2027

Employee Benefits Guide



Cushing Terrell

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Introduction

We are pleased to provide you with this summary of benefits. At Cushing Terrell, our team members — you — are our most valuable resource. As such, we make a point to invest in your health and well-being and help protect you and your family.

Medical Eligibility

Active full-time and part-time team members working 30+ hours weekly are eligible to participate in Cushing Terrell's medical, dental, vision, dependent care flex spending, and health savings plans.

When Coverage Begins

Coverage for newly eligible team members begins on the first of the month following date of hire.

Annual Open Enrollment

Cushing Terrell's annual open enrollment is held during the last quarter of the year, with elected coverage effective January 1.

Administration

Cushing Terrell offers a self-insured high-deductible health plan (HDHP). Our focus is to keep costs at a minimum while providing robust benefits.

Cushing Terrell partners with Blue Cross Blue Shield of Montana (BCBS) as our third-party administrator (TPA). BCBS facilitates claim processing and eligibility and ensures that we are legally compliant in all areas of health insurance and the Affordable Care Act (ACA).

Team members may elect benefits for themselves, their partner/spouse, and eligible dependent children, including:

- Legal spouse or qualified domestic partner.*†
- Children up to age 26, or, if fully dependent on you for support due to ongoing mental or physical disability, regardless of age.

You must be a member of the health plan to provide medical benefits for your family members. You may also make changes mid-year if you experience a qualifying life event.

** Verification may be required to confirm eligibility.*

† Domestic partners do not qualify for life or AD&D eligibility.



Disclaimers

This summary outlines eligibility, enrollment options, and coverage effective dates. It is not a legal plan document and does not imply a guarantee of coverage. Full details of each benefit plan are contained within the summary plan description (SPD). In the event of a discrepancy, the SPD prevails. A copy of each benefit SPD may be obtained by contacting Human Resources.

Cushing Terrell reserves the right to add to, modify, or delete any policy and/or benefit program at any time, with or without notice. Furthermore, no information contained in this document in any way constitutes a contract for employment, express or implied, for any specified period of time. Cushing Terrell is an equal opportunity and affirmative action employer, including protections for Veterans and disabled individuals.

Plans are reviewed periodically to determine their effectiveness in meeting team member needs and how they compare with programs offered by other employers in our industry and trade areas. Cushing Terrell, at its discretion, may change service providers and benefits without advance notice. Further, Cushing Terrell reserves the exclusive right and authority to administer, apply, and interpret the benefit plans described herein, and to decide all matters arising in connection with the operation of administration of such plans.



2027 Medical/Dental/ Vision Premiums

What you pay each paycheck to have health insurance.

	SEMI-MONTHLY PREMIUM	EMPLOYEE MONTHLY PREMIUM	CUSHING TERRELL'S MONTHLY CONTRIBUTION
Team Member	$77	$154	**$614**
Team Member + Spouse	$260	$520	**$1,453**
Team Member + Child(ren)	$217	$434	**$1,221**
Team Member + Family	$402	$804	**$1,877**



What is Self-Funding?

Cushing Terrell operates a self-funded group health plan, rather than paying high fixed premiums to an insurance company—which would then assume the cost—Cushing Terrell pays for each of your medical, prescription, dental, and vision claims, only utilizing BCBSMT as the intermediary claims processor.

You Can Help!

Because Cushing Terrell assumes the financial risk of providing health care benefits, the overall cost of the plan is directly impacted by the claims incurred. We are committed to offering high-quality benefits, but as health care costs continue to rise, your participation in cost-saving practices is essential.

Here are a few simple ways you can help save money—for yourself and the health plan:

- **Use in-network providers** when possible.
- **Choose independent clinics** for labs, X-rays, CT scans, MRIs, mammograms, and colonoscopies. These facilities often charge up to three times less than hospitals.
- **Visit urgent care clinics instead of the emergency room for non-life-threatening issues.**

Your Benefits Plan

Cushing Terrell is pleased to offer a comprehensive benefits program to our team members.

In the following pages, you will learn more about the benefits Cushing Terrell offers. You will also see how choosing the right combination of benefits can help protect you and your family's health and financial future.

CARRIER	PLAN	WEBSITE	PHONE #
BCBS*	Medical	**www.bcbsmt.com** Group Number #251689	855.258.3489
MDLive/ BCBS*	Medical/ Virtual appt.	**www.mdlive.com/bcbsmt**	888.684.4233
BCBS*	Dental	**www.bcbsmt.com** Group Number #251690	866.739.4090
BCBS*	Vision Exam/ Hardware	**www.bcbsmt.com** Group Number #251686	800.447.7828
BCBS*	Prime Therapeutics	**www.myprime.com**	877.627.6337
ExpressScripts	Mail Order Prescriptions	**www.express-scripts.com/rx**	800.282.2881
Equitable	Basic Life, Vol. Life, AD&D/ Disability, Accident, Critical Illness, and Hospital Indemnity	**"The Hive"** Group Number: #005818	866.274.9887
ComPsych	EAP	**www.guidanceresources.com**	866.641.3178
HealthEquity	HSA/ Dependent Care Flex	**www.healthequity.com**	866.346.5800
Empower	401k	**participant.empower-retirement.com**	800.338.4015

**BCBS (Blue Cross Blue Shield)*



WHEN CAN I ENROLL?

Benefit-eligible team members can sign up for benefits at any of the following times:

- Within 30 days from date of hire
- During the annual open enrollment period
- Within 30 days of a qualifying life event

If you do not enroll at the above times, you must wait for the next annual open enrollment period.

2027 Medical Plan

ADMINISTRATOR: BLUE CROSS BLUE SHIELD OF MONTANA

BENEFITS	YOUR MEDICAL PLAN
In-Network Benefits Annual Deductible (the amount you pay before the medical plan pays)	
Employee-Only Coverage	$1,750
Family Coverage (Non Embedded)	$3,500*
Annual Out-of-Pocket Maximum (the most you'll pay in a calendar year)	
Employee-Only Coverage	$5,500 (includes deductible)
Family Coverage (Embedded)	$11,000
Preventive Care	
Office Visit/Well-Child Care	Covered in Full
Professional	
MDLive Virtual Visits	$40 copay per visit
Office Visit	20% after deductible
Virtual Provider Visit*	20% after deductible
Outpatient Specialist Visit	20% after deductible
Hospital/Facility	
Inpatient Care	20% after deductible
Outpatient Care	20% after deductible
Mental Health/Substance Abuse	
Inpatient	20% after deductible
Outpatient	20% after deductible
Other Services	
Diagnostic X-Ray and Lab Tests	20% after deductible
Major Imaging (PET/CAT scans, MRIs)	20% after deductible
Emergency Room (emergency)	20% after deductible
Emergency Room (non-emergency)	$ 50 copay**, and 20% coinsurance after deductible
Urgent Care	20% after deductible
Chiropractic Services (24 visits per calendar year)	20% after deductible
Hearing Aid	$3,000 per 3 calendar years
Physician-Led Weight Management (age 18+, BMI 30+) 26 visit maximum	20% after deductible
Mental Health Professional/Facility	20% after deductible

**Virtual visit through your own healthcare provider (not MDLive) will be subject to standard deductibles and costs.*

***Copay for Emergency room care not related to emergency medical condition, accidental injury, mental Illness, or substance use disorder.*

TERMS TO KNOW

Deductible

The insurance deductible is the amount of money you will pay for insurance claims before the coverage kicks in and the company starts paying your claims.

