

# EMPLOYEE BENEFITS

2026 BENEFIT GUIDE



# Important Contacts

| Coverage                    | Contact           | Phone          | Website  |
|-----------------------------|-------------------|----------------|--|
| Medical                     | UMR               | 800-826-9781   | <a href="http://www.umar.com">www.umar.com</a>   |
| Pharmacy                    | SmithRx           | 844-454-5201   | <a href="http://www.smithrx.com">www.smithrx.com</a>   |
| Telemedicine                | Teladoc           | 800-835-2362   | <a href="https://www.teladoc.com/">https://www.teladoc.com/</a>  |
| Health Savings Account      | Lively            | 888-576-4837   | <a href="http://www.livelyme.com">www.livelyme.com</a>   |
| Flexible Spending Accounts  | Lively            | 888-576-4837   | <a href="http://www.livelyme.com">www.livelyme.com</a>   |
| Dental                      | United Healthcare | 1-800-445-9090 | <a href="http://www.myuhc.com">www.myuhc.com</a>   |
| Vision                      | United Healthcare | 1-800-638-3120 | <a href="http://www.myuhcvision.com">www.myuhcvision.com</a>   |
| Life and AD&D               | United Healthcare | 1-888-299-2070 | <a href="http://www.myuhcftp.com">www.myuhcftp.com</a>   |
| Disability                  | United Healthcare | 1-888-299-2070 | <a href="http://www.myuhcftp.com">www.myuhcftp.com</a>   |
| Employee Assistance Program | United Healthcare | 1-877-660-3806 | <a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a>   |
| Critical Illness            | United Healthcare | 1-888-299-2070 | <a href="http://www.myuhcftp.com">www.myuhcftp.com</a>   |
| Accident Insurance          | United Healthcare | 1-888-299-2070 | <a href="http://www.myuhcftp.com">www.myuhcftp.com</a>   |
| Pet Insurance               | Pet Partners      | 866-774-1113   | <a href="http://www.petpartners.com">www.petpartners.com</a>   |
| Identity Theft              | Norton LifeLock   | 800-607-9174   | <a href="http://www.nortonlifelock.com/us/en/">www.nortonlifelock.com/us/en/</a>   |
| 401(k) Retirement           | John Hancock      | 800-225-5291   | <a href="http://www.johnhancock.com/retirement.html">www.johnhancock.com/retirement.html</a>   |
| Human Resources             | HR Assistance     | 309-797-1500   | <a href="mailto:HR@rockislandauction.com">HR@rockislandauction.com</a><br><a href="mailto:HR@cmbbeb5visa.com">HR@cmbbeb5visa.com</a> |

## IMPORTANT MEDICARE NOTICE:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 30 for Medicare Part D coverage information.

# Welcome to Your Benefits!

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

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



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# Welcome!

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

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

## Qualifying Life Events

Your benefit elections made during Open Enrollment will be effective January 1<sup>st</sup>, 2026. You may not make changes to your elections unless you experience a qualifying life event, including change in legal marital status (marriage, divorce, death of spouse), change in dependents (birth, adoption), change in employment status (termination, part-time), or if you gain/lose coverage elsewhere.



**TAKE ACTION!**

## OPEN ENROLLMENT

**November 10 – 21, 2025**

This Open Enrollment is an active enrollment, meaning all employees must enroll to have benefits in the new plan year. If you do not enroll, your benefits will be waived beginning **January 1, 2026**, and you will not be able to enroll until the next Open Enrollment unless you experience a Qualifying Life Event (QLE).

## IMPORTANT

If you need to make a change before the next Open Enrollment period due to a change in status, you must submit the required documentation **WITHIN 30 DAYS** of the qualifying life change event.

Contact HR or login to UKG to process a Qualifying Life Event.

# Benefits Eligibility

You and your eligible family members may participate in the 2026 employee benefits program if you're a regular, full-time employee working a minimum of 30 hours per week.

## New-Hire Eligibility

New hires can join the plan the first of the month following 60 days from hire. Spouses and dependent children of the employee are also eligible to participate in our benefit plans.

## Dependent Eligibility

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

### Children under the age of 26

*Regardless of marital status, full-student, or dependency.*

### Your legal spouse

### Children over the age of 26

*And claimed as a dependent on your federal income tax return as fully dependent due to a mental or physical disability.*



# Choose Your Medical Plan




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

Elections you make during Open Enrollment will be effective January 1<sup>st</sup>, 2026, and remain in effect until December 31<sup>st</sup>, 2026, unless you experience a qualifying life event.

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



## **TAKE ACTION!**

-  **Register Online**  
Your connection to great healthcare is only a click away. Register for an account at [www.umar.com](http://www.umar.com) so you can access time-saving tools, find tips for healthy living, choose a doctor, manage your EOBs, and more!
-  **Download the Mobile App**  
With the UMR mobile app, you've got the tools you need to manage your healthcare from your smartphone. The mobile app is available in the Apple and Google Play stores.
-  **Search, Compare, & Save**  
UMR provides tools to help you find the right options for you. Visit [www.umar.com](http://www.umar.com) or use the UMR app.

