

HM • CLAUSE



2026-2027 Benefit Guide Regular Full-Time

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2026–2027 Benefit Guide

Regular Full-Time



Health
that supports you



Benefits
that fit your life



Security
for what matters



**People.
Wellness.
Together.**

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Coverage	Contact	Group #	Phone	Website	Email
Benefits Portal / App				ourbenefitsinfo.com	
Benefit Assistance / Helpline	Health Advocate		877-619-3435	Healthadvocate.com/members	answers@healthadvocate.com
Medical	Blue Shield of CA	W3000986	866-346-7198	blueshieldca.com	
Family Building (Blue Shield participants only)	Maven			mavenclinic.com	
24/7 NurseLine	Blue Shield of CA		877-304-0504		
Dental	Delta Dental	DPPO: 00511	800-765-6003	deltadentalins.com	
	Delta Dental	HMO: 70602	800-422-4234	deltadentalins.com	
Vision	VSP	30058404	800-877-7195	vsp.com	
Pharmacy Retail Rx	Navitus	HMC	844-268-9789	Navitus.com	
Pharmacy Mail Order	Birdi		888-240-2211	Birdirx.com	
Pharmacy Specialty Rx	Lumicera		855-847-3553	Lumicera.com	
Flexible Spending Account (FSA)	Health Equity		866-346-5800	Healthequity.com	memberservices@healthequity.com
Health Savings Account (HSA)	Health Equity		866-346-5800	Healthequity.com	memberservices@healthequity.com
Employee Assistance Program	Health Advocate		866-799-2728	Healthadvocate.com/members	answers@healthadvocate.com
Wellness Program	HealthCheck 360		866-511-0360 x5099	myHealthCheck360.com	support@healthcheck360.com
Life and AD&D	Unum	474059	800-421-0344	unum.com	askunum@unum.com
Disability	Unum	142600	800-421-0344	unum.com	askunum@unum.com
Legal Plan	ARAG	17943	800-247-4184	ARAGlegal.com	
Voluntary Products	Unum	Accident 805091 Critical Illness 805092 Hospital Indemnity 805093	800-635-5597	unum.com	
Business Travel Accident (U.S. and Canada)	Zurich	ZE 931078 50-10	844-632-0002	zurichtravelassist.com	
Business Travel Accident (Outside U.S and Canada)	Zurich	ZE 931078 50-10	416-646-5602	zurichtravelassist.com	
Retirement 401k	Empower	700201	877-778-2100	empowermyretirement.com	
Retirement Pension	Empower	17404	877-778-2100	empowermyretirement.com	

Welcome to HM Clause!

“At HM.CLAUSE we aim to become the Company of Choice for our customers, employees and communities where we operate.”

As part of your total rewards package, we are pleased to offer a comprehensive array of quality benefits to protect your health, your family and your way of life, such as healthcare, retirement, flexible spending accounts, educational assistance, pre paid legal plan, and life & disability benefits.

At HM Clause, we believe in empowering our employees to make informed decisions when it comes to selecting benefits options that work best for them and their families. That’s why we’ve put together this comprehensive guide, aimed at answering some of the basic questions you may have about your benefits.

So, grab a cup of coffee and take a few moments to read through this guide, along with any supplemental materials you may have received. We’ve also made additional detailed information available online at ourbenefitsinfo.com, our self-service website. Be sure to check it out and take advantage of all the resources we’ve made available to you.

Eligibility

HM Clause is pleased to announce our 2026 benefits program for our valued employees and their families. We've designed a benefits package with a variety of coverage options because we want to help you stay healthy, feel secure, and maintain a work/life balance. For full details about our plans, please refer to the summary plan descriptions, which are located on the Benefits Website at <https://www.ourbenefitsinfo.com/>.

REGULAR FULL-TIME ELIGIBILITY

In general, regular full-time employees working 30 or more hours per week are eligible for the benefits outlined in this overview.

ELIGIBLE DEPENDENTS

- Your spouse (the person you are legally married to under state law, including same-sex spouse).
- Your same gender domestic partner OR opposite gender domestic partner is eligible for coverage with proof of registration (in states where it is allowed) or you have completed a Domestic Partner Affidavit (email hr.ampa@hmclause.com for a copy).
- Your children or your Domestic Partner's children:
 - *Under age 26 are generally eligible to enroll in coverage. They do not have to live with you or be enrolled in school. They can be married and/or living and working on their own.*
 - *Over age 26 ONLY if they are incapacitated due to a disability and primarily dependent on you for support.*

For age 26 and over, please refer to the benefit booklets for each benefit.

If you experience a Qualifying Event and need to change your coverage, you must contact benefits@hmclause.com within 31 days following the event. If you miss the deadline and fail to make election changes, you must wait until the next Open Enrollment period to make changes. Please contact HR for more information.

WHEN YOU CAN ENROLL

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins on the first of the month coinciding with or next following the date of hire as long as you enroll within 31 days of becoming eligible. If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason or if you experience a Qualifying Life Event).

HMC Employee New Hire Benefits Orientation (Presentation)

Thank you for taking a moment to view the HMC Employee New Hire Presentation. You may also view this presentation on your mobile device:



Wellness Program

WHAT IS LIFESTYLE REWARDS?

The Lifestyle Rewards program allows you to build healthy habits through the workplace, the community, and at home. By setting small goals and consistently meeting those goals over the course of the year, you will build healthy habits that benefit your overall health. We would like to reward you for taking the next steps and engaging in year round activities that benefit your well being. Upon creating an account on myHealthCheck360, you will have access to Lifestyle Rewards and can begin earning points by completing a variety of different activities. We believe little steps over time can lead to positive changes to your health and well being.

WHY PARTICIPATE IN LIFESTYLE REWARDS?

Lifestyle Rewards is designed with you in mind. You are in charge of your own unique wellness journey though you do not have to do it alone! Benefits to participating include:

- » *Improving your health score*
- » *Techniques for helping you manage stress*
- » *Learning how to build small, sustainable healthy habits to be the best version of yourself*
- » *Being happier and healthier*

We understand that you are on the go, so your wellness program needs to be easily accessible anywhere, anytime. That's why HealthCheck360 brings the support and tools through the convenience of the myHealthCheck360 app. The goal to earn your incentive is to accumulate 400 points from the list of activities on the next page.

