VALSOFT

2025 Benefits

A GUIDE TO YOUR

Benefits

January 1, 2025 - December 31, 2025

Welcome

Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of valuable benefits to protect your health, family and way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

You are eligible for benefits if you work 30 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

When Coverage Begins

- **New Hires:** You must complete the enrollment process within 30 days of your date of hire. If you enroll on time, coverage is effective on the first of the month following your date of hire. If you fail to enroll on time, you will NOT have benefits coverage (except for company-paid benefits) until you enroll during our next annual Open Enrollment period.
- **Open Enrollment:** Changes made during Open Enrollment are effective January 1, 2025 - December 31, 2025.

Choose Carefully

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualifying life event during the year. Following are examples of the most common qualifying life events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse, or child
- You lose coverage under your spouse's plan
- You gain access to state coverage under Medicaid or The Children's Health Insurance Program

Making Changes

To change your benefit elections, you must contact Human Resources within 31 days of the qualifying life event. Be prepared to show documentation of the event, such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to change your elections.

- For all benefit related changes, please contact us at benefits@valsoftcorp.com

Required Information*—You will be required to enter a Social Security number (SSN) for all covered dependents when you enroll. The Affordable Care Act (ACA) requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.*

Inside

Medical

Health Savings Account (HSA)

Dental

Voluntary Benefits

Vision

Life & AD&D

Disability

Flexible Spending Accounts (FSAs)

Contact Information

Enrollment

Go to https://lfg.benselect.com/enroll/login

There you will find detailed information about the plans available to you and instructions for enrolling.

Medical - UMR

We're proud to offer you a choice of medical plans. The following is a high-level overview of the coverage available.
Everyone will be receiving new medical ID cards as we transition to the UMR platform. You can download the UMR app or go to their website www.UMR.com to register. Please be sure to have your UMR medical ID card handy when registering. Once you have registered, you can view in-network providers, pharmacy costs and in-network facilities through the app/website. You can also obtain a digital copy of your medical ID card on your UMR app. To search if your provider is in-network, visit - https://www.umr.com/find-a-provider

Key Medical Benefits	UMR - $500 PPO Traditional Plan		UMR - $1,500 PPO Traditional Plan	
	In-Network Only	Out-of-Network[1]	In-Network Only	Out-of-Network[1]
Deductible (per calendar year)				
Individual / Family	$500 / $1,000	$3,000 / $6,000	$1,500 / $3,000	$3,000 / $6,000
Out-of-Pocket Maximum (per calendar year)				
Individual / Family	$5,000 / $10,000	$10,000 / $20,000	$6,000 / $12,000	$12,000 / $24,000
Covered Services				
Office Visits (Age 0-17 / Age18 +)	$0 / $25 copay	50%*	$0 / $25 copay	50%*
Specialist Visit	$75 copay	50%*	$75 copay	50%*
Telehealth	$0 / $25 copay	50%*	$0 / $25 copay	50%*
Teledoc	$10 copay	NA	$10 copay	NA
Routine Preventive Care	No charge	50%*	No charge	50%*
Outpatient Diagnostic (lab/X-ray)	30%*	50%*	30%*	50%*
Complex Imaging	30%*	50%*	30%*	50%*
Chiropractic	$25 copay	50%*	$25 copay	50%*
Ambulance	30%*	30%*	30%*	30%*
Emergency Room	$300 copay + 30%*	$300 copay + 30%*	$300 copay + 30%*	$300 copay + 30%*
Urgent Care Facility	$50 copay	50%*	$50 copay	50%*
Inpatient Hospital Stay	30%*	50%*	30%*	50%*
Outpatient Surgery	30%*	50%*	30%*	50%*
Prescription Drugs (Tier 1 / Tier 2 / Tier 3 / Tier 4 (Tier 1 / Tier 2 / Tier 3)				
Retail (31-day supply)	$10 / $35 / $75 / Specialty T1 ($10) T2 ($150) T3 ($350)	If you use a Non-Network Pharmacy, you are responsible for payment upfront.	$10 / $35 / $75 / Specialty T1 ($10) T2 ($150) T3 ($350)	If you use a Non-Network Pharmacy, you are responsible for payment upfront.
Retail / Mail Order (32-90 Day Supply) Cost Per Prescription	$25 / $87.50 / $187.50	If you use a Non-Network Pharmacy, you are responsible for payment upfront.	$25 / $87.50 / $187.50	If you use a Non-Network Pharmacy, you are responsible for payment upfront.