Non Embedded

The family coverage deductible shown to the left is 'non embedded'. This means the plan will begin paying benefits only when the entire family coverage deductible has been satisfied in full by one or more members of the covered family unit.

Out-of-Pocket Maximum

The most you have to pay for in-network covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

Embedded Out-of-Pocket Maximum

The family out-of-pocket maximum shown to the left is "embedded." This means each covered family member has an individual out-of-pocket limit within the overall family maximum. If one covered person reaches their individual limit, the plan will begin paying 100% of eligible in-network covered expenses for that person, even if the family maximum has not yet been reached.

Medical Plans (continued)

BENEFITS	YOUR MEDICAL PLAN
Out-of-Network Benefits	
Annual Deductible (Employee Only Coverage)	$1,750
Annual Deductible (Family Coverage)	$3,500
Annual Out-of-Pocket Maximum (Employee Only Coverage)	$5,500 (includes deductible)
Annual Out-of-Pocket Maximum (Family Coverage)	$11,000
Office/Specialist Visit	40%, after deductible
Preventive Care Office Visit	40%, after deductible
Hospital/Facility	40%, after deductible
Emergency Room (Emergency)	20%, after deductible
Emergency Room (Non-emergency)	$50**, 40%, after deductible
Physician Led Weight Management (age 18+, BMI 30+) 26 visit maximum	40%, after deductible
Mental Health Professional/Facility	40% after deductible

***Copay for emergency room care not related to emergency medical condition, accidental injury, mental lllness, or substance use disorder.*



Out of Network Benefits - Out of Pocket Maximum

When utilizing an out-of-network provider, services that are not covered, or any costs above the allowed amount for service will not be covered by BCBS, and will not count towards your out-of-pocket maximum.



IMPORTANT INFORMATION

In-Network Providers

Providers and facilities that are part of a health plan's network of providers and negotiated discounts. You usually pay less and have lower deductibles, coinsurance, and out-of-pocket maximums when using an in-network provider. Locate in-network providers before going in for services at: www.bcbsmt.com

BCBS Montana

Your medical plan administrator. Your national medical network, consisting of physicians, hospitals, and ancillary providers. Providers send your claims to them and they process medical claims (that Cushing Terrell then pays for) and provide customer service support.



Prescription Drugs

ADMINISTRATOR: PRIME THERAPEUTICS

Below is a brief overview of what you can expect to pay for a prescription drug after your medical deductible is met. Preventive prescriptions are not subject to the medical deductible.

BENEFITS

	Participating Retail *(30-day/90-day supply at a pharmacy in the extended supply network*)*	Mail Order
Generic	$0 copay	$0 copay
Formulary	$30 copay	$60 copay
Non-Formulary	50%	50%
Preventive Medication	$0	$0
Specialty Drugs	Deductible may apply, $200 copay through Alliance Rx Walgreens Prime	

** Most retail pharmacies can only fill up to a 30-day supply of medicine. An extended supply network pharmacy can fill up to a 90-day supply of maintenance medications. These are usually medicines that you take every day to treat a chronic condition like high blood pressure or cholesterol, or for preventive purposes.*

Curious about the actual cost of your prescriptions, or if it is even covered?

Check out Prime Therapeutics (through BCBS) to compare costs for medicines and find the best cost at your local pharmacy.

If you have a maintenance drug (taken daily/weekly/monthly), take advantage of the mail-order program through Express Scripts Pharmacy.

Prescription Drugs (continued)

IMPORTANT INFORMATION

Balance List

This is your list (aka formulary) of covered drugs. Drugs that are not shown are not covered. A drug shown on this list will be covered so long as the drug is proven medically necessary for you, and the prescription is filled at an in-network pharmacy. The drug list is regularly updated. For the most up-to-date information, visit bcbsmt.com and log in to Blue Access for Members > My Coverage > Prescription Drugs. Under Related Links, click on Prescription Drug Benefits and Services > Prime Therapeutics and you will be signed into your account in MyPrime. You can also contact the pharmacy customer service line for more information by calling toll free 866.325.5230.

Copay Tier

Copay tier drugs on the balanced drug list are grouped into tier designations. The tier designation that your medication is in determines your portion of the drug cost. Generic drugs generally fall into the lowest-cost tier. The balanced drug list also shows if the drug is a specialty medication, requires prior authorization, or dispensing limits are subject to step therapy.

Generic Drug vs. Brand-Name Drug

Generic drugs are identical to their brand-name counterparts in dosage, form, active ingredients, safety, strength, route of administration, quality, and performance characteristics. Generics typically cost less than brand-name drugs. Ask your doctor and/or pharmacist if there is a generic equivalent available.

MDLive

MDLive allows telephonic access to a board-certified doctor for medical and behavioral health needs. Consultations with a doctor are **$40 per visit**. This service can be used as an alternative to urgent care or your doctor's office for common non-emergency medical conditions like the flu, sinus problems, pink eye, depression, stress/anxiety, addiction, and more, which will save you time and money. The doctor can write a prescription, if needed, and send it to your pharmacy.

MDLive contact: 888.684.4233

Dental Plan

ADMINISTRATOR: BCBS

All employees and dependents enrolled in the medical plan are automatically enrolled in the dental plan.

BENEFITS	DENTAL
Benefit Year Maximum	$1,500, includes preventive care
Annual Deductible	
Individual	$50 per covered person
Dental Categories	
Preventive & Diagnostic Care	100%
Basic Restorative Care	80%
Major Restorative Care	50%
Orthodontia	
Benefits (adults and children under 24 years of age)	50% Lifetime maximum $1,000
Temporomandibular Joint Dysfunction	Lifetime maximum $1,000



TERMS TO KNOW

Preventive & Diagnostic Care
Examples are exams, cleanings, and x-rays.

