MINNESOTA UROLOGY

2026

Benefits Guide Class II (Directors, Managers, APPs)

An overview of the wide array of benefits offered by Minnesota Urology to help you enjoy increased well-being.

These benefits are effective on January 1, 2026.

Prepared by Christensen Group, Inc for Minnesota Urology

Eligibility and Benefits Offered

Minnesota Urology is proud to offer a comprehensive benefit package for you and your family. This program is designed to take care of you when you need it. Make sure to explore all the options to help you make the selections that best meet your needs.

When your Benefits Begin

For new hires, all benefits begin on the first of the month following 30 days of employment with MN Urology. Enrollment must be completed within 30 days.

Eligible Members

All regular, full-time employees scheduled to work 30 hours or more per week and their eligible dependents are benefit eligible for the upcoming plan year. This includes the following:

- Employee
- Legal Married Spouse
- Legal Children
- Step-Children
- Domestic Partners (please see below)

When adding a domestic partner, the value of the insurance premium paid by the employer for that partner may be considered taxable income to the employee under IRS regulations. As a result, you may pay more in federal or state income taxes as well as payroll taxes because the overall taxable income has increased.

Enrollment and Coverage Change Notice

For most benefit plans, enrollment and changes to existing coverage are permitted only during the annual open enrollment period or if you have a qualifying life event.

Qualifying life events include the loss of other coverage, a job status change, marriage, divorce, legal separation, birth, adoption, ceasing to be a dependent child, and other events as prescribed by law.

- For a qualifying life event, you have 30 days from the date of the event to enroll in benefit plans with MNU. Proof of prior coverage and the event must be sent to HR before you can enroll.

Benefits Offered

Throughout this guide we will cover the following employee benefits being offered by Minnesota Urology.

- Medical Insurance
- Health Savings Account (HSA)
- Flexible Spending Account (FSA)
- Dependent Care Account (FSA)
- Dental Insurance
- Vision Insurance
- Basic Life Insurance
- Voluntary Life Insurance
- Short Term Disability Insurance
- Long Term Disability Insurance
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance

Important Contacts

Minnesota Urology offers a wide range of benefits designed to enhance your overall well-being, assist in unforeseen medical situations or accidents, and maintain a healthy work-life balance. These benefits are thorough and competitive.

The table below summarizes the benefits available to eligible employees and their dependents. These benefits are described in greater detail throughout this booklet.

QUESTIONS?

If you have any questions about your benefits, please contact:

Kirsten Fogt
Human Resources Business Partner
651.999.2726
kfogt@mnurology.com or
HumanResources@mnurology.com

Coverage	Carrier	Group #	Phone	Website
Medical	UnitedHealthCare	936766	866.801.4409	www.myuhc.com
Health Savings Account (HSA)	HSA Bank	-	800.357.6246	ww.hsabank.com
Flexible Spending Account (FSA)	WEX	-	866.451.3399	www.customerservice@wexhealth.com
Dependent Care Account (DCA)	WEX	-	866.451.3399	www.customerservice@wexhealth.com
Dental	Delta Dental of MN	955276	800.448.3815	www.deltadentalmn.org
Vision	EyeMed	1040993	866.939.3633	www.eyemed.com
Basic Life	MGIS		800.969.6447	www.mgis.com
Voluntary Life	MGIS		800.969.6447	www.mgis.com
Short Term Disability	MGIS		800.969.6447	www.mgis.com
Long Term Disability	MGIS		800.969.6447	www.mgis.com
Critical Illness	MGIS		800.969.6447	www.mgis.com
Hospital Indemnity	MGIS		800.969.6447	www.mgis.com
Accident	MGIS		800.969.6447	www.mgis.com

Medical Plan

Preventive Care

Understanding the full value of benefits allows you to take responsibility for maintaining good health and incorporate healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms and immunizations.

Through the medical plans offered by Minnesota Urology, covered employees and dependents are eligible to receive routine wellness services, at no cost; all copays, coinsurance, and deductibles are waived.

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e. Health Care Reform) compliant insurance plans should cover at 100% for in-network providers.

The list below are common services that are included in the plans offered this year.

Update on health care reform

Effective January 1, 2019, the Tax Cuts and Jobs Act (TCJA) repealed the individual mandate to maintain health insurance or be responsible for a "shared responsibility payment". We hope to keep offering these benefits as a valuable part of your total compensation in the future. However, because we offer you coverage that satisfies all the health reform requirements, you will not qualify for any federal assistance to purchase an individual or family policy on the open market (the "marketplace").

Covered Preventive Care Services (No Cost to Employee In Network)

- Routine Physical Exam
- Well Baby and Well Child visits
- Immunizations
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation Programs
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence

Medical Plan

UnitedHealthcare

(866) 414-1959
www.myuhc.com

Find a Medical Provider

UnitedHealthcare Network Options (2 Options)

For plan year 2026, you will have 2 network choices. You must select one:

1. Choice Plus

The Choice Plus network will give you access to the largest national network of providers UHC has without requiring a referral. Click this link to search for providers: https://whyuhc.com/choiceplus

2. Core Network

The Core network is a smaller network of providers that includes M Health Fairview, North Memorial Health, Entira Family Clinics, Stellis Health, Voyage Healthcare and access to academic medicine via the University of Minnesota Physicians and Level 1 trauma care from North memorial health hospital. Click this link to search for providers: https://www.whyuhc.com/core

Medical Plan

Summary of Plan Options

The following three plans are your medical insurance options for 2026.