***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**
To be eligible for the HSA, you cannot be covered through Medicare Part A or Part B or TRICARE programs or enrolled in a PPO Plan. See the plan documents for full details.
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Medical (cont'd)

Key Medical Benefits	UMR - $3,500 HDHP - HSA		UMR - $6,350 HDHP - HSA	
	In-Network Only	Out-of-Network[1]	In-Network Only	Out-of-Network[1]
Deductible (per calendar year)				
Individual / Family	$3,500 / $7,000	$7,000 / $14,000	$6,350 / $12,700	$12,700 / $25,400
Out-of-Pocket Maximum (per calendar year)				
Individual / Family	$3,500 / $7,000	$16,000 / $32,000	$6,350 / $12,700	$25,400 / $50,800
Company Contribution to Your Health Savings Account (HSA) (per calendar year; prorated for new hires/newly eligible)				
Individual / Family	$250 / $500		$250 / $500	
Covered Services				
Office Visits (Age 0-17 / Age18 +)	0%*	50%*	0%*	50%*
Specialist Visit	0%*	50%*	0%*	50%*
Telehealth	0%*	50%*	0%*	50%*
Teledoc	0%*	NA	0%*	NA
Routine Preventive Care	No charge	50%*	No charge	50%*
Outpatient Diagnostic (lab/X-ray)	0%*	50%*	0%*	50%*
Complex Imaging	0%*	50%*	0%*	50%*
Chiropractic	0%*	50%*	0%*	50%*
Ambulance	0%*	0%*	0%*	0%*
Emergency Room	0%*	0%*	0%*	0%*
Urgent Care Facility	0%	50%*	0%*	50%*
Inpatient Hospital Stay	0%*	50%*	0%*	50%*
Outpatient Surgery	0%*	50%*	0%*	50%*
Prescription Drugs (Tier 1 / Tier 2 / Tier 3 / Tier 4)				
Retail (31-day supply)	0%* / 0%* / 0%* / 0%*	If you use a Non-Network Pharmacy, you are responsible for payment upfront	0%* / 0%* / 0%* / 0%*	If you use a Non-Network Pharmacy, you are responsible for payment upfront
Retail / Mail Order (32-90 Day Supply) Cost Per Prescription	0%* / 0%* / 0%* / 0%*	If you use a Non-Network Pharmacy, you are responsible for payment upfront	0%* / 0%* / 0%* / 0%*	If you use a Non-Network Pharmacy, you are responsible for payment upfront

***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**

To be eligible for the HSA, you cannot be covered through Medicare Part A or Part B or TRICARE programs or enrolled in a PPO Plan. See the plan documents for full details.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Health Savings Account

The HDHP comes with a type of savings account called a health savings account (HSA). The HSA lets you set aside pre-tax dollars to help offset your annual deductible and pay for qualified health care expenses.

Here's how the HSA works:

- You contribute pre-tax funds to the HSA through automatic payroll deductions.
- In addition, we will contribute to your HSA; company contribution amounts can be found on the medical overview grid.
- Your contributions, in addition to the company's contributions, may not exceed the annual IRS limits listed below.

HSA Contribution Limit	2025
Employee Only	$4,300
Family (employee + 1 or more)	$8,550
Catch-up (age 55+)	$1,000

- You can withdraw HSA funds, tax free, to pay for qualified health care expenses now or in the future. Unused funds roll over from year to year and are yours to keep, even if you change medical plans or leave your employer.

Important Notes:

- You must meet certain eligibility requirements to have an HSA: You must a) be at least 18 years old, b) be covered under a qualified HDHP, c) not be enrolled in Medicare and d) cannot be claimed as a dependent on another person's tax return. For more information, visit **www.irs.gov/forms-pubs/about-publication-969**.
- For a complete list of qualified health care expenses, visit **www.irs.gov/forms-pubs/about-publication-502**.
- Adult children must be claimed as dependents on your tax return for their medical expenses to qualify for payment or reimbursement from your HSA.

