Employee **2026** Benefits Guide

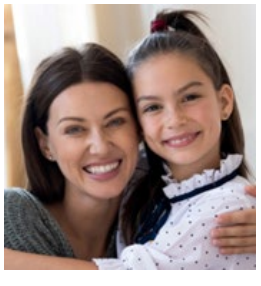
Effective January 2026 – December 2026

CAMPBELL STREET









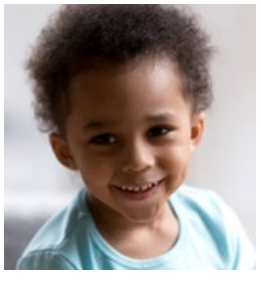
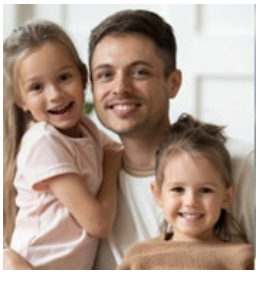




Table of Contents

Welcome	3	Critical Illness	23
Eligibility	4	Hospital Indemnity	24
Your Coverage	5	Whole Life	25
Enrollment	6	Legal Shield | ID Shield	30
How A Health Plan Works	7	Employee Assistance Program (EAP)	31
Medical	8	Contact Information	32
Dental	15	Your Total Cost	33
Vision	16		
How to Find a Provider	17		
Life and AD&D	18		
Voluntary Life and AD&D	19		
Disability	20		
Supplemental Health Benefits	21		
Accident	22		

Welcome

To our Valued Team Members of **Campbell Street**

At Campbell Street, our mission is **Developing Exceptional People Who Drive Extraordinary Care**, and your benefits are an essential part of that commitment. The way we support you directly impacts the way you support our residents, which is why we've been intentional in designing a benefits package that is clear, high-quality, and built with you in mind.

For **2026**, we've focused on **affordability, accessibility, and ease of use**. Some benefits are fully paid by Campbell Street; others are offered through shared cost; and additional optional benefits are available at competitive group rates. Together, these offerings create a total rewards package that reflects how much we value the work you do every day.

As you review your options, please note that **you will enroll in <u>two</u> separate systems**:

- **Paycom** for all *ancillary benefits* – dental, vision, life insurance, disability coverage, and supplemental plans.
- **Remodel Health** for your *medical benefits*.

Be sure to complete your enrollment in **<u>both</u>** systems so your coverage is active and accurate.

Please take a few minutes to review the benefits available to you and your family. Your well-being matters and when you're supported, our communities thrive.

Kind regards,
Your Campbell Street People Operations Team

CAMPBELL STREET

Eligibility

Who is Eligible?

- An active full-time employee working **30** or more hours per week

Your dependents are eligible if they are:

- Your legal spouse
- Your child(ren)†** up to age **26** and your disabled children up to any age (pursuant to plan documents and state law, please see Human Resources for more information)

† Includes natural, step, legally adopted/or a child placed for adoption, or a child under your legal guardianship

**May include non-children dependents required to be covered under state law

Making Benefit Changes During the Plan Year

The benefit elections you make during your enrollment period will be in effect through the end of the plan year. If you have a "qualifying life event," you may make changes to certain benefits if you apply for the change and provide supporting documentation to Human Resources within **30** days of the event. Proof of life events is subject to approval. Please reach out to your employer for specific documentation to be submitted for a qualified life event during the benefit year. Changes are effective prospectively unless the event is for birth, adoption, or placement for adoption.

Qualifying Life Event		
Change in Marital Status	Change in Dependents	Change in Employment
• Marriage • Divorce • Death of your spouse	• Birth, adoption or placement for adoption of an eligible child (Retroactive to the date of the event) • Death of your covered dependent • Gain or loss of Medicare or Medicaid during the year	• Change in you or your spouse's work status that affects benefits eligibility • Your spouse's Open Enrollment differs from yours • Relocation if the move impacts eligibility for the plan

Your Coverage

A Note About Health Care Reform

If you choose to purchase individual coverage through the Marketplace, you should know that because **Campbell Street** medical insurance meets specific ACA requirements, you may not be eligible to receive a federal subsidy. Additional information is available at www.healthcare.gov.

When Does Coverage Begin?

Benefits for new hires, unless explained otherwise, will become effective on the first of the month following **30 days** of employment.

If you do not enroll during your eligibility period, you may enroll at the next open enrollment period.

Termination of Coverage

If you or a covered dependent no longer meet the eligibility requirements or if your employment ceases, your benefits will end.

You are responsible for informing Human Resources within **30 days** if any of your dependents become ineligible for benefits.

Benefits can be canceled due to:

- Open Enrollment
- Termination (voluntary or involuntary)
- Retirement
- Qualified Life Event

SCAN ME

Please scan the QR code to access an electronic copy of this Benefit Booklet and your Annual Notices.

Enrollment

When Can I Enroll in Benefits?

You can enroll in benefits:

- Within **30 days** of first becoming eligible for benefits
- During the annual Open Enrollment period
- During the plan year, if you experience a Qualifying Life Event

How Do I Enroll?

To enroll (or make changes) to your **Ancillary** benefits, including Dental, Vision, Life, Disability & Supplemental plans, log into www.paycomonline.net/v4/ee/web.php/app/login

SCAN ME

To enroll (or make changes) to your **Medical** benefits, schedule an appointment with Remodel Health at app.remodelhealth.com.

Annual Open Enrollment

This is a once-a-year opportunity to review your benefit plan elections and make adjustments that meet the needs of you and your family. Changes will go into effect **January 1st**.

2026 Open Enrollment Window

11/24/2025 – 12/5/2025

How a Health Plan Works

Scan to view Glossary of Health Coverage and Medical Terms

Balance Billing

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not balance bill you for covered services.

Coinsurance

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

Copayment

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

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1,000, your plan won't pay anything until you've met your $1,000 deductible for covered health care services subject to the deductible.)

- **Embedded Deductible**

  Each family member has an individual deductible within the overall family deductible. Once a single person meets their individual deductible, their coverage kicks in—even if the family deductible hasn't been met yet.

- **Aggregate Deductible**

  The entire family deductible must be met before any coverage starts. There are no individual deductibles—all costs go toward one combined family deductible.

Maximum Out-of-Pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Welcome to Remodel Health!

We're excited to partner with you!

Remodel Health is proud to partner with your insurance broker & employer to provide a top-notch, tailored medical benefits experience for you. Over the next few weeks, our team will walk alongside you as you select a medical benefit that meets you and your family's needs. In the meantime, this guide will explain key details surrounding your medical benefits and what to expect as you onboard with Remodel Health.