# Medical Plan Comparison

## UMR

|  | Gold                            | Silver            | Bronze            |
|--|---------------------------------|-------------------|-------------------|
| <b>IN-NETWORK</b>                                |                                 |                   |                   |
| <b>DEDUCTIBLE</b> Calendar Year                  |                                 |                   |                   |
| Individual                                       | \$1,000                         | \$2,500           | \$6,000           |
| Family   | \$3,000                         | \$5,000           | \$12,000          |
| <b>OUT-OF-POCKET (OOP) MAXIMUM</b> Calendar Year |                                 |                   |                   |
| Individual                                       | \$2,500                         | \$5,500           | \$6,000           |
| Family   | \$7,500                         | \$12,000          | \$12,000          |
| <b>BENEFIT DETAILS</b>                           |                                 |                   |                   |
| Coinsurance Percentage                           | 10%                             | 30%               | 0%                |
| Virtual Visits                                   | \$25 copay                      | \$30 copay        | Deductible, 0%    |
| Teladoc Virtual Visits                           | No charge***                    | No charge***      | No charge***      |
| Preventive Care                                  | No charge                       | No charge         | No charge         |
| Primary Care Physician (PCP)                     | \$25 copay                      | \$30 copay        | Deductible, 0%    |
| Specialist*                                      | \$50 copay                      | \$60 copay        | Deductible, 0%    |
| Mental Health Office Visit                       | \$25 copay                      | \$30 copay        | Deductible, 0%    |
| Chiropractic Services                            | Deductible, 10%                 | Deductible, 30%   | Deductible, 0%    |
| Emergency Room                                   | \$200 copay                     | \$400 copay       | Deductible, 0%    |
| Inpatient Hospital                               | \$250 copay,<br>Deductible, 10% | Deductible, 30%   | Deductible, 0%    |
| Outpatient Hospital                              | Deductible, 10%                 | Deductible, 30%   | Deductible, 0%    |
| Urgent Care                                      | \$75 copay                      | \$75 copay        | Deductible, 0%    |
| Outpatient Surgery                               | Deductible, 10%                 | Deductible, 30%   | Deductible, 0%    |
| Lab/X-Ray (Outpatient) – CT/MRI                  | Deductible, 10%                 | Deductible, 30%   | Deductible, 0%    |
| <b>OUT-OF-NETWORK**</b>                          |                                 |                   |                   |
| Deductible – Individual/Family                   | \$5,000/\$15,000                | \$5,000/\$15,000  | \$10,000/\$20,000 |
| Coinsurance                                      | 40%                             | 50%               | 60%               |
| Out-of-Pocket Maximum (OOP) – Individual/Family  | \$16,500/\$30,600               | \$16,500/\$36,000 | \$12,000/\$24,000 |

\* Referrals may be required for some specialist visits.

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

\*\*\*Dermatology visits through Teladoc will have a copay or member cost-share depending on which plan you're enrolled in.

## Understanding Your Deductibles

In all plans the individual deductible in addition to the overall family deductible means that an individual participant may reach their deductible and begin having services paid by the plan regardless of whether the family deductible has been met.

# Pharmacy

SmithRx

## Specialty Medications

SmithRx provides resources and personalized support to help you manage your condition.

## Search, Compare, & Save

SmithRx provides tools to help you find the right options for you. Visit [www.smithrx.com](http://www.smithrx.com).

|                                     |                                  | Gold         | Silver       | Bronze         |
|-------------------------------------|----------------------------------|--------------|--------------|----------------|
| <b>Retail<br/>30-day supply</b>     | Preventive                       | No charge    | No charge    | No charge      |
|                                     | Tier 1 (Generic)                 | No charge    | No charge    | Deductible, 0% |
|                                     | Tier 2 (Preferred Brands)        | \$35 copay   | \$50 copay   | Deductible, 0% |
|                                     | Tier 3 (Non-Preferred Brands)    | \$75 copay   | \$100 copay  | Deductible, 0% |
|                                     | Tier 4 (Preferred Specialty)     | \$150 copay* | \$150 copay* | Deductible, 0% |
|                                     | Tier 5 (Non-Preferred Specialty) | \$250 copay* | \$250 copay* | Deductible, 0% |
| <b>Mail order<br/>90-day supply</b> | Tier 1 (Generic)                 | \$20 copay   | \$20 copay   | Deductible, 0% |
|                                     | Tier 2 (Preferred Brands)        | \$70 copay   | \$100 copay  | Deductible, 0% |
|                                     | Tier 3 (Non-Preferred Brands)    | \$150 copay  | \$200 copay  | Deductible, 0% |

\* 30-day supply limit

## Send Medications Right to Your Home

Home delivery is a convenient, cost-effective and safe option for medications you take regularly. There are four ways to place a new home delivery order:



### ePrescribe

Your doctor can send an electronic prescription



**Visit** the website on your ID card



**Call** the toll-free number on your ID card

For any questions about Smith Rx or your prescription drugs, call 844-454-5201

# Telehealth

## Teladoc

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

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

\*Dermatology visits through Teladoc will have a copay

We've all been there—it's the middle of the night and you have a sick child or maybe you are trying to get an appointment with your primary care provider, but the first appointment isn't for two weeks. Good news... there's an easier way! Telehealth is a convenient option for scheduling virtual doctor visits from your own home. With telehealth, you don't have to drive to the doctor's office or sit in a waiting room when you're sick—you can see your doctor from the comfort of your own bed or sofa.

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

**To access telehealth benefits please download the Teladoc app, visit <https://www.teladoc.com/> or call 800-835-2362**



# Health Savings Account (HSA)

Lively

## What is a Health Savings Account?

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



### Lower Paycheck Costs

Allowing you to keep more control of your money



### Tax-Advantaged Savings Account

Enrolling in and contributing to a Health Savings Account (HSA) helps you pay your deductible and out-of-pocket costs



### Comparable Benefits

These plans use the same networks that other plans offer, and in-network preventive care is still covered at 100%

## Who is Eligible for an HSA?

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

## How Much Can I Contribute?

Employee only coverage per calendar year:

**\$4,400**

Employee plus dependents coverage:

**\$8,750**

Anyone 55+ can make an additional annual catch-up contribution of

**\$1,000**

## HSAs and Your Taxes

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

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

*For a list of eligible expenses, see IRS Publication 502, available at [www.irs.gov](http://www.irs.gov).*

# Flexible Spending Account (FSA)

## Lively

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

## Health Care FSA

### Who can participate?

Employees who are not enrolled in the high-deductible health plan.

### What are the contribution limits?

Employees can contribute up to \$3,400 in 2026.

### What happens at the end of the year?

This benefit does not rollover year to year. If you do not spend the money in your FSA at the end of the year, you will forfeit those funds. However, your plan does allow you to rollover up to \$680 of unused FSA funds to use in the following year.

## Dependent Care FSA

### Who can participate?

Any employee.

### What are the contribution limits?

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

### What happens at the end of the year?

FSA funds expire at the end of each year. Use it or lose it. Unlike the healthcare FSA, your full election for the plan year is not available on the day your plan starts. For the dependent care FSA, you can only be reimbursed for qualified expenses up to the amount you have contributed to your FSA up to that point in time. As your contributions accrue, claims for reimbursement can be processed.