UnitedHealthcare
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In Network	$1,500 - $35 – 75% Copay Plan Choice Plus or Core Networks	$3,500-75% HSA Plan Choice Plus or Core Networks	$4,000-100% HSA Plan Choice Plus or Core Networks
Deductibles (Single / Family) Calendar Year	$1,500/$4,500	$3,500/$7,000	$4,000/$8,000
Out-of-Pocket Max (Single / Family) Calendar Year	$4,500/$9,000	$6,500/$13,000	$5,000/$10,000
Preventive Care	100%, deductible does not apply	100%, deductible does not apply	100%, deductible does not apply
Primary Care Visit	$35 copay	75% after deductible	100% after deductible
Specialist Visit	$35 copay (Designated Network) $70 (Network)	75% after deductible	100% after deductible
Virtual Care E-Visit	$35 copay	75% after deductible	100% after deductible
Inpatient & Outpatient	75% after deductible	75% after deductible	100% after deductible
Emergency Room	75% after deductible	75% after deductible	100% after deductible
Urgent Care	$35 copay	75% after deductible	100% after deductible
Pharmacy / Rx (31 Day Supply)	Tier 1: $10 copay Tier 2: $40 copay Tier 3: $80 copay	Tier 1: ded; then $10 copay Tier 2: ded; then $35 copay Tier 3: ded; then $60 copay	Tier 1: ded; then $10 copay Tier 2: ded; then $35 copay Tier 3: ded; then $60 copay
Out Of Network Deductible (Single/Family)	$3,000/$9,0000 (then; 50% coverage)	$7,000/$14,0000 (then; 50% coverage)	$8,000/$16,000 (then; 50% coverage)
Out of Network Out-of-Pocket Max (Single/Family)	$9,000/$18,0000	$19,500/$39,000	$15,000/$30,000

Please note: Annual Vision Exams are not part of the coverage under UHC.

Virtual Care Options

Visit with a medical provider 24/7 – whenever, wherever with 24-hour virtual visits. Connect to a medical provider by phone or video through myuhc.com or the UnitedHealthcare app. Sign in at myuhc.com/virtualvisits
National providers included: Amwell, Virtuwell, Doctor On Demand, and Teledoc.

Medical Plan – Prescription Drugs

UnitedHealthcare
(866) 414-1959
www.myuhc.com

What is a PDL? PDL stands for Prescription Drug List. This document is a list of the most commonly prescribed medications. It includes both brand-name and generic prescription medications approved by the Food and Drug Administration (FDA). Medications are listed by common categories or classes and placed in tiers that represent the cost you pay out-of-pocket. They are then listed in alphabetical order.

How do I use my PDL? You and your doctor can consult the PDL to help you select the most cost-effective prescription medications. This guide tells you if a medication is generic or a brand name, and if there are coverage requirements or limits.

What are tiers? Tiers are the different cost levels you pay for a medication. Each tier is assigned a cost, set by your benefit plan. This is how much you will pay when you fill a prescription.

How often does the PDL change? PDL changes typically occur 2-3 times per year. However, changes that have a positive impact for you – such as coverage for new medications or cost savings – may occur at any time. You can log in to the member website listed on your member ID card at any time to check your medication coverage and lower-cost options.

Based on a 3 tier structure

Drug Tier	Includes	Helpful Tips
Tier 1	$ Lower-cost	
	Medications that provide the highest overall value. Mostly generic drug. Some brand-name drugs may also be included.	Use Tier 1 drugs for the lowest out-of-pocket costs.
Tier 2	$$ Mid-range cost	
	Medications that provide good overall value. A mix of brand name and generic drugs.	Use Tier 2 drugs, instead of Tier 3, to help reduce your out-of-pocket costs.
Tier 3	$$$ Highest-cost	
	Medications that provide the lowest overall value. Mostly brand-name drugs, as well as some generics.	Ask your doctor if a Tier 1 or Tier 2 option could work for you.

What is the difference between brand-name and generic medications? Generic medications contain the same active ingredients (what makes the medication work) as brand-name medications, but they often cost less. Once the patent for a brand-name medication ends, the FDA can approve a generic version with the same active ingredients. These types of medications are known as generic medications. Sometimes, the same company that makes a brand-name medication also makes the generic version.

What if my doctor writes a brand-name prescription? If your doctor gives you a prescription for a brand-name medication, ask if a generic equivalent or lower cost option is available and could be right for you. Generic medications are usually your lowest-cost option, but not always. For some benefit plans, if a brand-name drug is prescribed and a generic equal is available, your cost-share may be the copay PLUS the cost difference between the brand-name drug and the generic equivalent.

What if I am taking a specialty medication? Specialty medications are high-cost and are used to treat rare or complex conditions that require additional care and support. For most plans, these medications are managed through the specialty pharmacy program. Take advantage of personalized support designed to help you get the most out of your treatment plan. Visit that member website listed on your member ID card or call the toll-free phone number on your member ID card to learn more.

To search the website for more information either log into your member portal or go to: https://www.uhc.com/member-resources/pharmacy-benefits

Medical Plan

UnitedHealthcare®
(866) 414-1959
www.myuhc.com

Summary of Plan Costs

Minnesota Urology pays a substantial portion of your medical insurance premiums when you enroll in one of our health plans. You pay the balance with pre-tax contributions. Refer to the information below to help you make your medical plan choice for 2026

Total Plan Cost Per Month	$1,500 - $35 – 75% Copay Plan		$3,500 – 75% HSA Plan		$4,000 – 100% HSA Plan	
	Choice Plus Network	Core Network	Choice Plus Network	Core Network	Choice Plus Network	Core Network
Employee	$1,208.47	$1,093.74	$892.12	$807.89	$1,020.10	$923.53
Employee + Spouse or Domestic Partner	$2,416.95	$2,187.49	$1,784.25	$1,615.79	$2,040.21	$1,847.07
Employee + Child(ren)	$2,296.11	$2,078.13	$1,695.05	$1,535.00	$1,938.21	$1,754.73
Family	$3,452.85	$3,125.05	$2,548.98	$2,308.31	$2,914.64	$2,638.72

MNU Contributions Per Month	$1,500 - $35 – 75% Copay Plan		$3,500 – 75% HSA Plan		$4,000 – 100% HSA Plan	
	Choice Plus Network	Core Network	Choice Plus Network	Core Network	Choice Plus Network	Core Network
Employee	$949.72	$868.90	$729.02	$663.33	$863.94	$782.81
Employee + Spouse or Domestic Partner	$1,460.76	$1,317.96	$1,036.48	$941.91	$1,334.60	$1,211.67
Employee + Child(ren)	$1,481.15	$1,354.93	$1,124.54	$1,006.74	$1,389.50	$1,265.19
Family	$2,237.65	$2,042.33	$1,642.62	$1,477.06	$2,047.37	$1,857.61

Employee Contributions Per Month	$1,500 - $35 – 75% Copay Plan		$3,500 – 75% HSA Plan		$4,000 – 100% HSA Plan	
	Choice Plus Network	Core Network	Choice Plus Network	Core Network	Choice Plus Network	Core Network
Employee	$258.75	$224.85	$163.10	$144.57	$156.17	$140.73
Employee + Spouse or Domestic Partner	$956.20	$869.53	$747.77	$673.88	$705.61	$635.40
Employee + Child(ren)	$814.97	$723.20	$570.51	$528.27	$548.71	$489.54
Family	$1,215.20	$1,082.72	$906.36	$831.25	$867.27	$781.11