Table of Contents

- Individual Plans
- Additional Benefits
- Next Steps
- Contact Information

If there is any conflict between this advertising and the Summary of Benefits for the policy the employee selects, the Summary of Benefits controls. See Summary of Benefits for details. If there is any conflict between this advertising and the insurance provided, the language of the insurance policy controls.

Individual plans

Who is Remodel Health?

Powered by our proprietary software and backed by a team of licensed health benefits experts, we provide individualized health benefits solutions tailored to businesses of all sizes, nonprofits, educational institutions, and beyond. Our unwavering commitment to exceptional customer service ensures every client experiences the best in the industry.

What is an ICHRA?

Individual Coverage Health Reimbursement Arrangements (ICHRAs) allow an employer to provide untaxed dollars to their employees to spend on individual plans. Very similar to the change from pension plans to 401(k)s for retirement benefits—the employer provides a contribution, and the employee gets to decide how to spend it.

With an ICHRA, you as the employee have personal choice in your medical benefits, and will be able to enroll in a plan that best fits your household's needs. ICHRAs allow your employer to customize employee health benefits to meet the individual needs of all employees and provide more ownership of the policy to you, the employee.

What type of plans are available?

Instead of your employer choosing one health policy for everyone, you now have the freedom to shop for health insurance coverage that best suits your needs. With the support of Remodel Health and our licensed health benefits advisors, you can select a plan that fits your preferred network, doctors, and health insurance premium. Below are a few considerations as you explore options:

High Deductible Health Plans (HDHP): These plans have higher deductibles, or initial costs for healthcare expenses, but lower premiums. Typically, the higher the deductible, the lower the premium. In many cases, you can utilize a health savings account with these plans.

Co-Pay Plans: Co-Pay plans have set amounts that you pay for each visit or prescription (copays), and often feature lower deductibles. With a co-pay plan, you will typically pay higher premiums than an HDHP because you are likely accessing your benefit more frequently.

Network: There are a variety of networks for plans such as PPO, EPO and HMO. With a PPO plan, you are likely to have the widest network and access to out-of-network coverage. An EPO can have a wide network with a greater likelihood for prior-authorization requests. Finally, an HMO network tends to be narrow and may request a referral before major procedures.

Individual plans

What is a deductible?

A deductible is the amount you are responsible for (aside from copays) **before insurance pays**. Generally speaking, the **higher** the deductible, the **lower** the premium. Once your deductible is met, your insurance carrier will provide additional benefits such as copays and/or coinsurance until your out-of-pocket maximum is met.

What is an HSA?

A Health Savings Account (HSA) is a medical savings account available to those enrolled in a HDHP as determined by the IRS. The funds contributed to an HSA are not subject to federal income tax and can be used for qualified medical expenses.

Eligible employees can open up an HSA account to use tax-free dollars for qualified medical expenses! HSA funds remain in your account until you use them (i.e. the money rolls over every year and can be accumulated over time). In addition, HSAs are "portable," meaning the account and all funds stay with you if you change employers.

Remodel Health encourages all employees enrolled in a HDHP to contribute the full amount to their HSA each year if possible. Remember, if you don't use the funds right away, they roll over and are tax-free. An HSA is a great safety net to have for whenever you may need it!

For more information about HSAs, please visit **hsabank.com** and click on "Learning Center."

2026 HSA Limits

Annual Individual Limit	**$4,400**
Annual Family Limit	**$8,750**
55+ Additional Amount	**$1,000**

Additional benefits

Licensed Benefits Advisors

Remodel Health's non-commissioned, licensed benefits advisors are available to help you choose the health benefit that best suits your needs and the needs of your household. **Schedule an advisement in your Remodel Health profile at: app.remodelhealth.com.**

Main point of contact

A customer success representative will be your contact for all the questions you have about your health benefits. Their goal is to be your advocate and answer any questions you may have regarding coverage. You'll want to reach out to your insurance carrier directly to process claims.
You can reach your Customer Success Representative at: care@remodelhealth.com.

Educational resources

Remodel Health customers have access to a variety of free educational resources through the Remodel Health platform. Learn how to best utilize your health benefits—from how to use an HSA, when to use Teladoc, and more!
Visit: help.remodelhealth.com

Next steps

Select your new plan

Create

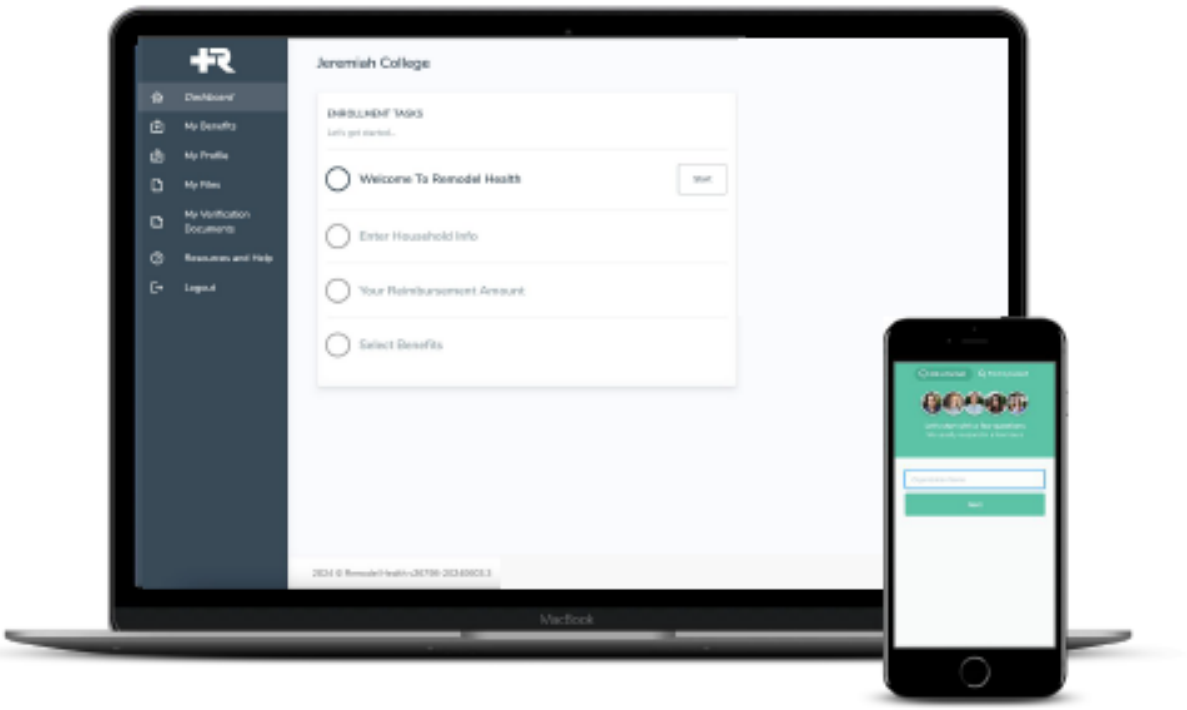
Create your Remodel Health account and complete your verification checklist.