Employer HSA Contributions

Coverage Level	
Employee Only Medical Election	$250
Employee Plus Dependent(s)	$500

If an employee elects a high deductible health plan, the above amounts are the Valsoft HSA annual contribution.

**These funds will be distributed monthly at the start of each month.

***For those enrolling in benefits after January 1, 2025, your employer contributed HSA funds will be prorated for the remainder of the year.

Dental - Ameritas

We are proud to offer you a dental plan. The following is a high-level overview of the coverage available. To check for in-network providers visit - https://www.ameritas.com/employee-benefits/find-a-provider/

Key Dental Benefits	Ameritas Dental	
	In-Network Only	Out-of-Network[1]
Deductible (per calendar year)		
Individual / Family	$25 / $75	N/A / N/A
Benefit Maximum (per calendar year; Preventive, Basic and Major services combined)		
Per Individual	$1,000	N/A
Covered Services		
Preventive Services	No charge	N/A
Basic Services	20%	N/A
Major Services	50%	N/A
Orthodontia (Child & Adult)	50%; $1,000 Max	N/A

Coinsurance percentages shown in the above chart represent what the member is responsible for paying.
***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

Voluntary Benefits - LFG

Our benefit plans are here to help you and your family live well—and stay well. But did you know that you can strengthen your coverage even further? It's true! Our voluntary benefits through **Lincoln Financial Group** are designed to complement your health care coverage and allow you to customize our benefits to you and your family's needs. The best part? Benefits from these plans are paid directly to you! Coverage is also available for your spouse and dependents. You can enroll in these plans during Open Enrollment—they're completely voluntary, which means you are responsible for paying for coverage at affordable group rates.

Hospital Indemnity Insurance

When you or a dependent need to be hospitalized, your family deserves to focus on their well-being, not the stress of the average three-day hospital stay, which can cost you $30,000[1]. Hospital indemnity insurance can help reduce costs by paying you or a covered dependent a benefit to help cover your deductible, coinsurance and other out-of-pocket costs due to a covered hospitalization.

Critical Illness

Most of us don't have an extra $7,000 ready to spend—and even if we do, we don't want to spend it on medical expenses. Unfortunately, the average cost to treat a critical illness is just that: $7,000[3]. But with critical illness insurance, you'll receive a lump-sum benefit if you are diagnosed with a covered condition. You can use this benefit however you like, including to help pay for: treatments, prescriptions, travel, increased living expenses and more.

Accident Insurance

Accident insurance can soften the financial impact of an accidental injury by paying a benefit to you to help cover the unexpected out-of-pocket costs related to treating your injuries. Some accidents, like breaking your leg, may seem straightforward: You visit the doctor, take an X-ray, put on a cast and rest up until you're healed. But in reality, treating a broken leg can cost up to $7,500[1]. And it's not only broken limbs—an average non-fatal injury could cost you $6,620 in medical bills[2]. When your medical bill arrives, you'll be relieved you have accident insurance on your side.

1. Why health insurance is important: Protection from high medical costs. HealthCare.gov
2. Average medical cost of fatal and non-fatal injuries by type in the USA, December 2019. National Library of Medicine.
3. MetLife Accident and Critical Illness Impact Study.
4. Cancer Facts & Figures, 2021. American Cancer Society.

Vision - Ameritas

We are proud to offer you a vision plan. The following is a high-level overview of the coverage available. To check for in-network providers visit - https://www.ameritas.com/employee-benefits/find-a-provider/

Key Vision Benefits	Ameritas	
	In-Network	Out-of-Network Reimbursement
Exam (once every 12 months)	$10	No charge
Materials Copay	$25	N/A
Lenses (once every 12 months)		
Single Vision	Covered in full	Up to $25
Bifocal	Covered in full	Up to $40
Trifocal	Covered in full	Up to $55
Frames (once every 24 months)	$130	Up to $65
Contact Lenses (once every 12 months; in lieu of glasses)	Up to $130	N/A

Disability - LFG

Disability insurance provides benefits that replace part of your lost income when you become unable to work due to a covered injury or illness.