Medical Plan

UnitedHealthcare Value-Added Services

UnitedHealthcare
(866) 414-1959
www.myuhc.com

Get The Most Out of Your Benefits with myuhc.com or the mobile app

Register for your personalized website on myuhc.com and download the UnitedHealthcare app. These digital tools are designed to help you understand your benefits and make informed decisions about your care.
Find care and compare costs with providers/services in network, check your plan balance and view claims, access wellness programs, 24/7 Virtual Visits, compare prescription costs and order refills

Employee Assistance Program (EAP)

Promotes employee productivity and resiliency by offering immediate phone consultation and, if needed, 1-on-1 counseling to help address personal challenges, problems of daily life or workplace concerns. Your EAP provides 24/7 direct access to personalized support, resources and no-cost referrals to help you, and your family with a range of issues. Three free counseling sessions per incident, per year. Confidential and private, services will not be shared with your employer. Call EAP at 1-888-887-4114.

Real Appeal

Real Appeal is a free weight loss program offered at no additional cost to you when you are enrolled in the UnitedHealthcare medical plan. Real Appeal offers you tools and support to help you start on your weight loss journey.

To get started, visit www.realappeal.com

Advocate4Me

Insurance can be confusing. UnitedHealthcare can help make it easier. By calling the customer service number on the back of your ID card, you can be connected with a professional that can help you understand your benefits, claims, and maximize your savings. Call the number on your health plan ID card or sign in to myuhc.com and click on **Call** or **Chat,** or open the UnitedHealthcare app

UHC Rewards

A digital experience where you can earn regards for reaching program goals and completing one-time reward activities. Rewards will be distributed to members through a gift card. The activities you choose are up to you. Earn up to $1,000 in rewards. There are 2 ways to get started – on the UnitedHealthcare app or on myuhc.com. Sign in or register and select **UHC Rewards**

Calm Health App

The Calm Health app provides programs and tools to help support your mental health and well-being, all at your own pace. Learn techniques that support your mind and body and help you work toward your goals. Sign into your account at myuhc.com or the UnitedHealthcare app to get started

This is a general outline of value-added services; they are subject to be amended or changed based on carrier agreements.
Please see your member materials from UnitedHealthcare for a full description of value-added services included with your specific medical plan coverage.

Health Savings Account (HSA)

Overview & Details

Health Savings Accounts (HSAs) provide advantages to all eligible individuals, including families and those approaching retirement. You save money on taxes in three ways:

Tax-Free Deposits — The money you contribute to your HSA isn't taxed (up to the IRS annual limit)

Tax-Free Earnings — Your interest and any investment earnings grow tax-free

Tax-Free Withdrawals — Money used toward eligible health care expenses isn't taxed – now or in the future

Funds in your HSA grow tax-free, and withdrawals for qualified medical expenses are also tax-free. This makes HSAs a powerful tool for managing healthcare costs and planning for future medical expenses.

Moreover, HSA funds roll over from year to year and accumulate in your account. There is no "use-it-or-lose-it" rule with HSAs, and you decide how and when to use your HSA funds for eligible expenses. If you maintain a balance of at least $1,000, there are investment opportunities available.

See a list of eligible HSA expenses: https://www.hsabank.com/hsabank/Learning-Center/IRS-Qualified-Medical-Expenses

2026 HSA Contribution Limits

Single Coverage: $4,400

Family Coverage: $8,750

If you are over 55, you may contribute an additional $1,000 to your HSA for 2026.

Employer Contribution

When you are enrolled in one of the UHC HSA-eligible health plans, MNU helps you fund your HSA by contributing to your account as follows:

HSA Health Plan Coverage Status	MNU Matching Deposits
Employee Only	$.50 for each $1.00 you contribute (maximum $42.31 bi-weekly up to $1,100/year)
Employee + One or more	$.50 for each $1.00 you contribute (maximum $84.62 bi-weekly up to $2,200/year)

Flexible Spending Account (FSA)

Overview & Details

A Flexible Spending Account (FSA) is an employer-sponsored benefit that lets you set aside pre-tax money to pay for qualified medical expenses and dependent care.

Medical FSA Eligible Expenses

- Medical expenses: co-pays, co-insurance, and deductibles
- Dental expenses: exams, cleanings, X-rays, and braces
- Vision expenses: exams, contact lenses and supplies, eyeglasses, and laser eye surgery
- Professional services: physical therapy, chiropractor, and acupuncture
- Prescription drugs and insulin
- Over-the-counter health care items: bandages, pain relievers, pregnancy test kids, blood pressure monitors, blood sugar monitors, etc.

Dependent Care FSA Eligible Expenses

- Licensed Care for your child who is under age 13
- Before and after-school care
- Babysitting and nanny expenses while you and your spouse are working
- Day care, nursery school, preschool, and summer day camp
- Care for a relative who is physically or mentally incapable of self care and lives in your home.

Medical FSA Options

Full Medical FSA: You may use pre-tax dollars to help pay for medical, dental and vision expenses up to $3,400.

Limited FSA – If you are enrolled in the HSA compatible plan and making contributions to the HSA. You may use pre-tax dollars to help pay for dental and vision expenses **only** (no medical expenses permitted per IRS rules) up to $3,400.

Carry Over

A unique feature of your medical FSA plan is that you can carry over up to $660 to use during the following plan year of 2027.

Dependent Care Maximums

$7,500 for a married person who files a joint tax return or an unmarried person

$3,750 if married and filing separate tax returns

Using your plan dollars

The Flexible Spending plan runs January 1st, 2026 – December 31st, 2026.

