2025
Benefits Guide

sonrava HEALTH®

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BENEFIT BASICS

CONTACTS

Need more information? Use this handy list to contact our benefit vendors directly with your questions.

Benefit	Vendor	Phone Number	Website / Email
General Information	Sonrava Health Benefits Department	**Phone:** 866-523-4359 **Fax:** 714-481-0835	**employeebenefits @westerndental.com** **Sonrava.benefitsinfo.com**
Medical (PPOs)	Powered by Personify Health	800-442-7247	**www.mycarehc.com**
Medical (HMOs) *Only available to team members in California.*	Kaiser Permanente	800-278-3296	**www.kp.org**
Health Savings Account	WEX	866-451-3399	**www.wexinc.com/contact/ health/**
Health Savings Account *Only available to team members in California.*	Kaiser Permanente	800-278-3296	**www.kp.org/healthpayment**
Dental	Sonrava Health	800-992-3366	**Sonrava.benefitsinfo.com**
Dental	Companion Life	877-676-5789	**www.companionlife.com**
Vision	Companion Life	877-676-5789	**www.companionlife.com**
Accident Insurance	Companion Life	877-676-5789	**www.companionlife.com**
Critical Illness			
Hospital Indemnity	Mutual of Omaha	800-877-5176	**www.mutualofomaha.com**
Flexible Spending Accounts	WEX	866-451-3399	**www.wexinc.com/contact/ health/**
Life & AD&D	Companion Life	877-676-5789	**www.companionlife.com**
Short-Term Disability	Companion Life	877-676-5789	**www.companionlife.com**
Long-Term Disability	Mutual of Omaha	800-877-5176	**www.mutualofomaha.com**

Benefit	Vendor	Phone Number	Website / Email
401(k) Plan	Voya	855-817-1667	**westerndental401k.voya. com**
Employee Assistance Plan	HealthySpark	800-968-8143	**www.firstsuneap-healthyspark.com**
Maternal Health	Ovia Health	N/A	**www.oviahealth.com/join** **support@oviahealth.com**
Cancer Coverage	Genomic Life	844-694-3666	**www.genomiclife.com** **navigation@genomiclife.com**
Identity Theft	IDShield	888-807-0407	**www.shieldbenefits.com/sonrava/overview**
Legal	LegalShield	888-807-0407	**www.shieldbenefits.com/sonrava/overview**
Ticket Discounts	TicketsatWork	**Direct:** 866-273-5825 **Toll Free:** 800-331-6483	**www.ticketsatwork.com** (company code: WDO714)
Commuter Benefits	WEX	866-451-3399	**customerservice@ wexhealth.com**
Leave of Absence	Alight	800-441-9052	**westerndental. myleaveproservice.com/**
Pet Insurance	Spot	800-905-1595	Use EB_SONRAVA **www.spotpet.link/sonrava**

ELIGIBILITY

EMPLOYEES

All active full-time team members regularly scheduled to work 30 or more hours per week (16 or more days per month for doctors) are eligible for health and welfare benefits. Coverage will begin on the first of the month following 60 days of continuous, active, full-time employment.

ELIGIBLE DEPENDENTS

You may also enroll dependents. Eligible dependents include your:

- Legal spouse.
- Domestic partner (registered in the state of residence).
- Children, children under legal guardianship, stepchildren, or adopted children.
- Enrolled children who have reached age 26 and are physically or mentally incapable of self-support and rely on you for support and maintenance (medical certification required).

QUALIFYING LIFE EVENTS

Other than during Annual Open Enrollment, you may only make changes to your benefit elections if you experience a qualified life event. You will be required to submit proof of the coverage change. The life event must be reported within 30 days of the effective date.

QUALIFIED LIFE EVENTS INCLUDE:

- Change in legal marital status, including marriage, divorce, or death of a spouse.
- Change in number of dependents, including birth, adoption, placement for adoption, or death of a dependent child.
- Change in employment status that affects benefit eligibility, including the start or termination of employment by you, your spouse, or your dependent child.
- Change in work schedule, including an increase or decrease in hours of employment by you, your spouse, or your dependent child, including a switch between part-time and full-time employment that affects eligibility for benefits.
- Change in a child's dependent status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them.
- Change in place of residence or worksite that affects the accessibility of network providers.
- Change in your health coverage or your spouse's coverage attributable to your spouse's employment.
- Change in an individual's eligibility for Medicare or Medicaid.
- A court order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) requiring coverage for your child.
- An event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act. Under provisions of the Act, team members have 60 days after the following events to request enrollment:
  - Team member or dependent loses eligibility for Medicaid or CHIP.
  - Team member or dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

Any change you make must be consistent with the change in status, and you must contact Employee Benefits within 30 days. Proof will be required prior to processing life events (i.e., marriage certificate, birth certificate, loss of kin, etc.)

HOW TO ENROLL

ASSISTED ENROLLMENT:

Sonrava Health is excited to announce it will be providing 1:1 virtual appointments with a personal Benefit Counselor to provide additional support during Open Enrollment and throughout the plan year.

Visit **sonrava.benefitsinfo.com** to schedule your appointment and learn more about our benefits.

TO SELF-ENROLL IN BENEFITS:

- ☑ Go Online: Visit **employeenavigator.com** on your computer or mobile device before the end of your enrollment period.
- ☑ New Users: Click the link to register as a new user to create your account, set a username and password. You'll need the Company Identifier: **Sonrava**
- ☑ Returning Users: Log-in with the username and password you selected. Forgot your username or password? Simply click the links on the log-in page to reset.
- ☑ Choose Your Benefits: Make sure you pay close attention to the benefits available to you, as well as the coverage levels from which you can choose.
- ☑ Confirm the Accuracy of Your Selections: It is always a good idea to confirm your selections after you complete enrollment. Once the enrollment period is over, you can't change your elections unless you experience a Qualified Life Event (QLE).

If you are having trouble logging on the system, contact your benefits department.

If you are…	And you enroll…	Your coverage effective date is…
A current team member	During Annual Open Enrollment	January 1, 2025
A new hire	Within 30 days of hire	The first day of the month following 60 days of employment
A team member who experiences a qualified life event	Within 30 days of the life event	The first of the following month, except for new births, which is the day of birth

COBRA

If you terminate employment with Sonrava Health and you qualify for COBRA coverage, you will receive a COBRA packet from Sonrava Health's COBRA Administrator, WEX, within 7 to 14 days of your termination.

If you would like to elect COBRA coverage, it is important that you review the information in the packet and follow the instruction provided to complete your COBRA enrollment in a timely manner.

Medical, Dental, and Vision coverage will remain in effect until the end of the month of your termination date. All other benefits will end on your last day of employment. If you are enrolled in a benefit with the option to port (or take the benefit with you), you will receive instructions from Companion Life and/or Mutual of Omaha.

THE COST OF YOUR BENEFITS

The following are amounts taken from your paycheck for each benefit.

MEDICAL – BI-WEEKLY

Type of Coverage	Cost Per Paycheck				
	Blue Shield			Kaiser	
	Gold PPO	Silver PPO	HDHP PPO w/HSA	HMO	HDHP HMO w/ HSA
Team Member Only	$301.79	$123.72	$81.18	$203.80	$133.97
Team Member + One	$562.98	$256.51	$213.29	$501.34	$369.93
Team Member + Family	$726.05	$394.50	$341.63	$724.92	$608.40

MEDICAL – SEMI-MONTHLY

Type of Coverage	Cost Per Paycheck				
	Blue Shield			Kaiser	
	Gold PPO	Silver PPO	HDHP PPO w/HSA	HMO	HDHP HMO w/ HSA
Team Member Only	$326.94	$134.03	$87.95	$220.79	$145.14
Team Member + One	$609.90	$277.89	$231.06	$543.11	$400.76
Team Member + Family	$786.55	$427.38	$370.10	$785.34	$659.10

DENTAL PPO – BI-WEEKLY

Type of Coverage	Cost Per Paycheck	
	Low (PPO)	High (PPO)
Team Member Only	$11.61	$17.74
Team Member + Spouse/ Domestic Partner	$23.04	$35.34
Team Member + Child(ren)	$25.67	$39.50
Team Member + Family	$39.72	$61.13