Lifestyle Rewards Activities

Activity	Points Per Activity	Maximum Points	Validation
Goal: Replace with: Earn 400 points from the activities below *Required Activities to earn wellness credit			
Download the myHealthCheck360 app	25	25	Submit for your points from the myHealthCheck360 mobile app.
Biometric Screening*	75	75	Points will be rewarded when your results are in the HC360 system.
Take Survey*	50	50	Points will be rewarded when you complete your survey.
Health Score of 75 or above or Improve your previous score by 5+ points	75	75	Points will be rewarded when your results are in the HC360 system.
Complete a Preventative Care Exam ** (Minimum of two required between July 1 and April 30 following year)	40	160	Preventative exams can include annual preventative exams, preventative dental services, and optometry visits.
Complete a Company Sponsored Challenge (Total of 6 events will be held during the Benefit Year)	20 for participation	120	Track at least once a week on your myHealthCheck360 portal during the challenge to earn points.
Complete a shortened Company Sponsored Challenge (2 weeks)	20	25	Track at least once a week on your myHealthCheck360 portal during the challenge to earn points.
Complete a HealthCheck360 Pathway or watch a HealthCheck360 webinar	15	50	Watch a webinar through your myHealthCheck360 portal and submit your completion.
Complete a Local Activity	25	75	Participate in a local activity. (5k walk or run, receive flu shot, volunteer, participate in food drive).
Receive routine or recommended vaccinations (influenza, COVID-19, or other applicable vaccinations)	35	140	Log into your myHealthCheck360 portal and submit your completion.
Fax Results to Physician	40	40	Submit your biometric screening results to your doctor through HC360+ portal.
TOTAL POINTS AVAILABLE		790+	

HEALTHCHECK 360 RESOURCES

HealthCheck360 is your well-being partner, devoted to improving your health and overall well-being. HealthCheck360 provides you with the tools, motivation, and support to assist you in your journey to a healthier you.

CHECK OUT THESE GREAT RESOURCES



**Download the
mobile app!**

AVAILABLE TO YOU:

Mobile App

The HealthCheck360 mobile app allows you to access all parts of your program and your health results on the go.

Unlimited Health Coaching

Contact us at 866-511-0360 ext. 5099 to speak to a health coach anytime, completely free.

Blog Articles

Subscribe to the HealthCheck360 blog to get recipes, exercises, health tips and more!

Social Media

Follow up on Facebook, Twitter, and Instagram for quick tips year-around.



Get more than ever before with the myHealthCheck360 mobile app. More access, more support, and better tracking. Get started with the myHealthCheck360 mobile app by following the steps below.

Create your account from your desktop computer

- » Go to myHealthCheck360.com
- » Click the link to Create a new account
- » Complete the onscreen details with your information.
 - » Your company code is HMCLS
 - » Your unique identifier is your last 4 SSN
- » Agree to the terms and conditions and click Sign Up

Create your account from the mobile app

- » Download the myHealthCheck360 app
- » Click Create an account and enter your information
 - » Your company code is HMCLS
 - » Your unique identifier is your last 4 SSN
- » Agree to the terms and conditions and click SIGN UP

Connect your device

Get the most from your myHealthCheck360 experience by connecting a device like Garmin, or a tracking app like Apple Health or My FitnessPal.

To connect to a device

- » Select More at the bottom of your screen
- » Select Connect Apps & Devices
- » Find your fitness app or device and select Connect
- » Select OK and login to your fitness app's account

How To Enroll Online

1. Using MS Edge, sign onto ADP through your single-sign on or website: <https://workforcenow.adp.com>.
2. Enter your credentials
3. If you cannot remember your user id or password, click on “Need help signing in”.
4. Select the applicable Enrollment event. If new hire > select New Hire Enrollment. If for Open Enrollment, select Open Enrollment..
5. Move through the pages to make elections as desired. If a benefit appears that you do not want to elect, select the Waive option.
6. Once all possible elections are made, ADP will provide a summary of costs. Click Submit once benefits are reviewed and ready to confirm election..
 - a. For your own records and documentation, we highly encourage that you print or download a copy of the elections you made in the enrollment session.

ADDING DEPENDENTS

If adding dependents to your insurance plans, the following documents are required and need to be uploaded into ADP at time of enrollment or emailed to hr.ampa@hmclause.com within two weeks of your benefit elections.

For adding a spouse:

- Copy of marriage license dated within 1 year AND copy of spouse’s Social Security Card, OR
- Copy of the first page of your latest federal or state tax return.

For adding children:

- Copy of each child’s birth certificate AND copy of each child’s Social Security Card, OR
- Copy of most recent federal / state tax return with dependent’s social listed

Medical Plans

Our medical coverage provides you and your family the protection you need for everyday health issues or when the unexpected happens. You can choose from any of the medical plans. Each medical plan offers: comprehensive healthcare benefits, coverage for eligible children up to age 26, in network preventive care covered at 100%, and prescription drug coverage.

CHOOSE THE PLAN THAT'S RIGHT FOR YOU

AVAILABLE PLANS

Blue Shield Preferred Provider Organization (PPO) The Blue Shield PPO plan provides greater freedom of choice by putting you in charge of where, when and from whom you receive medical care. However, optimal use of the plan requires that you pay strict attention to the PPO Network. PPO Network providers have contracted with the insurance company and have agreed to provide their services at a significant discount to their normal charges.

Blue Shield High Deductible Health Plan (HDHP)

When you are enrolled in the Blue Shield HDHP, you have the benefits of a PPO plan, plus an option to enjoy the added value of a tax advantaged Health Savings Account (HSA). To learn more about the HSA, please see the next page.

Blue Shield Exclusive Provider Organization (EPO)

EPO plans are a lot like HMOs. They generally do not cover care outside the plan's provider network. Members however, may not need a referral to see a specialist as long as you use the doctors and hospitals within Blue Shield's PPO network, but you cannot go outside the network for care. The key difference between the plans is the amount of money you'll pay each pay period and when you need care.

KEY TERMS TO KNOW

Annual deductible amount – The amount you pay each year for eligible in network and out of network charges before the plan begins to pay. All covered expenses accumulate toward both the in network and/or out of network deductible.

Out of pocket maximums – The most you will pay each year for eligible network services including prescriptions. All covered expenses accumulate toward both the in network and/or out of network out of pocket maximum.

Copay and coinsurance – Money you pay toward the cost of covered services. Copays do not accumulate toward the deductible; they do accumulate toward the out of pocket maximum.

Embedded Deductible – When a health plan has embedded deductibles, it just means that a single member of a family doesn't have to meet the full family deductible for after deductible benefits to kick in. They will only need to meet the individual portion within the family deductible.

To help you make an informed choice, a SUMMARY OF BENEFITS AND COVERAGE (SBC) provides an easy to understand summary about our health plans' benefits and coverage, making it easier to compare the different plans. SBCs are available on ourbenefitsinfo.com.

To obtain a hard copy, please contact HR at benefits@hmclause.com.

HMC Medical Benefits

Nothing is more important than good health, and it is recognized that all employees and their families have different needs when it comes to selecting their medical plan. That's why HMC provides plan choices that help you and your family maintain optimum health care.

