sure to add your email address.
 - *Custom enrollment*: to select your contribution rate, type and funds.

Put the magic of compound earnings to work for you

The money you save today could double in just 12 years and triple in 19 years.



FOR ILLUSTRATIVE PURPOSES ONLY. This hypothetical illustration does not reflect a particular investment and is not a guarantee of future results. This is a demonstration of the mathematical rules of 72 and 114 used to approximate the number of years it takes a given investment to double and triple in value. It assumes a 6% rate of return. Rates of return may vary.

▶ Visit empowermyretirement.com to register your account.

Additional plan details are available in the plan's Summary Plan Description and/or plan documents on the website.

You're In charge of creating your future

- Save as much or as little as you like up to the IRS maximum or plan limit.
- You can change your contribution rate anytime.
- You'll always have access to your savings if you need it through a loan. Fees may apply.

Find the best way to Invest for you

- Choose from a range of investments to manage your account on your own.

Asset allocation, diversification, and/or rebalancing do not ensure a profit or protect against loss.



Get a complete financial overview

Link accounts, such as banking, mortgage, credit card and other retirement plan accounts, to get a customized view of your overall financial situation.



Look into your future

You can easily view what percentage of your estimated income you are on track to replace.

FOR ILLUSTRATIVE PURPOSES ONLY.

Link outside accounts to see:



Your net worth



Your saving and spending trends



How you're tracking for retirement

Rates for Benefits

Medical

2025 Rates and Contributions		
5000 HSA		EE Monthly Cost
	Employee	\$50.00
	Employee + Spouse	\$100.00
	Employee + Family	\$150.00
2500 HSA		EE Monthly Cost
	Employee	\$70.00
	Employee + Spouse	\$135.00
	Employee + Family	\$200.00
1500 Traditional		EE Monthly Cost
	Employee	\$120.00
	Employee + Spouse	\$225.00
	Employee + Family	\$350.00

Dental

Dental Contributions	
	EE Monthly Cost
Employee	\$32.61
+ Spouse	\$68.57
Employee + Child	\$73.70
+ Family	\$98.25

Voluntary Life

Monthly Rates per \$1,000													
Age	<25	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
Rates	\$0.050	\$0.060	\$0.080	\$0.100	\$0.158	\$0.260	\$0.430	\$0.670	\$1.050	\$1.880	\$3.360	\$5.550	\$11.240
	Child		Employee AD&D				Spouse AD&D			Child AD&D			
	\$0.119		\$0.024				\$0.019			\$0.081			

Accident

MONTHLY RATES	
Employee	\$9.84
Employee & Spouse	\$16.67
Employee & Child	\$17.45
Family	\$24.28

Hospital Indemnity

MONTHLY RATES	
Employee	\$20.88
Employee & Spouse	\$50.15
Employee & Child	\$37.59
Family	\$66.86

Critical Illness

MONTHLY PREMIUM						
Employee						
Benefit Amounts	<30	30-39	40-49	50-59	60-69	70+
\$10,000	\$4.60	\$7.30	\$13.80	\$27.10	\$46.20	\$78.00
\$20,000	\$9.20	\$14.60	\$27.60	\$54.20	\$92.40	\$156.00
\$30,000	\$13.80	\$21.90	\$41.40	\$81.30	\$138.60	\$234.00
Spouse						
Benefit Amounts	<30	30-39	40-49	50-59	60-69	70+
\$10,000	\$4.60	\$7.30	\$13.80	\$27.10	\$46.20	\$78.00
\$20,000	\$9.20	\$14.60	\$27.60	\$54.20	\$92.40	\$156.00
\$30,000	\$13.80	\$21.90	\$41.40	\$81.30	\$138.60	\$234.00