Dental Insurance

Summary of Coverage, Plan Cost and Find a Provider

	Delta Dental PPO/Premier	Out of Network
Calendar Year Deductible (Single / Family)	$50/$150	$50/$150
Calendar Year Maximum Benefit (per person)	$1,500	$1,500
Preventive Care: *Exams, Cleanings, X-rays, Space Maintainers & Fluoride Treatments*	100%, deductible does not apply	100%, deductible does not apply
Basic Services: *Sealants, Emergency Treatment for Relief of Pain, Amalgam Restorations (Silver Fillings) and Composite Resin Restorations (White Fillings) on Anterior (Front) Teeth*	Deductible then 80% coverage	Deductible then 80% coverage
Endodontics: *Root Canal Therapy on Permanent Teeth, Pulpotomies on Primary Teeth for Dependent Children*	Deductible then 80% coverage	Deductible then 80% coverage
Periodontics: *Surgical/Nonsurgical Periodontics*	Deductible then 80% coverage	Deductible then 80% coverage
Major Restorative: *Crowns and Crown Repair, Composite Resin Restorations (White Fillings) on Posterior (Back) Teeth, Brides,*	Deductible then 50% coverage	Deductible then 50% coverage

Employee Contribution per Month	This is your contribution, paid pre-tax through payroll deductions
Employee	$19.30
Employee + Spouse or Domestic Partner	$41.63
Employee + Child(ren)	$44.95
Employee + Family	$59.20

PPO

Gives you the lowest out-of-pocket costs. Participating dentists in the network agree to accept lower fees for procedures, providing larger discounts that result in savings for Delta Dental members.

To search the PPO network for a dentist: deltadentalmn.org then click on find a dentist and search the Delta Dental PPO network by city and state.

Premier

The largest dentist network in the country. In fact, more than four-out of five dentists in the nation have agreed to accept Delta Dental's pre-negotiated fees for dental procedures. Seeing an out of network dentist is always an option. However, by utilizing one, you will be missing out on discounts available to you.

To search the Premier network for a dentist: deltadentalmn.org then click on find a dentist and search the Delta Dental Premier network.

Vision Insurance

Summary of Coverage, Plan Cost and Find a Provider

	Insight Network	Out of Network Member Reimbursement
Exam (Once every plan year)	$10 copay $0 copay – PLUS Providers	Up to $40
Lenses (Once every plan year; in lieu of contacts)		
Single Vision	$25 copay	Up to $30
Bifocal	$35 copay	Up to $50
Trifocal	$25 copay	Up to $70
Lenticular	$25 copay	Up to $70
Frames (Once every other plan year)	$0 copay; 20% off balance over $150 allowance $0 copay; 20% off balance over $200 allowance	Up to $105
Contact Lenses (Once every plan year, in lieu of lenses)		
Conventional	$0 copay; 15% off balance over $150 allowance	Up to $105
Disposable	$0 copay; 100% of balance over $150 allowance	Up to $105
Medically Necessary Contact Lenses	$0 copay; paid in full	Up to $300

Employee Contribution per Month	This is your contribution, paid pre-tax through payroll deductions
Employee	$7.65
Employee + Spouse or Domestic Partner	$14.54
Employee + Child(ren)	$15.30
Employee + Family	$22.49

EyeMed Insight Network: For the highest benefit level, use an Insight network provider. To find a network provider: eyemed.com, click on find an eye doctor and select the Insight network.

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Basic Life/AD&D and Voluntary Life/AD&D

Summary of Coverage

(800) 969-6447
www.mgis.com

Minnesota Urology pays 100% of the premiums for your Basic Life/AD&D. You pay 100% of the premiums for any additional Voluntary Life/AD&D.

Basic Life/AD&D Plan Features	Benefit
Employee Life & AD&D Benefit Amount	$100,000
Benefit Reduction Ages	Age 65 benefits reduce 33% Age 70 benefits reduce 55%

Voluntary Life and AD&D Plan Features	Benefit
Employee Life and AD&D Benefit Amount	Increments of $10,000 up to 5 times basic annual earnings, to a maximum of $500,000. You must be enrolled to purchase coverage for your spouse and/or children
Employee Guarantee Issue*	Up to $200,000
Spouse/Domestic Partner Life and AD&D Benefit Amount	Increments of $5,000, to a maximum of $250,000, not to exceed 100% of employee amount
Spouse/Domestic Partner Guarantee Issue*	Up to $25,000
Child Life and AD&D Benefit Amount	Birth to < 6 months $500, 6 months to age 21 (or age 26 if a full-time student) increments of $1,000, up to $10,000
Child Guarantee Issue	Up to $10,000

***Guarantee Issue Amount**

The employee guarantee amount is the amount of voluntary life insurance you can opt into without answering any medical questions. Evidence of insurability (EOI) is required for any increase to benefit amount.

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Voluntary Life/AD&D

Summary of Costs

(800) 969-6447
www.mgis.com

Voluntary Life Rate Current Age	Monthly Rate per $1,000 of Coverage Employee	Monthly Rate per $1,000 of Coverage Spouse or Domestic Partner
Under 30	$0.043	$0.043
30-34	$0.048	$0.048
35-39	$0.068	$0.068
40-44	$0.096	$0.096
45-49	$0.150	$0.150
50-54	$0.249	$0.249
55-59	$0.385	$0.385
60-64	$0.541	$0.541
65-69	$0.984	$0.984
70 and older	$1.867	$1.867
Child/ren Life Rate per month, per $1,000	$0.159	
AD&D Rate		
AD&D	$0.030	

Spouse/Domestic Partner rate is based on employee's age bracket.

Disability
Summary of Coverage

The following are your Disability benefits for the upcoming year. Minnesota Urology pays 100% of the premiums.

(800) 969-6447
www.mgis.com

Short Term Disability

Plan Features	
Employee Benefit Amount	60% of pre-disability earnings
Maximum Benefit Amount	Up to $1,000 per week
Elimination Period (Accident/Illness)	7 days
Benefit Duration	Up to 12 weeks
Pre-existing Condition Limitation	None

Long Term Disability

Plan Features	
Employee Benefit Amount	60% of pre-disability earnings
Maximum Benefit Amount	Up to $10,000 per month
Elimination Period	90 days
Benefit Duration	Up to Social Security Normal Retirement Age
Pre-existing Condition Limitation	Benefits may not be paid for disabilities due to conditions treated or diagnosed during the 3 months prior to your plan effective date until you have been insured for 12 months

Accident Insurance

Summary of Coverage

(800) 969-6447
www.mgis.com

Accident insurance provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident, or for accidental death and dismemberment. These benefits are paid directly to you and may be used for any reason, from deductibles and prescriptions to transportation and childcare.