## What's an Eligible Expense?

**Health Care FSA** – Plan deductibles, copays, coinsurance, and other health care expenses. To learn more, see IRS Publication 502 at [www.irs.gov](http://www.irs.gov).

**Dependent Care FSA** – Child day care, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at [www.irs.gov](http://www.irs.gov).

## Run-Out Period

The run-out period for submitting claims is 90 days after the end of the plan year, which means you have until March 31 of the following year to submit claims for expenses incurred during the plan year.



# HSA & FSA Comparison

This chart shows the features of the healthcare FSAs and the Health Savings Account (HSA)

|   | HSA  | Health Care FSA  |
|---|--|--|
| Available if you select these plans                 | Bronze   | Gold/Silver*   |
| How much you may contribute                         | \$4,400 (EE only)<br>\$8,750 (all other coverage levels)<br>Catch-up contributions of up to \$1,000 for 2026 year for age 55+  | Up to \$3,400 for plan year  |
| Expenses you may pay from your account              | Out-of-pocket<br>Medical<br>Prescription drug<br>Dental<br>Vision  | Out of pocket expenses incurred during the current calendar year:<br>Medical<br>Prescription drugs<br>Dental<br>Vision   |
| Account balance available to reimburse expenses     | Current account balance  | Entire contribution amount elected for the plan year   |
| Time limits for using your account balance          | No limit   | Must use 2026 account balance for expenses incurred through <b>December 31, 2026</b> . Claims must be filed by March 31, 2027.   |
| If you don't use all your account balance each year | Any account balance carries over from year-to-year   | You must submit claims by March 31, 2027, for all expenses incurred through <b>December 31, 2026</b> . The FSA plan allows you to rollover up to \$680 of unused FSA funds to use in the following year; but any additional funds will be forfeited. |
| How it saves you money                              | Your contributions are tax free, which reduces your taxable income. Any investment or interest earnings on your account balance is tax free. Distributions are tax free if used for qualified healthcare expenses. | Your contributions are tax-free, which reduces your taxable income and increases your take-home pay. You pay for healthcare expenses with pre-tax dollars.   |

\* You don't have to participate in a company medical plan to enroll in a healthcare FSA.



**Search, Compare, & Save** Lively provides tools to help you find the right options for you at [www.livelyme.com](http://www.livelyme.com). You may also visit [hsastore.com](http://hsastore.com) for more information.

# Dental Plan

## United Healthcare

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings and x-rays. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

Dental coverage is offered for basic and major services. You and your eligible dependents may enroll in the dental option administered by United Healthcare.

| <b>In-Network Plan Features</b>              |                         |
|--|-------------------------|
| Annual Calendar Year Deductible – Individual | \$25                    |
| Annual Calendar Year Deductible – Family     | \$75                    |
| Annual Maximum                               | \$1,500                 |
| Preventive Care                              | No Charge               |
| Basic Services                               | 20% after deductible    |
| Major Services                               | 50% after deductible    |
| Orthodontia Services (dependents to age 19)  | 50% (deductible waived) |
| Orthodontia Lifetime Maximum                 | \$1,500                 |



To find an in-network provider visit [www.myuhc.com](http://www.myuhc.com) and go to “Coverage and Benefits”, scroll down to “Dental”, and select “View dental plan”.

# Vision Plan

## United Healthcare

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

Your vision insurance is provided by United Healthcare and entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

|   | In Network                 | Out Of Network |
|---|----------------------------|----------------|
| <b>Routine Exam</b>                           |                            |                |
| Routine Exam                                  | No charge                  | Up to \$40     |
| <b>Eyeglass Lenses Materials &amp; Frames</b> |                            |                |
| Single Vision Lenses                          | No charge                  | Up to \$40     |
| Standard Lined Bifocal Lenses                 | No charge                  | Up to \$60     |
| Standard Trifocal Lenses                      | No charge                  | Up to \$80     |
| Lenticular                                    | No charge                  | Up to \$80     |
| Frames  | Up to \$200, then 30% off* | Up to \$45     |
| Elective Contact Lenses                       | Up to \$200                | Up to \$175    |
| Contact Lens Fitting/Evaluation               | Up to \$60                 | N/A            |
| <b>Frequency of Services</b>                  |                            |                |
| Comprehensive Eye Exam                        | 12 months                  |                |
| Lenses  | 12 months                  |                |
| Frames  | 24 months                  |                |
| Contact Lenses                                | 12 months                  |                |

\*At participating providers

To find an in-network provider visit [www.myuhcvision.com](http://www.myuhcvision.com)

# Life Insurance

## United Healthcare

### Basic Life & Accidental Death & Dismemberment (AD&D)

The Basic Life and AD&D plan provides a benefit in the event of your death, dismemberment or paralysis. This benefit is sponsored by UP Management so you will automatically be enrolled at no cost to you. Your coverage will be 1 times your salary up to \$50,000.

### Supplemental Life Insurance

You may purchase additional life insurance at group rates:

- Available in increments of \$10,000 up to \$500,000, not to exceed 5x your annual salary
- You pay the full cost of this plan, and the amount deducted depends on the age of the associate and the amount of coverage elected
- If you do not elect this coverage when first becoming eligible or an election over \$120,000 is made, you are subject to medical underwriting by the carrier

### Life Insurance for Spouses & Dependents

You may purchase additional dependent life insurance at group rates:

- Spousal life is available in increments of \$5,000 up to a max of \$250,000, not to exceed 100% of your election
- Can elect up to \$25,000 without medical underwriting as a new hire
- Child life is available for \$1,000 from birth to 6 months and in increments of \$1,000 up to a max of \$10,000 for children 6 months and older
- Children are not subject to medical underwriting
  - The cost remains the same regardless of the number of children you have

### TAKE ACTION!

Don't forget to designate a beneficiary!

**Note:** Upon loss of eligibility or termination of employment, you and/or your dependents may elect to continue your employer-sponsored Basic or Voluntary Term Life Insurance coverage by either porting or converting it.

If you can continue your life insurance policy, you can port it, which means continuing the same type of policy, or you can convert it, which means change it to a new type of individual policy. Remember, no matter which option you choose, you become responsible for the premiums.

### Benefit Reduction

Benefits will automatically be reduced according to the table shown.