How to Enroll

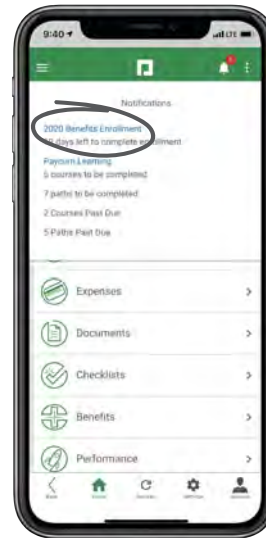
SHOW ME HOW

to Enroll in Benefits
Benefits



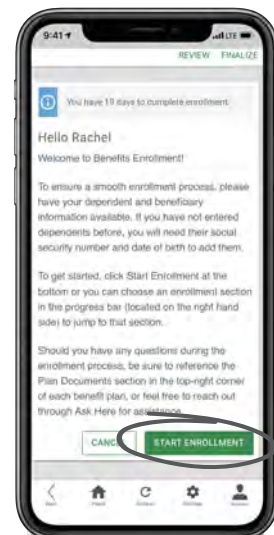
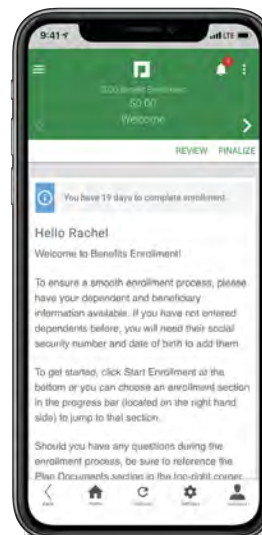
STEP 1

Log into the Paycom app.
From the Notification Center
or from the Benefits section,
click the current year's Benefits
Enrollment.



STEP 2

Review initial instructions and
click "Start Enrollment." Then,
enter your personal information
and any dependents or
beneficiaries.



EMPLOYEES

Visit the Help Menu for the most up-to-date version of this guide.



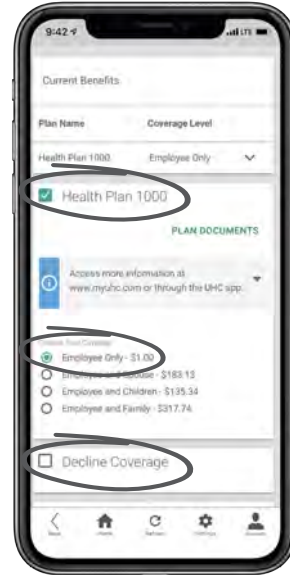
SHOW ME HOW

to Enroll in Benefits
Benefits



STEP 3

After determining which plan will work for you, choose your coverage level, then select either to enroll or decline.



STEP 4

To complete enrollment, click "Finalize," then "Sign and Submit."



HELPFUL TIPS

- Have your dependent/beneficiary information ready, such as Social Security numbers, before beginning the enrollment process.

EMPLOYEES

Visit the Help Menu for the most up-to-date version of this guide.





Save Money with Gallagher Marketplace

Clients saved \$400+ on auto insurance in 2024.*

Get a free, no-obligation quote and save on your home and auto insurance with over 40 carriers nationwide.

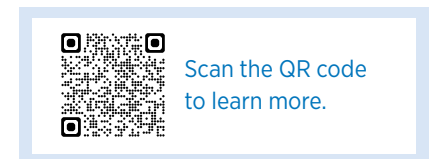
Looking for more savings? Our program offers significant savings on things you are already buying — like pre-paid legal services, identity theft protection, pet insurance, renters insurance and boat or RV insurance, as well as extended vehicle warranties and an employee discount program — all in one centralized hub.

Discover what benefits your organization offers through Gallagher Marketplace.

The value	The convenience
<ul style="list-style-type: none"> • Whether full-time, part-time or contract workers, all employees and their families are eligible. • Compare real, no-obligation quotes from multiple carriers on one site. • Potential cost savings compared to shopping on your own. • Call and talk to licensed insurance advisors to help understand and find the policy that meets your needs. 	<ul style="list-style-type: none"> • Enroll any time of the year, not just during open enrollment. • Monthly, quarterly and annual payment option available. • Schedule a callback from licensed insurance advisors for a time that's most convenient. • All programs are portable so you can keep the coverage no matter where life takes you.

How it works

- 1** Visit [Gallagher Marketplace](#) to see your available benefits.
- 2** Select a product to view more details.
- 3** Click on the partner link to learn more, get a free no-obligation quote or apply for coverage.
- 4** Enter your employer name when prompted.



AJG.com The Gallagher Way. Since 1927.

*Insurance is subject to availability and individual eligibility. Savings based on 2024 Insuramatch customer survey.

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Contact Information

If you have specific questions about any of the benefit plans, please contact the administrator listed below, or your Human Resources department.