DENTAL PPO – SEMI-MONTHLY

Type of Coverage	Cost Per Paycheck	
	Low (PPO)	High (PPO)
Team Member Only	$12.58	$19.22
Team Member + Spouse/ Domestic Partner	$24.97	$38.30
Team Member + Child(ren)	$27.81	$42.80
Team Member + Family	$43.03	$66.23

DISCOUNT DENTAL – BI-WEEKLY *Only available at Western Dental and Brident offices.*

Type of Coverage	Cost Per Paycheck		
	Premier Choice (AZ)	Discount Program (TX & NV)	Sonrava Health DHMO (CA)
Team Member Only	$1.91	$0.00	$2.71
Team Member + Spouse/ Domestic Partner	$3.62	$0.00	$4.58
Team Member + Family	$4.96	$0.00	$6.75

DISCOUNT DENTAL – SEMI-MONTHLY *Only available at Western Dental and Brident offices.*

Type of Coverage	Cost Per Paycheck		
	Premier Choice (AZ)	Discount Program (TX & NV)	Sonrava Health DHMO (CA)
Team Member Only	$2.07	$0.00	$2.94
Team Member + Spouse/ Domestic Partner	$3.92	$0.00	$4.96
Team Member + Family	$5.37	$0.00	$7.31

VISION – BI-WEEKLY

Type of Coverage	Cost Per Paycheck
	VSP Vision Plan
Team Member Only	$3.06
Team Member + One	$6.64
Team Member + Family	$10.70

VISION – SEMI-MONTHLY

Type of Coverage	Cost Per Paycheck
	VSP Vision Plan
Team Member Only	$3.32
Team Member + One	$7.20
Team Member + Family	$11.59

VOLUNTARY LIFE AND AD&D

Age of Covered Individual (Team Member/Spouse)	**Cost Per Month** (Per $1,000 in Voluntary Coverage)
Under Age 30	$0.053
Age 30-34	$0.056
Age 35-39	$0.075
Age 40-44	$0.116
Age 45-49	$0.168
Age 50-54	$0.248
Age 55-59	$0.448
Age 60-64	$0.608
Age 65-69	$0.878
Age 70 and over	$1.618

Age of Covered Individual (Child)	**Cost Per Month*** (Per Covered Child and Coverage Amount)			
	$2,500 in Child Coverage	$5,000 in Child Coverage	$7,500 in Child Coverage	$10,000 in Child Coverage
Child is covered up to age 26	$0.34	$0.68	$1.02	$1.36

** Children ages 14 days to 6 months are only eligible for $1,000 of coverage.*

SHORT-TERM DISABILITY

Your contribution to this benefit is taken from your paycheck after taxes (excluding California and New Jersey employees).

Your Age	**Cost Per Month** (Per $10 in Coverage)
	Short-Term Disability Insurance
All Ages	$ 1.02

LONG-TERM DISABILITY

Your contribution to this benefit is taken from your paycheck after taxes.

Your Age	**Cost Per Month** (Per $100 of Monthly Covered Payroll)	
	All Employees Outside of California: Class 1	All Employees In California: Class 2
Age 18-24	$0.15	$0.12
Age 25-29	$0.25	$0.23
Age 30-34	$0.44	$0.40
Age 35-39	$0.71	$0.64
Age 40-44	$1.22	$1.10
Age 45-49	$1.59	$1.43
Age 50-54	$2.26	$2.03
Age 55-59	$2.91	$2.62
Age 60-64	$2.24	$2.02
Age 65 and over	$1.52	$1.37

HOSPITAL INDEMNITY – BI-WEEKLY

Type of Coverage	Cost Per Paycheck
Team Member Only	$8.71
Team Member + Spouse/Domestic Partner	$19.17
Team Member + Child(ren)	$11.72
Team Member + Family	$23.45

HOSPITAL INDEMNITY – SEMI-MONTHLY

Type of Coverage	Cost Per Paycheck
Team Member Only	$9.44
Team Member + Spouse/Domestic Partner	$20.77
Team Member + Child(ren)	$12.70
Team Member + Family	$24.40

CRITICAL ILLNESS

Employee **Options of $5,000-$50,000** (based on $1,000 coverage level)	
Employee Age	Monthly Premium
18-29	$0.22
30-39	$0.48
40-49	$0.97
50-59	$1.88
60-64	$3.15
65-69	$4.01
70+	$8.16

Employee + Family **Options of $1,250-$12,500** (based on $1,000 coverage level)	
Employee Age	Monthly Premium
18-29	$1.10
30-39	$1.36
40-49	$1.85
50-59	$2.76
60-64	$4.03
65-69	$4.89
70+	$9.04

ACCIDENT – BI-WEEKLY

Type of Coverage	**Cost Per Paycheck** (based on $100,000 coverage level)
Team Member Only	$6.71
Team Member + Spouse	$10.59
Team Member + Child(ren)	$12.74
Team Member + Family	$16.62

ACCIDENT – SEMI-MONTHLY

Type of Coverage	**Cost Per Paycheck** (based on $100,000 coverage level)
Team Member Only	$7.27
Team Member + Spouse	$11.47
Team Member + Child(ren)	$13.80
Team Member + Family	$18.00

GENOMIC LIFE [CANCER TESTING] – BI-WEEKLY

Type of Coverage	Cost Per Paycheck	
	Team Member Only	Team Member + Family
Up to 50	$8.31	$16.61
50-64	$10.15	$20.31
65+	$12.00	$24.00

GENOMIC LIFE [CANCER TESTING] – SEMI-MONTHLY

Type of Coverage	Cost Per Paycheck	
	Team Member Only	Team Member + Family
Up to 50	$9.00	$17.99
50-64	$11.00	$22.00
65+	$13.00	$26.00

LEGAL/CREDIT – BI-WEEKLY

Type of Coverage	Cost Per Paycheck		
	LegalShield	IDShield	LegalShield + IDShield
Team Member Only	$6.23	$3.00	$8.54
Team Member Plus Family		$5.19	$10.27

LEGAL/CREDIT – SEMI-MONTHLY

Type of Coverage	Cost Per Paycheck		
	LegalShield	IDShield	LegalShield + IDShield
Team Member Only	$6.75	$3.25	$9.25
Team Member Plus Family		$5.63	$11.13

SPOT PET INSURANCE

Type of Coverage	Cost Per Paycheck
	Pet Insurance
Dog	For more information and to receive a quote, visit: **https://spotpet.link/sonrava** Or Call 800-905-1595 and Use EB_SONRAVA
Cat	

HEALTH

MEDICAL

Sonrava Health offers eligible team members access to several medical plan options.

MEDICAL PLAN OPTIONS

You can choose from three PPO medical plans through Blue Shield powered by Personify Health. If you are in California, you can also choose from two additional medical plans through Kaiser Permanente.

All medical plans provide comprehensive medical coverage intended to:

- Keep your health on track by offering **fully-covered preventive care**. .
- Be there for you when you're ill; covering a wide range of services, including **comprehensive prescription drug coverage**.
- **Protect you** from the catastrophic financial effects of a serious illness or injury.

SONRAVA HEALTH MEDICAL PLANS

HOW THE MEDICAL PLANS WORK

1. **Preventive Services** (such as checkups, patient counseling, and screenings to prevent illness, disease, and other health related problems) are **covered at 100%** when provided through network providers. Covered preventive services for adults, women, and children are included in all medical plan options.
2. Some non-preventive services (called Diagnostic Services) may require you to pay a pre-set dollar amount — called a **copay** — at the time of service. The copay is required regardless of whether you have met your deductible.
3. Other non-preventive services may require you to pay the full cost of the service out of pocket until you meet the **plan deductible requirement.** The amount of your plan deductible is based on which medical plan you select, the level of coverage and the provider network.
4. Once the deductible is met and you pay any required copays, you and the plan begin sharing eligible expenses — called **coinsurance**.
5. As a safety net, there is an **out-of-pocket maximum** that limits how much you pay out of your own pocket per year and protects you from the impact of large claims. Once this out-of-pocket maximum is met, the plan pays 100% of eligible expenses for the remainder of the plan year, subject to reasonable and customary charges.

   Deductibles, copayments, coinsurance, and other payments for qualified medical benefits covered by the plan will count toward the out-of-pocket maximum. An additional out-of-pocket maximum applies to prescription drug benefits.