Basic
Examples are fillings, oral surgery, and root canals.

Major
Examples are crowns, dentures, and bridges.

Benefit Year Maximum
The most the dental plan will pay towards each covered members' dental services each calendar year.

IMPORTANT INFORMATION

BCBS

Your dental plan administrator. They process claims and provide customer service support.

Network

Non-participating providers are allowed. You may be balanced-billed for the difference between the billed and allowed. Simply provide your dental provider with your BCBS card.

Late Entrant Limitation

When benefits are elected after the new hire/new eligibility enrollment period. For the first 90 days, coverage will be limited to only Class I (preventive) and Class II (basic) services.



Vision Benefit

ADMINISTRATOR: BCBS

All employees and dependents enrolled in the medical plan are automatically enrolled in the vision plan.

BENEFITS	BCBS
Preventive Exam	Paid at 100% annually
Frames	Paid 100% up to $100 annually for one pair
Lenses and/or Contacts	Paid 100% up to $200 annually

Make sure to show your eye care provider your BCBS vision ID card for your exam.

BLUE365

Members can save on eye exams, eyeglasses, contact lenses and accessories. Members may also qualify for savings on laser vision correction.

Sign up for Blue365 at blue365deals.com/bcbsmt and then check out the "Featured Deals".

DID YOU KNOW?

If your vision provider doesn't use BCBS insurance, you can submit your claim directly to BCBS (via mail) to request reimbursement.

GO Wellbeing

ADMINISTRATOR: BCBS

Team members enrolled in the Cushing Terrell medical plan through BCBS are automatically eligible for GO Wellbeing. This program is designed to help you build healthy habits by providing personalized guidance, wellness tools, activities, and rewards that support your physical, mental, and financial well-being.

Why Wellness Matters

Taking an active role in your well-being may help you catch health concerns earlier, avoid preventable medical expenses, miss fewer days of work, manage stress, and maintain the energy needed for everyday life. GO Wellbeing provides practical tools and rewards to help turn small choices into healthier habits.

What GO Wellbeing Offers

Start with the RealAge Test, which looks at your daily habits — like eating, exercise, sleep and stress — to estimate your body's real age. After the test, you'll get easy-to-follow steps to help you improve your health.

More helpful features include:

- Health articles and learning tools just for you (in multiple languages)
- The option to connect your Wearable devices and apps, and earn rewards on activities you're already doing as well as new healthy habits
- Wellness challenges to keep you engaged and on track with your goals
- Community Wellbeing Index that shows you where you can enjoy the outdoors in your area and how your activity levels compare with others around the country
- Articles via the GO Wellbeing app on important topics such as:
  - Physical health
  - Mental Wellbeing
  - Financial health

START YOUR WELLNESS JOURNEY IN JUST THREE STEPS:

1. Download the GO Wellbeing app.

2. Take the RealAge Test.

3. Follow personalized tips, or join any activity you choose!

WITH GO WELLBEING, YOU CAN:

- Find tools and tips to support your mind and body
- Take the RealAge Test to see how your body's age compares to your actual age and get simple, personalized steps on how to maintain or improve your health
- Earn rewards for healthy activities like sleep tracking, connecting a wearable health device, learning about financial fitness and more
- Join fun challenges to stay motivated and boost your progress

Health Savings Account

HDHP MEDICAL ACCOUNT ADMINISTRATOR: HealthEquity

Cushing Terrell covers the monthly charge of $2.25 for an HSA account. Before contributing to an HSA, here are a few things you should know:

- The amount you contribute to an HSA is deducted from your paycheck before income taxes.
- Any money left in the account at the end of the year will roll forward to the next year.
- You may no longer contribute to your HSA beginning with the first month you are enrolled in Medicare.
- Keep your receipts!

2027 MAX CONTRIBUTION

$4,500

For single coverage

$9,000

For family coverage



If you are an eligible individual who is age 55 or older at the end of the tax year, you may contribute an additional $1,000 as a catch-up contribution each year.

EMPLOYER HSA CONTRIBUTIONS

$100 will be contributed by employer upon completion of each of the below steps

To start: At the beginning of the year or when you enroll in the benefit.

For preventive care: After completing a biometric screening or wellness exam through ISWM or your provider.

For wellness participation: Participate in wellness programs during the year to earn an additional contribution the following year.



Who qualifies?

To be eligible for a Health Savings Account (HSA), you must:

- Be covered under a Qualified High Deductible Health Plan (QHDHP) on the first day of the month
- Not be enrolled in Medicare
- Have no other non-QHDHP coverage
- Not be claimed as a dependent on another person's tax return

THE FINE PRINT

HSA funds are to be used for eligible medical expenses, as defined by the IRS (see IRS Publication 502, Medical and Dental Expenses for more details at http://www.irs.gov/pub/irs-pdf/p502.pdf). Distributions from the HSA for ineligible expenses are subject to taxation and penalties.



Dependent Care Expense Account

Funds can be added to this account on a pre-tax basis and can be used to pay for eligible dependent care services, including:

- Preschool
- Before or after-school programs
- Summer day camp
- Child or adult daycare

Cushing Terrell allows a voluntary contribution of up to

$7,500 per family

DID YOU KNOW?

- Funds can be used for any dependent care claims incurred within the plan year
- Reimbursements are allowable up to the amount you have contributed to the flex account to date
- Reimbursement is available by direct deposit and can be requested on the Benefit Wallet website or app
- You have 60 days after the first of the calendar year to use your daycare flex funds from the previous plan year
- You may be able to start or change your Dependent Care Expense Account election during the year if you experience a qualifying life event or an eligible change in dependent care needs. Contact Human Resources within 30 days of the event to determine whether your requested change is permitted under the plan.
- Cushing Terrell covers the $3.50 monthly charge



Parental Leave Benefits

ADMINISTRATOR: CUSHING TERRELL

We provide paid leave to all eligible team members.*

100%

How much of your average weekly earnings is covered by parental leave benefits.*

No waiting period.

You can begin receiving benefits the first weekday after the birth, foster, or adoption of a new dependent.

***State Paid Leave – where a state program provides wage replacement the following applies:**

- **Birthing Parent:** Cushing Terrell will supplement state paid leave to 100% during eligible leave.
- **Non-Birthing Parent:** Cushing Terrell does not supplement state paid leave benefits.

Contact Human Resources for more information.