Benefit	Administrator	Phone	Website / Email
Medical	UMR	800.834.3482	www.umar.com
Pharmacy (Rx)	SmithRx	844.454.5201	www.smithrx.com
Dental	Delta Dental	800.521.2651	deltadentalins.com
Vision	UMR	800.834.3482	www.umar.com
Telemedicine	Teladoc	800.835.2362	www.teladoc.com
Health Savings Account	Health Equity	866.346.5800	www.healthequity.com
Flexible Spending Account	Health Equity	866.346.5800	www.healthequity.com
Life and AD&D, Voluntary Life and AD&D, STD, LTD, Accident, Critical Illness, Hospital Indemnity	Guardian	888.600.1600	Guardianlife.com
Thatcher Benefit Center		833.385.7153	bac.thatchercompanyadvocates@ajg.com



Legal Notices

Women's Health and Cancer Rights Act

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 the plan. Therefore, the following deductibles and coinsurance apply:

UTAH EMPLOYEES

Plan 1: Untied Healthcare Options PPO \$1,500 Traditional Plan (Individual: 20% coinsurance and \$1,500 deductible; Family: 20% coinsurance and \$3,000 deductible)

Plan 2: United Healthcare Options PPO UMR HDHP \$2,500 (Individual: 20% coinsurance and \$2,500 deductible; Family: 20% coinsurance and \$5,000 deductible)

Plan 3: United Healthcare Options PPO UMR HDHP \$5,000 (Individual: 20% coinsurance and \$5,000 deductible; Family: 20% coinsurance and \$10,000 deductible)

NON-UTAH EMPLOYEES

Plan 1: Untied Healthcare Options Choice Plus \$1,500 Traditional Plan (Individual: 20% coinsurance and \$1,500 deductible; Family: 20% coinsurance and \$3,000 deductible)

Plan 2: United Healthcare Options Choice Plus UMR HDHP \$2,500 (Individual: 20% coinsurance and \$2,500 deductible; Family: 20% coinsurance and \$5,000 deductible)

Plan 3: United Healthcare Options Choice Plus UMR HDHP \$5,000 (Individual: 20% coinsurance and \$5,000 deductible; Family: 20% coinsurance and \$10,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 720-252-7513 or rebecca.serr@tchem.com.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Special Enrollment Rights

Thatcher Group, Inc. Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Thatcher Group, Inc. Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

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

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Rebecca Serr - HR Manager at 720-252-7513 or rebecca.serr@tchem.com.

Qualified Medical Child Support Orders

Coverage will be provided to any of your dependent child(ren) if a Qualified Medical Child Support Order (QMCSO) is issued, regardless of whether the child(ren) currently reside with you. A QMCSO may be issued by a court of law or issued by a state agency as a National Medical Support Notice (NMSN), which is treated as a QMCSO. If a QMCSO is issued, the child or children shall become an alternate recipient treated as provisions, and procedures as all other plan participants.

Patient Protection Disclosure Notice

The Thatcher Group, Inc. Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, UMR designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the UMR at 800.834.3482 or www.umar.com.

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

You do not need prior authorization from UMR or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the UMR at 800.834.3482 or www.umar.com.

Preventive Care

Certain preventive care services must be provided by non-grandfathered group health plans without member cost-sharing (such as deductibles or copays) when these services are provided by a network provider. Please refer to your insurance company for more information. Contact information is listed under "Contacts" in this Guide.

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

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/df/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, 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.

OMB Control Number 1210-0137 (expires 1/31/2026)

Notice of Creditable Coverage

Important Notice from Thatcher Group, Inc.

About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Thatcher Group, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. 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. Thatcher Group, Inc. has determined that the prescription drug coverage offered by the medical 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 15th to December 7th. 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 may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may still be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your current company coverage, be aware that you and your dependents may be able to get this coverage back by enrolling back into the company benefit plan during the Open Enrollment period under the company benefit plan.

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 Thatcher Group, Inc. 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 Thatcher Group, Inc. changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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: October 01, 2025
Name of Entity/Sender: Thatcher Group, Inc.
Contact—Position/Office: Rebecca Serr - HR Manager
Office Address: 1905 W Fortune Rd
Salt Lake City, Utah 84104-3724
United States
Phone Number: 720-252-7513

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed by the employer and its affiliates, if any, and how you can get access to this information as mandated for health plans that are subject to HIPAA. Please review it carefully.

The Health Insurance and Portability and Accountability Act of 1996

(HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, received, or maintained by the Employer-sponsored health plans (the plans). The regulations will supersede any discrepancy between the information in this notice and the regulations. The plans need to create, receive, and maintain records that contain health information about you to administer the plans and provide you with healthcare benefits. This notice describes the plans' health information privacy policy for your healthcare, dental, personal spending account and flexible reimbursement account benefits. The notice tells you the ways the plans may use and disclose health information about you, describes your rights, and the obligations the plans have regarding the use and disclosure of your health information. It does not address the health information policies or practices of your healthcare providers.