SAVE WITH PRE-TAX DOLLARS!

Dependent upon the medical plan you choose, you have access to the Health Care FSA or the Health Savings Account to help offset any deductible and to pay for eligible medical, prescription drug, dental, or vision expenses with pre-tax contributions.

BLUE SHIELD PREFERRED PROVIDER ORGANIZATION (PPO) PLANS

(Offered through Personify Health to Team Members living in and outside of California)

The PPO Plans let you visit the **doctor of your choice**. You may see an out-of-network provider; however, **your out-of-pocket expenses will be less when you see an in-network provider**. Once you reach the deductible, you will pay coinsurance until the out-of-pocket maximum is met; then the plan will pay 100 percent.

SUMMARY OF BENEFITS

Feature	Blue Shield Gold PPO	Blue Shield Silver PPO	Blue Shield HDHP PPO w/HSA
Network	In-Network You Pay	In-Network You Pay	In-Network You Pay *
Deductible	**Aggregate**	**Aggregate**	**Embedded**
Individual	$500	$2,500	$3,300
Family	$1,000	$5,000	$6,600
Out of Pocket Maximum *The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.*			
Individual	$3,500	$7,500	$7,000
Family	$7,000	$15,000	$14,000
Lifetime Maximum			
Individual	Unlimited	Unlimited	Unlimited
Family	Unlimited	Unlimited	Unlimited
Physician Services			
Annual Physicals	$0	$0	$0
Physician office visit	$25 copay	$25 copay	$30 after deductible
Specialist	$40 copay	$40 copay	$30 after deductible
X-rays or lab diagnostics	20% after deductible	20% after deductible	30% after deductible
Emergency Room Services	$500 copay (waived if admitted)	$750 copay (waived if admitted)	30% after deductible
Prescription Drugs			
Retail (30-day supply)	• **Generic**: $10 copay • **Brand Preferred:** $30 copay • **Brand Nonpreferred:** $45 copay • **Specialty:** 50% ($200 max)	• **Generic**: $10 copay • **Brand Preferred:** $30 copay • **Brand Nonpreferred:** $45 copay • **Specialty:** 50% ($400 max)	• **Generic**: $15 copay • **Brand Preferred:** $30 copay • **Brand Nonpreferred:** $50 copay • **Specialty:** 50% ($400 max)
Mail Order (90-day supply)	• **Generic**: $20 copay • **Brand Preferred:** $60 copay • **Brand Nonpreferred:** $90 copay • **Specialty:** n/a	• **Generic**: $20 copay • **Brand Preferred:** $60 copay • **Brand Nonpreferred:** $90 copay • **Specialty:** n/a	• **Generic**: $30 copay • **Brand Preferred:** $60 copay • **Brand Nonpreferred:** $100 copay • **Specialty:** n/a

**Blue Shield HDHP copays and coinsurance is after deductible.*

Embedded Deductible: *Each individual family member has their own deductible, and those individual deductibles also count towards the overall family deductible. Once the individual deductible has been met for a individual family member, the insurance starts paying its portion for that member, even if the overall family deductible has not been met.*

Aggregate Deductible: *All family members expenses contribute to the family deductible regardless of who incurs them. Once the family deductible has been met, the insurance starts paying its portion for all family members.*

HOW MUCH CAN I PUT IN MY HSA?

If you enroll in the Blue Shield HDHP PPO with HSA, you're eligible to contribute to a health savings account to help offset the cost of your medical coverage. See the "**Health Savings Account**" section for details.

Sonrava Health will contribute $100 semi-annually in January and June for those opting for the Blue Shield HDHP PPO with HSA Plan.

HEALTH MAINTENANCE ORGANIZATION (HMO) PLANS

(Offered through Kaiser Permanente to Team Members living in California)

The HMO Plans provide health coverage through a select group of doctors and providers. Under an HMO, you must receive care from an in-network provider – there is no out-of-network coverage. By limiting coverage to only in-network providers, your cost for coverage is generally lower than for other kinds of health insurance.

As an HMO participant you must choose a primary care physician (PCP) from the network of local providers. Your PCP is your first point of contact for all health-related issues. In other words, you start the process by meeting with your PCP, who will coordinate your care – for example, referring you to a specialist.

SUMMARY OF BENEFITS

Feature	Kaiser Permanente HMO	Kaiser Permanente HDHP HMO with HSA
Network	All care must be received in-network	
Deductible *Once each family member meets his/her "embedded" deductible, health insurance begins paying for covered services, regardless of whether the larger family deductible is met.*		
Individual	$1,500	$3,500
Family	$3,000	$7,000
Out of Pocket Maximum *The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.*		
Individual	$4,000	$6,350
Family	$8,000	$12,700
Lifetime Maximum		
Individual	Unlimited	Unlimited
Family	Unlimited	Unlimited
Physician Services		
Annual Physicals	$0	$0
Physician office visit	$20 copay	$30 copay
X-rays or lab diagnostics	$10 copay after deductible	$30 copay after deductible
Emergency Room Services	20% after deductible	30% after deductible
Prescription Drugs		
Retail (30-day supply)	**Generic**: $10 copay **Brand:** $30 copay **Specialty:** $30 copay	**Generic**: $15 copay **Brand:** $40 copay **Specialty:** $40 copay
Mail Order (90-day supply)	**Generic**: $20 copay **Brand Preferred:** $60 copay **Specialty:** n/a	**Generic**: $30 copay **Brand:** $80 copay **Specialty:** n/a

HOW MUCH CAN I PUT IN MY HSA?

If you enroll in the Kaiser Permanente HDHP HMO with HSA, you're eligible to contribute to a health savings account to help offset the cost of your medical coverage. See the "**Health Savings Account**" section for details.

MEDICAL CONTRIBUTIONS - YOUR BI-WEEKLY COSTS

See the **The Cost of Your Benefits** section for details.

Sonrava Health will contribute $100 semi-annually in January and June for those opting for the Blue Shield HDHP PPO with HSA Plan.

PLAN PROGRAMS

There are a number of special programs you can participate in that can help you get the most out of your benefits. These include:

Program	Description
ImpaxRx	ImpaxRX™ is an integrated patient advocacy program that will assist you with high-cost medications (over $1,500). Once approved, you will receive medication directly from the manufacturer and no cost or copay. Qualifying members will be contacted directly by an ImpaxRX Advocate. You can contact ImpaxRX by calling 844-467-2979, option 1.
Ovia Health	Ovia Health offers you daily support for your maternity, parenthood and personal health journey. Get a health assessment, track symptoms, access personalized content and tips, search our benefit library or access more than 50+ physician-developed health programs. Visit **www.oviahealth.com** to learn more about Ovia's maternity and family benefits.
Telemedicine (Blue Shield Plans)	Blue Shield offers a convenient telemedicine program providing virtual care 24/7/365. This program allows you to connect with a doctor over video via your computer, smartphone, or tablet. Telemedicine doctors can answer questions, make a diagnosis, and even prescribe basic medications when needed. You can contact Teladoc at: **Web:** Log into **www.teladoc.com/bsc** **Mobile:** Visit **www.teladoc.com/mobile** and download the app **Phone:** 800-Teladoc (835-2362)
Telemedicine (Kaiser Plans)	Get care from a doctor for minor health conditions such as allergies and colds over the phone. The cost is the same as a visit to your primary care physician. To manage your account online, visit **www.kp.org**. Appointments are scheduled for the same day after speaking to a KP Service Associate by calling 800-278-3296.
TicketsatWork	TicketsatWork gives you access to exclusive savings on movie tickets, theme parks, hotels, tours, Broadway and Vegas shows and much more! The program's products and discounts are constantly updated, so visit **www.ticketsatwork.com** (company code: WDO714) to see what's available today.