How long you can be out and receive payments

BIRTHING PARENT LEAVE
For the parent who gives birth

1-60 MONTHS OF SERVICE

4 WEEKS

61+ MONTHS OF SERVICE

8 WEEKS

NON-BIRTHING PARENT LEAVE
For partners, adoptive and foster parents

AFTER 1 MONTH OF SERVICE

1 WEEK

EFFECTIVE DATE:
JANUARY 1, 2027



Company-Paid Life/AD&D Benefits

ADMINISTRATOR: EQUITABLE

Cushing Terrell purchases a basic life and accidental death insurance policy for you and your family.

	BENEFITS	LIFE INSURANCE	AD&D
BENEFITS	**Owners**	$50,000	$100,000
BENEFITS	**Non-Owners**	$35,000	$70,000
DEPENDENTS	**Spouses**	$10,000	
DEPENDENTS	**Children**	Live birth to less than 15 days: $500 15 days to 26 years: $2,000	
DEPENDENTS	**Family**	$12,000	

Supplemental Life Benefits

ADMINISTRATOR: EQUITABLE

Cushing Terrell provides supplemental life insurance plans to help provide peace of mind. If you choose to purchase extra life insurance for yourself, you can also buy up to half that amount for your spouse. Newly eligible employees qualify for up to $200k without evidence of insurability (EOI), and up to 5x salary (or no more than $500k) with EOI. Employees enrolling after their first 30 days of benefit eligibility will be required to complete an evidence of insurability application with our provider.

YOU	**BUY UP TO $200,000 WITHOUT EOI**	**BUY UP TO 5X YOUR ANNUAL SALARY** (NO MORE THAN 500K)
SPOUSE	**UP TO HALF OF YOUR SUPPLEMENTAL LIFE ENROLLMENT** ($50,000 WITHOUT EOI)	**BUY UP TO $250,000** IN INCREMENTS OF $5,000 WITH EOI
CHILD	**BUY UP TO $10,000 MAX** IN INCREMENTS OF $2,500 (REQUIRES ENROLLMENT IN EMPLOYEE SUPPLEMENTAL LIFE)	

Spouse coverage is limited to half the amount of the employee coverage (for example, if the employee has $50,000, the spouse can be insured at $25,000).

Supplemental Life Benefits (continued)

THE FINE PRINT

Evidence of Insurability (EOI)

Evidence of Insurability (also known as proof of good health), may be required if you are a late enrollee or you request any additional coverage above your guaranteed issue amount. You may be required to complete a medical questionnaire and the carrier may request medical records from your provider. The carrier will either approve or deny the coverage requested above your guaranteed issue amount.

Supplemental Life Guaranteed Issue of Increased Benefit

If you enroll for at least $10,000 when you are first eligible for coverage, you may increase your benefit amount by $20,000 during annual enrollment on a guaranteed issue basis.

Benefit Reduction

Benefits begin to reduce at age 65. Please refer to your booklet for further details.

Taxation

IRS regulations require taxation of life benefits above $50,000 to the employee. Taxes will be deducted automatically through payroll deductions.

Beneficiary Designation

A beneficiary is someone who receives the benefit amount of your policy if something were to happen to you. It's important to make sure you have people on file listed as your beneficiary. If you are married and living in a community property state, your insurance carrier may require that you designate your spouse (or in some cases a registered domestic partner) for at least 50% of the benefit unless you have a waiver notice on file from your spouse. Community property states are Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, and Wisconsin. Consult your legal or tax advisor for further guidance on this issue.

Supplemental AD&D Benefits

ADMINISTRATOR: EQUITABLE

You must purchase supplemental life in order to purchase accidental death & dismemberment (AD&D) coverage.

YOU	**BUY UP TO 100% OF ELECTED EMPLOYEE SUPPLEMENTAL LIFE ENROLLMENT,** IN INCREMENTS OF $10,000	
SPOUSE	**BUY UP TO 50% OF THE ENROLLED EMPLOYEE AD&D AMOUNT**	INCREMENTS OF $10,000 (REQUIRES ENROLLMENT IN SPOUSE LIFE BENEFIT)
CHILD	**BUY UP TO $10,000 MAX IN INCREMENTS OF $2,500**	(REQUIRES ENROLLMENT IN CHILD LIFE BENEFIT)



TERMS TO KNOW

Accidental Death and Dismemberment Insurance

Provides a lump sum benefit for an accidental death; pays in addition to the life insurance benefit. This coverage also provides lump sum benefits for dismemberments caused by an accident, such as loss of a finger, limb, or eyesight.



Group Short-Term Disability Benefits

ADMINISTRATOR: CUSHING TERRELL

We provide short-term salary protection to all benefit-eligible employees.

5 days

Accident/sickness waiting period

100%

How much of your weekly earnings you get when you're on disability

In the event of a disability claim, payments received under this plan will be considered taxable income.

How long you can be out and receive payments

0–36 MONTHS (3 YEARS)

2 WEEKS

37–72 MONTHS (3–6 YEARS)

4 WEEKS

73–108 MONTHS (6–9 YEARS)

7 WEEKS

109+ MONTHS (9+ YEARS)

9 WEEKS

Group Long-Term Disability Benefits

ADMINISTRATOR: EQUITABLE

To ensure long-term salary protection, Cushing Terrell provides each eligible employee with long-term disability benefits.

90 days

Waiting period of continuous disability from the day your earnings loss is 20% or more, *or* a loss of one or more duties of your occupation

60%

How much of your weekly earnings you get when you're on disability

$6,000

Maximum monthly benefit amount

$10,000

Maximum monthly benefit amount for owners

THE FINE PRINT

Definition of Disability
Due to an illness or injury, you are unable to work full time in your regular occupation and you experience at least one or more losses of duty. You must experience at least a 20% earnings loss or have had a loss of one or more duties *and* be unable to work full time in your occupation to remain eligible for payments through this policy.

Benefit Duration
The policy may provide benefit payments up to your Social Security normal retirement age (SSNRA). Final benefit duration will be based on physician statement, medical records, and claim approval.

Pre-Existing Condition Limitation
A pre-existing condition is a condition, regardless of cause, for which medical advice, diagnosis, care, or treatment was recommended or received in the 12 months prior to your enrollment date. The plan will not pay benefits for any pre-existing conditions that result in disability during your first 12 consecutive months of coverage.

Income
In the event of a disability claim, payments will be considered non-taxable income.

Voluntary Accident Insurance

ADMINISTRATOR: EQUITABLE



If you broke a leg, would it break your bank account too?

Don't let an accident catch you off guard. Protect your family's finances with accident insurance from Equitable.

An accident insurance policy supplements your medical coverage and provides a cash benefit for injuries you or an insured family member sustain from an accident. This benefit can be used to pay out-of-pocket medical expenses, help supplement your daily living expenses, and cover unpaid time off work.