Our Commitment Regarding Health Information Privacy

The privacy policy and practices of the plans protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your healthcare expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plans

The plans are required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the plans' legal duties and privacy practices for health information about you; and (c) follow the terms of the notice that is currently in effect.

How the Plans May Use and Disclose Health Information about You

The following are the different ways the plans may use and disclose your PHI without your written authorization:

For Treatment. The plans may disclose your PHI to a healthcare provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The plans may use and disclose your PHI so claims for healthcare treatment, services, and supplies you receive from healthcare providers may be paid according to the terms of the plans. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

For Healthcare Operations. The plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the plans' participants receive their health benefits. For example, the plans may use your PHI for case management or to perform population-based studies designed to reduce healthcare costs. In addition, the plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The plans may also combine health information about many plan participants and disclose it to the Employer and its affiliates, if any, in summary fashion so it can decide what coverages the plans should provide. The plans may remove information that identifies you from health information disclosed so it may be used without the Employer's learning who the specific participants are.

To the Employer. The plans may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative

To a Business Associate. Certain services are provided to the plans by third-party administrators known as "business associates." For example, the plans may input information about your healthcare treatment into an electronic claim processing system maintained by the business associate so your claim may be paid. In so doing, the plans will disclose your PHI to its business associate so it can perform its claims payment function. However, the plans will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The plans may disclose PHI to a close friend or family member involved in or who helps pay for your healthcare. The plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Required by Law. The plans will disclose your PHI when required to do so by Federal, State, or local law, including those that require the reporting of certain types of wounds or physical injuries.

To the Secretary of the Department of Health and Human Services (HHS). The plans may disclose your PHI to HHS for the investigation or determination of compliance with privacy regulations.

Special Use and Disclosure Situations

The plans may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The plans may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims. Or the identity, description, or location of the person who committed the crime.

Workers Compensation. The plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the plans may release medical information about you as deemed necessary by military authorities.

Health-Related Benefits and Services. The plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

To Avert Serious Threat to Health or Safety. The plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the healthcare system and government programs.

Research. Under certain circumstances, the plans may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The plans may release your PHI to authorized Federal officials: 1) for intelligence, counterintelligence, and other national security activities authorized by law and 2) to enable them to provide protection to the members of the U. S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The plans may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the plans maintain about are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plans may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the plans have about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the plans. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The plans may deny your request if you ask to amend health information that was: accurate and complete, not created by the plans; not part of the health information kept by or for the plans; or not information that you would be permitted to inspect or copy.

Right to an Accounting of Disclosures. You have the right to request an “accounting of disclosures”. This is a list of disclosures of your PHI that the plans have made to others, except for those necessary to carry out healthcare treatment, payment, or operations; disclosures made to you; disclosures made prior to this effective date at the end of this notice; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the account was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the plans use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information the plans disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that the plans not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the plans’ use, disclosure, or both; and 3) to whom you want the limit(s) to apply. Note: The plans are not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the plans communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the plans send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Officer. The plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

A Note About Personal Representatives

You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- » A power of attorney for healthcare purposes, notarized by a notary public;
- » A court order of appointment of the person as the conservator or guardian of the individual; or
- » An individual who is the parent of a minor child.

The plans retain discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Change to this Notice

The plans reserve the right to change this notice at any time and to make the revised or changed notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The plans will post a copy of the current notice in the Employer’s office. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

Notice of Breach of PHI

You have a right to receive a notice when there is a breach of your unsecured PHI.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may file a complaint with the Secretary of the U. S. Department of Health and Human Services (Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201), generally within 180 days of when the act or omission complained of occurred. Note: The plans, the Employer, and nay of its affiliates will not retaliate against you for filing a complaint.

Other Uses and Disclosures of Health Information

A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use and disclosure of psychotherapy notes.

Plans (excluding long-term care plans) are prohibited from using or disclosing PHI that is genetic information for underwriting purposes.

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the plans will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the plans will not reverse any uses or disclosures already made.

Contact Information: If you have any questions about this notice, please contact the Privacy Officer at the Employer, Attention: Privacy Officer.

Updated and effective March 26, 2013



Notes

This benefit summary prepared by



Gallagher

Insurance | Risk Management | Consulting