Short-Term Disability	
Provided at NO COST to you through Lincoln Financial Group.	
Benefit Percentage	60%
Weekly Benefit Maximum	$1,750
When Benefits Begin	After 14th day of disability
Maximum Benefit Duration	11 weeks

Long-Term Disability	
Provided at NO COST to you through Lincoln Financial Group.	
Benefit Percentage	60%
Monthly Benefit Maximum	$7,500
When Benefits Begin	After 90th day of disability
Maximum Benefit Duration	Social Security Retirement Age

Life and AD&D - LFG

Life insurance provides your named beneficiary(ies) with a benefit after your death**. Accidental death and dismemberment (AD&D) insurance** provides specified benefits to you in the event of a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that your death occurs due to a covered accident, both the life and the AD&D benefit would be payable.

Basic Life/AD&D (Company-paid)

This benefit is provided at NO COST to you through Lincoln Financial Group.

Benefit Amount	
Benefit Amount 1x annual earnings, rounded to the next higher $1,000	Minimum: $50,000 Maximum: $100,000

Supplemental Life/AD&D (Employee-paid)

If you determine you need more than the basic coverage, you may purchase additional coverage through LFG for yourself and your eligible family members.

	Benefit Option	Guaranteed Issue[1]
Employee	$10,000 increments; maximum of $500,000	$100,000
Spouse/RDP	$5,000 increments; maximum of $250,000; not to exceed 50% of spouse	$30,000
Child(ren)	$2,000 increments	$10,000

1. During your initial eligibility period only, you can receive coverage up to the Guaranteed Issue amounts without having to provide Evidence of Insurability (EOI, or information about your health). Coverage amounts that require EOI will not be effective unless approved by the insurance carrier.

- At their INITIAL Enrollment: Employees are GI $100,000, spouses at $30,000, no EOI ever asked for on kids.
- On subsequent annual limited open enrollments, employees can increase their coverage two increments of $10,000.
  - Example: Someone at 0 can move to $20,000, or someone at $100,000 can move to $120,000
  - Spouses can increase annually by 2 increments of $5,000

Flexible Spending Accounts

We provide you with an opportunity to participate in our flexible spending accounts (FSAs) administered by Health Equity. FSAs allow you to set aside a portion of your income, before taxes, to pay for qualified health care and/or dependent care expenses. Because that portion of your income is not taxed, you pay less in federal income, Social Security and Medicare taxes.

Health Care FSA

For 2025, you may contribute up to $3,300 to cover qualified health care expenses incurred by you, your spouse and your children up to age 26. Some qualified expenses include:

- Coinsurance
- Copayments
- Deductibles
- Prescriptions and Over-the-Counter Drugs
- Menstrual Care
- Dental treatment
- Orthodontia
- Eye Exams, Materials, LASIK

For a complete list of eligible expenses, visit **www.irs.gov/pub/irs-pdf/p502.pdf**.

Limited-Purpose Health Care FSA (for HSA participants)

If you enroll in the HSA medical plan, you may only participate in a limited-purpose Health Care FSA. This type of FSA allows you to be reimbursed for eligible dental, orthodontia and vision expenses while preserving your HSA funds for eligible medical expenses.

Dependent Care FSA

For 2025, you may contribute up to $5,000 (per family) to cover eligible dependent care expenses ($2,500 if you and your spouse file separate tax returns). Some qualified expenses include:

- Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or daycare centers
- Care of a household member who is physically or mentally incapable of caring for him/herself and qualifies as your federal tax dependent

For a complete list of eligible expenses, visit www.irs.gov/pub/irs-pdf/p503.pdf.

FSA Rules

YOU MUST ENROLL EACH YEAR TO PARTICIPATE

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

Health Care FSA: Unused funds will **NOT** be returned to you or carried over to the following year.

Dependent Care FSA: Unused funds will **NOT** be returned to you or carried over to the following year.

You can incur expenses through December 31, 2025, and must file claims by March 31,2026.

Cost of Benefits

Your contributions toward the cost of benefits are automatically deducted from your paycheck before taxes. The amount will depend upon the plan you select and if you choose to cover eligible family members. Please see the Benefits Team for your rate sheet.