#### Benefit Reduction Schedule:

|      |     |     |
|------|-----|-----|
| Age  | 65  | 70  |
| Rate | 35% | 50% |

**Note:** Employee rates automatically increase with age.

### GUARANTEED ISSUE AND EVIDENCE OF INSURABILITY

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

**2026 Open Enrollment Only:** you may elect up to the guaranteed issue (GI) amount without medical underwriting even if you waived the voluntary life and AD&D insurance as a new hire.

# Disability Insurance

## United Healthcare

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

### Short-Term Disability (STD)

The Short-Term Disability (STD) plan provides full-time employees with income replacement while disabled and unable to work due to a non-occupational illness or injury, including pregnancy. The benefit payment is based on your employment status.

Your STD benefits begin on the 8<sup>th</sup> consecutive day of your disability. STD replaces up to 60% of your monthly income with a maximum benefit of \$1,500 per week for up to 25 weeks per claim.

**2026 Open Enrollment Only:** you may elect short-term disability without medical underwriting even if you waived coverage as a new hire.

### Long-Term Disability (LTD)

Long-Term Disability (LTD) is available after your short-term disability benefits end or 180 days after the illness or injury -- whichever is greater.

If you elect LTD, the benefit is 60% of your pre-disability earnings, up to a maximum of \$10,000 per month. Disability benefits last until you recover or reach your Social Security retirement age.

### Filing a Short-Term Disability Claim

In order to receive benefits, you must report your disability claim to United Healthcare if you will be out of work for more than seven days.

#### SHORT-TERM DISABILITY COVERAGE

- 60% of your weekly earnings up to \$1,500 maximum for 25 weeks
- Benefit begins after 7 days of disability.

#### LONG TERM DISABILITY COVERAGE

- Coverage you pay for based on your age and salary
- 60% of your monthly earnings to a \$10,000 maximum
- Benefit begins after 180 days of disability and payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner

**Long-Term Disability Pre-existing condition limitation:** If you've received medical treatment consultation, care, or services, including diagnostic measures, or have taken prescribed drugs or medicines within twelve months prior to the effective date for any injury or sickness, a period of disability related to that diagnosis will not be covered for 12 months after your effective date.

You can contact United Healthcare by phone at 1-888-299-2070 or sign in to [www.myuhcfc.com](http://www.myuhcfc.com)

# Employee Assistance Program

## United Healthcare

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

The United Healthcare EAP is designed to assist staff members and families with personal challenges in many different areas including depression, stress management, drug and alcohol abuse, relationships, grief, domestic violence, legal and financial issues, parenting, childcare and elder care.

Participation in the EAP is voluntary, confidential and free of cost for the first 3 visits. For those who require referrals for long-term treatment, there may be fees for the services of outside providers.

However, EAP counselors will coordinate referrals, whenever possible, to take advantage of existing insurance coverage and community resources in order to minimize costs. We encourage you and your eligible family members to take advantage of your EAP benefit and to reach out to United Healthcare.



**24 HOURS A DAY, 7 DAYS A WEEK**

Professional counselors are available to provide you with support, guidance and resources. Spanish and TTY/TDD phone lines also available.



**[www.liveandworkwell.com](http://www.liveandworkwell.com) (enter anonymously using access code FP3EAP)**

**1-877-660-3806**

# Voluntary Benefits

United Healthcare

**Wellness Benefit** – Both Accident and Critical Illness plans include an annual health screening benefit of \$50. This is payable once per calendar year per insured person. Health screening examples include blood screenings, annual physical exams, colonoscopies and more.

## Accident Insurance

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

### How Does Accident Insurance Work?

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

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

### Accident Covered Expenses Include:

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

## Critical Illness Insurance

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

### How Will a Critical Illness Claim Get Paid?

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

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

### Critical Illness Covered Expenses Include:

- Heart attack
- Multiple Sclerosis
- Stroke
- Alzheimer's disease
- Parkinson's disease
- Major organ transplant

Learn more about your new United Healthcare plans!



1-888-299-2070



[www.myuhcfp.com](http://www.myuhcfp.com)

# Voluntary Benefits

## Pet Partners/Norton LifeLock

### Pet Insurance

Let's not forget about our furry friends! Pet Insurance offers offset the cost of caring for your pet with a wide range of covered medical treatments.

Pet Partners covers everything from preventive care to accidents and illness, as well as the costs of X-rays, office visits, medications, surgeries, and hospital stays. You can either choose your own vet or use a licensed in-network vet. The cost of coverage depends on your pet's age, species, and the coverage level (Accident only or Accident & Illness) that you select.

### Identity Theft Protection

Identity Theft insurance provides credit monitoring and fully managed identity restoration services should you or an immediate family member become a victim of identity theft. This will help you remain productive at home and at work while your identity is restored to pre-theft status.

**Identity theft protection provides all-in-one protection** for your identity. Once enrolled, you will receive an email with instructions on how to take full advantage of your membership.

**Identity theft protection** looks for uses of your personal information and, with proprietary technology, alerts you to a wide range of potential threats to your identity.

**Norton Device Security** protects against existing and emerging threats, including ransomware, viruses, spyware, malware and other online threats.

**Parental Control** helps keep your kids safer online. Help your kids explore the web more safely by staying informed of sites they are visiting and blocking harmful or inappropriate ones.

**Privacy Monitor** scans common public people-search websites for your personal information and helps you opt out, giving you peace of mind and greater control over your online privacy.



# Financial Security

John Hancock

## 401(k) Plan

Helping you prepare for retirement is extremely important to UP Management, LLC. To help you achieve long-term retirement security, UP Management offers you the ability to build individual wealth through the 401(k) employee contributions.

## Eligibility for Employee Contribution

The first of the month after you have completed 60 days of service, you are eligible to make pre- and post-tax contributions to the plan. Employee contributions will be effective as soon as administratively feasible after election.

## Enrollment

The HR department will reach out to you once become eligible to enroll.