Program	Description
Prescription Drug Program (Blue Shield Plans)	The prescription drug benefit program is managed by OptumRX Member Services. Members have access to a variety of tools to make managing their prescriptions convenient and cost effective. Register for your online account at **www.optumrx.com** or call 855-812-4302
Prescription Drug Program (Kaiser Plans)	Covers drugs that have been approved through the Kaiser Permanente formulary process. You have two options for how to fill prescriptions: • For short-term medications (up to a 30-day supply) and long-term medications (up to a 90-day supply), fill your prescription at a Kaiser Permanente pharmacy. • Order refills online or call the phone number at the top of your prescription label to receive your prescription refills by mail. You can contact Kaiser RX by calling 800-464-4000.
Purchasing Power	Purchasing Power is a reliable way to buy computers, appliances, electronics and more when paying with cash or credit is challenging. Get your product upfront and pay over 6 to 12 months directly from your paycheck with no downpayment. With Purchasing Power you get: • Access to the things you need with no credit check. • The ability to find the items you need to create a more comfortable and productive home. • A better alternative to loans, high-interest credit cards or rent-to-own. To view program details and see if you're eligible, visit **www.wd.purchasingpower.com**.
Sera PreTRM	If you're expecting, a PreTRM Test is a single blood draw, usually done in weeks 18 through 20 of your pregnancy. Coordinated through Sera Prognostics, the test measures proteins in the blood that can show if you are at higher risk of giving birth prematurely. This report is then sent to your doctor, who can advise you about your individual risk and adjust your treatment plans if needed. By knowing your risk early in your pregnancy, you have time to plan and prepare. All medical information and test results stay between you and your provider – the results are not shared with the company. For more information about how to obtain the test, visit www.PreTRM.com or call the Sera Prognostics Customer Support Team at 801-990-6605.
Solera Health	Solera is a free 16-week program that helps you lose weight, maintain healthy habits and reduce your risk of type 2 diabetes. Solera provides access to a personal health coach, weekly lessons, small group for support and tools like a wireless scale or an activity tracker. To see if you qualify, visit **www.solera4me.com** and answer a few simple questions.

DENTAL

Regular dental care is important to your overall health. A routine dental exam can help identify many diseases — including heart disease, diabetes, anemia, kidney disease and more. It also can save you money by catching a minor dental issue before it becomes a major one.

HOW THE PLANS WORK

- You can choose any dental provider you wish to use; however, when you use an in-network dentist, you'll generally pay less.
- If you choose an out-of-network provider in the Premier Choice, Discount Program or Western Dental and Brident Discount Program, you may be billed the difference between what the provider pays, and what your out-of-network provider charges for the services.
- The Companion Life Dental High and Low plans provide access to the United Concordia, DenteMax and Zellis for in-network services. To search in-network providers visit **www.compainonlife.com**.

SUMMARY OF BENEFITS – DENTAL PPO OPTIONS

Feature	Companion Life – Low		Companion Life – High	
	In-Network	Out-of Network	In-Network	Out-of Network
Annual Deductible	$50 per individual *Maximum of $150 per family*			
Annual Maximum Benefit *Maximum amount apples to Basic and Major Services Only*	$1,000	$1,000	$2,500	$2,500
Preventive Services *No waiting period Cleanings (2 per 12 months), exams, space maintainers, emergency pain, radiographs-bitewings (1 per 12 months), radiographs-full mouth x-rays*	100%	100%	100%	100%
Basic Services *No waiting period Restorations (amalgams and anterior resin), restorations (posterior resin), simple extractions, oral surgery, and crown, bridge and denture repairs*	80%	80%	90%	80%
Major Services *12-month waiting period* Surgical extractions, endodontics, periodontal maintenance, non-surgical and surgical periodontics, Inlays, onlays, crowns, bridges, dentures, implants and anesthesia*	50%	50%	60%	50%
Orthodontia *12-month waiting period* Coverage for High Dental Plan only*	Not covered	Not covered	50% Lifetime maximum of $1,500	50% Lifetime maximum of $1,500

SUMMARY OF BENEFITS – WESTERN DENTAL & BRIDENT DISCOUNT PROGRAM

Feature	Premier Choice (AZ)	Discount Program (TX & NV)	Sonrava Health DHMO (CA)
	In-Network Coverage		
Annual Deductible	None	None	None
Preventive Services	$0	$0	$0
Basic Services	Copays vary	Copays vary	Copays vary
Major Services			
Orthodontia			

VISION

COMPANION LIFE - VSP SUMMARY OF BENEFITS

Feature	Coverage	
	In-Network	Out-of-Network
Examination (every 12 months)	$10 copay	Plan reimburses up to $45
Materials	$25 copay	n/a
Lenses		
Single	No charge after materials copay	Plan reimburses up to $30
Bifocal	No charge after materials copay	Plan reimburses up to $50
Trifocal	No charge after materials copay	Plan reimburses up to $65
Frames (every 24 months)	Plan pays up to $180	Plan reimburses up to $70
Contact Lenses (every 12 months in lieu of lenses and frames)	Plan pays up to $180	Plan reimburses up to $105

Vision insurance does not provide a Member ID card for services; simply find a provider and make an appointment. Your member ID is your Social Security number. To find a provider, please login to **www.vsp.com**.

VISION CONTRIBUTIONS - YOUR BI-WEEKLY AND SEMI-MONTHLY COSTS

See the **The Cost of Your Benefits** section for details.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Make a positive change in your personal or professional life with the HealthySpark well-being program. The program offers you easy access to services and resources to help you lead a better life. A confidential call connects you to an intake specialist who will get you to the right resources. Start using your services today!

HOW THE PROGRAM WORKS

NO COST/NO ENROLLMENT

Sonrava Health covers the full cost for you and your dependent family members. You are automatically enrolled.

VARIOUS FORMS OF SUPPORT

Offers short-term counseling, referral and follow-up services and various topics.

ADDITIONAL SUPPORT

Visit **www.firstsuneap-healthyspark.com** or call 800-968-8143 for more information.

COUNSELING SESSIONS

Receive counseling sessions that fit your lifestyle via in-person, video, telephonic, chat or messaging. Benefit includes 3 counseling sessions – over the phone – per family, per year.

CONFIDENTIAL

Details of your participation and your discussions with EAP cannot generally be released to anyone without your consent.

WHAT'S COVERED?

The program's experienced counselors provided through First Sun — one of the nation's premier providers of Employee Assistance Program services — can talk to you about anything going on in your life, including:

- **CHILD & FAMILY**: Going through a divorce, caring for an elderly family member, returning to work after having a baby.
- **WORK:** Job relocation, building relationships with co-workers and managers, professional growth or navigating through reorganization.
- **FINANCIAL:** Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues.
- **LEGAL SERVICES:** Issues relating to civil, personal and family law, financial matters, real estate and estate planning.
- **IDENTITY THEFT RECOVERY:** ID theft prevention tips and help from a financial counselor if you are victimized.
- **PETS:** Get help with referral services for emergency care, groomers, pet sitting and obedience programs.
- **HEALTH:** Coping with anxiety or depression, substance misuse, or trauma.
- **EVERYDAY LIFE:** Moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, and spiritual matters.
- **EDUCATION:** Referrals for financial aid and scholarships, tutors and test prep courses, school/collection selections and testing for adults with learning disabilities.

PROTECTION

BASIC LIFE & ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Basic Life and AD&D insurance is an important part of your financial security — especially if others depend on you for support. Coverage is designed to provide assurance that your loved ones are protected from a financial hardship in the event of your death or dismemberment.

NEW $50,000 Basic Life benefit for benefit-eligible team members at no cost; 100% employer-paid.

HOW THE PROGRAM WORKS

- You do not need to enroll for this coverage. Sonrava Health pays 100% of the cost of this benefit.
- **NEW** maximum benefit is **$50,000.**
- No evidence of insurability (EOI) is required.

MAKE SURE TO NAME YOUR BENEFICIARY!

You'll need to name one or more beneficiaries for your life and AD&D benefits. If you don't, you're taking a chance that your assets won't be passed to your loved ones in the event of your death.

VOLUNTARY LIFE INSURANCE

If you would like additional protection beyond the Basic Life and AD&D Insurance coverage, you can choose to purchase Voluntary Life and AD&D Insurance at favorable group rates.

HOW THE PROGRAM WORKS

- Voluntary Life and AD&D Insurance is available for you, your spouse, and your dependent children.
- You must enroll yourself in voluntary coverage before enrolling your spouse or children.
- If you don't enroll in this coverage when it's first available to you (or you elect an amount over the guaranteed issue amount), you may be required to complete an Evidence of Insurability (EOI) form.