- Coverage is 100% employee paid
- Benefits are paid directly to you
- Cash benefits for unexpected injuries
- Additional Youth organized sports benefit – 25% benefit increase if accident occurs while participating in an organized youth sport

Employee Monthly Premiums	
Employee	$9.60
Employee + Spouse or Domestic Partner	$14.80
Employee + Child(ren)	$18.25
Family	$23.50

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Critical Illness
Summary of Coverage

(800) 969-6447
www.mgis.com

Critical illness insurance provides a fixed, lump-sum benefit upon diagnosis of a critical illness, which can include heart attack, stroke, paralysis and more. These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and childcare

Employee: Choose from a minimum of $5,000 to a maximum of $20,000 in $5,000 increments

Spouse: Choose from a minimum of $5,000 to a maximum of $20,000 in $5,000 increments, not to exceed 100% of employee amount

Child: 25% of employee coverage

Benefit paid is a percentage of coverage amount, please see schedule of benefits for conditions and percentage details

Wellness Benefits – Any preventative health screening or test including but not limited to, annual physicals, immunizations, dental exams and mental health screenings

Employee Monthly Rates Per Benefit Amount				
Age	$5,000	$10,000	$15,000	$20,000
<30	$1.05	$2.10	$3.15	$4.20
30-39	$1.75	$3.50	$5.25	$7.00
40-49	$3.85	$7.70	$11.55	$15.40
50-59	$8.25	$16.50	$24.75	$33.00
60-69	$15.50	$31.00	$46.50	$62.00
70+	$25.95	$51.90	$77.85	$103.80

Spouse/Domestic Partner Monthly Rates Per Benefit Amount				
Age	$5,000	$10,000	$15,000	$20,000
<30	$1.05	$2.10	$3.15	$4.20
30-39	$1.75	$3.50	$5.25	$7.00
40-49	$3.85	$7.70	$11.55	$15.40
50-59	$8.25	$16.50	$24.75	$33.00
60-69	$15.50	$31.00	$46.50	$62.00
70+	$25.95	$51.90	$77.85	$103.80

If enrolling children, employee needs to include them in their election. The child benefit amount is 25% of the employee amount and is included in the cost of the employee election.

Hospital Indemnity Insurance

Summary of Coverage

(800) 969-6447
www.mgis.com

Hospital indemnity insurance provides a range of fixed, lump-sum daily benefits to help cover costs associated with a hospital admission, including room and board costs. These benefits are paid directly to you following a hospitalization that meets the criteria for benefit payment.

- Guaranteed issue, no medical questions
- Hospitalizations due to mental and nervous or substance abuse not excluded
- No maternity waiting period
- Hospital daily confinement benefit begins on day one.
- Cash payments are made directly to you and can be used for any purpose.
- Coverage is 100% employee paid

Employee Monthly Premiums	
Employee	$10.25
Employee + Spouse/Domestic Partner	$18.00
Employee + Child(ren)	$14.95
Family	$26.45

Important Definitions

Annual Deductible

The amount you must pay each year before the plan starts paying a portion of your medical or dental expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

Copays & Coinsurance

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount and are usually due at the time you receive care. Coinsurance is your share of the allowed amount charged for a service and is generally billed to you after the health or dental insurance company reconciles the bill with the providers.

Network

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

Out-of-pocket Maximum

This is the total amount you can pay out of pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible, copays and coinsurance.

Pre-existing Condition Limitation

A condition that is excluded from coverage for a specific period, based on diagnosis or treatment.

Premium

The amount you pay for your health or dental insurance every month. In addition to your premium, you usually have to pay other costs for your health or dental care, including a deductible, copayments, and coinsurance.

Preventive Care

Preventive care helps detect or prevent serious diseases and medical problems before they become major. Annual check-ups, immunizations, and flu shots, as well as certain tests and screenings, are a few examples of preventive care. This may also be called routine care.

Legal Notices

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

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default. asps
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.co m/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecov ery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health- insurance-premium-payment-program-hippa 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	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)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – 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/d ms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care- coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp. htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/Medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

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

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bm s/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699- 8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p- 10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs- and-eligibility/ Phone: 1-800-251-1269

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

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that OMB Control Number 1210-0137 (expires 1/31/2026) 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.

General Notice of COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

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

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

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

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

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

If you have questions

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

Family Medical Leave Act (FMLA)

Who is eligible for FMLA leave?

An employee is eligible for FMLA leave if the employee has been employed by a covered employer for at least 12 months and has worked at least 1,250 hours for that employer during the previous 12-month period. An eligible employee must also be employed at a worksite where the employer employs at least 50 employees within a 75-mile radius of the worksite.

For purposes of determining whether an employee who is a flight crew member meets the hours-of-service requirement above, the employee will be considered to meet the requirement if he or she:

- Has worked or been paid for not less than 60 percent of the applicable total monthly guarantee for the previous 12-month period; and
- Has worked or been paid for not less than 504 hours during the previous 12-month period.

What are the qualifying reasons for FMLA leave?

The following circumstances qualify for **12 workweeks** of FMLA leave:

- ✓ Birth and care of an employee's son or daughter;
- ✓ Placement of a son or daughter with the employee for adoption or foster care;
- ✓ Care for an employee's spouse, son, daughter or parent who has a serious health condition;
- ✓ An employee's own serious health condition that makes the employee unable to perform any one of the essential functions of the employee's position; or
- ✓ Any qualifying exigency arising out of the fact that a family member (spouse, son, daughter or parent of the employee) is a covered military member on covered active duty or has been notified of an impending call or order to covered active duty in the Armed Forces.

In addition, eligible employees may take **26 workweeks** of leave in a single 12-month period to care for a spouse, son, daughter, parent or next of kin who is a covered service member with a serious injury or illness.

What is a "serious health condition" under the FMLA?

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves **inpatient care** or **continuing treatment** by a health care provider. The FMLA does not apply to routine medical examinations, such as a physical, or to common medical conditions, such as an upset stomach, unless complications develop.

For all conditions, "incapacity" means inability to work, including being unable to perform any one of the essential functions of the employee's position, or inability to attend school, or perform other regular daily activities due to the serious health condition, treatment of the serious health condition, or recovery from the serious health condition. The term "treatment" includes, but is not limited to, examinations to determine if a serious health condition exists and evaluations of the condition.

Serious health conditions may include conditions that involve an inpatient hospital stay or ones that include one or more visits to a health care provider and ongoing treatment. Chronic conditions and long-term or permanent periods of incapacity may also meet the requirements. Certain conditions requiring multiple treatments may also be FMLA-qualifying.

When should an employee provide notice of his or her need for FMLA leave?