	Blue Shield Standard PPO		Blue Shield Choice PPO		Blue Shield HDHP		Blue Shield EPO (CA Only)
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Calendar Year Deductible							
Individual	\$500	\$1,500	\$2,000	\$4,000	\$3,000	\$4,500	\$500
Family	\$1,000	\$3,000	\$4,000	\$8,000	\$6,000	\$9,000	\$1,000
Calendar Year Out of Pocket Maximum (Includes Deductible)							
Individual	\$1,875	\$3,750	\$5,000	\$10,000	\$6,000	\$12,000	\$4,000
Family	\$3,750	\$7,500	\$10,000	\$20,000	\$12,000	\$24,000	\$8,000
Copay / Coinsurance							
Telemedicine	\$20	Not Covered	\$30	Not Covered	\$30*	40%*	\$20
Preventive Care	\$0	30%*	\$0	40%*	\$0*	40%*	\$0
Primary Care Physician	\$20	30%*	\$30	40%*	\$30*	40%*	\$20
Specialist	\$30	30%*	\$30	40%*	\$30*	40%*	\$20
Urgent Care	\$30	30%*	\$30	40%*	\$30*	40%*	\$20
Emergency Room	10%*	10%*	20%*	20%*	20%*	20%*	\$100* ¹
Chiropractic	10%*	30%*	20%*	40%*	20%*	40%*	\$20
Infertility - Lifetime	\$5,000		\$5,000		\$5,000		\$5,000
PHARMACY							
Retail Rx (up to 30-day supply)							
Generic	\$15	\$15	\$20	\$20	\$20*	\$20*	\$10
Formulary Brand	\$30	\$30	\$35	\$35	\$35*	\$35*	\$25
Non-Formulary	\$55	\$55	\$60	\$60	\$60*	\$60*	\$50
Specialty	20% up to \$90	Not Covered	20% up to \$90	Not Covered	20% up to \$90	Not Covered	20% up to \$90
Mail Order Rx (HMC: up to 90-day supply)							
Generic	\$30	Not Covered	\$40	Not Covered	\$40*	Not Covered	\$20
Formulary Brand	\$60	Not Covered	\$70	Not Covered	\$70*	Not Covered	\$50
Non-Formulary	\$110	Not Covered	\$120	Not Covered	\$120*	Not Covered	\$100

*subject to deductible

¹Copay waived if admitted

The HDHP and HSA: How They Work Together

Together, your contribution can cover a portion of your deductible and coinsurance.



Free In-Network Preventive Care

To emphasize the importance of wellness, preventive care is covered at 100% if you receive this care from in-network providers.



Deductible

You pay for your initial medical costs until you meet your annual deductible. This deductible is higher compared to the other medical plan but offset by HAS contributions you may make.



Coinsurance

Once the deductible is met, you and the Company share any further health care costs until you meet the out-of-pocket maximum.

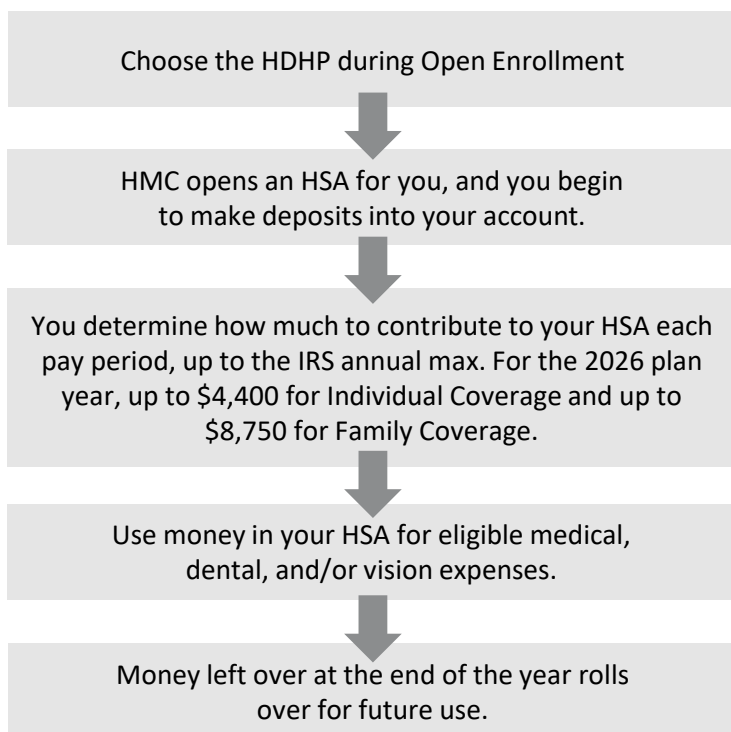


Out-of-Pocket Maximum

The plan limits the total amount you'll pay each year. Once you meet your out-of-pocket maximum, the plan pays 100% of your eligible, in-network expenses for the remainder of the year.

How the HSA Works

Please note: Funds available for reimbursement are limited to the balance in your HSA.



Yolanda enrolls herself only in the HDHP with HSA. She chooses to use her HSA to pay for covered services – this reduces her out-of-pocket amount needed to meet her deductible before her health plan begins to pay.

YEAR 1 EXAMPLE	YEAR 2 EXAMPLE
Yolanda contributes \$3,000 to her HSA	Yolanda contributes \$3,000 toward her HSA for the plan year
	\$2,300 rolls over from last year for a total of \$5,300
She uses her HSA to pay \$700 of eligible expenses	She uses her HSA to pay \$1,250 of eligible expenses
She has \$2,300 in her HSA to roll over to next year!	She has \$4,050 in her HSA to roll over to next year!

Maven and Blue Shield's Additional Programs

Blue Shield Connect	Blue Shield's highest-level service model providing members real time assistance with clinical outreach, claims and provider assistance
Advanced Imaging	Radiology benefit management for non-emergent, advanced, outpatient radiology services including CT, MRI, MRA, PET and cardiac nuclear medicine.
Spine and Pain Management	Utilization management program designed to ensure that key spine procedures are delivered according to national clinical guidelines. Includes outpatient and non-emergent inpatient lumbar and cervical spine surgery, as well as outpatient interventional patient pain management.
Teladoc Behavioral Health	Available through Teladoc's General Medical Services only, offers experienced psychiatrists, psychologists, therapists, and social workers to help provide relief of issues like addiction, depression, stress or anxiety , domestic abuse, grief counseling and more. The confidential consultations must be scheduled in advance and may be conducted over phone or online video.
Wellvolution	A lifestyle medicine platform that creates a personalized path to help with everything from improving nutrition, to getting better sleep, preventing diabetes, along with providing tools based on your lifestyle goals.
Maven	Personalized support for family building, pos partum, parenting & pediatrics, menopause. Maven Wallet available for adoption and surrogacy.

Dental Plan

Your dental health is an important part of your overall wellness. Dental insurance gives you a reason to smile. It's affordable and covers preventive care (including regular checkups) as well as fillings, bridges, crowns and other dental services.

When you enroll in the Dental plan, you may visit any dentist you choose, but in-network providers offer larger discounts and can file your claims for you. If you prefer to see an out of network provider, keep in mind, since they are not under a contract, they may charge you for any amount billed in excess of the negotiated discounted rate.

Our dental plan is covered through Delta Dental PPO. You can choose from 2 plans, the Dental PPO Plan or DHMO Plan (California Only). Visit their website at www.deltadentalins.com and to find a dentist in your area or call Delta Dental at PPO: 800-765-6003 and HMO: 800-422-4234.