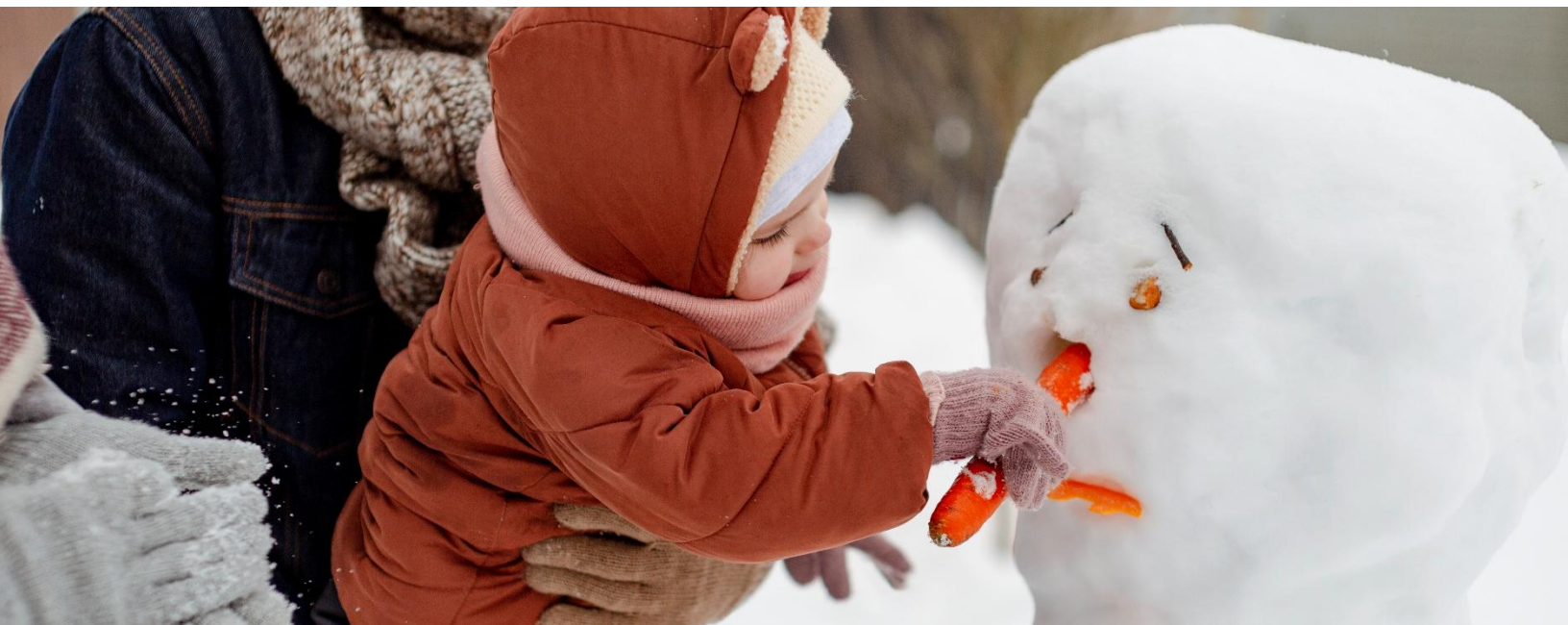
Visit the John Hancock website to:

View your current 401(k) balance and investments

Add or change your beneficiary on the plan

Rollover funds from a previous employer plan or qualified 401(k) plan

For more information and access to the John Hancock site, go to [www.johnhancock.com/retirement.html](http://www.johnhancock.com/retirement.html) or call 800-225-5291.



# Employee Contributions

Rates will be paid on a weekly basis

| Medical               | Gold     | Silver   | Bronze  |
|-----------------------|----------|----------|---------|
| Employee              | \$71.54  | \$38.08  | \$18.46 |
| Employee & Spouse     | \$190.07 | \$120.95 | \$81.47 |
| Employee & Child(ren) | \$162.62 | \$82.88  | \$42.10 |
| Family                | \$225.00 | \$148.85 | \$94.53 |

| Dental                |         | Vision                |        |
|-----------------------|---------|-----------------------|--------|
| Employee              | \$3.97  | Employee              | \$1.20 |
| Employee & Spouse     | \$7.94  | Employee & Spouse     | \$2.28 |
| Employee & Child(ren) | \$10.46 | Employee & Child(ren) | \$2.68 |
| Family                | \$15.71 | Family                | \$3.77 |

| Pet Insurance (per animal) | Accident Only | Accident & Illness |
|----------------------------|---------------|--------------------|
| Cat                        | \$2.33        | \$6.29             |
| Dog                        | \$2.33        | \$12.45            |

| ID Theft          | Essential | Premier |
|-------------------|-----------|---------|
| Employee          | \$2.07    | \$3.46  |
| Employee & Family | \$4.15    | \$6.92  |

| Accident              |        |
|-----------------------|--------|
| Employee              | \$2.31 |
| Employee & Spouse     | \$3.66 |
| Employee & Child(ren) | \$5.44 |
| Family                | \$8.12 |

# Employee Contributions *Continued*

Rates will be paid on a weekly basis

| Short-Term Disability Rates Per \$10 of Weekly Benefit |         |
|--|---------|
| Age  | Rate    |
| Under 25   | \$0.502 |
| 25-29  | \$0.527 |
| 30-34  | \$0.478 |
| 35-39  | \$0.444 |
| 40-44  | \$0.434 |
| 45-49  | \$0.455 |
| 50-54  | \$0.551 |
| 55-59  | \$0.718 |
| 60-64  | \$0.891 |
| 65+  | \$0.912 |

| Long-Term Disability Rates Per \$100 of Monthly Covered Payroll |         |
|---|---------|
| Age   | Rate    |
| Under 25  | \$0.048 |
| 25-29   | \$0.084 |
| 30-34   | \$0.149 |
| 35-39   | \$0.205 |
| 40-44   | \$0.350 |
| 45-49   | \$0.440 |
| 50-54   | \$0.622 |
| 55-59   | \$0.800 |
| 60-64   | \$0.478 |
| 65+   | \$0.602 |

| Voluntary Life Monthly Rates Per \$1,000 of Coverage (Spouse Rate Based on Spouse age) |         |
|--|---------|
| Age  | Rate    |
| Under 24   | \$0.057 |
| 25-29  | \$0.063 |
| 30-34  | \$0.085 |
| 35-39  | \$0.126 |
| 40-44  | \$0.192 |
| 45-49  | \$0.299 |
| 50-54  | \$0.440 |
| 55-59  | \$0.630 |
| 60-64  | \$0.810 |
| 65-69  | \$1.270 |
| 70-74  | \$2.182 |
| 75+  | \$6.744 |
| AD&D   | \$0.026 |
| Child Rate – All Ages 26 and Under   |         |
| Life   | \$0.150 |
| AD&D   | \$0.050 |