Insurance Coverage	Benefit
Voluntary Team Member Life and AD&D	Up to a maximum of $500,000
Voluntary Spouse Life and AD&D	Up to a maximum of $500,000
Voluntary Child Life and AD&D	$10,000 per child

YOUR CONTRIBUTIONS

See the **The Cost of Your Benefits** section for details.

SHORT-TERM DISABILITY (STD)

Sonrava Health provides the opportunity to elect Short Term Disability (STD) coverage for full-time team members working outside of California and New Jersey. **NOTE:** Team members working in California and New Jersey are covered by State Disability Insurance (SDI). For more information on SDI, contact the Employment Development Department (EDD) at **edd.ca.gov**.

HOW THE PLAN WORKS

- STD replaces a portion of your income if you are unable to work due to a covered injury or illness that is non-work related.
- Pregnancy is covered under this benefit the same as any other disability or incapacitation.
- This coverage pays a weekly benefit to provide some income during a time of need.

Short-Term Disability Coverage	
Weekly Benefit Amount	60% of your weekly pay (to a maximum of $1,000 per week)
Benefits Begin	15th day after your disability begins (the "elimination period") **Note:** Any unused PTO can be used to cover the elimination period.
Duration	Benefits end the earlier of: • The date your disability ends, or • 11 weeks

LONG-TERM DISABILITY (LTD)

Long-term disability insurance offers you financial protection if you become totally disabled, due to illness or injury, for an extended period and can no longer work. The plan will also help you return to work, if applicable.

HOW THE PLAN WORKS

- Long-Term Disability begins after your short-term disability benefits end or at the end of the elimination period below (if you do not elect short-term disability).
- If you become totally disabled, you'll receive a percentage of your pay, up to a certain maximum.
- This benefit amount may be offset by other benefits you are receiving, such as Social Security or workers' compensation.

Long-Term Disability Coverage	
Monthly Benefit Amount	60% of your monthly pay (to a maximum of $8,000 per month)
Benefits Begin	All Team Members Outside of California: After 90 days All Team Members in California: After 360 days
Duration	Benefits end the earlier of: • The date your disability ends, or • Your date of death

YOUR CONTRIBUTIONS

See the **The Cost of Your Benefits** section for details.

FINANCIAL BENEFITS & PROGRAMS

401(K) PLAN

Sonrava Health offers the 401(k) Plan to help you plan for and enjoy a secure retirement. All Sonrava Health team members are eligible to contribute to the 401(k) Plan.

HOW THE PLAN WORKS

1. YOU CONTRIBUTE

- If you are a new hire, you are automatically enrolled to contribute 3% of your eligible compensation to the 401(k) Plan beginning on the first of the month following 30 days of your hire date. You may opt out at any time by contacting the 401(k) administrator, Voya.
- You may contribute from a minimum of 1% of your eligible compensation up to 50% or the IRS limits (for 2025 the IRS limits are $23,500. If you're age 50 and older, **you can add an extra $7,500 per year in "catch-up" contributions, bringing your total 401(k) contributions for 2025 to $31,000.**
- You'll save and invest a piece of your paycheck before taxes are taken out – lowering the amount of your paycheck that is subject to federal income taxes.

2. YOUR FUNDS GROW

- You can choose from a variety of investment options so you can create an investment plan using different funds based on your personal financial goals.
- Your account balance grows as tax-deferred until you withdraw the funds.
- Note: The IRS has regulations on when you can withdraw your money, and there may be penalties if you withdraw before retirement age. Be sure to talk with your tax advisor before withdrawing these funds.

3. YOU BUILD OWNERSHIP

- You are always 100% vested (have ownership) in your own contributions.

For a full plan summary, visit **westerndental401k.voya.com** or contact Voya at 855-817-1667.

FLEXIBLE SPENDING ACCOUNTS (FSAs)

If you do not make an election during Annual Open Enrollment, you will not be able to participate in a flexible spending account for 2025 unless you have a qualified life event.

A great way to plan ahead and save money over the course of a year is to participate in an FSA. An FSA lets you redirect a portion of your salary on a pre-tax basis into a reimbursement account, saving you money on taxes.

Three important things to remember about FSA participation:

- **You must enroll each year to participate.** FSA participation does not carry over – you must elect the amount you want to contribute.
- **You forfeit any unused FSA amounts.** Unused funds at the end of the plan's grace period, as described below, are automatically forfeited.
- **You cannot participate in the Healthcare FSA if you are in an HSA medical plan.** If you enrolled in Blue Shield HDHP with HSA or the Kaiser HDHP HMO with HSA, you're not allowed to contribute to the Healthcare FSA. You can, however, contribute to the Limited Purpose FSA and Dependent Care FSA.

Sonrava Health offers three types of FSAs that can help you save on a pre-tax basis for out-of-pocket expenses.

Flexible Spending Account	Contribution Maximum
Healthcare FSA	$3,300 (employee only)
Limited Purpose FSA	$3,300 (employee only)
Dependent Care FSA	$5,000 (individual) $2,500 (married, filing separately)

HEALTHCARE FSA

The Healthcare Flexible Spending Account (FSA) is a great way to save on income taxes while you budget for health care expenses. Every dollar you set aside in your account reduces your taxes and allows you to be reimbursed for qualified expenses that you are already paying for—making Healthcare FSAs an easy, convenient way to help stretch your health care dollars.

LIMITED PURPOSE FSA

The Limited Purpose Flexible Spending Account (FSA) is a great way to save on income taxes while you budget specifically for dental and vision expenses. This plan is designed to be used in conjunction with your High Deductible Health Plan and Health Savings Account (HSA). Use the Limited Purpose FSA for immediate dental and vision needs while still contributing to and growing your HSA. Every dollar you set aside in your account reduces your taxes and allows you to be reimbursed for qualified expenses that you are already paying for—making Limited Purpose FSAs an easy, convenient way to help stretch your benefit dollars.

HOW THE ACCOUNT WORKS

1 CHOOSE

You choose the amount you want to contribute on a pre-tax basis through payroll contributions, up to a maximum amount set by the IRS each year. (2025 IRS Limit is $3,300)

2 SAVE

The money you contribute is not subject to payroll taxes, so you end up paying less in taxes and taking home more of your paycheck. Funds are available at the beginning of the plan year.

3 USE

Use your funds to pay for qualified eligible expenses such as copays, deductibles, coinsurance and other out-of-pocket costs.

4 ACCESS FUNDS

You can access your health care FSA funds through a debit issued by WEX. With this card, you can pay your expenses directly, without the need to complete a reimbursement form.