	Delta Dental DPPO			Delta DHMO
	PPO Network	Premier Network	Out-of-Network	In-Network
Calendar Year Deductible and Annual Plan Maximum				
Deductible Individual / Family	\$25 / \$75	\$50 / \$150	\$50 / \$150	\$0 / \$0
Annual Maximum for Basic and Major Services	\$2,000 per individual	\$1,200 per individual (Combined w/ in-network)	\$1,200 per individual (Combined w/ in-network)	Unlimited
Preventive Care Services				
Exams, Cleanings, X-rays, Fluoride Treatments	\$0	\$0	\$0	Schedule of Benefits
Basic Services				
Fillings, Space Maintainers, Sealants, Extractions, Oral Surgery, Endodontics, Periodontics, Emergency Exams	20%*	20%	20%	Schedule of Benefits
Major Services				
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	40%*	50%*	50%*	Schedule of Benefits
Orthodontia				
Adults and Children (to age 26)	50%*	50%*	50%*	Schedule of Benefits
Lifetime Orthodontia Maximum	\$1,500 per individual	\$1,000 per individual	\$1,000 per individual	Unlimited
* Deductible and coinsurance amounts represent what you pay for services				

This chart contains a brief overview of your dental plan options. It is limited in scope and is not intended to replace or represent complete plan descriptions. Please refer to the applicable Evidence of Coverage (EOC) booklet, for complete descriptions of benefits, exclusions and limitations under the plan.

Vision Plan

You may elect vision care coverage, which provides affordable, quality vision care nationwide. Although vision care services and supplies are covered in network and out of network, your benefits are generally greater when you use in network providers.

You pay copay shown and any amount over allowance.	IN NETWORK	OUT OF NETWORK
	You Pay	Reimbursement
Cost		
Exam	\$0	Up to \$45
Materials	\$20	Reimbursed by item
Covered Services - Standard Lenses and Frames		
Single Lenses	\$0 of basic lens	Up to \$30
Bifocals	\$0 of basic lens	Up to \$50
Trifocals	\$0 of basic lens	Up to \$65
Frames	\$150 allowance + 20% of balance	Up to \$70
Covered Services Contacts in lieu of Frames/Lenses		
Contacts Elective	\$150 allowance	Up to \$105
Benefit Frequency	Once every 12 months	Once every 12 months
Exams / Lenses / Frames / Contacts		
Exams	Once every 12 months	
Lenses / Frames / Contacts	Once every 12 months	

If covered services are received from a non-participating provider, you are responsible for paying the provider in full. You or the provider must submit the itemized bill and a copy of your prescription with the Claim Form to VSP.

EXTRA DISCOUNTS AND SAVINGS

- » *Laser Vision Correction average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.*
- » *TruHearing Discount receive discounts on hearing aids and additional batteries by enrolling at www.truhearing.com/vsp or by calling 877-396-7194 to schedule an appointment for an exam and discounts on hearing aids.*

No ID card is necessary, and there are no claim forms to complete when you see a contracted provider. Any questions about your vision coverage can be directed to VSP by calling 800-877-7195 or visiting www.vsp.com.

PROTEC SAFETY FRAME

Effective 1/1/2025, under the ProTec Safety Plan, members have a choice when selecting your American Standards Institute (ANSI) certified safety frames:

- Covered in full from the Protec Eyewear® Collection
 - Based on frame type, ProTec Eyewear safety frames include detachable side shield (permanent are available) and a frame case
- Covered in full up to the retail frame allowance \$65 from the doctor's safety frame collection
 - 20% savings on any amount above the retail allowance
- Covered in full safety frame from any Visionworks location

This chart contains a brief overview of your vision plan options. It is limited in scope and is not intended to replace or represent complete plan descriptions. Please refer to the applicable Evidence of Coverage (EOC) booklet, for complete descriptions of benefits, exclusions and limitations under the plan.

Monthly Premium Rates

Premium Rates are deducted semi-monthly on a pretax basis through payroll with the exception of Domestic Partners (DP). DP contributions are the same for those who cover a legal spouse. However, due to IRS restrictions, the additional cost of Domestic Partner coverage is paid post-tax and the value of Domestic Partner coverage will be taxable as imputed income. (Imputed Income is included in your paycheck and year-end W-2 and is subject to all applicable taxes.) Please call HR for more information.

WELLNESS RATES

If you are participating in HMC's Wellness Plan, below are your monthly payroll deductions.

MEDICAL	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Blue Shield EPO	\$214.40	\$483.06	\$441.46	\$691.08
Blue Shield Standard PPO	\$198.76	\$455.98	\$414.90	\$650.20
Blue Shield Choice PPO	\$112.90	\$257.50	\$234.58	\$368.88
Blue Shield HDHP	\$87.46	\$204.34	\$185.22	\$274.89
DENTAL	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Delta Dental DPPO	\$14.00	\$30.00	\$26.00	\$42.00
Delta Dental DHMO	\$6.18	\$12.36	\$12.36	\$18.54
VISION	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
VSP Vision	\$5.50	\$13.00	\$11.00	\$17.50

NON-WELLNESS RATES

If you are **not** participating in HMC's Wellness Plan, below are your monthly payroll deductions.

MEDICAL	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Blue Shield EPO	\$306.30	\$690.06	\$630.64	\$987.26
Blue Shield Standard PPO	\$217.81	\$499.63	\$454.67	\$712.48
Blue Shield Choice PPO	\$161.28	\$367.86	\$335.10	\$526.98
Blue Shield HDHP	\$124.96	\$291.90	\$264.60	\$392.70
DENTAL	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
Delta Dental DPPO	\$14.00	\$30.00	\$26.00	\$42.00
Delta Dental DHMO	\$6.18	\$12.36	\$12.36	\$18.54
VISION	Employee	Employee + Spouse	Employee + Child(ren)	Employee + Family
VSP Vision	\$5.50	\$13.00	\$11.00	\$17.50

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify HM. Clause, Inc. if your domestic partner is your tax dependent.

Flexible Spending Accounts

Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using tax free dollars. **There are three types of FSAs — the Health Care FSA, the Limited Purpose Health Care FSA and the Dependent Care FSA:**

Examples of expenses eligible for reimbursement
from your Flexible spending accounts.

IT'S EASY TO USE THESE ACCOUNTS

1

First, you contribute to the account(s) with pretax dollars deducted from your paycheck. That means no taxes (federal, state or Social Security) will be withheld from any of those dollars.

2

Then, you pay for certain eligible expenses out of your pocket as usual. You may use your debit card or submit a claim (along with the appropriate documentation) to be reimbursed for those expenses from the dollars in your account.

IMPORTANT NOTES!