Employees should give employers as much notice as possible when requesting leave under the FMLA. While not required to use the term "FMLA" when seeking leave, the employee must provide sufficient information for the employer to determine if the leave qualifies for FMLA protection. When an employee seeks leave due to an FMLA-qualifying reason for which the employer has previously provided FMLA-protected leave, the employee must specifically reference the qualifying reason for leave in notifying the employer.

If leave is foreseeable for the birth of a child, to adopt or place a foster child, for planned medical treatment of a serious health condition of the employee or family member, or for the

planned medical treatment for a serious injury or illness of a covered service member, employees must provide the employer with **at least 30 days' advance notice** before the leave begins. If 30 days' advance notice is not provided, the employer has the right to delay the taking of FMLA until 30 days' notice is provided.

When leave will begin in less than 30 days, employees must give notice to an employer as soon as practicable.

For foreseeable qualifying exigency leave, notice must be provided as soon as practicable, regardless of how far in advance the leave is foreseeable.

Plan Benefits While on FMLA Leave

If you take a leave of absence that is not a family or medical leave under the Family and Medical Leave Act of 1993 (FMLA), the way in which you participate in the Plan will depend on whether or not you continue to get a paycheck from your employer while you are on leave. If your employer does not pay you while you are on leave, your participation in the Plan will be treated in the same way as if you had terminated your employment, unless you pay for benefits, on an after-tax basis while you are on leave. When you return to work your prior benefits will start again.

If you take a leave of absence that is a family or medical leave under the FMLA, you should contact the employer in order to discuss your continued participation in the Plan during the leave. In general, if you take an unpaid family or medical leave under the FMLA, you may continue to participate in the Plan, but you may be required to continue your contribution.

Please contact the company as soon as you know you will be taking a Family or Medical Leave.

Women's Health and Cancer Rights Act of 1998 Notice

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. As specified in the Act, if you or a covered family member had or are going to have a mastectomy, you maybe 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 at all stages of the mastectomy, including lymphedema.

The coverage will be provided in a manner determined in consultation with the attending physician and the patient. Deductibles and co- insurance established for other benefits under your plan also apply to these reconstructive surgery benefits.

USERRA Rights

If you, or your spouse or dependent, are absent from work for uniformed service, you may have the right to continue participating in the Plan under the Uniform Services Reemployment and Rights Act (USERRA). USERRA is intended to lessen the difficulty that may occur if you need to be absent from your civilian employment to serve in the United States uniformed services. USERRA seeks to make sure that those who serve their country can keep their civilian employment and benefits and can seek reemployment without discrimination because of their service.

Under USERRA, employees absent for uniformed service (and their covered spouse and covered dependents) are eligible for continuation coverage for the period of service (plus time allowed under USERRA to apply for reemployment) or for up to twenty-four (24) months, whichever is less. If your service is for less than thirty-one (31) days, the plan may charge only your share of the monthly health care premium. If your service is more than thirty-one (31) days, your employer may charge the full premium plus 2% (for a total of 102% of the premium). You may have rights under both COBRA and USERRA and are entitled to the continued coverage that provides the more favorable benefit.

An individual who serves in the military will be considered on leave of absence and will be entitled to all rights and benefits not determined by seniority that are generally provided to similarly situated employees on leave of absence or other types of leave.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA.

Mental Health Parity and Addiction Equity Act of 2008

Under the Mental Health Parity and Addiction Equity Act of 2008, the conditions (for example, copayments and deductibles) and treatment limitations for mental health and substance use disorders generally must not be more restrictive than those applicable to medical and surgical procedures. Review your plan documents for additional information about mental

health coverage.

Michelle's Law

Certain covered dependents may be eligible to extend their plan coverage for a limited period of time when that coverage would otherwise end due to loss of student status.

Under Michelle's Law, the Plan cannot terminate coverage for a dependent child whose enrollment in a plan requires student status at a postsecondary educational institution, if the student status is lost because of a medically necessary leave of absence. In this situation, the Plan will continue the dependent's coverage until the earlier of:

The date that is one year after the first day of the medically necessary leave of absence. The date on which the dependent's coverage

would otherwise end under the Plan's terms.

A dependent in this situation will be eligible for continued Plan coverage under Michelle's Law if you provide the Plan a written certification from the dependent's treating physician stating that:

The dependent is suffering from a serious illness or injury.

The leave of absence (or other change of enrollment) is medically necessary.

A medically necessary leave of absence means a leave of absence from a postsecondary educational institution, or any other change in enrollment of the dependent at the institution, that:

Begins while the dependent is suffering from a serious illness or injury.

Causes the dependent to lose student status for purposes of coverage under the Plan's terms.

Newborns' and Mothers' Health Protection Act

Generally, group health plans, cannot restrict any hospital length of stay in connection with childbirth for the mother or the baby to less than forty-eight (48) hours after a vaginal delivery, or less than ninety-six (96) hours after a cesarean delivery. Group health plans cannot require that an attending doctor get permission from the plan to keep the mother and baby longer than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean delivery. The attending doctor may consult with the mother and decide to release the mother and baby earlier than forty-eight (48) hours after a vaginal delivery or ninety-six (96) hours after a cesarean delivery.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes numerous requirements on employer health plans regarding how certain individually identifiable health information – known as protected health information or PHI – may be used and disclosed. This Notice describes how the plan, and any third party that assists in the administration of the plan, may use and disclose your protected health information for treatment, payment, or health care operations and for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your protected health information. "Protected health information" is information that is maintained or transmitted by the Plans, which may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

We will use PHI to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request of it. Our insurers' Notices of Privacy Practices will apply, except for the limited medical information the we may receive and maintain from you when you ask us to assist you in a claims processing or benefit determination dispute, information related to your enrollment or disenrollment in the plan, and certain summary health information.

Your personal doctor or health care provider may have different policies or notices regarding their use and disclosure of your medical information.

We are required by law to abide by the terms of this notice to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the Notice that is currently in effect.

It is important to note that these rules apply to the Plans, not the company as an employer.

1. How We May Use and Disclose Medical Information About You. HIPAA generally permits use and disclosure of your health information without your permission for purposes of health care treatment, payment activities, and health care operations. These uses and disclosures are more fully described below. Please note that this Notice does not list every use or disclosure; instead it gives examples of the most common uses and disclosures.