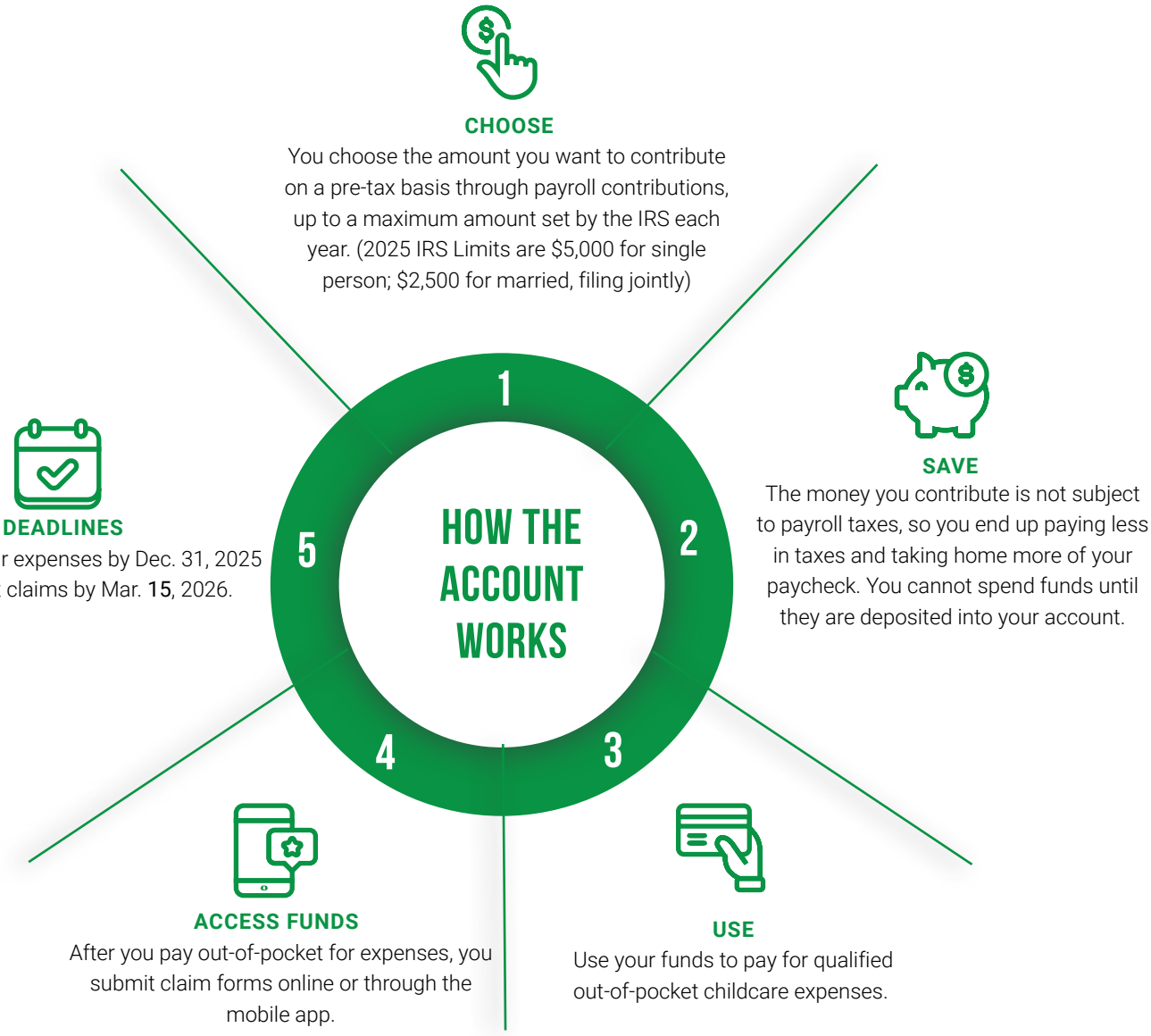
5 DEADLINES

FSAs are "use-it-or-lose-it" accounts, meaning any funds remaining after the end of the plan year will be forfeited. However, our plan has a carryover benefit allowing up to $660 of unused funds to continue onto the next plan year. Additionally, our plan has a 2½ month runout period that gives you additional time to file claims for expenses incurred during the previous plan year. After this runout period, however, you automatically forfeit any remaining amounts above the carryover threshold as determined each year by the IRS.

DEPENDENT CARE FSA

The dependent care FSA allows you to set aside money pre-tax to pay eligible out-of-pocket day care services, such as: Eligible expenses include (but are not limited to) child or adult (elder) day care, after-school care, work-related babysitting services, a nanny or au pair, as well as transportation to and from that care (if necessary). It is not available for non-work related care, child or elder activities, or household services. For full details on each FSA, including a current list of eligible expenses, claims filing deadlines and other information, visit the WEX website at www.wexinc.com/contact/health or call 866-451-3399.

Preschool	Summer Day Camp	Before or After School Programs	Child or Adult Daycare



CHOOSE

You choose the amount you want to contribute on a pre-tax basis through payroll contributions, up to a maximum amount set by the IRS each year. (2025 IRS Limits are $5,000 for single person; $2,500 for married, filing jointly)

SAVE

The money you contribute is not subject to payroll taxes, so you end up paying less in taxes and taking home more of your paycheck. You cannot spend funds until they are deposited into your account.

USE

Use your funds to pay for qualified out-of-pocket childcare expenses.

ACCESS FUNDS

After you pay out-of-pocket for expenses, you submit claim forms online or through the mobile app.

DEADLINES

You must incur expenses by Dec. 31, 2025 and submit claims by Mar. 15, 2026.

HEALTH SAVINGS ACCOUNT (HSA)

An HSA is a personal healthcare bank account you can use to pay out-of-pocket medical expenses with pre-tax dollars. You can open an HSA if you enroll in the:

- Blue Shield HDHP with HSA. Sonrava Health will contribute $100 semi-annually in January and June for those opting for the Blue Shield HDHP PPO with HSA Plan
- Kaiser Permanente HDHP HMO with HSA (available to California residents only).

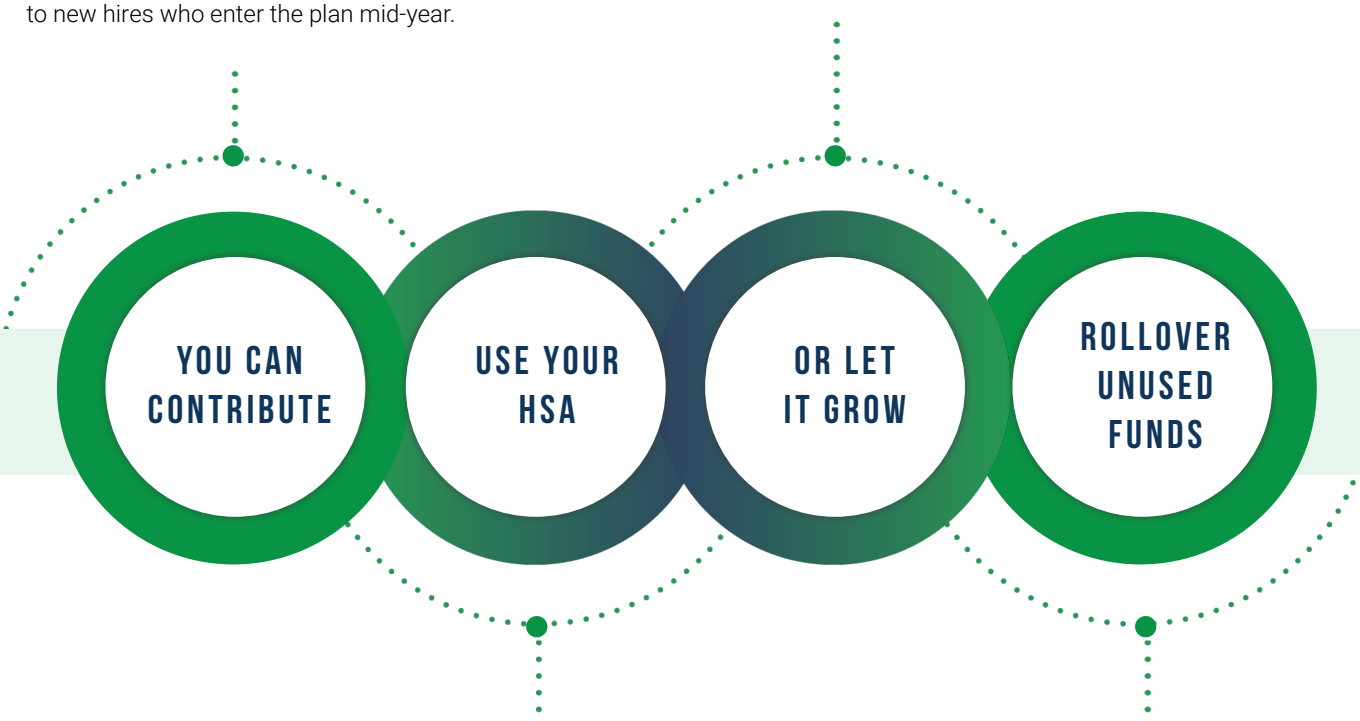
Common eligible expenses may include:

- Deductibles,Copays, and Coinsurance
- Eligible Prescriptions
- Vision Care
- Dental Care

HOW THE ACCOUNT WORKS

You are encouraged to contribute to your HSA on a pre-tax basis up to an annual limit set by the IRS (see Contribution Limits below). There are restrictions on eligibility for an HSA. See below for those specifications. If you are a new hire, please note that certain rules apply to new hires who enter the plan mid-year.

Unused HSA funds stay in your account from year to year, and you can use this money to reduce future out-of-pocket health expenses. You can even invest your HSA funds so your available healthcare dollars can grow over time.



You decide when to withdraw money from your HSA to pay for qualified medical expenses, including your deductible and coinsurance payments. It works like a bank account. You can access your HSA funds directly by using your HSA debit card. No claim forms to fill out.