| Critical Illness Per \$1,000 of Coverage (Spouse Rate Based on Employee's Age) |               |             |
|--|---------------|-------------|
| Employee Age   | Employee Rate | Spouse Rate |
| Under 25   | \$0.250       | \$0.240     |
| 25-29  | \$0.320       | \$0.320     |
| 30-34  | \$0.410       | \$0.430     |
| 35-39  | \$0.570       | \$0.590     |
| 40-44  | \$0.880       | \$0.890     |
| 45-49  | \$1.430       | \$1.260     |
| 50-54  | \$2.380       | \$2.010     |
| 55-59  | \$3.150       | \$3.070     |
| 60-64  | \$3.640       | \$4.490     |
| 65-69  | \$6.910       | \$4.140     |
| 70-74  | \$8.640       | \$8.640     |
| 75+  | \$11.700      | \$12.420    |
| Child Rate   |               |             |
| All Ages 26 and Under  | \$0.47        |             |



# How Do I Enroll?

## 1 Log In

Log into UKG and review your current elections.

## 2 Choose Your 2026 Plans

Utilize this guide to help choose the lowest-cost, best-value health plan based on your medical needs.

## 3 Enroll By Date

If you don't complete your enrollment by November 21<sup>st</sup>, 2025, you will not have coverage in 2026.

### *Reminder*



Benefit mid-year changes must be completed within 30 days of a qualifying life event.

# How a Claim is Paid

- 1. Filing the Claim:** The process begins when the policyholder experiences a loss or damage covered by their insurance policy. They then contact their insurance company to file a claim, providing details about the incident. This can often be done online, over the phone, or through a mobile app.
- 2. Claim Acknowledgment:** After the claim is filed, the insurance company acknowledges receipt of the claim. This may include providing the policyholder with a claim number and details about the next steps in the process.
- 3. Documentation and Evidence Collection:** The policyholder is usually required to provide documentation and evidence to support their claim. This can include photos, receipts, police reports, medical reports, or any other relevant documentation that demonstrates the extent of the loss or damage.
- 4. Assignment of a Claims Adjuster:** The insurance company assigns a claims adjuster to investigate the claim. The adjuster's role is to assess the validity of the claim, evaluate the extent of the damage or loss, and determine the appropriate amount of compensation.
- 5. Investigation and Evaluation:** The claims adjuster conducts a thorough investigation, which may involve visiting the site of the incident, interviewing witnesses, reviewing documents, and consulting with experts if necessary. They evaluate the extent of the damage or loss and determine the value of the claim based on the policy's terms and conditions.
- 6. Claim Decision:** After the investigation and evaluation, the claims adjuster makes a decision regarding the claim. The insurance company will inform the policyholder whether the claim has been approved, partially approved, or denied. If the claim is denied, the policyholder will receive an explanation for the denial.
- 7. Settlement Offer:** If the claim is approved, the insurance company makes a settlement offer to the policyholder. This offer outlines the amount of money that will be paid to cover the loss or damage. The policyholder reviews the offer and can accept or negotiate if they believe the amount is insufficient.
- 8. Payment:** Once the settlement offer is accepted, the insurance company processes the payment. Payment can be made in various forms, such as a direct deposit, a check, or sometimes directly to service providers (e.g., a repair shop or medical provider) if agreed upon.
- 9. Resolution and Closure:** After payment is made, the claim is considered resolved and closed. The policyholder may need to sign a release form indicating that they accept the settlement and waive any further claims related to the incident.

Throughout the process, clear communication between the policyholder and the insurance company is essential to ensure a smooth and timely resolution of the claim. If the policyholder is dissatisfied with the outcome, they may have the option to appeal the decision or seek external resolution methods, such as mediation or legal action.

# Benefits Definitions

## Deductible

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

## Coinsurance

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

## Out-of-pocket maximum

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

## Copayment

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

## Network

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

## Network provider

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

There is no first dollar coverage with the exception of preventative services.

## Provider

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

## Out-of-network provider

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

## Referral

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

## Premium

You typically pay premiums through payroll deductions.

## High-deductible health plan (HDHP)

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

# 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%<sup>1</sup> 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.<sup>1 2</sup>

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

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

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

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

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

To learn more, visit [HealthCare.gov](https://www.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](https://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 Human Resources, 309-797-1500. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://HealthCare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1. Indexed annually; see [irs.gov/pub/irs-drop/rp-22-34.pdf](https://irs.gov/pub/irs-drop/rp-22-34.pdf) for 2023.
2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

## **Special Enrollment Notice**

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

### **LOSS OF OTHER COVERAGE**

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

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

### **MARRIAGE, BIRTH OR ADOPTION**

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

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

### **MEDICAID OR CHIP**

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

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

### **FOR MORE INFORMATION OR ASSISTANCE**

To request special enrollment or obtain more information, please contact: Human Resources, 309-797-1500.

## **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 YOUR BENEFITS AND COMPLIANCE PARTNER AT [HR@cmbcb5visa.com](mailto:HR@cmbcb5visa.com) / 309-797-1500 IF YOU HAVE ANY QUESTIONS.

**Please review it carefully.**

**YOUR RIGHTS**

You have the right to:

- Consent to most uses and disclosures of your health information
- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a list of health care providers who have received your information through certain third parties
- Get a copy of this privacy notice
- Choose in advance whether to receive fundraising communications
- Discuss this notice with someone in our program
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

**YOUR CHOICES**

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

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

**OUR USES AND DISCLOSURES**

We may use and share your information without your consent as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- For your medical emergencies
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Assist with cause of death inquiries
- Communicate within our program and with contractors
- Respond to management and financial audits and program evaluation
- Prevent or reduce crime in our program

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

## **YOUR RIGHTS**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

### **Get a copy of health and claims records**

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

### **Ask us to correct health and claims records**

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

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

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

### **Ask us to limit what we use or share**

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

### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

### **Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

### **Discuss this notice with someone in our program**

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

### **Choose in advance about fundraising**

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

### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

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

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

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not retaliate against you for filing a complaint.