Select

Select your preferred plan or talk with a licensed advisor.

Receive

Receive ongoing support from your Remodel Health Customer Success Representative.



Contact information

Your Remodel Health team

We're with you every step of the way.

Our dedicated team of licensed benefits advisors and customer success representatives seek to understand not only your financial needs but also your unique healthcare needs. Every step of the way, Remodel Health is there to help you find a plan and utilize it well!

Benefits Advisors

We work with you to choose, understand and use your new individual health plans.

Customer Success

We serve all year long to help with provider searches, carrier questions, payroll and more.

Nothing herein should be considered tax or legal advise. If you have any questions, you should consult your tax or legal advisor.

Questions? Contact Us!

care@remodelhealth.com

844.748.3240

After creating your profile, log in at: app.remodelhealth.com.

If there is any conflict between this advertising and the Summary of Benefits for the policy the employee selects, the Summary of Benefits controls. See Summary of Benefits for details. If there is any conflict between this advertising and the insurance provided, the language of the insurance policy controls.

GoodRx

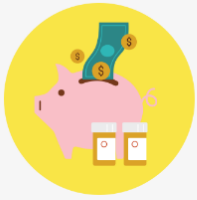
Find the cheapest prescription drug prices at local and online pharmacies

1: Find free coupons

Coupons work at virtually every U.S. pharmacy. Prices may even beat your insurance!

2: Show coupon to your pharmacist

Text, email or print your coupon. No approvals or paperwork needed.

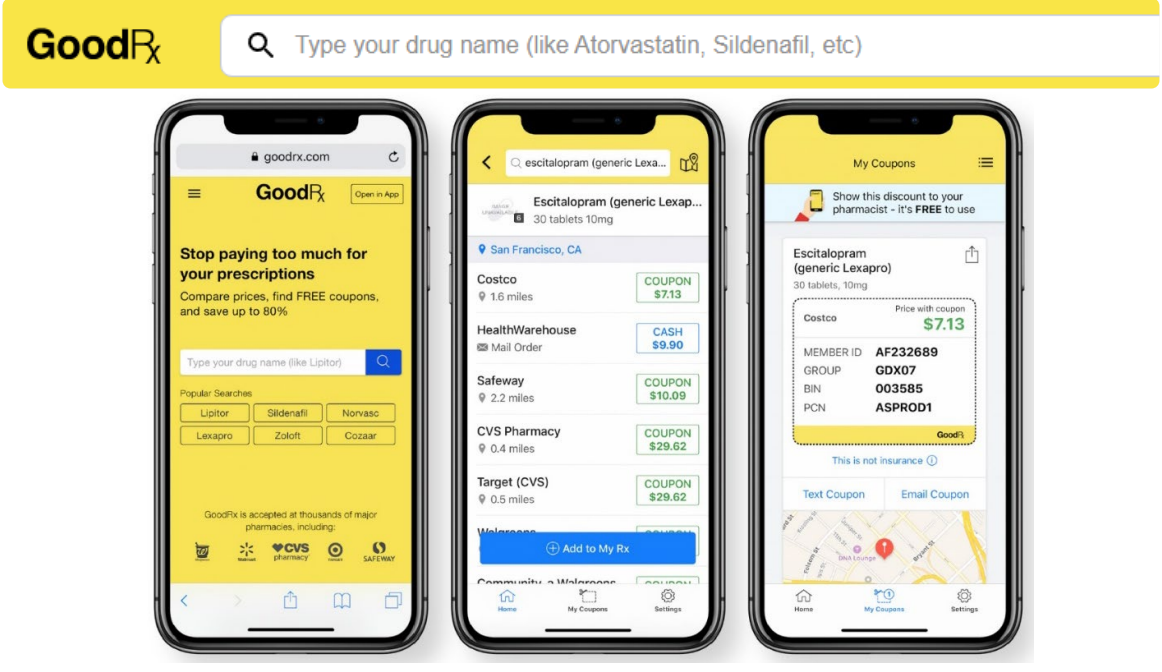


3: Save up to 80%

Save on all of your family's prescriptions. Coupons work for refills too!

- GoodRx gathers current prices and discounts to help you find the lowest cost pharmacy for your prescriptions.
- GoodRx may be able to find you a lower price than using your insurance!
- Hundreds of generic medications are available for $4 or even free without insurance.
- GoodRx is a **FREE** service that will show you prices, coupons, discounts and saving tips.

Avoid paying too much for your prescriptions by visiting https://www.goodrx.com/ or by downloading the FREE GoodRx App on your mobile device today!



You can use a GoodRx discount instead of your medical insurance if the cost through GoodRx is lower. GoodRx discounts and coupons cannot be combined with your insurance and will not track towards your deductible and out of pocket.

Dental (PPO)

Dental insurance is offered through **Guardian**. Your choice of dentists can determine the cost savings you receive.

If you enroll on the Low Plan*, this option does NOT require the use of a network dentist. The plan will reimburse dentists at negotiated usual and customary rate that has been set for each dental procedure code. This is referred to as the Maximum Allowable Charge (MAC). If your dentist charges more than the set reimbursement amounts, you can be balance billed and will be responsible for paying the difference.

If you enroll on the High Plan*, you will pay less for in-network services. For out-of-network providers, **Guardian** will pay claims based on reasonable and customary (R&C) charges. You are responsible for paying the balance of the bill.

	Low PPO Plan	High PPO Plan
Dental Network	DentalGuard Preferred	
Waiting Period	N/A	
Benefit Maximum Per Person		
Calendar Year Annual Max	$1,000 plus rollover	$1,500 plus rollover
Orthodontia Lifetime Max	N/A	$1,500
Deductible (applies only to Basic & Major Services)		
Individual	$50	
Family	$150	
Benefit	You Pay	
Preventive Services *Exams, Cleanings, X-Rays, etc.*	20% DW	Covered in full DW
Basic Services *Fillings*	40% after deductible	20% after deductible
Major Services *Extractions, Bridges, Crowns, Dentures, etc.*	50% after deductible	
Orthodontia (to age 19)	Not Covered	50%

Semi-Monthly Deductions	Low PPO Plan	High PPO Plan
Employee Only	$9.35	$15.84
Employee + Spouse	$18.98	$32.14
Employee + Child(ren)	$20.63	$40.26
Employee + Family	$31.99	$60.32

**Please refer to plan summary for out-of-network benefits, subject to balance billing, and limitations.*
DW = Deductible Waived

Vision

Routine eye exams are important for maintaining good vision and can also provide early warning of other health conditions. The **Guardian** vision plan provides coverage for exams, glasses and contact lenses, as shown below.