At the end of the year, any unused HSA balance automatically carries over for use toward the upcoming year's eligible expenses. By managing your medical expenses wisely, you can grow your account year to year for use in the future, even during retirement. You own the account even when you leave or retire from Sonrava Health.

HSA ELIGIBILITY

You are eligible to open and fund an HSA if you:

- Are enrolled in the Blue Shield HDHP with HSA or the Kaiser HDHP HMO with HSA.
- **NEW:** Sonrava Health will make semi-annual contributions of $100 in January and June for those electing the Blue Shield HDHP PPO with HSA Plan.
- Are not enrolled in any other non-HSA qualified medical plan.
- Are not covered by your spouse's health plan (unless it is a qualified high-deductible health plan), flexible spending account (FSA) or health reimbursement account (HRA).
- Are not eligible to be claimed as a dependent on someone else's tax return.
- Are not enrolled in Medicare, TRICARE or TRICARE For Life.
- Received care through the Veteran's Administration (VA) in the prior three calendar months, and that care was dental, vision or preventive care or was provided to a veteran who has a disability rating from the VA.

CONTRIBUTION LIMITS

If you have medical coverage for…	The maximum HSA contribution if you are under age 55 is…	The maximum HSA contribution if you are age 55 or older is…
You	$4,300	$5,300 (includes $1,000 "catch-up" contribution)
You and your family	$8,550	$9,550 (includes $1,000 "catch-up" contribution)

For full HSA details, contact your HSA vendor:

- Blue Shield HDHP with HSA: **www.wexhealthinc.com**
- Kaiser Permanente HDHP HMO with HSA: **www.kp.org/healthpayment**

PET INSURANCE

GET PEACE OF MIND TODAY WITH OUR PET COVERAGE

ACCIDENTS
Spot plans help ensure your pet is covered from head-to-tail for unexpected accidents and injuries.

ILLNESSES
Spot plans cover exams for qualified illnesses and related treatment, including things like surgeries & medications.

WELLNESS
Spot's optional Preventitive Care plans focus on routine care and regular check-ups to help ensure their routine wellbeing.

SPOT PERKS
Special discounts on pet products and services from your favorite brands.

24/7 TELEHEALTH LINE
Get unlimited 24/7 virtual pet care from vet experts for your pet

SIMPLE & EASY CLAIMS PROCESS
1. Visit Any Vet in the U.S or Canada
2. Submit Your Claim Online
3. Get Cash Back for Covered Vet Bills!

WHAT'S COVERED?

- **Vet Exam Fees**
- **Behavioral Issues**
- **Dental Illnesses**
- **Surgery**
- **Microchip Implantation**
- **Unexpected Emergencies**
- **Hereditary Conditions**
- **Prescription Medications**
- **Diagnostics**
- **X-Rays & Tests**
- **Cancer & Growths**
- **And Much More...**

Browse your coverage options and enroll your pets through our unique Sonrava Health link. Members who enroll through our partnership with Spot, you will receive a 20% discount when compared to traditional pet insurance rates.

For more information and to receive a quote,
- visit: **https://spotpet.link/sonrava**
- Or Call 1-800-905-1595 and Use EB_SONRAVA

VOLUNTARY BENEFITS

HOSPITAL INDEMNITY INSURANCE

Although your medical benefit pays a portion of costs associated with a hospital stay, there are expenses not covered by your medical benefit that add up. Hospital Indemnity insurance is designed to provide financial assistance for those additional expenses by paying you a direct benefit if you become hospitalized.

HOW THE PLAN WORKS

Cash Benefit Paid Directly to You

Hospital Indemnity insurance can help safeguard your finances by providing you with a lump-sum payment when you or your family needs it most. The extra cash can help you focus on getting back on track — without worrying about finding the money to cover some of your expenses – including your or your family's everyday living expenses while you recover. It is yours to use as you see fit.

Timing of Benefit Payment

You are eligible to begin receiving benefits when you are admitted to a hospital or intensive care unit, and for each day you're confined.

YOUR COSTS

See the **The Cost of Your Benefits** section for details.

CRITICAL ILLNESS INSURANCE

Besides the mental and physical stress an unexpected medical diagnosis can create, the financial toll can be significant. Critical illness insurance helps protect yourself when out-of-pocket expenses increase as a result of a specified illness.

The plan covers the following medical conditions:

- Cancer
- Heart attack
- Stroke
- Coronary artery bypass graft
- Kidney failure
- Major organ transplants
- Coma
- Blindness
- Deafness
- Paralysis
- Accidental loss of speech

HOW THE PLAN WORKS

- Receive a cash benefit – paid directly to you - if you are diagnosed with a covered medical condition and meet certain criteria.
- If you have an initial diagnosis and there is a recurrence after a certain length of time, the plan pays recurrence benefits.

YOUR COSTS

See the **The Cost of Your Benefits** section for details.

ACCIDENT INSURANCE

Accidents happen – and with it can come unexpected expenses that are not covered by medical insurance. Accident insurance can help you get back on your feet if you are in an accident and incur associated expenses.

HOW THE PLAN WORKS

You may want to consider accident insurance if you and your family have an active lifestyle, your children play sports or you're enrolled in a medical plan with high deductibles or co-pays. This benefit:

- Does not have a waiting period.
- Supplements your existing medical coverage.
- Covers your family for a wide variety of accidental injuries, including broken bones, concussions, dislocations, and second- and third-degree burns.
- Provides a lump-sum payment when a covered person has medical services and treatments related to accidental injuries, such as certain doctor visits, ambulance transportation, medical testing and physical therapy.
- Provides payment directly to you, which you can use any way you see fit.

YOUR COSTS

See the **The Cost of Your Benefits** section for details.

GENOMIC LIFE

Genomic Life is a new and innovative, high touch support program designed to provide you and your family with the genetic testing, dedicated resources, and technology needed to effectively navigate cancer while improving chances of survival. Some features of Genomic Life include:

- Hereditary screening tests.
- Comprehensive genomic (DNA) profiling.
- Genomic Life Support Line.
- Dedicated nurse case manager.
- Medical records storage and transmission platform.

YOUR COSTS

See the **The Cost of Your Benefits** section for details.

For a full plan summary and rate information, contact Genomic Life:

- By phone, at 844-694-3666.
- On the web, at **www.genomiclife.com**.

LEGALSHIELD / IDSHIELD

SHIELD YOURSELF AND YOUR FAMILY WITH LEGAL AND IDENTITY THEFT PROTECTION

LegalShield Legal Protection

The legal plan, administered by LegalShield, provides you, your spouse, your parents and in-laws*, and eligible, unmarried dependent children up to age 26, with direct access to a dedicated provider law firm for a wide range of personal legal matters including, but not limited to:

- **Advice and Consultation:** Demand letters, phone calls made on your behalf, legal research, and the ability to meet with your provider lawyer in-office or by phone.
- **Family Law:** adoption and paternity, guardianship, name change, juvenile matters, prenuptial agreements, elder care, gender rights, immigration assistance, pet protection, reproductive assistance, and more.
- **Home:** Deeds, home sales or purchases, easements, landlord/tenant matters (tenant only), foreclosures.
- **Finance:** Bankruptcy, collection letters, billing disputes, tax audit and collection, personal property protection, consumer protection, and more.
- **Wills and Estate Planning:** Wills, living wills, trusts, powers of attorney, and physician's directives.
- **Motor Vehicle:** Moving traffic violations, license reinstatement.

Additional benefits include contract and document review, 24/7 emergency access for covered emergencies, free legal forms, and a mobile app.

IDShield Identity Theft Protection

The identity theft protection plan, administered by IDShield, covers you under the Individual Plan and can be extended to your spouse/domestic partner and dependent children under the Family Plan.*Benefits include but are not limited to:

- Monitors Personal Identifiable Information (PII), such as SSN, passport, driver's license, etc., and alerts you if any risk is detected.
- Assigns a licensed private investigator to help restore your identity to pre-theft status in the case of identity theft —including pre-existing events.
- Comes with an Identity Fraud Protection Plan, which can cover identity theft expenses up to $3 million.
- Assigns identity theft specialists available for consultation and advice about any identity theft or online privacy concern.
- Provides 24/7/365 emergency support and a mobile app, which you can use to check your monthly credit score, review identity threat alerts, and obtain emergency assistance.