**YOUR CHOICES**

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

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

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

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

- Marketing purposes
- Sale of your information

**OUR USES AND DISCLOSURES**

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Help manage the health care treatment you receive**

We can use your health information and share it with professionals who are treating you.

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

**Run our organization**

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

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

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

**Bill and Pay for your health services**

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

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

**Administer your plan**

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

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

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: <https://www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html>

### **Help with public health and safety issues**

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

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

### **For your medical emergencies**

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

### **Do research**

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

### **Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Legal Proceedings and Court Orders**

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

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

### **Assist with cause of death inquiries**

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

### **Communicate within our program and with contractors**

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

### **Respond to management and financial audits and program evaluation**

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

### **Prevent or reduce crime in our program**

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

### **Redisclosure According to HIPAA**

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

### **OUR RESPONSIBILITIES**

- We are required to obtain your consent for most uses and sharing of your information.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **CHANGES TO THE TERMS OF THIS NOTICE**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date: 01/01/2026

Benefits and Compliance Business Partner: Carilee Fore

[HR@cmb5visa.com](mailto:HR@cmb5visa.com) / 309-797-1500

## **Important Notice from UP Management, LLC. 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 UP Management, LLC. 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. UP Management, LLC. has determined that the prescription drug coverage offered by the [Name of 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 UP Management, LLC. 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 UP Management, LLC. 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](http://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](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: 01/01/2026

Name of Entity/Sender: UP Management, LLC.

Contact--Position/Office: Human Resources

Address: 7819 42nd Street West, Rock Island, IL 61201

Phone Number: 309-757-1500

## **Continuation Coverage Rights Under COBRA**

### **INTRODUCTION**

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

### **WHAT IS COBRA CONTINUATION COVERAGE?**

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

#### **WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources.**

#### **HOW IS COBRA CONTINUATION COVERAGE PROVIDED?**

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

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

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

#### **Disability Extension of 18-month Period of COBRA Continuation Coverage**

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

## **ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?**

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

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

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

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

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

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

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

## **IF YOU HAVE QUESTIONS**

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

## **KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES**

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

## **PLAN CONTACT INFORMATION**

UP Management, Human Resources, 309-797-1500, 7819 42<sup>nd</sup> Street West, Rock Island, IL 61201

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

# **Women's Health and Cancer Rights Act**

## **ENROLLMENT NOTICE**

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: see medical plan comparison page in this benefits guide. If you would like more information on WHCRA benefits, call your plan administrator at 309-797-1500.

## **ANNUAL NOTICE**

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and

complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 309-757-1500 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 balance 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 1-800-985-3059.

Visit [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

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

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

| STATE                                | WEBSITE/EMAIL  | PHONE  |
|--------------------------------------|--|--|
| <b>Alabama</b><br>Medicaid           | <a href="http://myalhipp.com">myalhipp.com</a>   | 855-692-5447   |
| <b>Alaska</b><br>Medicaid            | Premium Payment Program: <a href="http://myakhipp.com">myakhipp.com</a><br>Medicaid Eligibility: <a href="http://health.alaska.gov/dpa">health.alaska.gov/dpa</a><br>Email: <a href="mailto:customerservice@myakhipp.com">customerservice@myakhipp.com</a> | 866-251-4861   |
| <b>Arkansas</b><br>Medicaid          | <a href="http://myarhipp.com/">http://myarhipp.com/</a>  | 855-MyARHIPP<br>(855-692-7447)                                   |
| <b>California</b><br>Medicaid        | <a href="http://dhcs.ca.gov/hipp">dhcs.ca.gov/hipp</a><br>Email: <a href="mailto:hipp@dhcs.ca.gov">hipp@dhcs.ca.gov</a>  | 916-445-8322<br>916-440-5676 (fax)                               |
| <b>Colorado</b><br>Medicaid and CHIP | Medicaid: <a href="http://healthfirstcolorado.com">healthfirstcolorado.com</a><br>CHIP: <a href="http://hcpf.colorado.gov/child-health-plan-plus">hcpf.colorado.gov/child-health-plan-plus</a><br>HIBI: <a href="http://mycohibi.com">mycohibi.com</a>     | 800-221-3943 Relay 711<br>800-359-1991 Relay 711<br>855-692-6442 |
| <b>Florida</b><br>Medicaid           | <a href="http://flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html">flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html</a>   | 877-357-3268   |
| <b>Georgia</b><br>Medicaid           | HIPP: <a href="http://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a>   | 678-564-1162, press 1<br>678-564-1162, press 2                   |