As an active employee of Cushing Terrell, you may purchase this coverage for yourself and your family members, and premiums can be deducted from your paycheck. It's a simple and affordable way for your family to receive added financial protection.

Accident Coverage Example

This insurance pays a benefit for each injury, treatment, or service included in the policy that occurs as the result of a covered accident.

For example, Jeff's son, Jake, was playing soccer during recess at school. He was tripped and falls hard, injures his shoulder, and is transported by ambulance to the ER due to concerns fo head trauma. The ER doctor orders a CT scan to check for any facial or head injuries and a shoulder X-ray.

Jake was diagnosed with a concussion and a broken collarbone. His arm was set in a sling, and he was released to his pediatrician for follow-up care. Jake visits his pediatrician at two weeks and one month after the accident to make sure he's healing well.

In the meantime, Jeff starts receiving bills for the care Jake received. The ambulance bill alone was $556. He's a pretty healthy kid, so a health insurance deductible of $1,500 had to be met before Jeff's health insurance would begin covering Jake's care, and after that, there's a 20% copay.

Accident benefits pay in addition to other insurance, and can be used to help cover gaps in health insurance or other expenses if the unexpected happens.

BENEFITS	AMOUNT
Ambulance	$400
ER Visit	$100
CT Scan	$100
X-ray	$50
Concussion	$150
Broken Collarbone	$375
Follow-Up Visit 1	$50
Follow-Up Visit 2	$50
Total Benefit	$1,275

Note: The benefits shown in this example are for a sample design and may vary from the benefits that are available to you.



Voluntary Critical Illness Insurance

ADMINISTRATOR: EQUITABLE

Why Consider Critical Illness Coverage?

A serious illness can create expenses beyond what your medical plan covers. Critical Illness insurance pays a lump-sum benefit upon diagnosis of a covered condition. The benefit is paid directly to you and can help offset out-of-pocket medical costs, lost income, travel expenses, and other unexpected financial burdens associated with a serious illness.

The critical illness insurance amount for the employee/member and any dependent(s) is selected at time of enrollment within the following parameters. Child insurance is automatic (a separate election is not required).

	MINIMUM AMOUNT	MAXIMUM AMOUNT	INCREMENTS	GUARANTEED ISSUE AMOUNT*
Employee/Member	$5,000	$30,000	$5,000	$30,000
Spouse	$2,500	50% of employee/ member benefit amount	$2,500	$15,000
All Children †	25% of employee/member benefit, up to $8,000			

* Guaranteed issue is only available if the minimum participation requirement is met. If participation does not reach the required level, the guaranteed issue amount(s) may be reduced or rescinded.

† Child coverage begins at birth and terminates at age 26 unless the child is incapacitated.

Covered Conditions	Benefit Percentages	Recurrence Benefit Percentages
Heart Attack	100%	100%
Sudden Cardiac Arrest	100%	100%
Stroke	100%	100%
Major Organ Failure	100%	100%
End-stage Kidney Disease	100%	100%
Coronary Artery Bypass	25%	25%
Angioplasty	5%	5%
Invasive Cancer	100%	100%
Non-Invasive Cancer	25%	25%
Skin Cancer	5%	5%
Benign Brain Tumor	100%	100%
Coma	100%	100%
Blindness	100%	N/A
Paralysis	100%	N/A
Advanced Multiple Sclerosis	100%	N/A
Advanced ALS/Lou Gehrig's Disease	100%	N/A
Advanced Alzheimer's Disease	100%	N/A
Advanced Parkinson's Disease	100%	N/A
Severe Burns	100%	100%

Covered Conditions	Benefit Percentages	Recurrence Benefit Percentages
Hospitalized Infectious Disease	25%	25%
Childhood Specific Conditions (Autism, Sickle Cell Disease, Down Syndrome, Cerebral Palsy, Complex Congenital Heart Disease, Cystic Fibrosis, Spina Bifida, Cleft Lip/Palate, Type 1 Diabetes Mellitus, Muscular Dystrophy, PANDAS)	100%	N/A
Wellness Benefit		
Annual benefit for covered wellness exams & screenings	$50, once per year for each insured	

Monthly Premium Illustration for Employee Benefit - includes Child(ren) Premium

BENEFIT	<39	40-49	50-59	60+
$5,000	$2.85	$6.75	$13.10	$20.45
$10,000	$5.70	$13.50	$26.20	$40.90
$15,000	$8.55	$20.25	$39.30	$61.35
$20,000	$11.40	$27.00	$52.40	$81.80
$25,000	$14.25	$33.75	$65.50	$102.25
$30,000	$17.10	$40.50	$78.60	$122.70

Voluntary Hospital Indemnity

ADMINISTRATOR: EQUITABLE

Hospital indemnity insurance is a type of supplemental insurance plan that can be added to an existing health insurance plan to help cover the costs of a hospital stay. It does not replace a health insurance plan. This type of plan pays you a predetermined benefit amount per day for each hospital admission, typically up to a year.

What your benefits cover:

Included Benefits	Benefit Amount
First Day Hospital Confinement	$500, once per year
First Day Intensive Care Unit (ICU) Confinement	$1,000, once per year
Daily Hospital Confinement	$100, up to 365 days per year
Daily ICU Confinement	**$200, up to 60 days per year**
Daily Rehabilitation Unit Confinement	$50, up to 60 days per year
Annual Wellness Screening	$50, once per year for each insured

Admission and confinement benefits are not additive.

VOLUNTARY HOSPITAL INDEMNITY RATES	MONTHLY RATE
Employee/Member	$9.45
Employee/Member + Spouse	$19.89
Employee/Member + Child(ren)	$15.60
Employee/Member + Family	$26.04

When can I make changes?

Generally, you can only change your benefit choices during the annual benefits enrollment period. You may be able to change some of your benefit choices when you have a qualifying life event—provided you properly notify your employer and the change is permitted under the plan terms. If you have a qualifying life event, contact Human Resources within 30 days to complete the necessary steps. For more information, refer to your benefits booklet.

EXAMPLES OF THESE CHANGE-IN-STATUS EVENTS MAY INCLUDE:



Marriage Status Changes

- Your marriage
- Your divorce or legal separation
- Death of your spouse



Child Status Changes

- Birth or adoption of an eligible child
- Death of your covered child
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)
- Certain changes in dependent-care eligibility, services, providers, or costs may also allow you to change your Dependent Care Expense Account election. Contact Human Resources within 30 days of the change for assistance.



Employment Status Changes

- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your spouse's work status that affects their benefits

Retirement Savings Plan

ADMINISTRATOR: EMPOWER

401(k) Retirement Plan

Employees who are 21+ years of age and work 500 hours annually are eligible to participate in Cushing Terrell's 401(k) plans which feature two retirement options for your contributions.