In-network coverage is provided when you use **Davis Network** providers. Refer to plan summary for out-of-network benefits and limitations.

	In-Network	Out-of-Network
	Amount You Pay/Allowance	Reimbursement Schedule
Vision Network	Davis Network	
Eye Exam *Once every 12 months*	$10 Copay	Up to $50 Reimbursement
Lenses - *Once every 12 months*		
Single Vision	$25 Copay	Up to $48 Reimbursement
Standard Bifocal		Up to $67 Reimbursement
Standard Trifocal		Up to $86 Reimbursement
Standard Progressive	$50 - $175 Copay	N/A
Frames *Once every 24 months*	Allowance up to $130 + 20% off balance	Up to $48 Reimbursement
Contacts - *Once every 12 months*		
Elective, instead of glasses	Allowance up to $130 + 15% discount	Up to $105 Reimbursement
Medically Necessary	Covered in full	Up to $210 Reimbursement

LASIK Surgery: Savings of 20-35% off national average

Semi-Monthly Deductions	Vision Plan
Employee Only	$2.64
Employee + Spouse	$4.99
Employee + Child(ren)	$5.09
Employee + Family	$8.05

How to Find a Provider

Dental

SCAN ME

To find an In-Network Provider, go to www.guardianlife.com or scan the QR code then follow the steps below.

- Select **Find a Dentist**
- Under 'Dental benefits bought through your workplace', select **Find a Dentist**
- Under the **Plan Type DentalGuard Preferred**, you can now start searching by **ZIP Code** & **Mileage Radius** or entering an **Office Name** or **Dentist Last Name**
- You can filter results by **Specialty** & **language spoken** if needed

Vision

SCAN ME

To find an In-Network Provider, go to www.guardianlife.com or scan the QR code then follow the steps below.

- Select **Find a Vision provider**
- Under 'Select your vision network', choose **Davis**
- Enter your **ZIP Code** or **Address** to 'Search by Location', then click **Search**
- You can also search by **Office** or **Doctor**

**Please Note – The above steps may differ depending on the device being used and may not reflect recent website changes.*

Employer Paid Life Insurance

Basic Life/AD&D

A Basic Life insurance policy is provided to you at no cost through **Guardian**. You are automatically enrolled in this benefit. This coverage includes an Accidental Death and Dismemberment (AD&D) provision, at the same coverage amount, in the event of accidental death and other conditions. Please refer to the benefit summary for details.

According to federal law, only the first $50,000 of employer-paid life insurance is not taxable. Premium paid by **Campbell Street** for coverage levels over $50,000 will be taxable to you and will be included on your year-end W-2 statement.

What is Life Insurance?

- A lump sum payment distributed to beneficiaries upon death of the insured or insureds
- Reassurance that your loved ones would be financially secure if you passed away unexpectedly
- Ability to assist with funeral costs – the average funeral cost is $10,000

Basic Life and AD&D Plan	
Benefit Amount	Your Benefit Amount will be based on your **Class**. You will receive additional details during enrollment.
Guaranteed Issue Amount	Full Amount
The below shows how much your benefits will reduce by at certain ages:	
Age Band	**Benefit Reduction**
65	35%
70	60%
75	75%
80	85%

Reminder! Update your Beneficiaries!

Plan for your expected and unexpected life changes by ensuring you and your family are protected. Update your beneficiaries now and keep them current each year.

Voluntary Life Insurance

Voluntary Life and AD&D

You can purchase Voluntary Life insurance through **Guardian** for you, your legal spouse and dependent children. Please refer to the benefit summary for details.

Voluntary Life and AD&D		
	Plan Features	Benefit Reduction/Termination
Employee	$10,000 increments up to $500,000 Guaranteed issue†: $300,000	35% at age 65 60% at age 70 75% at age 75 85% at age 80
Spouse	$5,000 increments to a maximum of $250,000 not to exceed 50% of employee amount Guaranteed issue†: $50,000	Terminates when Spouse turns 70
Child	$2,500 increments to a maximum of $10,000 *Infants (0-14 days old): $500* Guaranteed issue†: $10,000	Terminates when Child turns 26

Important Note:

For the Guaranteed Issue (GI) amounts to be approved automatically, you must elect coverage when first eligible, otherwise you will be required to complete an Evidence of Insurability (EOI) form, subject to carrier approval. Any amount elected over the Guaranteed Issue amount is subject to the EOI process.

If you have coverage today, you can elect up to $50,000 of additional coverage (not to exceed the GI amount) without submitting an EOI.

† *Guaranteed issue is the amount of coverage you or your dependents can elect up to without medical questions.*

Reminder! Update your Beneficiaries!

Plan for your expected and unexpected life changes by ensuring you and your family are protected. Update your beneficiaries now and keep them current each year.

Disability

Guardian administers our Disability insurance benefit plans for any full-time employee who chooses to enroll. You will pay the full cost of this benefit with post-tax payroll deductions, therefore your benefit while out on Disability will not be taxed.

Short-Term Disability

Short-Term Disability (STD) benefits are payable when you are unable to work due to an injury or illness unrelated to work.

When do the benefits start?
8th day of accident or illness

(Benefit duration is reduced by the initial disability waiting period (before benefits begin)

How much would the benefit pay?
$50 increments from **$100** to **$1,000** not to exceed **60%** of your weekly earnings

Are there any pre-existing exclusions?
3 prior / 12 exclusion

How long will the benefit pay?
Up to **13** weeks

Long-Term Disability

Long-Term Disability (LTD) benefits are provided as income protection in the event you become disabled for an extended period. Proof of disability is required.

When do the benefits start?
After **90** days of qualified disability

*(*This plan will begin to pay after the Short-Term Disability benefits end, if elected**.***)*

How much would the benefit pay?
60% of basic monthly earnings up to **$10,000** per month

Are there any pre-existing exclusions?
6 prior / 24 exclusion

How long will the benefit pay?
2 years

Important Notes:

You must elect coverage when first eligible, otherwise you will be required to complete an Evidence of Insurability (EOI) form, subject to carrier approval.

A pre-existing condition is any accident or illness for which you have received advice or treatment in the months prior to your coverage effective date and will be excluded from this benefit for the month exclusion period listed.

STD benefits integrate with state mandated disability plans. Maternity claims fall under this policy.

Supplemental Health Benefits

Campbell Street Senior Living offers additional voluntary benefit plans through **Guardian**. These plans are not medical insurance and do not replace your medical coverage, but rather pay cash directly to you in addition to any benefits you receive from your health plan.