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|   | CHIPRA: <a href="http://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a>   |  |
| <b>Indiana</b><br>Medicaid                | HIPP: <a href="https://www.in.gov/fssa/dfr/">https://www.in.gov/fssa/dfr/</a><br>All other Medicaid: <a href="http://in.gov/medicaid">in.gov/medicaid</a>  | 800-403-0864<br>800-457-4584   |
| <b>Iowa</b><br>Medicaid and CHIP          | Medicaid: <a href="http://hhs.iowa.gov/programs/welcome-iowa-medicaid">hhs.iowa.gov/programs/welcome-iowa-medicaid</a><br>CHIP: <a href="http://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki">hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki</a><br>HIPP: <a href="http://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp">hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp</a> | 800-338-8366<br>800-257-8563<br>888-346-9562   |
| <b>Kansas</b><br>Medicaid                 | <a href="http://kancare.ks.gov">kancare.ks.gov</a>   | 800-792-4884<br>HIPP: 800-967-4660   |
| <b>Kentucky</b><br>Medicaid and CHIP      | KI-HIPP: <a href="http://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a><br>KI-HIPP Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a><br>KCHIP: <a href="http://kynect.ky.gov">kynect.ky.gov</a><br>Medicaid: <a href="http://chfs.ky.gov/agencies/dms">chfs.ky.gov/agencies/dms</a>  | KI-HIPP: 855-459-6328<br><br>KCHIP: 877-524-4718   |
| <b>Louisiana</b><br>Medicaid              | <a href="http://ldh.la.gov/healthy-louisiana">ldh.la.gov/healthy-louisiana</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a>   | Medicaid: 888-342-6207<br>LaHIPP: 855-618-5488   |
| <b>Maine</b><br>Medicaid                  | Enrollment: <a href="http://mymaineconnection.gov/benefits">mymaineconnection.gov/benefits</a><br>Private health insurance premium: <a href="http://maine.gov/dhhs/ofa/applications-forms">maine.gov/dhhs/ofa/applications-forms</a>   | Enroll: 800-442-6003<br>Private HIP: 800-977-6740<br>TTY/Relay: 711                                    |
| <b>Massachusetts</b><br>Medicaid and CHIP | <a href="http://mass.gov/masshealth/pa">mass.gov/masshealth/pa</a><br>Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a>  | 800-862-4840<br>TTY/Relay: 711   |
| <b>Minnesota</b><br>Medicaid              | <a href="http://mn.gov/dhs/health-care-coverage">mn.gov/dhs/health-care-coverage</a>   | 800-657-3672   |
| <b>Missouri</b><br>Medicaid               | <a href="http://dss.mo.gov/mhd/participants/pages/hipp.htm">dss.mo.gov/mhd/participants/pages/hipp.htm</a>   | 573-751-2005   |
| <b>Montana</b><br>Medicaid                | HIPP: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a><br>HIPP Email: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a>   | 800-694-3084   |
| <b>Nebraska</b><br>Medicaid               | <a href="http://ACCESSNebraska.ne.gov">ACCESSNebraska.ne.gov</a>   | 855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178   |
| <b>Nevada</b><br>Medicaid                 | Medicaid: <a href="http://dhcfnv.gov">dhcfnv.gov</a>   | 800-992-0900   |
| <b>New Hampshire</b><br>Medicaid          | <a href="http://dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a><br>Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a>  | 603-271-5218 or<br>800-852-3345, ext. 15218  |
| <b>New Jersey</b><br>Medicaid and CHIP    | Medicaid: <a href="http://state.nj.gov/humanservices/dmahs/clients/medicaid">state.nj.gov/humanservices/dmahs/clients/medicaid</a><br>CHIP: <a href="http://njfamilycare.org/index.html">njfamilycare.org/index.html</a>   | Medicaid: 800-356-1561<br>CHIP Premium Assist:<br>609-631-2392<br>CHIP: 800-701-0710<br>TTY/Relay: 711 |
| <b>New York</b><br>Medicaid               | <a href="http://health.ny.gov/health_care/medicaid">health.ny.gov/health_care/medicaid</a>   | 800-541-2831   |
| <b>North Carolina</b><br>Medicaid         | <a href="http://medicaid.ncdhhs.gov">medicaid.ncdhhs.gov</a>   | 919-855-4100   |
| <b>North Dakota</b><br>Medicaid           | <a href="http://hhs.nd.gov/healthcare">hhs.nd.gov/healthcare</a>   | 844-854-4825   |
| <b>Oklahoma</b><br>Medicaid and CHIP      | <a href="http://insureoklahoma.org">insureoklahoma.org</a>   | 888-365-3742   |
| <b>Oregon</b><br>Medicaid                 | <a href="http://healthcare.oregon.gov/Pages/index.aspx">healthcare.oregon.gov/Pages/index.aspx</a>   | 800-699-9075   |
| <b>Pennsylvania</b><br>Medicaid and CHIP  | Medicaid: <a href="http://pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a><br>CHIP: <a href="http://dhs.pa.gov/CHIP/Pages/CHIP.aspx">dhs.pa.gov/CHIP/Pages/CHIP.aspx</a>   | Medicaid: 800-692-7462<br>CHIP: 800-986-KIDS<br>(5437)   |
| <b>Rhode Island</b><br>Medicaid and CHIP  | <a href="http://eohhs.ri.gov">eohhs.ri.gov</a>   | 855-697-4347 or<br>401-462-0311 (Direct RIte)  |
| <b>South Carolina</b><br>Medicaid         | <a href="http://scdhhs.gov">scdhhs.gov</a>   | 888-549-0820   |

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| <b>South Dakota</b><br>Medicaid           | <a href="https://dss.sd.gov">dss.sd.gov</a>   | 888-828-0059                                 |
| <b>Texas</b><br>Medicaid                  | <a href="https://hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program">hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program</a>   | 800-440-0493                                 |
| <b>Utah</b><br>Medicaid and CHIP          | UPP: <a href="https://medicaid.utah.gov/upp/">medicaid.utah.gov/upp/</a><br>UPP Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a><br>Adult Expansion: <a href="https://medicaid.utah.gov/expansion/">medicaid.utah.gov/expansion/</a><br>Utah Medicaid Buyout Program: <a href="https://medicaid.utah.gov/buyout-program/">medicaid.utah.gov/buyout-program/</a><br>CHIP: <a href="https://chip.utah.gov">chip.utah.gov</a> | UPP: 877-222-2542                            |
| <b>Vermont</b><br>Medicaid                | <a href="https://dvha.vermont.gov/members/medicaid/hipp-program">dvha.vermont.gov/members/medicaid/hipp-program</a>   | 800-250-8427                                 |
| <b>Virginia</b><br>Medicaid and CHIP      | <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a><br><a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a>  | Medicaid/CHIP:<br>800-432-5924               |
| <b>Washington</b><br>Medicaid             | <a href="https://hca.wa.gov">hca.wa.gov</a>   | 800-562-3022                                 |
| <b>West Virginia</b><br>Medicaid and CHIP | <a href="https://dhhr.wv.gov/bms/">dhhr.wv.gov/bms/</a><br><a href="https://mywvhipp.com/">mywvhipp.com/</a>  | Medicaid: 304-558-1700<br>CHIP: 855-699-8447 |
| <b>Wisconsin</b><br>Medicaid and CHIP     | <a href="https://dhs.wisconsin.gov/badgercareplus/p-10095.htm">dhs.wisconsin.gov/badgercareplus/p-10095.htm</a>   | 800-362-3002                                 |
| <b>Wyoming</b><br>Medicaid                | <a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility">health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility</a>   | 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  
[dol.gov/agencies/ebsa](https://dol.gov/agencies/ebsa)  
866-444-EBSA (3272)

U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services  
[cms.hhs.gov](https://cms.hhs.gov)  
877-267-2323, Menu Option 4, ext. 61565



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