- **TRADITIONAL 401(K)** Contributions made on a pre-tax basis.
- **ROTH 401(K)** Contributions made on a post-tax basis.

Automatic Enrollment

Effective January 1, 2027, eligible employees will be automatically enrolled in the 401(k) plan at a contribution rate of 5%. Your contribution rate will automatically increase by 1% each year on May 1 until it reaches 10%.

You remain in control of your contributions and may change your contribution rate or stop contributing at any time through your Empower account.

Cushing Terrell's Matching Contribution

Cushing Terrell provides a dollar-for-dollar matching contribution of up to 5% of your eligible earnings, subject to IRS limits. Employer matching contributions are deposited into the pre-tax Traditional 401(k), regardless of whether you choose Traditional, Roth, or a combination for your own contributions.

You may select from the investment options available through the plan and make enrollment, contribution rate, and investment changes online at any time. Additional retirement education opportunities are also offered throughout the year.

Eligible employees are immediately 100% vested in the plan, meaning you fully own both your contributions and Cushing Terrell's matching contributions. Eligible employees may begin contributing on the first of the month following their date of hire or eligibility. Participants who meet the applicable age requirements may also make catch-up contributions, subject to annual IRS limits.

401(k) Account Access

Begin your journey now.

Log on to: **empowermyretirement.com**

For first-time access:

- Log on and select **Register**.
- Choose the **I do not have a PIN** tab.
- Follow the prompts to create your username and password.
- If we don't have your email or phone number on file from your previous employer, or if you have another account with Empower (with a former employer, for example), you will need to call to access your new plan account.
- For more information or questions, please contact Empower Participant Services at 800.338.4015.

2027 IRS 401(K) CONTRIBUTION LIMITS

Individual	$24,500
Catch-up (5O-59)	$8,000
Catch-up (60-63)	$11,250

PTO and Holidays

ADMINISTRATOR: CUSHING TERRELL

Paid Time Off

YEAR COMPLETED	ANNUAL PTO	WEEKLY ACCRUAL	CARRY-OVER MAX
0 - 60 months	16 days	2.46 hours	21 days
61 - 72 months	17 days	2.62 hours	22 days
73 - 84 months	18 days	2.77 hours	23 days
85 - 96 months	19 days	2.92 hours	24 days
97 - 108 months	20 days	3.08 hours	25 days
109+ months	21 days	3.23 hours	26 days



Holidays

Cushing Terrell observes nine paid holidays

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving
- Day After Thanksgiving
- Christmas Day
- Two Floating Holidays

Employee Assistance Program

ADMINISTRATOR: EQUITABLE/COMPSYCH

Our employee assistance program (EAP) is available to all employees and their immediate family members. The services provided through our EAP are completely confidential.

We provide specialized knowledge and resources on topics including:

- Emotional well-being
- Healthy lifestyles
- Family and relationships
- Legal and financial issues
- Identity theft services
- Work/life transitions
- Online will preparation

To access the EAP, visit **www.guidanceresources.com** (web ID: EQUITABLE5) or call 866.641.3178.

Global Travel Health Insurance

ADMINISTRATOR: BLUE CROSS BLUE SHIELD GLOBAL CORE

You are never far from healthcare services — even when you're far from home. Through the Blue Cross Blue Shield Global Core program, you have access to doctors and hospitals around the world.

To learn more about Blue Cross Blue Shield Global Core:

- Visit **bcbsglobalcore.com**
- Use the Blue Cross Blue Shield Global Core app for Android*, iPhone, and iPod touch.** (Rates from your wireless provider may apply.)
- Call the BCBS Global Core Service Center at 855.258.3489 or collect at 804.673.1177. Accessible 24 hours a day, seven days a week.
- Call BCBS Customer Service at 855.258.3489.

The Blue Cross Blue Shield Global Core program was formerly known as BlueCard Worldwide®.

Blue Cross Blue Shield, the Blue Cross and Blue Shield symbols, BlueCard, BlueCard Worldwide, and Blue Cross Blue Shield Global are trademarks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield companies.

*Android is a trademark of Google Inc. **Apple, the Apple logo, iPod touch, and iTunes are trademarks of Apple Inc., registered in the U.S. and other countries. iPhone is a trademark of Apple Inc. App Store is a service mark of Apple Inc.*

Your Very Own Personal Navigator

ADMINISTERED BY: FEDLOGIC

Cushing Terrell has partnered with FEDlogic to provide state and federal benefits information and advocacy to you and your household members.

The service is confidential, unlimited, and free to you as an employee.

Reasons to call FEDlogic

- You've reached or are approaching Medicare age and need to learn more
- You're approaching retirement age and want to learn more about your Social Security benefits
- You or a household family member have been diagnosed with a major illness
- You have a child with a disability or born prematurely
- You have lost a spouse
- You need assistance navigating Medicaid, Marketplace, or COBRA
- You need help exploring alternative healthcare avenues based on your income
- You are currently on dialysis (ESRD)

Here's how it works

1. Make a phone consultation appointment

Call us at 877-837-4196 to schedule a phone consultation appointment with one of our federal and state benefit experts. Be sure to make the appointment at a time when family members are available to listen and ask questions as well. Calls typically last an hour.

2. Tell us your story, ask questions, and learn

You don't have to wade through tons of complex and confusing information to try and figure out what applies to you. We take the time to listen to your story and understand your needs, concerns, and goals. Then we empower you with the unbiased information you need to maximize your benefits and make the best decision for your situation.

3. Enroll for benefits

Once you feel confident you have the information you need to make the best decision for you and your family, we'll walk you through the application and approval process.

4. Relax and celebrate

Without education and advocacy, many people don't tap into all the Social Security and Medicare benefits they've paid into during a lifetime of employment. You'll have peace of mind knowing that you're getting all the benefits you deserve. So, sit back, relax, and celebrate.

877.837.4196
www.fedlogicgroup.com
services@fedlogicgroup.com

SNT BIOTECH:

At-Home Health Screenings Made Easy

Closing care gaps and saving lives through early detection.

snt biotech

WHAT SNT BIOTECH OFFERS

At-Home Screening Kits
Convenient, private, and easy-to-use kits shipped right to your home.

Key Health Screenings

- Colon cancer (FIT)
- Diabetes (HbA1c)
- Cervical Cancer Screening
- Kidney Function, and more.

Fast & Reliable Results
Samples processed in our accredited U.S. laboratory with secure result delivery.

Support at Every Step
Clear instructions, multilingual support, and live outreach if needed.