FOR MORE DETAILS

To learn more about these benefits visit **www.shieldbenefits.com/sonrava.**

**Refer to plan summary for compleate detail.*

LEAVE OF ABSENCE

TAKING A LEAVE OF ABSENCE

Sonrava Health's employee leave of absence (LOA) plans include federal Family and Medical Leave Act (FMLA), applicable state family and medical leave (CFRA/PDL), as well as Sonrava Health's company leave plans. Typical LOAs include:

- **Medical or pregnancy leave**
- **Family leave to care for a spouse, child or parent**
- **Military leave, including care for an injured or ill military service member**
- **Other company-specific leaves**

If you need to take an LOA, our absence management provider, Alight, can help guide you through the process from start to finish. A dedicated case manager will be your point of contact during your LOA and can answer questions about the leave process.

REQUESTING AN LOA

To request an LOA, start by notifying your supervisor and following the company's normal "call out" procedures. Next, call Alight to report your LOA and you'll be walked through the process. If you have more than one active leave, you must identify the specific leave and reason for that leave. Remember, an LOA must be used for the stated purpose. You can contact Alight by:

- Phone: 866-523-4359 between 8 a.m. and 8 p.m. EST, Monday through Friday
- Fax: 518-880-6885
- Web: **https://westerndental.myleaveproservice.com/**

MANAGE YOUR LOA WITH LEAVEPRO!

With LeavePro, you can more efficiently manage your leave online at your convenience. It's intuitive, streamlined navigation helps you quickly find leave information or complete leave tasks. With LeavePro you can:

- Submit an LOA request, manage a current leave, and view details of all leaves.
- Quickly view and complete your required tasks to keep your LOA request moving forward.
- Receive alerts and notifications (via text and/or email) to keep informed of LOA status.
- Securely upload documents via computer or mobile device (please have all documentation ready to upload at one time).
- View LOA status and remaining time available
- Add a time-off request to an intermittent leave; reporting must be completed as outlined in the company's leave policy
- View and confirm expected date for returning to work.

To access LeavePro online or through your mobile device, visit **https://westerndental.myleaveproservice.com/#home** at any time. For more information regarding the LOA process, please call the LOA Department at 866-523-4359.

REQUIRED NOTICES

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____

_____.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name		4. Employer Identification Number (EIN)
Western Dental Services, Inc.		33-0065869
5. Employer address		6. Employer phone number
530 S. Main Street		866-523-4359
7. City	8. State	9. ZIP code
Orange	CA	92868
10. Who can we contact about employee health coverage at this job?		
Employee Benefits Department		
11. Phone number (if different from above)	12. Email address	
	employeebenefits@westerndental.com	

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

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

    Employees working at least 30 hours per week.

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

    Your legal spouse, domestic partner and your dependent children up to age 26.

  - ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

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

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

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)_____
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

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

a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year? _____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $ Weekly _____
b. How often? ☐ ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

MEDICARE PART D NOTICE – ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

Two important things to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- We have determined the prescription drug coverage offered by your provider is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. Plan participants are eligible if they are within three months of turning age 65, are already 65 years old or if they are disabled. However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage will not be affected, and benefits will be coordinated with Medicare. Refer to your plan documents provided upon eligibility and open enrollment or contact your provider or the Plan Administrator for an explanation and/or copy of the prescription drug coverage plan provisions/options under the plan available to Medicare-eligible individuals when you become eligible for Medicare Part D.

Visit www.cms.hhs.gov/CreditableCoverage which outlines the prescription drug plan provisions/options Medicare-eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and current coverage is dropped, be aware you and your dependents will not be able to get this coverage back. Refer to plan documents or contact your provider or the Plan Administrator before making any decisions.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For more information about this notice or your current prescription drug coverage, contact the Plan Administrator for details. You will get this notice each year. You will also get it before the next Medicare part D drug plan enrollment period and if this coverage changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage

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

For more information about Medicare prescription drug coverage:

Visit www.Medicare.gov or call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help. Call 800-MEDICARE (800-633-4227) (TTY: 877- 486-2048). If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available.

For information about this extra help, visit Social Security on the web at www.socialsecurity.gov or call 800-772-1213 (TTY: 800-325-0778).

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

COBRA RIGHTS

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Company 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

when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. 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 coverage would otherwise end because of a life event known as a "qualifying event." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

If applicable, your participation in the Health Care Flexible Spending Account (FSA) can also continue on an after-tax basis through the remainder of the plan year in which you qualify for COBRA. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all qualified beneficiaries. If you make contributions to the Health Care FSA for the year in which your qualifying event occurs, you may continue to make these contributions on an after-tax basis. This way, you can be reimbursed for certain medical expenses you incur after your qualifying event, but before the end of the plan year.

You may be offered to continue your coverage under the Health Care FSA if you have not overspent your account. The determination of whether your account for a plan year is overspent or underspent as of the date of the qualifying event depends on three variables: (1) the elected annual limit for the qualified beneficiary for the plan year; (2) the total reimbursable claims submitted to the Cafeteria Plan for that plan year before the date of the qualifying event; and (3) the maximum amount that the Cafeteria Plan is permitted to require to be paid for COBRA coverage for the remainder of the plan year. The elected annual limit less the claims submitted is referred to as the "remaining annual limit." If the remaining annual limit is less than the maximum COBRA premium that can be charged for the rest of the year, then the account is overspent. You may not re-enroll in the Health Care FSA during any annual enrollment for any plan year that follows your qualifying event.

Supporting documentation like a divorce decree, death certificate or proof of other insurance may be required as proof of a qualifying event. This general notice does not fully describe COBRA or the plan. More complete information is available from the Plan Administrator and in the summary plan document.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 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. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

How is COBRA 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. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of

Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage.

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total 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 continuation coverage. Documentation from the Social Security administration certifying a disability will be required.

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

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you

If you have questions

Questions concerning your plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator indicated above or in the summary plan description. 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.

PATIENT PROTECTION

Kaiser Permanente allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If you are enrolled on an HMO plan, until you make this designation, Kaiser Permanente designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the medical insurance carrier, Kaiser Permanente at 800-464-4000. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Kaiser Permanente or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical insurance carrier, Kaiser Permanente at 800-464-4000.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Newborns' and Mothers' Health Protection Act (NMHPA) requires that group health plans and health insurance issuers who offer childbirth coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Refer to your plan document for specific information about childbirth coverage or contact your Plan Administrator.

For additional information about NMHPA provisions and how self-funded non-Federal governmental plans may opt- out of the NMHPA requirements, visit www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at the number above.

HIPAA SPECIAL ENROLLMENT RIGHTS

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we notify you about important provisions in the plan. You have the right to enroll in the plan under its "special enrollment provision" provided that you meet participation requirements, including: if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents

in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage) provided that you meet participation requirements. You must request enrollment, however, within 30 days or any longer period that applies under the plan, after you 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 or any longer period that applies under the plan, after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator mentioned above.

If you have declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this program if you or your dependents lose eligibility for that other coverage. You must, however, request enrollment within 60 days after you or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. You must, however, request enrollment within 60 days after you or your dependents become eligible for the premium assistance. To request special enrollment or obtain more information, contact the Plan Administrator.

PREVENTIVE CARE

Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventative services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, visit: www.HealthCare.gov/coverage/preventive-care-benefits

PRIVACY PRACTICES NOTICE REMINDER

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect.

You may request a copy of the current Privacy Practices from the Plan Administrator explaining how medical information about you may be used and disclosed, and how you can get access to this information.

We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions,

right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

SUMMARY OF BENEFITS AND COVERAGE (SBCs)

You may request a paper copy of the SBCs (free of charge), from your employer. Your employer is required to make SBCs available that summarize important information about health benefit plan options in a standard format, to help you compare across plans and make an informed choice. The health benefits available to you provide important protection for you and your family and choosing a health benefit option is an important decision.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/

	Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/HIBI Customer Service: 1-855-692-6442	Website: https://www.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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/membersMedicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

HIPP Phone: 1-888-346-9562	
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: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: 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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-selecthttps://coverva.dmas.virginia.gov/learn/premium -assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

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

To see if any other states have added a premium assistance program since January 31, 2024, 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

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