- Treatment: When and as appropriate, medical information may be used or disclosed to facilitate medical treatment or services by providers.
- Payment: When and as appropriate, medical information may be used and disclosed to determine your eligibility for the Plans' benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility and coverage under the plan, or to coordinate your coverage.
- Health Care Operations: When and as appropriate, medical information may be used and disclosed for the plan's operations, as needed. Your genetic information will not be used or disclosed for underwriting purposes.
- The plan will always try to ensure that the medical information used or disclosed is limited to a "Designated Record Set" and to the "Minimum Necessary" standard, including a "limited data set," as defined in the law for these purposes.

OTHER PERMITTED USES AND DISCLOSURES

- Disclosure to Others Involved in Your Care: Medical information may be disclosed to a relative, a friend, or to any other person you identify, provided the information is directly relevant to that person's involvement with your health care or payment for that care.
- Disclosure to Health Plan Sponsor: Information may be disclosed to another health plan for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to personnel solely for purposes of administering benefits under the plan.
- Workers' Compensation: We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- To Comply with Federal and State Requirements: Medical information will be disclosed when required to do so by federal, state, or local law.
- To Avert a Serious Threat to Health or Safety: Medical information may be disclosed 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 who is able to help prevent the threat.
- Military and Veterans: If you are a member of the armed forces, medical information may be released as required by military command authorities.
- Business Associates: Medical information may be disclosed to business associates. We have contracted with entities (defined as "business associates" under HIPAA) to help us administer your benefits. We will enter into contracts with these entities requiring them to only use and disclose your health information as we are permitted to do so under HIPAA.
- Other Uses: If you are an organ donor, we may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation. We may release your medical information to a coroner or medical examiner. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your information to the correctional institution or law enforcement official.

Uses and disclosures other than those described in this notice will generally require your written authorization. Your written authorization is required for: most uses and disclosures of psychotherapy notes; uses and disclosures of PHI for marketing purposes; and disclosures that are a sale of PHI. You may revoke your authorization at any time, but you cannot revoke your authorization if the Plans have already acted on it.

The privacy laws of a particular state or other federal laws might impose a more stringent privacy standard. If these more stringent laws apply and are not superseded by federal preemption rules under the Employee Retirement Income Security Act of 1974 (ERISA), the plan will comply with the more stringent law.

2. Your Rights Regarding Medical Information About You. You have the following rights regarding medical information that we maintain about you:

Right to Inspect and Copy: You have the right to inspect and obtain a copy of your medical information that may be used to make decisions about your benefits under the Plans. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. If the Plans do not maintain the health information, but know where it is maintained, you will be informed of where to direct your request.

- Your Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You also must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend any of the following information:
    - Information that is not part of the medical information kept by or for the plan.
    - Information that was not created by us, unless the person or entity that created the information is no longer available to

make the amendment.
  - Information that is not part of the information which you would be permitted to inspect and copy.
  - Information that is accurate and complete.

- Your Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" (that is, a list of certain disclosures the plan has made of your health information). Generally, you may receive an accounting of disclosures if the disclosure is required by law, made in connection with public health activities, or in situations similar to those listed above as "Other Permitted Uses and Disclosures". You do not have a right to an accounting of disclosures where such disclosure was made:
  - For treatment, payment, or health care operations.
  - To you about your own health information.
  - Incidental to other permitted disclosures.
  - Where authorization was provided.
  - To family or friends involved in your care (where disclosure is permitted without authorization).
  - For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
  - As part of a limited data set where the information disclosed excludes identifying information.

To request this list or accounting of disclosures, you must submit your request, which shall state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. Notwithstanding the foregoing, you may request an accounting of disclosures of any "electronic health record" (that is, an electronic record of health-related information about you that is created, gathered, managed, and consulted by authorized health care clinicians and staff). To do so, however, you must submit your request and state a time period, which may be no longer than three years prior to the date on which the accounting is requested.

- Your Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. If the Plans do agree to a request, a restriction may later be terminated by your written request, by agreement between you and the Plans (including orally), or unilaterally by the Plans for health information created or received after the Plans have notified you that they have removed the restrictions and for emergency treatment. To request restrictions, you must make your request in writing and must tell us the following information:
  - What information you want to limit.
  - Whether you want to limit our use, disclosure, or both.
  - To whom you want the limits to apply (for example, disclosures to your spouse).

- Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

3. Breach Notification. Pursuant to changes to HIPAA required by the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, "HITECH Act") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), this Notice also reflects federal breach notification requirements imposed on the Plans in the event that your "unsecured" protected health information (as defined under the HITECH Act) is acquired by an unauthorized party.

- The plan will notify you following the discovery of any "breach" of your unsecured protected health information as defined in the HITECH Act (the "Notice of Breach"). Your Notice of Breach will be in writing and provided via first-class mail, or alternatively, by email if you have previously agreed to receive such notices electronically. If the breach involves:
  - 10 or more individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute individual Notice of Breach by either posting the notice on the benefits website on the company intranet or by providing the notice in major print or broadcast media where the affected individuals likely reside.
  - Less than 10 individuals for whom we have insufficient or out-of-date contact information, then we will provide substitute Notice of Breach by an alternative form.

Your Notice of Breach shall be provided without unreasonable delay and in no case later than 60 days following the discovery of a breach and shall include, to the extent possible:

- A description of the breach.
- A description of the types of information that were involved in the breach.
- The steps you should take to protect yourself from potential harm.
- A brief description of what we are doing to investigate the breach, mitigate the harm, and prevent further breaches.
- Relevant contact information.

Additionally, for any substitute Notice of Breach provided via web posting or major print or broadcast media, the Notice of Breach shall include a toll-free number for you to contact us to determine if your protected health information was involved in the breach.

4. Changes to This Notice. We can change the terms of this notice at any time. If we do, the new terms and policies will be effective for all of the medical information we already have about you as well as any information we receive in the future. We will send you a copy of the revised notice.
5. Complaints. If you believe your privacy rights have been violated, you may file a complaint with the plan or with the Secretary of the Department of Health and Human Services.

All complaints must be submitted in writing. You will not be penalized for filing a complaint.

6. Other Uses of Medical Information. Other uses and disclosures of medical information that are not covered by this notice or the laws that apply to us will be made only with your written permission. If you grant us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we may be required to retain our records related to your benefit determinations and enrollment.

HIPAA Initial Notice of Special Enrollment Rights

This notice is to inform you of your right, under a federal law called the Health Insurance Portability and Accountability Act (HIPAA), to enroll in Plan at times other than the Plan's annual open enrollment periods, upon the occurrence of specified events (for example, if have a baby). These enrollment periods are known as "special enrollment" opportunities. Generally, you must request enrollment within 30 days or as outlined in the plan documents.