- » *The Health Care FSA and the Limited Purpose Health Care FSA has a rollover provision, allowing you to rollover \$680 unused funds to the following year.*
- » *Dependent Care FSA is used to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time.*
- » *For the Dependent Care FSA, you can contribute up to \$7,500 per year, pretax if filing jointly, or \$3,750 if filing separately. Any unused funds will be forfeited at the end of the calendar year.*
- » *You cannot use your Health Care FSA to pay for Dependent Care expenses.*

Group Life and Accidental Death & Dismemberment (AD&D)

HMC provides basic group life insurance, accidental death & dismemberment (AD&D) coverage, as well as short-term and long-term disability coverage through Unum to help protect you and your family members from financial hardships. You are automatically enrolled in these benefits.

ELIGIBILITY

You are eligible for life and disability insurance if you work at least 30 hours per week per HR records, effective the 1st of the month after date of hire.

GROUP LIFE INSURANCE AND AD&D COVERAGE

You are automatically enrolled in Basic Term Life and AD&D insurance and covered for 1.5 times your annual salary, up to \$350,000.

SHORT TERM DISABILITY COVERAGE

Your weekly STD benefits will be 60% of your weekly pre-disability earnings, up to a maximum of \$1,500 less deductible sources of income. Benefit begins after 7 days of disability. Benefits begin immediately if hospitalized. Enrollment is automatic for employees in all states except CA, HI, NJ, NY, and RI. Employees in these states have access to Short-Term Disability through another program, with benefits varying from state to state.

LONG TERM DISABILITY COVERAGE

Your monthly LTD Disability benefits will be 60% of your monthly pre-disability earnings, up to a maximum of \$5,000 less deductible sources of income. Benefit begins after 180 days of disability, and payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

If you are in California, your monthly LTD Disability benefits will be 60% of your monthly pre-disability earnings, up to a maximum of \$5,000 less deductible sources of income. Benefit begins after 365 days of disability, and payments will last until you reach age 65 or until you reach your Social Security Normal Retirement Age.

NOTE ABOUT IMPUTED INCOME

Under current tax laws, imputed income is the value of your Basic Life insurance that exceeds \$50,000 and is subject to federal income, Social Security, and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

BENEFICIARY REMINDER

Make sure that you have a named beneficiary for your life insurance benefit and update it if your family or marital status changes.



Voluntary Life and Accidental Death & Dismemberment (AD&D)

Voluntary Life insurance for you, your spouse, and children can help protect your family during difficult times. Eligible employees may purchase Voluntary Life and AD&D for themselves and their family. Please note that in order for your dependents to be eligible for coverage, you must also elect.

COVERAGE FOR	COVERAGE AVAILABLE
EMPLOYEE	Increments of \$10,000 up to 5 times your salary to a maximum of \$650,000
SPOUSE	Increments of \$5,000 up to \$250,000
CHILDREN	Increments of \$2,000 to a maximum of \$20,000; Live birth to 6 months: \$1,000

You may purchase additional Voluntary Life and AD&D insurance for you, your spouse and child(ren). Employees who elect coverage when first eligible can elect up to \$200,000 for employees, \$25,000 for spouses and \$20,000 for children “Guaranteed Issue” (GI) amounts without answering health questions or taking a health exam (“Evidence of Insurability”, or EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

AGE	EMPLOYEE & SPOUSE COST PER \$1,000
Under 25	\$0.060
25-29	\$0.070
30-34	\$0.080
35-39	\$0.090
40-44	\$0.120
45-49	\$0.200
50-54	\$0.330
55-59	\$0.510
60-64	\$0.790
65-69	\$1.420
70-74	\$2.540
75+	\$2.540
Child(ren)	\$0.200
AD&D MONTHLY COST	
Employee	\$0.014
Spouse	\$0.014
Child(ren)	\$0.034



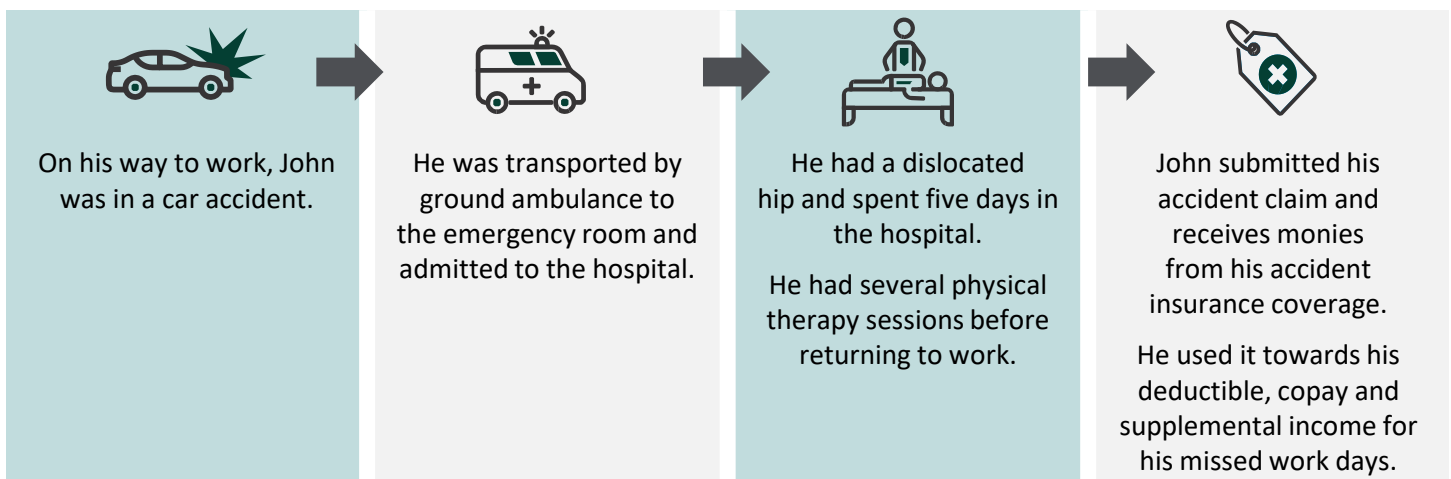
Accident Insurance

Just as it sounds, Accident insurance can help you pay for costs you may incur after an accidental injury. This type of injury includes things such as a car accident, a fall while skiing or even a fall down the stairs at home. This benefit is paid regardless of any other insurance coverage you might have (including your medical coverage).

	Emergency Room Visits		Medical Exams – including major diagnostic exams
	Hospital Stays		Physical Therapy
	Fractures and Dislocations		Transportation and Lodging – if you are away from home when the accident happens

HOW THE PLAN WORKS

Again, these benefits are in addition to any health insurance benefits you may receive. The benefit amount is paid directly to you. You can use this money in any way you like, including deductibles, childcare, housecleaning, groceries, utilities, or any purpose that can help you meet your personal, financial or household needs. Below is an example.



Example of benefit amounts you receive for the following:

Ground Ambulance	\$300	Urgent Care	\$75	Hip Joint	\$3,375
Emergency Room	\$100	Hospital Stay – Admission	\$1,000	Concussion	\$200
X-ray	\$50	Hospital Stay – Daily	\$300	Physical Therapy (10 sessions)	\$20

Please refer to the benefit summary for details of this coverage.