Contact Information

Coverage	Carrier	Phone #	Website/Email
Medical	UMR	(800) 826-9781	umr.com
Dental	Ameritas	(800) 487-5553	ameritas.com
Vision	Ameritas	(866) 289-0614	ameritas.com
Health Savings Account (HSA)	Health Equity	(866) 346-5800	healthequity.com
Life/AD&D	Lincoln Financial Group	(800) 423-2765	lincolnfinancial.com
Disability	Lincoln Financial Group	(800) 423-2765	lincolnfinancial.com
Voluntary Plans	Lincoln Financial Group	(800) 423-2765	lincolnfinancial.com

Benefits Website

Our benefits website **https://lfg.benselect.com/enroll/login** can be accessed anytime you want additional information on our benefit programs.

Questions?

If you have additional questions, you may also contact:

Benefits Team
benefits@valsoftcorp.com

DISCLAIMER: The material in this benefits brochure is for informational purposes only and is neither an offer of coverage or medical or legal advice. It contains only a partial description of plan or program benefits and does not constitute a contract. Please refer to the Summary Plan Description (SPD) for complete plan details. In case of a conflict between your plan documents and this information, the plan documents will always govern. **Annual Notices:** ERISA and various other state and federal laws require that employers provide disclosure and annual notices to their plan participants. The company will distribute all required notices annually.

VALSOFT

2025
Benefits

Notices

Medicare Part D Creditable Coverage Notice

Important Notice from Valsoft 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 **Valsoft** (the "Plan Sponsor") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

(1) Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

(2) The Plan Sponsor has determined that the prescription drug coverage offered by the **Valsoft** is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore

considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Plan Sponsor coverage may be affected. Moreover, if you do decide to join a Medicare drug plan and drop your current Plan Sponsor coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact the person listed at the end of this notice for more information about what happens to your coverage if you enroll in a Medicare Part D prescription Drug Plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with the Plan Sponsor and don't join a Medicare drug plan within 63

continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the Plan Sponsor changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You"

handbook for their telephone number) for personalized help
Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date: 10/15/2023
Name of Entity/Sender: **Valsoft**
Contact-Position/Office: Human Resources
Address: Valsoft, Inc 233 North 8th Street Suite 30
Lincoln, NE 68508
Phone Number: (402) 420-2430

CHIPRA/CHIP Notice

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, 2024. Contact your State for more information on eligibility:

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

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – 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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	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 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access (https://dvha.vermont.gov/members/medicaid/hipp-program) Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid and CHIP	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) (https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1 855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	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, 2023, or for more information on special enrollment rights, contact either:

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

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

Annual Notice of Women's Health and Cancer Rights Act

Do you know that your plan, as required by the Women's Health and Cancer Right Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses and treatment for complications resulting from a mastectomy, including lymphedema? Call your plan administrator at **benefits@valsoftcorp.com** for more information.

Notice of Availability of HIPAA Notice of Privacy Practices

To: Participants in the Health, Dental, and Vision Plans
From: Valsoft.

Re: Availability of Notice of Privacy Practices

The Health, Dental, and Vision Plans (each a "Plan") maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact Human Resources at **benefits@valsoftcorp.com**.

Notice of Marketplace Coverage Options

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% 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 November 30, 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 November 30, 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 November 30, 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 by your employer, please check your summary plan description or contact. Human Resources at **benefits@valsoftcorp.com**.

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

[1] An employer-sponsored 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.

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 Valsoft.		4. Employer Identification Number (EIN) 611907255
5. Employer address, 7. City, 8. State, 9. Zip Code 233 North 8th Street Suite 30 Lincoln, NE 68508		6. Employer phone number (402) 420-2430
10. Who can we contact about employee health coverage at this job? Ruben Zazyan – Human Resources		
11. Phone number (if different from above)	12. Email address **benefits@valsoftcorp.com**	

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

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

    You are an eligible if you are a full-time employee working 30 or more hours per week.

  - ☐ Some employees. Eligible employees are:

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Your legal spouse, your married or unmarried biological dependent children (under the age of 26).

  - ☐ We do not offer coverage.

☒ 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.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no later than 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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. However, you must request enrollment no later than 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009, if either of the following two events occur, you will have 60 days after the date of the event to request enrollment in your employer's plan:

- Your dependents lose Medicaid or CHIP coverage because they are no longer eligible.
- Your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event *and* provide the employer plan with timely notice of the event and your enrollment request.

To request special enrollment or obtain more information, contact Human Resources at **benefits@valsoftcorp.com**.