Accident Insurance*

Pays a cash benefit when you or your covered family members suffer injuries sustained in an accident.

$50 Cash Benefit for completing health screenings.

- Accidental Death Benefit
- Hospital Admission, Emergency Care and Ambulance
- Fractures, tears, concussion
- Burns

Critical Illness*

Helps protect you from financial loss by providing a lump-sum benefit upon diagnosis of a covered condition, such as Heart Attack, Stroke, Cancer, and Major Organ Failure, etc.

$50 Cash Benefit for completing health screenings.

What Can I Do with the Money I Receive?

- Cover cost of copays, deductibles, and coinsurance
- Reimburse yourself for transportation and lodging costs
- Help with childcare and other domestic expenses
- Assist with home health care cost
- Make up for lost wages
- Pay everyday expenses, such as rent, utilities, and groceries

**All Supplemental Health Guardian benefit plans are portable, which means you can take these benefits with you if you leave the company.*

Hospital Indemnity Insurance*

Cash benefit to assist you with out-of-pocket costs of hospitalization not covered by your major medical insurance.

Accident Insurance

Accident policies pay a cash benefit when you or your covered family members suffer injuries sustained in an accident.

	Accident Plan
	Amount You Receive
Coverage Type	Off Job
Wellness Benefit	$50 per covered member per year Must complete applicable wellness screenings or procedures
Ambulance	Air: $2,500 / Ground: $400
Burns	Schedule up to $15,000
Coma	$20,000
Concussion	$300
Dental Injury	Crowns: $400 Extractions: $100
Dislocations	Schedule up to $9,000
Emergency Room Treatment	$200
Fractures	Schedule up to $9,000
Tendon/Ligament/Rotator Cuff injury with surgical repair	1: $750 / 2 or more: $1,500

Semi-Monthly Deductions	Accident Plan
Employee Only	$4.39
Employee + Spouse	$8.07
Employee + Child(ren)	$9.43
Employee + Family	$13.11

The Guardian Accident plan is portable, which means you can take these benefits with you if you leave the company.

Critical Illness

Critical Illness policies helps protect you from financial loss by providing a lump-sum benefit upon diagnosis of a covered condition.

	Critical Illness Plan	
Employee Benefit Amount	Lump sum benefit in $10,000 increments up to $30,000	
Spouse Benefit Amount	Lump sum benefit in $10,000 increments up to $30,000 not to exceed 100% of employee amount *Rates are based on Employee's age*	
Child Benefit Amount	50% of employee's lump sum benefit *Coverage is available at no additional cost if you elect employee coverage* *For your child to be covered, you must elect child coverage when enrolling*	
Wellness Benefit	$50 per covered member per year Must complete applicable wellness screenings or procedures	
Covered Illness/Benefits	First Occurrence	Second Occurrence
Invasive Cancer	100%	
Cancer (Non-life Threatening)	30%	0%
Coronary Artery Disease **Coronary Artery Disease** – bypass needed	10% 50%	0%
Heart Attack	100%	
Major Organ Failure	100%	
Stroke – *Moderate* **Stroke** - *Severe*	50% 100%	
Guaranteed Issue Amounts		
Employee	$30,000	
Spouse		
Child	All Amounts	

The Guardian Critical Illness plan is portable, which means you can take these benefits with you if you leave the company.

Hospital Indemnity

Hospital Indemnity provides cash benefit to assist you with out-of-pocket costs of hospitalization not covered by your major medical insurance.

	Hospital Indemnity Plan
	Amount You Receive
Hospital Admission	$1,000 per admission / 2 admissions max per year
ICU Admissions	$2,000 per admission / 2 admissions max per year
Hospital Confinement	$100 per day
ICU Confinement	$200 per day
Max Days Per Year	15 days

Semi-Monthly Deductions	Hospital Indemnity Plan
Employee Only	$10.54
Employee + Spouse	$17.30
Employee + Child(ren)	$16.03
Employee + Family	$22.79

The Guardian Hospital Indemnity plan is portable, which means you can take these benefits with you if you leave the company.

GROUP WHOLE LIFE INSURANCE

Employee Coverage

Value of Whole Life Insurance

- Permanent Life Insurance
- Cash Value Accumulation
- Guaranteed Premiums and Death Benefits
- Affordable group rates available through payroll deductions for yourself, spouse and children
- Coverage can be taken with you if you change jobs or retire – we will bill you directly
- Guaranteed coverage with no medical questions

Financial protection throughout an entire lifetime

Our Group Whole Life insurance helps you prepare for the future, today. Should you change jobs, you can keep your insurance for as long as you want; and it also complements term life insurance, ensuring long-term protection. Once you've purchased coverage, your cost will not increase as you age.

79%

women said their death would substantially impact their family

https://bit.ly/2MFDLrB

Living benefits

Our plan has living benefits which can afford you the ability to take care of critical medical events that may arise during your lifetime.

These benefits can be used for:

- Nursing Home
- Home Healthcare
- Assisted Living Facility
- Adult Daycare

ATLANTIC AMERICAN
Employee Benefits

GROUP WHOLE LIFE INSURANCE
Coverage Details

Atlantic American Employee Benefits' Group Whole Life insurance plan includes the benefits listed below. Each benefit is subject to conditions for payment as detailed in the certificate.

70%

approx. chance of needing long-term care at 65+

https://cnb.cx/3zhwAyb

Plan Information	
Benefit Maximum	$100,000 in $10,000 increments
Available To	Employee ages 18-70
Guaranteed Issue	$100,000

Additional Plan Details	
Waiver of Premium for Disability Rider - Plan premiums are waived during disability period when insured has been disabled for 6 months. Included on issue ages 18-65; terminates at age 70.	Included
Accelerated Death Benefit Rider for Terminal Illness Rider - Insured can receive up to 50% of elected face amount during their life when there are diagnosed with a terminal illness that leaves them with a life expectancy of 12 months or less.	Included
Monthly Accelerated Death Benefit for Chronic Illness Rider - This living benefit allows the insured access to their whole life benefits during their lifetime in the event they are diagnosed with a qualifying chronic illness or cognitive impairment, and are unable to perform two of the six Activities of Daily Living (ADLs) which cause them to be either confined to a nursing home or assisted living facility, or receiving continuous care from a home health or adult day care provider.	Included

GROUP WHOLE LIFE INSURANCE

Spouse Coverage

Value of Whole Life Insurance

- Permanent life Insurance available to your spouse
- Affordable group rates
- Builds cash value
- Provides guarantee that premiums that won't go up
- Guaranteed death benefits
- No health or no medical questions, coverage is guaranteed
- Coverage if portable, if you change jobs or retire

Financial protection for your spouse

Our Group Whole Life insurance helps you prepare for the future by protecting the ones you love. This permanent life policy is available to your spouse, at affordable group rates. Our policy can help your family achieve its financial goals. Once you've purchased coverage, the rates are locked in and will not increase over time. Even if you leave your employer, you can keep your spouse's policy — we will bill you at home.