- If you or your dependents lose eligibility for other coverage that you were enrolled in, you may be able to enroll in this plan.
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Plan.
- If you, you spouse, or your dependents become eligible for assistance under Medicaid or a state children's health insurance program, or lose coverage under such a program, you may be allowed to enroll yourself and your dependents in the Plan.

Qualified Medical Child Support Orders (QMCSOs)

A description of the procedures governing qualified medical child support orders (QMCSOs) can be obtained, without cost, from the plan administrator.

Wellness Plans

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

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers covered under the law from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by the law. GINA's employment nondiscrimination requirements prohibit the company from discriminating against any employee or applicant with respect to hiring, discharge, compensation, terms, conditions or privileges of employment on the basis of genetic information with respect to the employee or applicant. As a result, the company will not fail or refuse to hire, or discharge any employee or applicant because of genetic information. The company will not limit, segregate or classify employees or applicants in any way that would deprive or tend to deprive them of employment opportunities or adversely affect their status as employees because of genetic information relating to the employees or applicants. The company will not discriminate or retaliate against individuals who oppose unlawful practices under GINA, or who make a charge, testify, assist or participate in any investigation, proceeding or hearing related to the employment nondiscrimination requirements. However, the company will not violate GINA if they limit or restrict an employee's job duties based on genetic information because they were required to do so by a law or regulation mandating genetic monitoring.

"Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Additionally, the plan will generally not:

- Request or require individuals or their family members to undergo genetic testing.
- Use genetic information to determine eligibility for coverage or to impose preexisting condition exclusions.
- Collect genetic information for underwriting purposes or with respect to any individual before enrollment or coverage.
- Adjust group premium or contribution amounts on the basis of genetic information.

Notice Regarding Designation of Primary Care Providers

The plan may allow or even require the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your employer. For children, you may designate a pediatrician as the primary care provider.

Notice Regarding Coverage for Obstetric or Gynecological Care

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

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 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 cots 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 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 that you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

Minnesota law prohibits balance billing

A network provider is prohibited from billing you for any amount in excess of the allowable amount the health carrier has a contractor for with the provider as a total payment for the health care service. A network provider is permitted to bill you the approved co-payment, deductible, or coinsurance. A network provider is permitted to bill you for services not covered by your health plan as long as you agree in writing in advance before the service is performed to pay for the noncovered service.

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 the No Surprise Help Desk (NSHD) at 1-800-985-3059 or the Minnesota Attorney General's Office at: 445 Minnesota St., Ste.1400, St. Paul, MN 55101; (800) 657-3787.

Visit cms.gov/nosurprises for more information about your rights under federal law.

Visit https://www.ag.state.mn.us/consumer/publications/MedicalBillingPointers.asp for more information about your rights under Minnesota state law, or for information about complaints related to health care, visit https://www.health.state.mn.us/facilities/insurance/clearinghouse/complaints.html

Model Creditable Coverage Disclosure Notice
(For Use for Plan Year Beginning January 1, 2026)

Important Notice from [Employer/Plan Sponsor Name] 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 [Employer/Plan Sponsor Name] and about your options under Medicare's prescription drug coverage.

Creditable Coverage Status
The prescription drug coverage offered by [Employer/Plan Sponsor Name] has been determined to be "Creditable Coverage." This means that the coverage is expected to pay, on average, as much as or more than the standard Medicare prescription drug coverage under Part D.

Because your coverage is Creditable, 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?
If you lose your current creditable prescription drug coverage through no fault of your own, you are eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan. Other SEPs may also apply, depending on your situation (for example, Medicaid or CHIP eligibility changes).

- You may enroll in a Medicare prescription drug plan when you first become eligible for Medicare.
- You also may enroll each year during Medicare's Annual Election Period (October 15 through December 7).
- If you lose or decide to leave your current employer/union coverage, you may also be eligible for a Special Enrollment Period (SEP).

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?
If you decide to enroll in a Medicare drug plan, your current [Employer/Plan Sponsor Name] coverage will [insert description of what happens, e.g., "continue alongside Medicare," or "end when Medicare drug coverage begins."].

You should compare your current coverage, including what drugs are covered, with the coverage and costs of the Medicare plans in your area.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
If you go 63 continuous days or longer without Creditable prescription drug coverage after your Initial Enrollment Period for Medicare, you may have to pay a Late Enrollment Penalty (LEP) when you join.

The penalty is an additional amount added to your monthly Medicare drug plan premium, for as long as you have Medicare drug coverage.

For More Information About This Notice or Your Current Coverage
Contact: [Employer/Plan Sponsor Name & Contact Info]
Phone: [HR/Benefits Office Phone Number]
Email: [HR/Benefits Office Email]

Additional Resources:
• Call your State Health Insurance Assistance Program (SHIP) for free, personalized help. You can find the number in the back of the 'Medicare & You' handbook.
• If you have limited income and resources, you may qualify for extra help with Medicare prescription drug coverage. For more information, visit www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

For More Information About Your Options Under Medicare Prescription Drug Coverage
• Visit www.medicare.gov
• Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
• See the “Medicare & You” handbook mailed each year to Medicare households.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based

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

[1] Indexed annually; see https://www.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 percent 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.

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.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost

that coverage.

Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023.

Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.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

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Minnesota Urology		4. Employer Identification Number (EIN): 41-0960332	
5. Employer address: 3001 Metro Drive Suite 460		6. Employer phone number: 651-999-2726	
7. City: Bloomington	8. State: MN	9. ZIP code: 55425	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)	12. Email address: HumanResources@mnurology.com		

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - [X] All employees. Eligible employees are:

    Regular, full-time employees working at least 30 hours per week
  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are:

    Spouses, domestic partners and eligible dependents of benefit eligible employees
  - [ ] We do not offer coverage.

[X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid–year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter

Disclaimers

This Guide is only a summary provided for your information. If there is a discrepancy between this Guide and the contract/certificates used for clarification of coverage/rates; the contract/certificates are deemed correct. Your Company reserves the right to change, amend, terminate, or otherwise alter any benefit described in this Guide at any time.

Value Added Services Disclaimer

This Guide provides a general outline of value-added services; they are subject to be amended or changed based carrier agreements. Please see your member materials from the carrier providing the value-added services for a full description of the services included with your specific coverage.