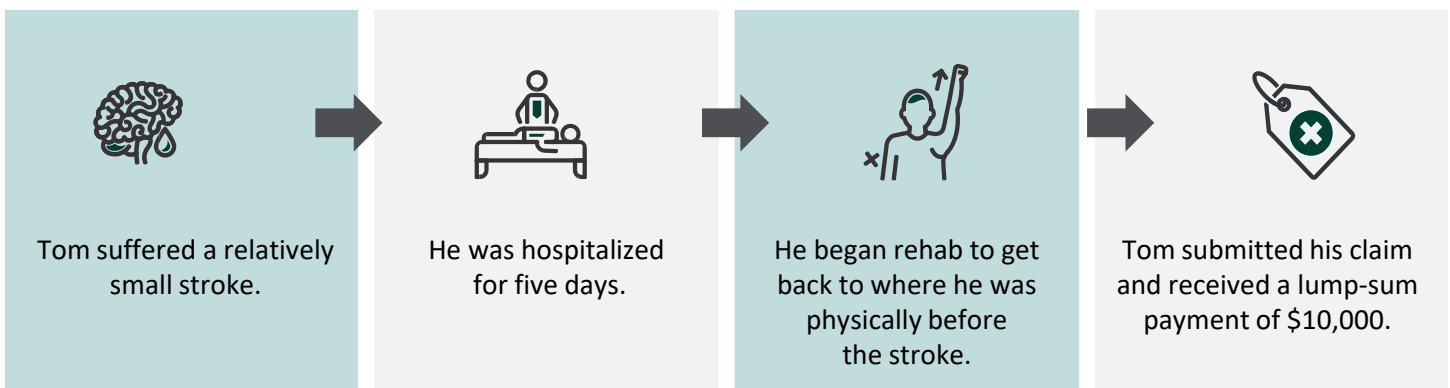
Critical Illness Insurance

Critical illnesses can have a huge impact on your life. A critical illness can keep you from working and can make it difficult to do simple, everyday things. Critical Illness insurance can help reduce your stress – financially and mentally – while you recover from your illness. These illnesses can include, but are not limited to, the following:

	Heart Attack		Alzheimer's Disease
	Systemic Sclerosis		Parkinson's Disease
	Stroke		Major Organ Failure

HOW THE PLAN WORKS

Critical Illness insurance pays a fixed one-time benefit amount if you are diagnosed with a covered disease or illness after your coverage effective date. You can use this money for any purpose you like. It can help pay for expenses not covered by your health care plan (such as your deductible or copays), lost income, childcare, travel to and from treatment, home health care costs or any of your regular household expenses. Below is an example.



TOTAL CRITICAL ILLNESS BENEFIT PAID: \$15,000

	BENEFIT AMOUNT	GUARANTEED ISSUE AMOUNT
Employee	\$10,000, \$20,000, \$30,000	All Guaranteed Issue
Spouse	100% of employee amount	All Guaranteed Issue
Children	50% of employee amount	All Guaranteed Issue

Please refer to the benefit summary for details of this coverage.

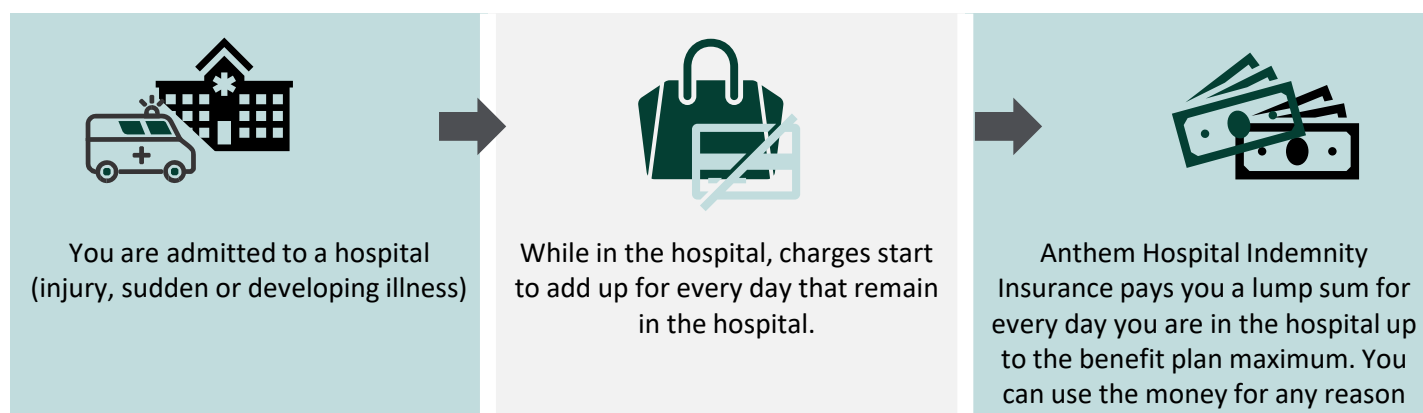
Hospital Indemnity Insurance

When it comes to the health of you and your family, unexpected or long-term hospitalizations should not be a time to worry about medical costs. Hospital indemnity insurance helps by putting recovery first over hospital bills. Hospital indemnity insurance supplements your existing health insurance coverage by helping pay expenses for hospital stays. Depending on the plan, hospital indemnity insurance gives you cash payments to help you pay for the added expenses that may come while you recover. Typically plans pay based on the number of days of hospitalization.

 Hospital Confinement – First day	 Intensive Care Unit Confinement
 Critical Care	 Health Screening

HOW THE PLAN WORKS

Hospital Indemnity provides a lump-sum cash benefit to help pay for costs that can come with a hospital stay that your health plan doesn't cover. Use your hospital indemnity coverage to help pay for out-of-pocket medical costs or daily expenses like rent, food or transportation.



BENEFITS		
	DAILY BENEFIT	ANNUAL MAX
Hospital Confinement – First Day	\$1,000	1 day
Hospital Confinement – Daily	\$100	365 days
Intensive Care Unit - Daily	\$100	30 days

Please refer to the benefit summary for details of this coverage.

Pre-Paid Legal Plan

AARG legal plan allows you to work with a network attorney, who can cover a wide range of legal needs to help you address life's legal situations. Attorney fees are 100% paid-in-full for most covered matters. When you have a legal need, you can go online, use the ARAG Legal app or call Customer Care and they will connect you with a list of local attorneys who can help you. You can meet with a network attorney over the phone, virtually or in person.

To learn more about your coverages and see the complete list of what this plan covers at ARAGlegal.com/myinfo with AccessCode: 17943hm or call 800-247-4184.