79%

women said their death would substantially impact their family

https://bit.ly/2MFDIrB

Living benefits

Our plan has living benefits which can afford your family the ability to take care of critical medical events that may arise during your lifetime.

These benefits can be used for:

- Nursing Home
- Home Healthcare
- Assisted Living Facility
- Adult Daycare

ATLANTIC AMERICAN
Employee Benefits

GROUP WHOLE LIFE INSURANCE

Spouse Coverage Details

Atlantic American Employee Benefits' Group Whole Life insurance plan has the below listed benefits available to your spouse. Each benefit is subject to conditions outlined in your certificate.

70%

approx. chance of needing long-term care at 65+

https://cnb.cx/3zhwAyb

Plan Information	
Benefit Maximum	$20,000 in $10,000 increments
Guaranteed Issue	Up to $20,000 of coverage - no health questions
Available To	Spouses ages 18 - 65, The employee must purchase coverage to add their spouse.
Limited To	100% of employee election

Additional Plan Details	
Accelerated Death Benefit Rider for Terminal Illness Rider - Insured can receive up to 50% of elected face amount during their life when there are diagnosed with a terminal illness that leaves them with a life expectancy of 12 months or less.	Included
Monthly Accelerated Death Benefit for Chronic Illness Rider - This living benefit allows the insured access to their whole life benefits during their lifetime in the event they are diagnosed with a qualifying chronic illness or cognitive impairment, and are unable to perform two of the six Activities of Daily Living (ADLs) which cause them to be either confined to a nursing home or assisted living facility, or receiving continuous care from a home health or adult day care provider.	Included

GROUP WHOLE LIFE INSURANCE

Dependent Children Term Life Rider

Value of Life Insurance

- Term Life coverage available to natural, step, or legally adopted children
- Coverage option for grandchildren who are legal dependents via tax filing
- Future conversion option; can be converted to a level premium Whole Life policy when the child turns 26 years old
- Affordable group rates which do not increase with age and are conveniently deducted from your paycheck
- Coverage can be taken with you if you change jobs or retire, billed directly to you at home
- Guaranteed coverage with no physical or medical questions

Financial protection for family

If an accident or illness were to claim the life of your child, our Child Term Life coverage, could provide the resources needed to deal with the financial strain of your loss — so you can take care of your family during this difficult time. This optional rider that can assist in protecting the entire family. Available to dependent children/ grandchildren of those currently enrolled in Whole Life — it's a smart choice that can ensure the most treasured individuals in the family are covered when the unthinkable happens.

$7,640

the national median cost of a funeral with viewing and burial

https://bit.ly/3BOsrbr

Plan Information

Benefit Maximum	$10,000 (employee must be enrolled in Whole Life)
Guaranteed Issue	$10,000 of coverage; no health questions
Available To	Children/Grandchildren ages 15 days through 25 years old; terminates at age 26. Employee must purchase Whole life policy.

MONTHLY PREMIUM RATES - CHILD TERM

FACE AMOUNTS OF COVERAGE	
CURRENT AGE	$10,000
0 Days to Age 26	$5.00

ATLANTIC AMERICAN
Employee Benefits

Scan QR code for video

Have You Ever...

- ☐ Needed your Will prepared or updated?
- ☐ Signed a contract?
- ☐ Received a moving traffic violation?
- ☐ Worried about being a victim of identity theft?
- ☐ Been concerned about your child's identity?
- ☐ Had social media accounts? (Facebook, Instagram, Twitter, Linkedin, Youtube)

The LegalShield Membership Includes:

- **Dedicated Law Firm** Direct access, no call center
- **Legal Advice/Consultation** On unlimited personal issues
- **Letters/Calls** Made on your behalf
- **Contracts/Documents Reviewed** Up to 15 pages
- **Residential Loan Document Assistance** For the purchase of your primary residence
- **Will Preparation** - Living Will, Health Care Power of Attorney
- **Speeding Ticket Assistance** Upload your speeding ticket from the mobile app directly to law firm
- **IRS Audit Assistance** (Begins with the tax return due April 15th of the year you enroll)
- **Trial Defense** (If named defendant/respondent in a covered civil action suit)
- **Uncontested Divorce, Separation, Adoption and/or Name Change Representation** (Available 90 days after enrollment)
- **25% Preferred Member Discount** (Bankruptcy, criminal charges, DUI, personal injury, etc.)
- **24/7 Emergency Access** For covered situations

The IDShield Membership Includes:

- **Credit Monitoring** Continuous credit monitoring through Experian
- **Online Privacy Management** IDShield provides consultation and guidance on ways participants can protect their privacy and personally identifiable information across the internet and on their smart devices.
- **Reputation Management & Score** Scans social media accounts for existing content that could be damaging to participants' online reputation. Ranks your online reputation risk by giving you a score based off the content found on your social media accounts.
- **Financial Account Monitoring** Accounts monitored include checking, savings, employer 401k accounts, loans and more.
- **$3 Million Protection Policy** Coverage for lost wages, legal defense fees, stolen funds and more
- **Unlimited Service Guarantee** Ensures that we won't give up until your identity is restored!
- **Identity Restoration** Performed by Licensed Private Investigators to restore your identity to its pre-theft status.
- **24/7 Emergency Access** In the event of an identity theft emergency

Plan	Individual Price	Family Price
LegalShield	$ 9.48 bi-monthly	Same as Individual
IDShield	$ 4.98 bi-monthly	$ 9.98 bi-monthly
Combined	$14.45 bi-monthly	$17.38 bi-monthly

Put your law firm and identity theft protection in the palm of your hand with the LegalShield and IDShield mobile apps!

Visit your LegalShield info site: **https://www.shieldbenefits.com/holdco**

FOR MORE INFORMATION PLEASE CONTACT AN INDEPENDENT ASSOCIATE:

Cap Stewart
cap@premiersolutionsintl.com
865.293.2453

Employee Assistance Program

Guardian · uprisehealth

Employee Assistance Program Overview

Our comprehensive Employee Assistance Program (EAP), available through Uprise Health, provides you and your family members with confidential, personal and online/web-based support on a wide variety of important and relevant topics — such as stress management, dependent/elder care, nutrition, fitness, and legal and financial issues.