WHY IT MATTERS

- Early detection can save lives and lower healthcare costs.
- At-home testing removes barriers like scheduling, transportation, and time off work.
- Empowers you to take charge of your health, on your own time, in your own space.

How Health Screens with SNT Biotech Work

1. Receive your kit in the mail.
2. Follow the simple instructions to collect your sample.
3. Return your sample in the prepaid package.
4. Get your results quickly and securely.

NEED HELP?

For questions or help with your kit, visit **www.sntbiotech.com** or call our member support line at **312.715.7101**

When calling, you must disclose that you are part of Tribute Insurance PIC.

Remember, this all happens at no cost to you. These tests are fully covered by your health plan.

Leavitt Group

Tribute INSURANCE PIC

Cancer Expert Now

If you or your family member have been diagnosed with cancer, we are here for you. Contact us to connect with one of the world's top cancer doctors—all from the comfort of your home.

Get the answers you need. We'll match you with a top expert in your cancer type.

Your information is uploaded into a secure, HIPAA-compliant portal. We will not share any details about your diagnosis with your employer.

A cost-free solution for the whole family.

Cancer Expert Now is a service offered by your employer free of charge. You, your spouse, children, parents, and parents-in-law can use our service at any time, however many times you need.

Ask the expert anything.

There is no question too big or small. Ask about…

- A screening
- A new or existing diagnosis
- A procedure or sugery
- A treatment plan
- Medications
- Survivor protocols
- A condition requiring a specialist
- And more…

CANCER EXPERT NOW IS HERE FOR YOU!

Contact us to schedule an appointment with a top expert.

carenavigator@onviv.com
+1 855-946-5735
CancerExpertNow.com/access/welcome

We're available Monday–Friday, 8:00 AM–5:30 PM ET.

Your privacy is important to us.

Your information is uploaded into a secure, HIPAA-compliant portal. We will not share any details about your diagnosis with your employer.

Speak directly with a top cancer expert from the comfort of your home.

Cancer Expert Now connects you to the world's leading experts in cancer research, care, and treatment. Find comfort in knowing that you are speaking with the best physician for your cancer type.

Pet Insurance

ADMINISTRATOR: METLIFE

MetLife Pet Insurance helps cover the costs of unexpected accidents or illnesses, so nothing gets in the way of caring for your pet when they need it most.

Coverage that's a breed apart

With MetLife Pet Insurance, you can count on:

- The freedom to visit any U.S. veterinarian. Exam fees are covered for accidents and illnesses.
- Flexible plans with no breed exclusions. Find coverage that fits your pet's needs and your budget.
- Extra savings with value-driven policies, options and discounts.
  - **Multi-pet policy** – 5% for the 2nd policy and 10% for each additional policy
  - **Family Plans option** – One policy and a shared deductible for up to three dogs and cats
  - **Discounts of up to 30%** – And additional savings on pet care, where available
- Preventive care coverage (optional) for dogs and cats – Save on routine wellness expenses.

You'll have the power of choice to customize your coverage

With our flexible plans, you can select the plan that fits your pet's needs and your finances. Here are just some of the treatments and conditions we cover:

- Accidental injuries
- Illnesses
- Exam fees
- Surgeries
- Medications
- Ultrasounds
- Hospital stays
- X-rays and diagnostic tests
- Hereditary conditions
- Congenital conditions
- Alternative therapies
- And more!

Preventive care coverage (optional) for dogs and cats such as:

- Vaccinations
- Flea/tick medications
- Wellness visits

How does MetLife Pet Insurance work?

- Choose the coverage that's right for you and your pet, and download our mobile app
- Visit any U.S. licensed veterinarian or emergency clinic
- Pay the bill within 90 days and send it with your claim documents to us via our mobile app, online portal, email, fax, or mail
- Get a percentage of your money reimbursed by check or direct deposit if the claim expense is covered under the policy

Get the coverage that best fits your pet.
metlife.com/getpetquote
800.GET.MET8

Group Health Plan Notices

Annual Required Legal Notices and Disclosures for Plan Participants

The following notices provide important information about your employer provided group health plan. Please read the notices carefully and keep a copy for your records. If you have any questions regarding these notices, please contact Human Resources or the plan administrator.

Leavitt Group

Women's Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact the plan administrator.

Newborns' and Mothers' Health Protection Act Notice

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

HIPAA Notice of Privacy Practices

Notice of Health Information Privacy Practices

This Notice of Privacy Practices describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice describes the legal obligations of your group health plan and your legal rights regarding certain health information, called protected health information (PHI), held by the group health plan under the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and the corresponding regulations (collectively referred to as "HIPAA"). The group health plan is sponsored by your employer. If you have any questions about this notice or about the group health plan's privacy practices, or wish to exercise any of your privacy rights, please contact human resources.

How the Health Plan Uses and Discloses Protected Health Information

Under HIPAA, the plan may use or disclose protected health information (PHI) under certain circumstances without your permission, provided that the legal requirements applicable to the use or disclosure are followed. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. However, all the ways permitted to use and disclose information will fall within one of the categories. Most of the time the plan will use, disclose, and request only the minimum information necessary for these purposes.

For treatment. The plan may use or disclose PHI to facilitate medical treatment or services by health providers. The plan may disclose health information about you to health care providers, including doctors, nurses, technicians, or hospital personnel who need the information to take care of you. For example, the plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription conflicts with your current prescriptions.

For payment. The plan may use or disclose PHI to make payments to health care providers who are taking care of you. The plan may also use and disclose PHI to determine your eligibility for plan benefits, to evaluate the plan's benefit responsibility, and to coordinate plan coverage with other coverage you may have. For example, the plan may share information with health care providers to determine whether the plan will cover a particular treatment. The plan may also share your PHI with another organization to assist with financial recoveries from responsible third parties

For health care operations. The plan may use and disclose PHI to run the plan. For example, the plan may use PHI in connection with quality assessment and improvement activities; care coordination and case management; underwriting, premium rating, and other activities relating to plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general plan administrative activities. However, the plan will not use genetic information for underwriting purposes.

To Business Associates. The plan may contract with third parties, known as "Business Associates," to perform various functions or provide various services on behalf of the plan. To perform these functions or to provide these services, Business Associates may receive, create, maintain, transmit, use, and

disclose protected health information, but only after they agree in writing to safeguard PHI and respect your HIPAA rights. For example, the plan may disclose PHI to a third-party administrator to process claims for plan benefits.

As required by law. The plan will disclose PHI when required to do so by federal, state, or local law.