Consumer Protection	Real Estate & Home Ownership	Family
• Auto repair • Buy or sell a car • Consumer fraud • Consumer protection for goods or services • Home improvement • Personal property disputes • Small claims court	• Buying a home • Deeds • Foreclosure • Contractor issues • Neighbor disputes • Promissory notes • Real estate disputes • Selling a home	• Adoption • Guardianship/conservatorship • Name change • Pet related matters • Divorce
Debt-related Matters	Wills & Estate Planning	Services for Tenants
• Debt collection • Garnishments • Personal bankruptcy • Student loan debt	• Powers of attorney • Trusts • Wills	• Contracts/lease agreements • Eviction • Security deposit • Disputes with a landlord
Criminal Matters	Driving Matters	Tax Issues
• Juvenile • Parental responsibility	• License suspension/revocation • Traffic tickets	• IRS tax audit • IRS tax collection

DIVERSITY, EQUITY, INCLUSION COVERAGE

ARAG is constantly evolving and adapting to meet the needs of all employees. Whether it's an employee with a disability, a veteran or a member of the LGBTQ+ community, our coverage provides solutions that include:

- » *Domestic Partnership Agreement*
- » *HIPAA/Hospital Visitation*

AUTHORIZATION

- » *Funeral Directive*
- » *Gender Identifier Change*
- » *Social Security/Veterans/Medicare Dispute*
- » *School Administration Hearing*
- » *And network attorney fees for most covered matters like these are 100% paid in full.*

LEGAL NEEDS ARE IN YOUR FUTURE

You can't predict your future, but you can plan for it, thanks to legal insurance.

Legal insurance provides a benefit you can use to plan for it all – the expected and unexpected times in your life. Visit ARAGlegal.com/future or scan the QR code.

Retirement (401k)

PREPARE FOR RETIREMENT

To enhance your ability to save for retirement HMC offers an automatic 401(k) enrollment feature for our 401(k) retirement plan.

Your HM Clause 401(k) Retirement Plan can help you get ready to have the retirement you want. Get started today by using the plan's tools to help you set aside the retirement income you may need.

Enroll at <https://empowermyretirement.com> or by calling 855-756-4738 on Mondays through Friday at 8am-10pm ET and Saturdays at 9am-5:30pm ET.

ELIGIBILITY

As a regular employee, you are eligible to participate the first of the month following 30 days of employment (must be age 18 or older), and will you can contribute between 1% and 70% of eligible compensation up to the IRS limit of \$22,500. Please note that contributions will cease when highly compensated employees hit the IRS limit.

COMPANY MATCH

HMC matches 100% of applicable contributions up to 6% of eligible compensation. This means: You contribute 6% to your retirement account and HMC matches that amount 100%!

An additional Retirement Supplement is also provided to eligible employees the 1st of the month following 6 months of service. This supplement provides between 3-7% of additional company contributions based on how close you are to retirement age.

BENEFICIARIES

One of the first things you should do when electing to participate in the 401(k) plan is to designate a beneficiary online via your personal retirement account. Maintaining this important information online is easy and reliable.

If you experience a life event (e.g. change in marital status or birth), you may need to update the beneficiary designation. It is recommended that you review your designations at least once a year.

BEFORE TAX & ROTH CONTRIBUTIONS

With the traditional 401(k), your contributions are made on a pre-tax basis and 50% vested after 1 year of service. And you pay taxes only when you take a distribution.

All Roth contributions are made with after-tax dollars. In other words, with the Roth option, you've already paid taxes on the money you contribute.

Annual contributions limits to 401(k) retirement accounts are set by the IRS each year. Please check our benefits page for more information.

VESTING

Vesting refers to the percentage of ownership in your account. You are always 100% vested in your own 401(k) contributions (before-tax and Roth). In addition, any 401(k) employer contributions ("the match") and earnings are always 50% vested, and earnings are 100% vested after 2 years of employment.

ROLLOVERS

If you have outside retirement accounts from a previous employer, you can rollover those funds to your HMC 401(k) retirement account. For more information about initiating a rollover, please contact Empower at 855-756-4738.

INVESTMENT OPTIONS

A wide array of core investment options is available through your plan, including Target Date Retirement Funds. Each option is explained in further detail in the plan's fund sheets.

Special Programs

EMPLOYEE ASSISTANCE PROGRAM (EAP)

This program consists of access via website or telephone, 24 hours a day/7 days a week. The EAP provider, Health Advocate, is available for assistance with numerous types of family counseling, financial issues, child care, legal issues and many other topics. You have a benefit of up to 8 visits per incident, whether it be in-person or video counseling for short-term issues.

Their website is healthadvocate.com/members. Access services by calling or reaching out to support at answers@HealthAdvocate.com or 866-695-8622.

BUSINESS TRAVEL ASSISTANCE

HM.CLAUSE provides you with business travel insurance. This coverage applies to any trips more than 100 miles from home. Coverage through this policy includes:

- » *In-hospital indemnity for lost wages*
- » *Accidental medical expenses*
- » *Life and AD&D benefit*
- » *Medical evacuation and repatriation*
 - » *For help, contact Zurich at:*
 - » *U.S. & Canada: (844) 632-0002*
 - » *Anywhere else: (416) 646-5602*

Benefits Resource Site

For a one-stop resource to find information and important contacts, visit our employee benefits website, ourbenefitsinfo.com. There you will find documents, descriptions, media, and links to other resources and information.

The image is a screenshot of a web browser displaying the HM Clause Employee Benefits Resource Site. The top navigation bar is dark green with white text for 'Home', 'Benefits', 'Resources', 'Your Costs', 'Contacts', and 'Help'. The main content area has a light gray background with a large white box in the center. Inside this box, the 'HM • CLAUSE' logo is at the top, followed by the heading 'Your Benefits' in a large, dark green font. Below this is a yellow horizontal line, and then a bold, black, all-caps notice: 'IMPORTANT: TO ENROLL OR MAKE CHANGES TO YOUR BENEFITS, PLEASE CLICK ON "HOW TO ENROLL" (SEE MENU) TO ACCESS PLANSOURCE (OUR ENROLLMENT SYSTEM).' This is followed by three paragraphs of text: a welcome message, a note about enrollment through DayForce, and a reference to the Bulletin Board section. The background of the website shows a close-up of hands holding a stack of papers.

Additional Resources

BENEFIT RESOURCE CENTER

Questions about your Medical, Dental and Vision benefits? HMC provides a dedicated benefits helpline that allows you to seek assistance from an insurance professional to handle benefit issues and questions.

Just pick up the phone and an efficient, compassionate representative is waiting to offer the personalized counsel you need.

The BRC is open to both you and your dependents, regardless of your enrollment in benefits!

- » *Learn more about your benefits*
- » *Receive assistance with your claims*
- » *Supply requests such as ID cards and claim forms*
- » *Get information about health providers and plan utilization*

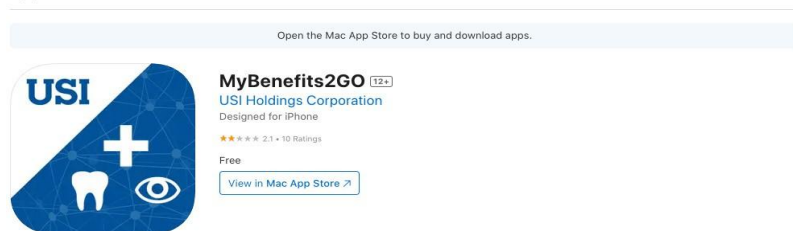
USI MOBILE APP

An additional resource is our USI mobile app. The mobile app gives you access to HMC's benefit information on your phone 24/7/365. Go to your phone's app store (Apple or Google), and download the free app called "MyBenefits2GO," and enter our plan code **U49470**. You will have plan information in the palm of your hands.