Employee assistance program consultative services

- **Online modules and coaching** — learn, develop, and practice new skills to improve mental fitness; includes a well-being check, online modules selected specifically for you, and up to 3 coaching sessions
- **Face-to-face and virtual counseling** — up to 3 visits per employee/household member per issue, per year
- **Bereavement** — support available through telephonic or face-to-face sessions; online resources available on EAP website
- **EAP website resources** — includes webinars, podcasts, articles, videos, FAQs, etc.; additionally, individuals can chat online with an EAP consultant

Work-life assistance and resources

- **Work-life services** — unlimited 24/7 access to work-life specialists (subject matter experts) in the areas of family and care giving, health and wellness, emotional well-being, daily living, and balancing work and life responsibilities
- **Child and elder care referral** — unlimited telephonic consultation with a work-life specialist (part of Work-life services)
- **Employee discounts** — access to discounts on a large number of products and services, from gym memberships to dental, vision and pharmacy items, entertainment, restaurants, computers, cars, and much more
- **Medical billing negotiation tools** — information and guidance on negotiating medical bills

Legal/Financial assistance and resources*

- **Legal consultation** — unlimited telephonic support and free initial 30-minute face-to-face consultation with an attorney, includes a 25% discount on attorney services thereafter; online legal forms; extensive online law library
- **Financial consultation** — unlimited telephonic support for financial problems or planning needs; 30 days of financial coaching; extensive online financial library and calculators
- **ID theft** — free consultation with a trained Fraud Resolution specialist that will assist with ID theft resolution and education; ID theft educational materials available online
- **WillPrep** — online self-service documents available on EAP website; discounted estate planning package options available includes: $100 attorney assisted will package, $179 couples will package, $649 individual trust package, and $999 couples trust package**
- **Tax consultation** — tax questions only can be answered as part of the financial consultation offering
- **Online self-service legal documents** — examples include, but are not limited to, living trust, will, power of attorney, deeds

worklife.uprisehealth.com

Access code: worklife
Phone: 1-800-386-7055
24 hour crisis help available. Regular office hours: Monday-Friday 6am-5pm PST.

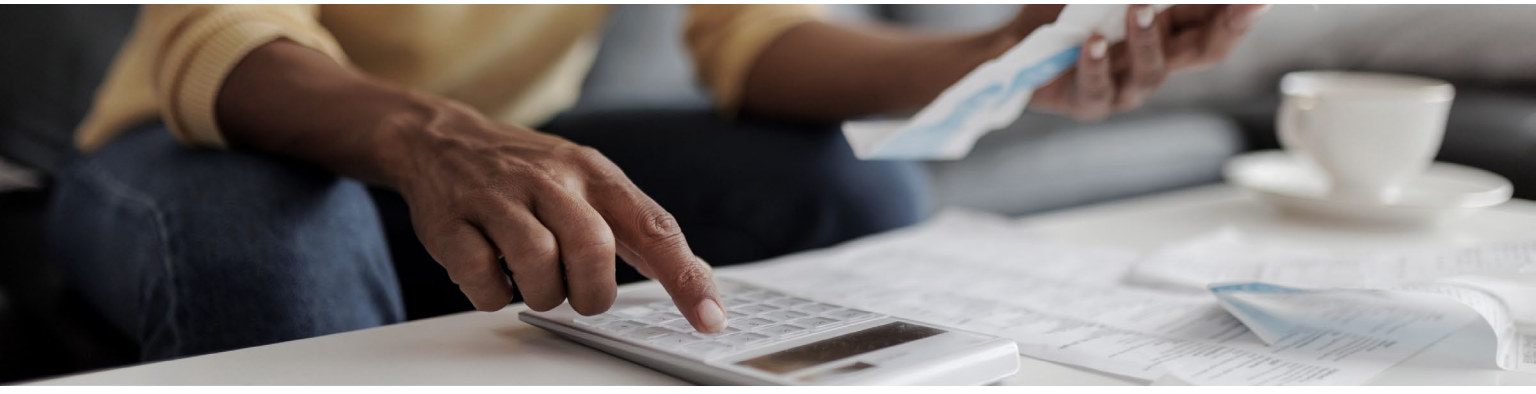
Contact Information

Provider directories and additional resources are available online and provide the most up-to-date information. You may also contact carriers directly with your questions.

We recommended you register for an online account with each carrier if an employee/member portal is available. This will allow you to manage your benefits, view your ID card, plan information, Explanation of Benefits (EOB), claim status and find in-network providers.

Benefit	Partner	Website / Phone
Medical & Prescription	Remodel Health	launch@remodelhealth.com
Dental Group #: 00028755	Guardian	guardianlife.com (800) 541-7846
Vision Group #: 00028755		guardianlife.com (877) 393-7363
Life Group #: 00028755		guardianlife.com (888) 482-7342
Disability Group #: 00028755		guardianlife.com Short-Term (800) 268-2525 Long-Term (800) 538-4583
Accident, Hospital, Critical Illness, Cancer		guardianlife.com (800) 541-7846
Employee Assistance Program (EAP)		(800) 386-7055 **Access Code**: Worksite

Your Total Cost



Please review your benefit options carefully and select the plans that best meet the needs of you and your family for the upcoming year.

As a reminder, once your benefits begin, you will not be able to make changes unless you experience a Qualified Life Event (please see the Eligibility page for further information).

You can use the table below to help you calculate your total cost of coverage.

Benefit	Coverage Tier	Cost Per Pay Period
Total Cost Per Pay Period		

Benefits Help Desk

You have access to the Prepare Benefits Help Desk through Propel Insurance. The Help Desk serves as a liaison between Campbell Street employees and insurance carriers to help you understand and navigate your benefits.

Website: **https://campbellstreet.benefitsinfo.com/**

Click the link above to schedule an appointment with a Benefit Counselor.
Available **Monday - Friday, 9AM - 6PM EST** *English & Spanish speaking counselors available*

Benefits Effective January 2026 – December 2026

(*) DISCLAIMER: This document has been prepared by Alera Group, Inc. (collectively with its parent, subsidiaries and affiliates, "Alera Group") to provide an overview of your employer's benefits program. Alera Group, its directors, officers, managers, employees, representatives and affiliates, make no representation or warranty, express or implied, as to the accuracy or completeness of the information contained herein regarding those lines of coverage for which Alera Group is not the exclusive broker of record. This document is not a contract and confers no contractual rights between you and Alera Group. The terms of your benefits are governed by the legal plan documents and insurance contracts ("Plan Documents") between your employer and one or more insurance carriers. This document is not a certificate of coverage, and the benefit descriptions in this document are not a guarantee of current or future claim coverage, nor does it replace or amend the underlying Plan Documents. If there is any difference between the benefit descriptions in this document and the Plan Documents, the terms of the Plan Documents will control. Your employer reserves the right to change, discontinue or terminate the benefit plans at any time.

CAMPBELL STREET

TO: Employees Eligible for Group Health Benefits under the HoldCo Tabletop LLC Group Health Plans

DATE: January 1, 2026

SUBJECT: Required Annual Notices for Group Health Plans

Important Information – Action May Be Required

To make sure that you have all the information you need to make informed decisions for you and your family, the law requires HoldCo Tabletop LLC to provide you with notice of certain legal rights that you may have and legal obligations that apply to the HoldCo Tabletop LLC Employee Benefits Plan. These rights and obligations are described in more detail in the enclosed notices.

Contents

Women's Health and Cancer Rights Act (WHCRA) Notice	Page 2
Newborns' and Mother's Health Protection Act (NMHPA) Notice	Page 2
Medical Loss Ratio (MLR) Rule Notice	Page 2
Notice of HIPAA Privacy Practices	Page 3
Notice of HIPAA Special Enrollment Rights	Page 6
Health Insurance Marketplace Coverage Options and Your Health Coverage	Page 7
Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)	Page 9
Model General Notice of COBRA Continuation Coverage Rights	Page 14
Your Rights and Protections Against Surprise Medical Bills	Page 18
ACA Reporting Notice	Page 20

You should review these notices closely and keep them with other materials that you receive about benefits available under the Plan. If you have any questions about any of the legal rights and obligations described below or the Plan, you should write or call:

Allison Morris, VP of HR & Talent Strategy
200 N LaSalle, Suite 1550 | Chicago, IL 60606
(770) 855-8364 | amorris@campbellstreetsl.com

The following notices are not intended to be a description of the benefits offered under the Plan. For more information about specific benefits, refer to the Summary Plan Descriptions for the Plan, which are available by logging into Paycom or contacting Human Resources.

Women's Health and Cancer Rights Act (WHCRA) Notice

Enrollment Notice

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

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

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

-

If you would like more information on WHCRA benefits, contact your plan administrator:

Allison Morris
VP of HR & Talent Strategy
(770) 855-8364
amorris@campbellstreetsl.com

Annual Notice

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

Newborns' and Mother's Health Protection Act (NMHPA) Notice

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

Medical Loss Ratio (MLR) Rule Notice

The Affordable Care Act requires health insurers in the individual and small group markets to spend at least 80 percent of the premiums they receive on health care services and activities to improve health care quality (in the large group market of 51+ employees, this amount is 85 percent). This is referred to as the Medical Loss Ratio (MLR) rule or the 80/20 rule. If a health insurer does not spend at least 80 (85 for large

groups) percent of the premiums it receives on health care services and activities to improve health care quality, the insurer must rebate the difference.

Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice is intended to inform you of the privacy practices followed by the HoldCo Tabletop LLC Health Plan and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on 01/01/2026.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. HoldCo Tabletop LLC requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share

information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of HoldCo Tabletop LLC for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities. We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Allison Morris
VP of HR & Talent Strategy
(770) 855-8364
amorris@campbellstreetsl.com

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Notice of HIPAA Special Enrollment Rights

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

Loss of Other Coverage

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

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.

Medicaid or CHIP

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

To request special enrollment or obtain more information, please contact:

Allison Morris
VP of HR & Talent Strategy
(770) 855-8364
amorris@campbellstreetsl.com

Health Insurance Marketplace Coverage Options and Your Health Coverage

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 9.96% (2026, indexed annually) 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 9.96% (2026, indexed annually) of the employee's household income.

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

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

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

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. 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 www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

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

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

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

List begins on next page.

ALABAMA – Medicaid	ALASKA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: www.myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: www.myarhipp.com Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: www.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: www.healthfirstcolorado.com HFC Member Contact Center: 1-800-221-3943 / State Relay 711 CHP+ Website: https://hcpf.colorado.gov/child-health-plan-plus CHP + Customer Service: 1-800-359-1991 / State Relay 711 Health Insurance Buy-In Program (HIBI): www.mycohibi.com HIBI Customer Service: 1-855-692-6442	Website: www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.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: www.in.gov/medicaid or 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: https://hhs.iowa.gov/programs/ welcome-iowa-medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: https://hhs.iowa.gov/programs/ welcome-iowa-medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://hhs.iowa.gov/programs/ welcome-iowa-medicaid/fee-service/hipp 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	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: 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: www.dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA - Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: 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: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx 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: 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: www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 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: https://dvha.vermont.gov/members/medicaid/hipp-program 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/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

Model General Notice of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice in case, once enrolled, your coverage under a group health plan (the Plan) ends due to a qualifying life event (described later). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

Allison Morris
VP of HR & Talent Strategy
(770) 855-8364
amorris@campbellstreetsl.com

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability

would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must provide this notice to:

Allison Morris
VP of HR & Talent Strategy
(770) 855-8364
amorris@campbellstreetsl.com

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

*For more information on the 8-month special enrollment period visit:
www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

To obtain more information about the Plan and COBRA continuation coverage upon request, contact the following person:

Allison Morris
VP of HR & Talent Strategy
(770) 855-8364
amorris@campbellstreetsl.com

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, or deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

As of August 2022, the following 18 states had enacted comprehensive Balance Billing Protections: California, Colorado, Connecticut, Florida, Georgia, Illinois, Maine, Maryland, Michigan, New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon Texas, Virginia, Washington.

As of August 2022, the following 15 states had enacted limited Balance-Billing Protections: Arizona, Delaware, Indiana, Iowa, Massachusetts, Minnesota, Mississippi, Missouri, Nebraska, Nevada, North Carolina, Pennsylvania, Rhode Island, Vermont, West Virginia.

Generally, those state passed protections apply to fully insured medical plans governed by the specific state and not self-funded medical plans. Check the state insurance commissioner website for details on specific state laws.

If your state is not listed, check your state commissioner's website as states may adopt a surprising billing mandate at any time.

Certain Services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network

cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

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

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, you may contact the US Dept. of Health & Human Services at 1-877-696-6775 or your State Insurance Commissioner.

ACA Reporting Notice

In an effort to reduce waste and promote efficiency, HoldCo Tabletop LLC Employee Benefits Plan is taking advantage of a new law that allows us to make your IRS Form 1095-C or Form 1095-B available to you only upon request. We are required to file this form with the IRS to show whether we offered you healthcare coverage in one or more months of calendar year 2025. If you recall, in the past, this form was mailed you in the first quarter of the year. However, pursuant to the new law, we will not be mailing the forms this year.

While we are no longer automatically mailing the form to you, you can request a copy of your form at any time. If you are interested in obtaining a copy of your form, you may contact:

Allison Morris
VP of HR & Talent Strategy
(770) 855-8364
amorris@campbellstreetsl.com

We will provide the form to you within thirty (30) days of your request.