To prevent a serious threat to health or safety. The plan may use and disclose PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

To the employer. The plan may disclose PHI to certain employees of the employer who are involved with plan administration. These employees are permitted to use or disclose PHI only to perform plan administration functions or as otherwise permitted or required by HIPAA, unless you have authorized further disclosures. PHI cannot be used for employment purposes without your specific authorization.

Workers' compensation. The plan may disclose PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public health. The plan may disclose PHI for public health activities, including, for example, to prevent or control disease, injury, or disability; or to report child abuse or neglect.

Health oversight. The plan may disclose PHI to a health oversight agency for activities authorized by law, including, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and disputes. The plan may disclose PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Law enforcement. The plan may disclose PHI if asked to do so by a law-enforcement official in certain limited circumstances.

Family members. The plan may disclose PHI to a family member or close personal friend who is involved in your care or payment for your care or for notification purposes. Generally, you will have an opportunity to object to these disclosures. With only limited exceptions, all mail regarding the plan will be sent to the employee unless we have agreed otherwise. This includes mail relating to participation of the employee's spouse and other family members in the plan, such as availability of plan benefits and information on the processing of any plan benefits (including explanations of benefits (EOBs)).

Coroners, medical examiners, and funeral directors. The plan may disclose PHI to a coroner, medical examiner, or funeral director, as necessary for them to carry out their duties.

National security and intelligence activities. The plan may disclose PHI to authorized federal officials for national security activities authorized by law.

Military. The plan may disclose PHI as required by military and veterans authorities if you are or were a member of the uniformed services.

Research. In very limited situations, the plan may disclose protected health information to researchers; however, usually we will need to get your authorization.

Compliance with HIPAA. The plan is required to disclose PHI to the United States Department of Health and Human Services when requested to determine compliance with HIPAA.

Substance Use Disorder (SUD) Treatment Information. To the extent that we have your substance use disorder patient records, subject to 42 CFR Part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Authorizations. Other uses or disclosures of PHI not described above will be made only with your written authorization. For example, the plan generally needs your authorization to disclose psychiatric notes about you; to use or disclose PHI for marketing; or to sell PHI. You may revoke your authorizations at any time, so long as the revocation is in writing. However, the revocation will not be effective for any uses or disclosures made in reliance upon the authorization.

Your Rights

You have the rights described below with respect to PHI about you, subject to certain conditions and exceptions.

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

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

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

Ask us to limit what we use or share. You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.

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.

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

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

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

Your Choices

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

In these cases, you have both the right and choice to tell us to: (1) Share information with your family, close friends, or others involved in payment for your care. (2) 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: (1) Marketing purposes. (2) Sale of your information.

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy and security of your PHI.
- Let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- Follow the duties and privacy practices described in this notice and give you a copy of it.
- 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.

More Information

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact Human Resources and the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer, or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.
- The plan reserves the right to change the terms of this notice and to make new provisions effective for all PHI that the plan maintains, including PHI created or received prior to any revision. If significant changes are made, the plan will furnish you with a revised copy.

Continuation Coverage Rights Under COBRA

Your employer's group health plan may not be subject to COBRA (and this notice will not apply) if your employer had fewer than 20 employees on a typical business day during the preceding calendar year. If your plan is not subject to COBRA, it may be subject to state continuation rights which are similar to COBRA continuation rights.

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When is COBRA Continuation Coverage Available?

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

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

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

How is COBRA Continuation 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, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[2] 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 Human Resources. 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.

(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.

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.

[2] *https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.*

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

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

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

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

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

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

ALABAMA – MEDICAID	ALASKA – MEDICAID
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – MEDICAID

Website: http://myarhipp.com/

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program
Website: https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/

Phone: 916-445-8322

Fax: 916-440-5676

Email: hipp@dhcs.ca.gov

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com/

Health First Colorado Member Contact Center:

1-800-221-3943/State Relay 711

CHP+: https://hcpf.colorado.gov/child-health-plan-plus

CHP+ Customer Service: 1-800-359-1991/State Relay 711

Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/

HIBI Customer Service: 1-855-692-6442

FLORIDA – MEDICAID

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

Phone: 1-877-357-3268

GEORGIA – MEDICAID

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 678-564-1162, Press 1

GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra

Phone: 678-564-1162, Press 2

ILLINOIS – MEDICAID

Illinois Medicaid Premium Assistance Information

Medicaid application website: https://abe.illinois.gov

HIPP Hotline Number: 217-524-8268

HIPP Email: mhfs.boc.hipp@illinois.gov

INDIANA – MEDICAID

Health Insurance Premium Payment Program

All other Medicaid

Website: https://www.in.gov/medicaid/

http://www.in.gov/fssa/dfr/

Family and Social Services Administration

Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website:

Iowa Medicaid | Health & Human Services

Medicaid Phone: 1-800-338-8366

Hawki Website:

Hawki - Healthy and Well Kids in Iowa | Health & Human Services

Hawki Phone: 1-800-257-8563

HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)

HIPP Phone: 1-888-346-9562

KANSAS – MEDICAID

Website: https://www.kancare.ks.gov/

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:

https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kynect.ky.gov

Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – MEDICAID

Louisiana Medicaid Website:

https://www.ldh.la.gov/healthy-louisiana

Medicaid Customer Service Line: 1-888-342-6207

Louisiana Medicaid email: healthy@la.gov

Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp

LaHIPP phone: 1-877-697-6703

LaHIPP email: La.HIPP@la.gov

LaHIPP fax: 1-888-716-9787

LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – MEDICAID

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:

https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 1-800-977-6740

TTY: Maine relay 711

MASSACHUSETTS – MEDICAID	MINNESOTA – MEDICAID
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – MEDICAID	**MONTANA – MEDICAID**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – MEDICAID	**NEVADA – MEDICAID**
Website: http://accessnebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – MEDICAID	**NEW JERSEY – MEDICAID AND CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – MEDICAID	**NORTH CAROLINA – MEDICAID**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – MEDICAID	**OKLAHOMA – MEDICAID AND CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

OREGON – MEDICAID	PENNSYLVANIA – MEDICAID AND CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – MEDICAID AND CHIP	**SOUTH CAROLINA – MEDICAID**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – MEDICAID	**TEXAS – MEDICAID**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – MEDICAID AND CHIP	**VERMONT – MEDICAID**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – MEDICAID AND CHIP	**WASHINGTON – MEDICAID**
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – MEDICAID AND CHIP	WISCONSIN – MEDICAID AND CHIP
Website: https://bms.wv.gov/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

WYOMING – MEDICAID AND CHIP	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare and Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

PAPERWORK REDUCTION ACT STATEMENT

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

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

OMB Control Number 1210-0137 (expires 5/31/2029)

Contact Information

Questions regarding any of this information can be directed to hr_support@cushingterrell.com



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