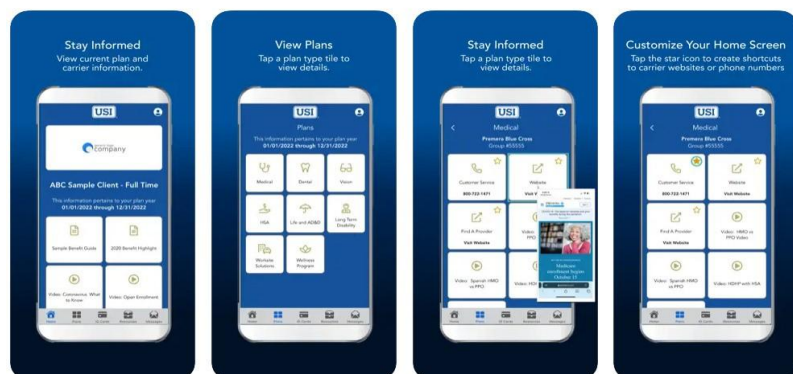


If you have questions or need assistance, let the BRC Benefit Specialists help you!
 Call: 888 336-7463
 Email: brcca@usi.com
 Available Monday through Friday
 8:00 a.m. to 5:00 p.m. PST

App Store Preview



iPhone Screenshots



Blue Shield Nurseline

Finding the right answers at the right time is important for good health. Blue Shield's NurseLine gives you access to registered nurses for advice and information whenever you need it.

The nurse line helps you:

- Understand your health care choices
- Learn about symptoms and medication use
- Manage non-urgent conditions by providing simple home care measures
- Reduce unnecessary trips to the emergency room or doctor by telling you about appropriate care options
- Save time, money, and worry

Blue Shield's registered nurses use trusted care guidelines and are supported by medical directors. Multilingual services are also available.

Help is only a phone call away, 24 hours a day, seven days a week at 877-304-0504.

HM.Clause, Inc.

Important Legal Notices



If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.
Please see page 10 for more details.

IMPORTANT NOTICE: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.



Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE – FEDERAL

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

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 within 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 within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

ADA NOTICE REGARDING WELLNESS PROGRAMS

HealthCheck360 is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test for glucose, HDL, LDL, triglycerides and total cholesterol. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of as described in our wellness program materials. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities as described in our wellness program materials. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting plan administrator at 530-747-3789.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and HM.Clause, Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, HealthCheck360 will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a health coach in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the plan administrator at 530-747-3789.

HIPAA WELLNESS PROGRAM DISCLOSURE

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 at 530-747-3789 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.

PATIENT PROTECTION MODEL DISCLOSURE

Blue Shield of California generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Blue Shield of California designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Blue Shield of California at 866-346-719.

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

You do not need prior authorization from Blue Shield of California or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Blue Shield of California at 866-346-719.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may

require the Plan Administrator to provide the materials and pay you up to \$110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Wendy Relich
260 Cousteau Place, Suite 210
Davis, California United States 95618
530-747-3734
wendy.relich@hmclause.com

Your Information. Your Rights. Our Responsibilities.

*Recipients of the notice are encouraged to read the entire notice.
Contact information for questions or complaints is available at the end of the notice.*

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

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

Your Choices

For certain health information, you can tell us your choices about what we share.

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

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

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
Marketing purposes
Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

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

Help manage the health care treatment you receive

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

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

Pay for your health services

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

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

Administer your plan

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

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

Run our organization

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

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

How else can we use or share your health information?

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

Help with public health and safety issues

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

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

Do research

We can use or share your information for health research.

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Uses and Disclosures of Substance Use Disorder (SUD) Treatment Information

If we receive or maintain records about you from a SUD treatment program subject to 42 CFR part 2 (a "Part 2 Program") through consent you provide the Part 2 Program to use or disclose the records, or testimony relaying the content of such records, they are given extra protection. These records shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless you provide written consent, or a court order is issued after notice and an opportunity to be heard is provided by you or the holder of the records.

Our Responsibilities

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

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

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

Other Instructions for Notice

- July 1, 2026
- Wendy Relich, 530-747-3734, wendy.relich@hmclause.com

If you are receiving a copy of this notice electronically, you are responsible for providing a copy of it to any Part-D eligible dependents covered under the group health plan.

Important Notice from HM.Clause, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with HM.Clause, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. HM.Clause, Inc. has determined that the prescription drug coverage offered by the **Blue Shield of California medical plans (EPO – California Only, Standard PPO, Choice PPO, HSA PPO medical plans)** for the plan year 2025-2026 are, 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, the following options may apply:

- You may stay in the Blue Shield of California medical plans and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
 - During the Medicare prescription drug annual enrollment period, or
 - If you lose Blue Shield of California medical plans creditable coverage.
- You may stay in the Blue Shield of California medical plans and also enroll in a Medicare prescription drug plan. The Blue Shield of California medical plans will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Blue Shield of California medical plans and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Blue Shield of California medical plans, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through HM.Clause, Inc. changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

**Rememb
er: Keep
this
Creditabl
e**

Date:	07/01/2026
Name/Entity of Sender:	HM.Clause, Inc
Contact Position/Office:	Wendy Relich
Address:	260 Cousteau Place, Suite 210 Davis, California 95618
Phone Number:	530-747-3734

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 January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ARKANSAS – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	CALIFORNIA – Medicaid
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 Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.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-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	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/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	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: HHSHIPProgram@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/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

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



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.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 these factors in determining whether to purchase a health plan through the Marketplace.

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

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset

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.

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:

Name of Entity/Sender:	HM.Clause, Inc.
Contact--Position/Office:	Wendy Relich
Address:	260 Cousteau Place, Suite 210 Davis, California 95618
Phone Number:	530-747-3734

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 HM. Clause, Inc.		4. Employer Identification Number (EIN) 94-1695235	
5. Employer address 260 Cousteau Place, Suite 210		6. Employer phone number 530-747-3722	
7. City Davis	8. State California	7. City Davis	
10. Who can we contact about employee health coverage at this job? Wendy Relich			
11. Phone number (if different from above) 530-747-3734		12. Email address wendy.relich@hmclause.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:

Full time employees working 30+ hours per week.

- ☒ Some employees. Eligible employees are:

Seasonal employees are eligible to participate in the Choice PPO option only if they work at least one thousand (1,000) hours but not more than one thousand seven hundred (1,700 hours) in a twelve (12) month period consistent with the measurement periods as defined by the ACA.

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

Spouse (the person you are legally married to under state law, including same-sex spouse), same gender domestic partner OR opposite gender domestic partner, child(ren) and child(ren) of your Domestic Partner.

- ☐ 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.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly