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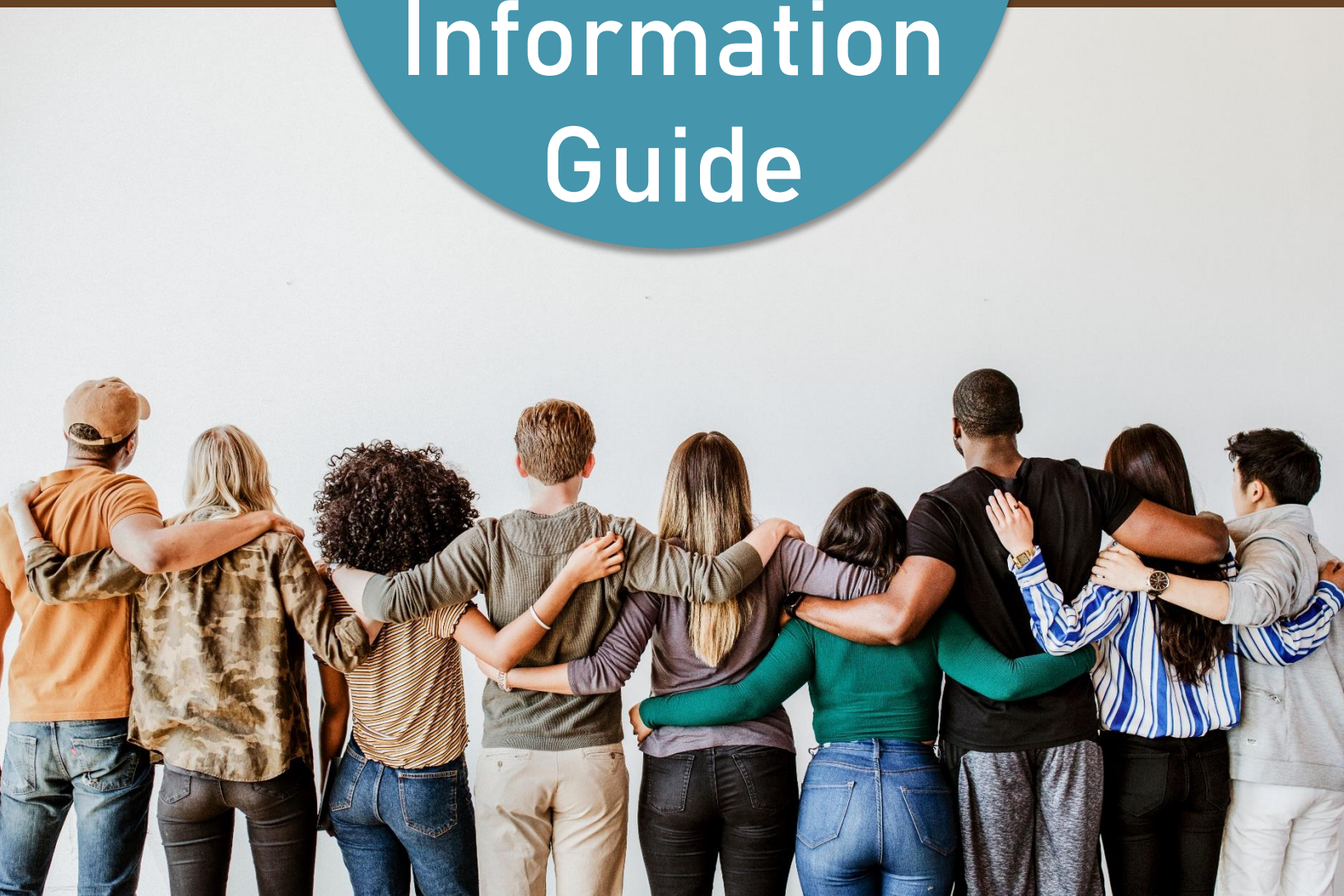
Family of Companies

alumus®

2025 Benefits Information Guide



Welcome

The Alumus Family of Companies (Alante, Aleca, Encore and Sante) has carefully chosen the benefits provided in this guide in support of your life choices and decisions, inside and outside of work. Whether you're checking it out for the first time or stopping by for a visit, this guide is crafted to help you choose the right benefits. This guide will provide you with information about medical, dental, spending accounts, retirement, and much more.

We'll also help you put those benefits to use whenever you need them throughout the plan year. You'll find answers to important questions like "How do I add my child to my insurance?" or "How much paid time off do I get, again?"

Let's get started!

Plan summary

Does this guide contain everything I need to know about my health plan?

While there are many brief benefit summaries listed throughout this guide, they're just that: summaries. When you're trying to figure out whether a medical service or a medical supply will be paid for by your health plan, it's best to take a look at the Plan Document (the Plan) or Summary of Benefits of Coverage (SBC) as well.

One important thing to note is that in order for a service or supply to be paid for by your health plan, it must be overseen by a licensed healthcare professional. Some of the guidelines for coverage also come down to the type of plan you choose, which you'll learn more about in this guide.

There's more important information in your health plan documents called (the Plan or SBC). These documents have more details about your coverage and are the binding agreement between you and the plan. You can find them in Dayforce under your Benefits section, or by contacting benefits@alumus.com.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 42 for more details.

Check out your benefits

Dig into options, programs, and resources

Keep an eye out for benefit EXAMPLES

Quick note: these examples are meant to help you understand the different health plans we offer. If you have specific questions, it's a good idea to reach out to benefits@alumus.com. You can also read the details of your plan summaries in Dayforce under your Benefits section.

Eligibility & Enrollment

Eligibility & Enrollment

Quick answers to your questions

Who can sign up?

All employees who regularly work at least 30 hours per week and are regular full-time employees are eligible to enroll in our medical/dental/vision programs. You can also cover your spouse, eligible child(ren), and any other individual described in an eligible class for that benefit. Just keep in mind, you may be required to enter into a registered domestic partnership or other official domestic partnership arrangement with a state in order to elect coverage for a domestic partner or your domestic partner's child(ren). Coverage for your domestic partner and children will not be tax-free if they do not qualify as your tax dependent(s).

It may be possible for a registered domestic partner and/or their child(ren) to qualify as your tax dependents for state tax purposes even when they do not qualify as your federal tax dependent(s).

How do I sign up?

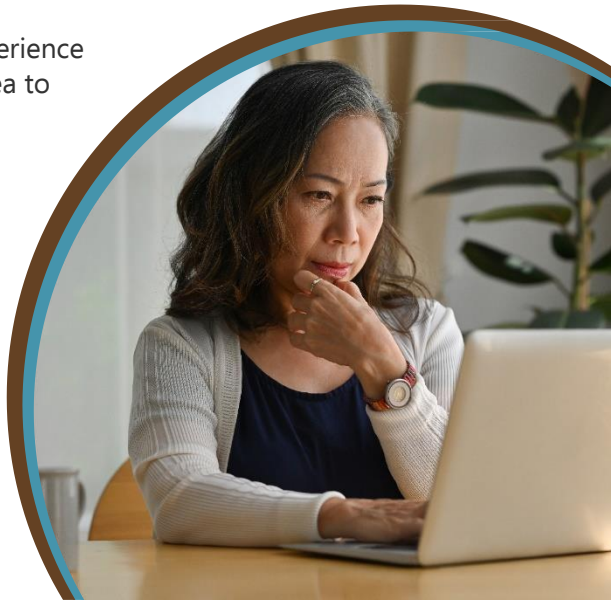
Dayforce

- Dayforce Home Page: Dayforce (dayforcehcm.com)
- Select Benefits l Start Enrollment to begin open enrollment
- As you select coverages, they will appear to the right of your screen
- You MUST select each dependent you are covering for each coverage you select as you enroll and confirm your selection.
- Confirm & Submit once you've elected the necessary coverages. You may print your confirmation or save to your computer
- If you have questions when completing your enrollment, contact Benefits@alumus.com

When does my coverage start?

Regular, full-time employees: Starting January 1st, 2025 all new full time employees are eligible to enroll in our benefits programs and coverage will start on the 1st of the month following 30 days of hire for Medical, Dental, and Vision. Company paid and voluntary life/disability insurance are effective the first of the month following 30 days of hire.

If you miss the deadline to sign up, you can't enroll later unless you experience what's called a Qualifying Life Event (QLE) change. It's always a good idea to check with benefits@alumus.com or the Plan Document to see if you're allowed to make a mid-year change based on your situation.



Can I make changes after I sign up (QLE's)?

After you've signed up, you can only make changes to your benefits in the next Open Enrollment season or if you have a Qualifying Life Event or a QLE. A QLE is something that happens to you or someone in your family. The list of QLE's is defined by the federal government. Some examples are:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Death of a dependent
- You or your spouse lose or gain coverage through our organization or another employer
- Medicare or Medicaid enrollment

These are just some examples. You can find a complete explanation of qualifying life event changes your employers section 125 document.

You might be able to add or drop coverage if one or more of these things happen to your family after you sign up. Most Qualified Life Event changes, such as getting married or having a baby, are time-sensitive and must be addressed within 30 days. Alternatively, if you lost eligibility or enrolled in Medicaid, Medicare, or state health insurance programs, you have to submit the request for change within 60 days. It's always a good idea to reach out to your HR plan administrator - benefits@alumus.com to find out if you can make changes.

Do I have to sign up?

No. You can "waive" medical/dental/and/or vision coverage if you're covered through another plan, such as a plan offered through your spouse's job. To waive coverage, you must log into Dayforce Self-Service employee portal and waive your coverage. Keep in mind that if you waive coverage, you won't be able to enroll in our group benefits again until next year on January 1, 2026, unless you experience a QLE.

If you don't sign up for any health insurance coverage or voluntarily waive coverage, the system will assume you did not elect coverage and will automatically waive your benefits after Open Enrollment has closed. This is known as an "active" Open Enrollment.

Although the federal penalty requiring individuals to maintain health coverage was reduced to $0, some states have their own mandates. To avoid paying these penalties in certain states, you can sign up for health insurance through our benefits program or purchase coverage from somewhere else, such as from a State or Federal Health Insurance Exchange.

Curious about Healthcare Reform and the Individual Mandate? Visit www.healthcare.gov. For employees that live in California, you can visit www.coveredca.com for details on the Covered California State Health Insurance Exchange.

What happens to my benefits when I leave employment?

Medical, Dental, and Vision coverage terminates at the end of the month from the termination effective date. You will be provided an opportunity to continue coverage through "COBRA" (Consolidated Omnibus Budget Reconciliation Act of 1985). COBRA will be available to you and other eligible family members the first of the month following the termination effective date. For more information about your rights and obligations under the Plan and under federal law, please see page 56 in this Benefits Information Guide or contact benefits@alumus.com.

Medical Plans

Medical Plans

Breaking down plan types (and understanding acronyms)

PPO

On a Preferred Provider Organization plan or PPO, you have more flexibility to choose your providers. However, you'll save the most money when you choose a provider or hospital inside the health plan's network. You may choose a provider who is not in the health plan's network, but it might cost more.

Advantages

- Choose from more providers
- You won't need a referral to see a specialist

Out-of-pocket costs

Your health plan can charge different fees such as a flat fee called a "copay", a fee that's a percentage of the total cost of the service, called "coinsurance", and an amount that must be paid before your plan kicks in, called a "deductible." On a PPO plan, you'll still be responsible for these types of fees.

Ideal if...

...you want flexibility and provider options. You're comfortable paying a bit more out of your paycheck each month, while paying less out of pocket for your deductible.

Note:

You may choose your health care providers, but keep in mind that you might have to pay more for services that are outside your health plan's network.

Example: Using a PPO plan

Syd was experiencing a lot of anxiety and wanted to see a psychiatrist. Syd went to the insurance company website and located an in-network provider. Syd paid a set copay after visiting the psychiatrist. The psychiatrist prescribed a generic medication and Syd had a copay for that as well. Both payments count toward Syd's out of pocket maximum.

The PPO plan was the best choice for Syd because planning for regular specialist visits was important. By choosing the PPO, Syd saved money by selecting an in-network provider and got great care.

To find a provider in your PPO plan's network:

- Go to www.azblue.com and select "Find Care" & "Browse the Network"
- Select "2025" for coverage year, "Employer Provided" for Type of Coverage, "Medical" for Provider Type, and "Statewide/National PPO" for network.
- Search by location, name, specialty, or advanced search

Using a PPO (In-network or Out-of-network)

Primary Care Physician or **Specialist**

Saving money on your medications

Your benefits cover a lot of prescription medications, but how much you pay for them, and how much your health plan covers, is determined by a system of "tiers." These tiers are more like a layer cake than a rating system: The quality is the same no matter where you are, but the higher you go on these tiers, the more expensive and/or hard to access the medication may be.

Here are some examples of the types of medications in each tier:

Tier 1 - Generic Formulary:

These medications have the same active ingredients as brand-name medications, but they cost less.

Tier 2 - Brand name:

These medications are only made by one manufacturer. They're proven to be the most effective medications in their class.

Tier 3 - Non-formulary:

Medications that aren't on your health plan's list of preferred medications, which is called their "formulary." Usually, this happens when there is a safe and effective alternative that is less expensive—often a generic. If your doctor prescribes a non-formulary prescription, it's a good idea to speak with them or your pharmacist about generic alternatives.

Tier 4 - Specialty:

These medications treat chronic or complex conditions. They might require special storage or careful monitoring.

Why pay more for your medications?

Use the mail

You can save time and money by getting your medications shipped directly to you through a mail-order service. You can have a larger quantity, usually an 90-day supply, regularly shipped to your door. Go to www.azblue.com to confirm your Rx is eligible and sign-up for delivery service.

Shop around

Some pharmacies offer less expensive medications. Try calling pharmacies inside warehouse clubs or discount stores to see if they offer a lower price. Shopping around could pay off.

Try over-the-counter

For colds, headaches, and other common conditions, over-the-counter medications can sometimes work just as well as prescription ones—and cost a lot less, too.

Need to reach a provider right away?

Telehealth services

Video chat for work, for school, for violin lessons, for…your sore throat? Yes! That miraculous little device in your hand can connect with a doctor for a video or voice chat. You can also use your desktop computer! These virtual visits save time and effort.

If your provider recommends a prescription medication during your virtual visit, BlueCare Anywhere will send it to a local pharmacy. You can also get your medication through the mail.

It's affordable, too. Through BCBS – BlueCare Anywhere, telehealth services on your PPO plans will cost $10 per e-Visit. The dependents on your health plan can use it, too. Video visits for all!

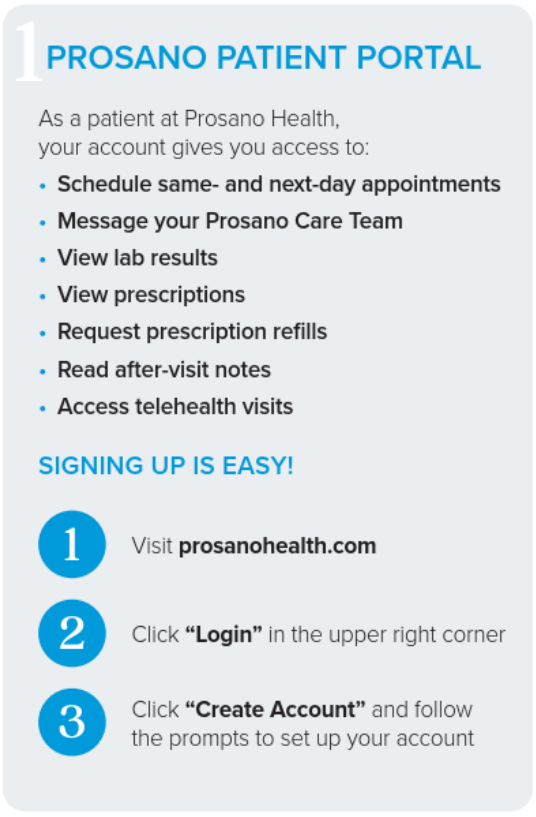
Start your telehealth visit

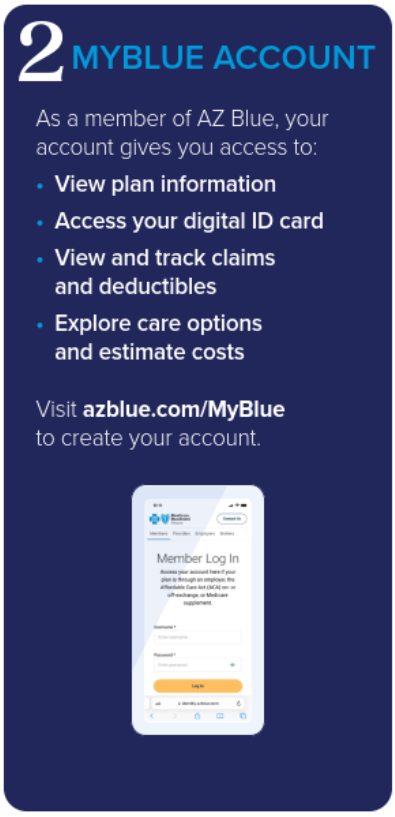
- Online: www.bluecareanywhereaz.com
- Download BlueCareAnywhere mobile app

Prosano Health Care Centers (Arizona Only)

With BlueSignature Prosano, you're covered whether you need preventive care, sick care, labs, after-hours care, or even help with your benefits or specialist appointments. These are the Care Centers where you have exclusive access to advanced primary care, including:

- Same- or next-day appointments on-site and virtually
- Chronic condition management and sick care
- Preventive and wellness care[1]
- Behavioral health, on-site and virtual
- On-site laboratory services[2]
- Care guides to navigate referrals outside the Care Centers
- Benefit liaisons to help you optimize your plan
- Access to after-hours care
- Convenient access to common prescription drugs[3]





1 Wellness and preventive care for ages 5 and older.
2 The Prosano Health team will can draw and process basic primary care laboratory testing panels.
3 Prescription copayments apply as specified in your benefit plan. Acute care and first start medications not exceeding 30 days or first treatment length.

"How much will specific services cost?"

Plan Highlights	BCBS PPO $2,000		BCBS PPO $5,000	
	In-network (Statewide/National PPO)	**Out-of-network**	**In-network** (Statewide/National PPO)	**Out-of-network**
Annual Calendar Year Deductible				
Individual	$2,000	$4,000	$5,000	$10,000
Family	$4,000	$8,000	$10,000	$20,000
Maximum Calendar Year Out-of-pocket [1]				
Individual	$7,000	$14,000	$8,000	$16,000
Family	$14,000	$28,000	$16,000	$32,000
Professional Services				
Primary Care Physician (PCP)	$20 copay	50% after deductible	$20 copay	50% after deductible
Specialist	$35 copay	50% after deductible	$35 copay	50% after deductible
Telehealth Visit	$10 copay	50% after deductible	$10 copay	50% after deductible
Preventive Care Exam	No charge	50% after deductible	No charge	50% after deductible
Diagnostic X-ray and Lab	Office visit copay or 20% after deductible	50% after deductible	Office visit copay or 20% after deductible	50% after deductible
Complex Diagnostics (MRI/CT Scan)	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Chiropractic Services	$35 copay	50% after deductible	$35 copay	50% after deductible
Hospital Services				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Urgent Care	$75 copay	50% after deductible	$75 copay	50% after deductible
Emergency Room	$400 copay	$400 copay	$400 copay	$400 copay
Mental Health & Substance Abuse				
Inpatient	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient	Office visit copay or 20% after deductible	50% after deductible	Office visit copay or 20% after deductible	50% after deductible
Retail Prescription Drugs (30-day supply)				
Tier 1	$5 copay	50% after deductible	$5 copay	50% after deductible
Tier 2	$35 copay	50% after deductible	$35 copay	50% after deductible
Tier 3	$60 copay	50% after deductible	$60 copay	50% after deductible
Tier 4	Tiered - $60 l $110 l $160 l $210	50% after deductible	Tiered - $60 l $110 l $160 l $210	50% after deductible
Mail Order Prescription Drugs (90-day supply)				
Tier 1	$10 copay	50% after deductible	$10 copay	50% after deductible
Tier 2	$70 copay	50% after deductible	$70 copay	50% after deductible
Tier 3	$120 copay	50% after deductible	$120 copay	50% after deductible

[1] Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to the Plan Document for complete details of Plan benefits, limitations and exclusions.

Supplemental Health Plans

Supplemental Health Plans

Prepare for the unexpected twists and turns

Critical Illness Insurance

If you choose to sign up for this coverage, Mutual of Omaha will pay you a lump sum of money if you're diagnosed with a specific critical illness.

What can critical illness coverage pay for?

This type of coverage pays you directly in cash, so you can use the funds however you want. Here are a few examples:

- Medical expenses
- Lost income
- Everyday expenses such as groceries and utilities
- Alternative treatments
- Lodging and travel to see specialists

Some covered illnesses:

- Cancer
- Heart Attack
- Stroke
- Alzheimer's
- Kidney Failure
- Organ Transplant

100% employee-paid

Your employer doesn't cover any part of this optional benefit. If you choose to sign up, the cost of coverage will be deducted from your paycheck. Monthly post-tax rates will be in Dayforce.

Election	Benefit Amounts & Guaranteed Issue
Employee	Increments of $5,000 up to $40,000 (All Guaranteed Issue during initial eligibility period)
Spouse	Increments of $5,000 up to $40,000 (All Guaranteed Issue during initial eligibility period) not to exceed 100% of employee election.
Child(ren)	$5,000 maximum – not to exceed 25% of employee election

Example: Using critical illness insurance

Theo was diagnosed with cancer and needed a life-saving surgery right away, followed by chemotherapy. Theo's health plan required he pay the deductible and a co-insurance after the hospital stay. Critical illness insurance provided a lump-sum cash payment after Theo's diagnosis. Theo used the funds to cover his deductible and co-insurance fees, plus the co-pay for each chemo session. Theo was able to pay his rent and hire a part-time dog walker, too, so he could focus all his energy on getting well.

Want to learn more?

You have to sign up for this type of coverage when you first become eligible, or during the annual open enrollment period. For more info, please see your full plan summary within Dayforce.

Hospital Insurance

Hospital stays are difficult, especially if your health plan doesn't cover costs. To help ensure you can afford a hospital stay, you can sign up for hospital insurance through Mutual of Omaha. This benefit will pay cash to you or your family to offset medical and non-medical bills that you get after staying in the hospital.

What can hospital insurance pay for?

This type of coverage pays you directly in cash, so you can use the funds however you want. Here are a few examples:

- Copayments
- Deductibles
- Transportation expenses
- Child care
- Lodging expenses for a companion
- Lost income

100% employee-paid

Your employer doesn't cover any part of this optional benefit. If you choose to sign up, the cost of coverage will be deducted from your paycheck. Monthly post-tax rates will be in Dayforce.

Example: Using hospital insurance (not guaranteed benefit amounts)

Morgan needed gallbladder removal surgery, and due to some complications, had to stay in the hospital for five days. Morgan has health insurance, but it didn't cover the full cost of the stay. Morgan's health plan required she pay the deductible and a co-insurance fee. Hospital insurance helped make up the difference. It paid a set amount for an admission benefit plus a set amount for each additional day. This helped reduce Morgan's cost for her stay.

Out-of-Pocket Expenses	Hospital Indemnity
$500 deductible	$1,000 admission benefit
$3,000 co-insurance	$150/day x 4 additional days = $600
Total: $3,500	Total benefits paid to Morgan: $1,600

Want to learn more?

You have to sign up for this type of coverage when you first become eligible, or during the annual open enrollment period. For more info, please see your full plan summary within the Employee Benefits Portal in Dayforce.

Accident Insurance

We all know they happen, but not everyone is prepared. Accident insurance is optional coverage that helps you pay for expenses if something unexpected occurs. The benefits are paid directly to you to help cover specific treatments, and the amount depends on the type of injury you have and what care you need.

What can accident insurance pay for?

This type of coverage pays you directly in cash, so you can use the funds however you want. You could use the funds to pay for:

- Emergency room visits
- Ambulance transportation
- Doctor visits
- Hospital admission
- Surgery
- Medical equipment
- Outpatient therapy
- Diagnostic imaging

100% employee-paid

Alumus doesn't cover any part of this optional benefit. If you choose to sign up, the cost of coverage will be deducted from your semi-monthly paycheck (post-tax).

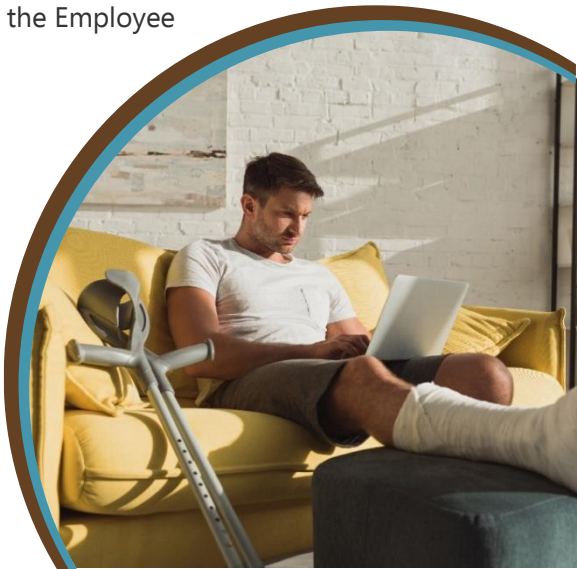
Example: Using accident insurance (not guaranteed benefit amounts)

Sam was involved in a car accident and needed physical therapy. The treatment was intense, so Sam couldn't work during recovery. Sam's accident insurance policy provided payments that Sam could use towards things such as the out-of-pocket costs of treatment, monthly mortgage payments, or daycare fees. Accident insurance helped Sam focus on recovery instead of worrying about how to pay for it.

Covered Event/Injury	Benefit Amount
Ambulance (ground)	$300
Emergency room care	$150
Physician follow-up ($75 x 2)	$150
X-ray	$50
Concussion	$150
Broken tooth (repaired by crown)	$300
Total benefit paid by Sam's Accident Plan	$1,100

Want to learn more?

You have to sign up for this type of coverage when you first become eligible, or during the annual open enrollment period. For more info, please see your full plan summary within the Employee Benefits Portal in Dayforce.



Wellness Programs

Wellness Programs

Benefits for your body and mind

What is wellness—and why should I care?

When it comes to your overall well-being, it's all about the journey, not the destination. Be sure to bring along the right tools and an enthusiastic support system! Healthy, active lifestyles can help reduce the risk of chronic disease and may lower your annual health care costs. Your wellness benefits support this approach to total well-being for your mind and body. Plus, they're free.

Employee Wellness Program: Choose Wellness, Choose You!

This companywide Wellness Program is designed to foster a culture of holistic well-being that encompasses physical, mental, social, and financial wellness, too.

The Alumus Choose Wellness, Choose You! program offers:

1. **Fitness Initiatives:** From walking competitions to virtual workout sessions, we will provide options to help you achieve your desired fitness level, no matter your schedule or location.
2. **Financial Fitness:** Access to seminars and webinars focusing on building current and future financial goals to help you enjoy life well into retirement.
3. **Mental Health Resources:** Your mental well-being is paramount. We provide confidential counseling services, mindfulness workshops, and resources to help you manage stress and build resilience.
4. **Work-Life Balance:** Time management workshops, and tools for setting boundaries will help you achieve harmony between your professional and personal life.
5. **Eat Right Feel Right:** Access to monthly recipes to encourage and support healthier eating choices.

To learn more about the Alumus Wellness Program visit: [Choose Wellness, Choose You! (sharepoint.com)]

Dental Plans

Dental Plan PPO

Taking care of your smile

With the Dental PPO plan, you can pick any licensed dentist. Just keep in mind that your dental plan has settled on lower rates with a smaller group of providers—those in their network. If you choose a dentist outside that network for yourself or your dependents, you might have to pay more.

To find out if your dentist is in your provider network, you can search on www.deltadentalaz.com/member or calling Delta Dental.

"How much will specific services cost?"

Plan Highlights	PPO Low Plan		PPO + Premier High Plan	
	In-network (PPO Network)	**Out-of-network (Including Premier Network)**	**In-network (PPO +Premier Network)**	**Out-of-network**
Calendar Year Deductible				
Individual	$75	$100	$50	$50
Family	$225	$100 per person (no max)	$150	$150
Annual Maximum	$1,250	$200	$1,750	
Preventive	100%	10%	100%	100%
Basic Services	80%	10%	80%	80%
Major Services	50%	10%	50%	50%
Orthodontia Services				
Children to age 19	Not covered	Not covered	50%	50%
Lifetime Maximum	Not covered	Not covered	$1,000	

The above information is a summary only. Please refer to the Plan Document for complete details of Plan benefits, limitations and exclusions.

Vision Plans

Vision Plans

Bringing your benefits into focus

VSP offers vision coverage as a Preferred Provider Organization (PPO) plan. With the vision plan, you can pick where to receive services. Just keep in mind that your vision plan has settled on lower rates with a smaller group of vision providers—those in their network. If you choose a vision provider outside that network for yourself or your dependents, you will have to pay for all the expenses yourself at the time of service. Then, you'll submit a claim, and VSP will reimburse you up to a certain "allowed" amount.

To find out if a vision provider is in your network, you can search on www.vsp.com or calling VSP.

Plan Highlights	VSP Vision	
	In-network	**Out-of-network**
Exam – Every 12 months	$10 copay	Up to $45 reimbursement
Lenses – Every 12 months		
Single	$25 copay	Up to $30 reimbursement
Bifocal	$25 copay	Up to $50 reimbursement
Trifocal	$25 copay	Up to $65 reimbursement
Frames – Every 12 months	$170 featured brand allowance $150 standard frame allowance + 20% amount over allowance	Up to $70 reimbursement
Additional Pairs of Glasses	20% savings on additional glasses/sunglasses	NA
Contacts – Every 12 months, in lieu of lenses & frames	$60 copay	
Medically Necessary	Covered in full	Up to $210 reimbursement
Cosmetic	$150 allowance	Up to $105 reimbursement
LASIK	Average of 15% off regular price Discount available at contracted facilities	NA

The above information is a summary only. Please refer to the Plan Document for complete details of Plan benefits, limitations and exclusions.

Spending Accounts

Spending Accounts

Make your money work for you

Flexible Spending Account (FSA)

With this type of account, you and your spouse, plus any eligible dependents, can use pre-tax dollars to cover health care and dependent care. There are different types of FSAs, but they all help reduce your taxable income. This voluntary benefit is 100% paid by the employee, and Alumus does not contribute to the FSA plans. Here are the different types of FSAs available to you.

FSA Type		Detail
	Healthcare FSA	• Can reimburse for eligible healthcare expenses not covered by your medical, dental, and vision insurance. • Maximum contribution for 2025 is $3,300.
	Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Eligibility rules require that if you are married, your spouse needs to be working, looking for work or attending school full-time. • Maximum contribution for 2025 is $5,000.

Questions about your FSA? Reach out to Health Equity healthequity.com (Group# 60622) or benefits@alumus.com.

How to use your FSA

Estimate how much you'll need to cover with FSA funds this year.

Set up annual (pre-tax) deductions from your paycheck.

Use your FSA debit card for purchases made on your own behalf.

Use it or lose it! FSA funds don't roll over to the next year. Don't panic, though - you can still use the funds during a grace period through March 31, 2025.

Life & Disability

Life & Disability

Life Insurance and AD&D

There's no easy way to talk about death, but your family might need help if something happens to you. A life and accidental death and dismemberment (AD&D) policy can provide that help. You are automatically signed up for this benefit and your family will be paid a lump sum of money when you die. If your death was caused by an accident, or if you lose a limb, you or the people you choose, called "beneficiaries," may get additional coverage.

Alumus pays for 100% of this benefit through Mutual of Omaha. It includes the following:

- Basic Life Insurance in the amount below according to your eligible class
- AD&D in the matching amount of your Basic Life Insurance
- Your benefits may reduce when you turn 65

There are 3 pay classes of eligible participants, and each have a max level of basic life insurance to include:

- Executive employees: $50,000
- Middle-Management employees: $30,000
- All other eligible employees: $10,000

Quick note on IRS Regulations: You can receive employer-paid life insurance coverage up to $50,000 on a tax-free basis and do not have to report the payment as income. However, coverage of more than $50,000 will trigger taxable income for the "economic value" of the coverage provided to you.

Voluntary Life and AD&D

You can choose to add more life insurance and AD&D coverage for you and/or your dependents. These can be taken out of your regular paycheck by Mutual of Omaha. Here are details on the additional coverage amounts you can choose from:

	**For employees:**	• Increments of $10,000 up to a $500,000 maximum (not to exceed 5x your annual salary) with a guarantee issue benefit of $200,000 if you enroll in the plan within 30 days of your initial eligibility.
	**For your spouse:**	• Increments of $5,000 up to a $100,000 maximum (not to exceed 50% of the employee election) with a guarantee issue benefit of $40,000 if you enroll in the plan within 30 days of your initial eligibility.
	**For your child(ren):**	• From age 14 days old, through age 26, increments of $2,000 up to a maximum of $10,000.
	**Optional AD&D:**	• AD&D coverage is set up to match your life insurance election automatically.

If you choose to get additional coverage, the insurance company may want to make sure you're in good health. The insurance amounts here are subject to review and won't be effective until the insurance company approves. You may be required by the insurance company to complete an Evidence of Insurability form that will determine the amount of insurance you will be eligible for.

You can enroll in additional coverage during your enrollment period. If you wait, you might have to prove that you're in good health and wait for the insurance company to approve your coverage. There's more info in the Plan Document.

Please note: Benefits coverage may reduce when you turn 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Take a look at your Summary of Benefits or Coverage for exclusions and further detail.

Don't forget to update your beneficiaries!

The people or entities who you want to receive benefits from your policy are called beneficiaries. It's very important that they are up to date.

- You may change your beneficiaries at any time
- You may designate one person as your beneficiary or choose multiple beneficiaries, who will each get a percentage of the payout amount
- To select or change your beneficiary, please log into Dayforce or contact benefits@alumus.com.

Disability Insurance

When you're too sick or injured to work, you need time to focus on healing—not worrying about your income. Enrolling in disability insurance offers you and your family peace of mind by helping to replace some of your income if you have a non-work related illness or injury.

Your Plans	Coverage Details
Voluntary Short Term Disability (STD)	• Administered by Mutual of Omaha, STD coverage provides a benefit equal to 60% of your earnings, up to $1,500 per week for a period up to 25 weeks. • The plan begins paying these benefits at the time of disability/after you have been absent from work for 7 consecutive days. • There is a 3/6 pre-existing condition under this plan. Which means any condition you have received medical attention for in the 3 months prior to your coverage effective date resulting in a disability during the initial 6 months of coverage, would not be covered. • Alumus does not contribute to the STD benefit (employee-paid only).
Employer Paid Long Term Disability (LTD)	• If your disability extends beyond 180 days, the LTD coverage through Mutual of Omaha can replace 60% of your earnings, up to maximum of $6,000 per month. • Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability. • There is a 3/12 pre-existing condition under this plan. Which means any condition you have received medical attention for in the 3 months prior to your coverage effective date resulting in a disability during the initial 12 months of coverage, would not be covered.

Note: Please note, the state you reside in may provide a partial wage-replacement disability insurance plan.

Retirement

Retirement

Planning for the future

Your 401(k) Plan, administered by Empower

No matter how wonderful your job is, it's good to plan ahead for retirement. A 401(k) plan helps you plan for your future by squirreling away a portion of each paycheck. These funds are withdrawn each pay period and invested so they can grow (subject to federal law and plan guidelines). You can withdraw the funds when you retire or separate from employment.

You are eligible to enroll in the Sante 401k plan during the 1st quarter after 60 days of service.

Enrollment & Account Access

AUTO ENROLLMENT & ESCALATION: Once you meet the eligibility criteria, we will automatically enroll you in the Plan at 1% of your pay. Employees can increase their contribution greater than 1% or opt-out of the Plan at any time. If no changes are made, every January 1st your contribution increases by 1% of your pay up to a limit of 10%. If you have questions about enrollment, please contact Jeremy at 971.366.3513 or jeremy@fosterandwood.com.

OPTING OUT: If you want to opt out of the Plan, you must Sign In to the Plan's website: User login | Empower: Saving, investing and advice (empower-retirement.com) and select Account/Sante Operations, LLC 401(k) Profit Sharing Plan and Trust/Contributions/ and select the "Edit" button and change your contribution to "0%" to decline participation.

Additional 401(k) Information

Contribution Limits: For 2025, the IRS annual contribution limits are $24,000 for everyone under age 50 or an additional $10,000 for anyone that is age 50 or over prior to December 31, 2024. If you have multiple employers during the year, all your contributions are combined. Restrictions may apply to these limits based on plan documents and annual testing requirements.

Contribution Changes: You'll need to check with benefits@alumus.com to find out how to adjust your contribution limit. You may also stop contributing any time. Requests to change or stop your contributions must be made through the provider website or in writing to benefits@alumus.com.

Employer Contributions: 25% on the first 4% you contribute. 4% from you earns 1% from Alumus!

Company matching is subject to a vesting schedule. You are always 100% vested in money you contribute. Here's the company match vesting schedule: 1 year or less of service – 0% l 2 years of service – 40% l 3 years of service – 60% l 4 years of service – 80% l 5 years of service or more – 100%

Loans & Hardship Withdrawals: If allowed by the plan document, please see benefits@alumus.com for information and requirements for either option.

Rollover Contributions: You can combine your accounts through something called a "rollover." If you have other qualified retirement plans or account such as a 401(k) from a previous employer, 403(b), 457(b) or IRA, you may be able to transfer that account into your new plan. Please contact Foster & Wood Investment Fiduciaries for more information.

Termination of Employment: When your employment is terminated, regardless of reason, you can request a full distribution of your vested account balance. You can roll over your account to another qualified plan or IRA without any penalty. You may also request a lump-sum cash payment to yourself, but know that might come with tax penalties.

Employee Assistance Program (EAP)

Employee Assistance Program

Free resources for tough moments

Your Employee Assistance Program (EAP) provided by Mutual of Omaha is a set of services that can support you through personal and professional challenges with resources, information, and counseling. Everything is confidential—what you talk about won't be shared with your employer—and free.

Program Component	Coverage Details
Number of sessions	3 face-to-face sessions per year per member per incident
How to access	Phone or face-to-face sessions
Topics may include	**Mental Health Support:** • Marital, relationship or family problems • Bereavement or grief counseling • Substance use disorder and recovery **Community Support:** • Child and eldercare • Legal services and identity theft • Financial support
Who can utilize	You, your dependents, and even other members of your household.

Get in touch:

- By phone: 800.316.2796
- Online: www.mutualofomaha.com/eap

Paid Leave Benefits

Paid Leave Benefits

Finally, the fun stuff

Your benefits package isn't all insurance. It still knows how to have fun. In that spirit, your employer gives you these perks. For more information about our Paid Leave Benefits, please refer to the Employee Handbook.

Holidays

These are our company's paid holidays. Yes, you heard that right - they're paid, but you don't have to work.

- New Year's Day (January 1st)
- Memorial Day (Monday, May 4th)
- Independence Day (July 4th)
- Labor Day (Monday, September 1st)
- Thanksgiving Day (Thursday, November 4th)
- Christmas Day (December 25th)
- Floating Holiday (8 hours per year for full-time employees only)

Paid Time Off (PTO)

What happens when you want, or need, a break? Your paid time off, or PTO, is a combination of sick time, vacation time, and other days you can take off work. Your company pays you while you're using this time off.

Exempt (Salaried) Associates

Length of Service	Yearly Accrual (hours)	Accrual per semi-monthly pay period	Maximum Accrual (hours)
Less than 2 years	104	4.3333	156
2 years	144	6.0000	216
5 years	184	7.6666	276

Non-Exempt (Hourly) Associates

Length of Service	Yearly Accrual (hours)	Accrual per semi-monthly pay period	Maximum Accrual (hours)
Less than 2 years	80	0.0385	120
2 years	120	0.0577	180
5 years	160	0.0770	240

Paid Time Off (PTO) Continued

Bereavement Leave

Full-time employees are eligible immediately upon hire for three paid days (8 hours per day) for the death of an immediate family member. Members of the immediate family include spouses, domestic partners, parents, brothers, sisters, children, children of domestic partners, grandchildren, grandparents, parents-in-law and parents of domestic partners.

Jury Duty

If you are summoned for jury duty, notify your supervisor as soon as possible to make scheduling arrangements. If you are classified as salaried or exempt, you will not incur any deduction in pay for a partial week's absence due to jury duty. If you are classified as hourly or nonexempt, you will not be compensated for time spent on jury duty.

Other time off, such as time you want to take off for family or medical reasons, may be honored based on state and federal law.

Costs & Directory

Costs Breakdown

Let's sum it all up!

The rates below are effective January 1, 2025 through December 31, 2025

Coverage Level	Payroll Deduction
	Employee Semimonthly
BCBS PPO $2,000	
Employee Only	$110.75
Employee and Spouse/Domestic Partner	$507.15
Employee and Child(ren)	$173.37
Employee and Family	$605.48
BCBS PPO $5,000	
Employee Only	$42.44
Employee and Spouse/Domestic Partner	$398.48
Employee and Child(ren)	$94.71
Employee and Family	$395.89
Delta Dental Low Plan	
Employee Only	$5.82
Employee and Spouse/Domestic Partner	$16.17
Employee and Child(ren)	$19.78
Employee and Family	$31.80
Delta Dental High Plan	
Employee Only	$10.61
Employee and Spouse/Domestic Partner	$27.23
Employee and Child(ren)	$38.33
Employee and Family	$61.05
VSP Vision	
Employee Only	$2.04
Employee and Spouse/Domestic Partner	$5.83
Employee and Child(ren)	$6.47
Employee and Family	$11.36

Directory & Resources

Below, please find important contact information and resources for Alumus.

Information Regarding	Group / Policy #	Phone #	Contact Information
Enrollment & Eligibility			
Corporate Benefit Offices		480.397.1491	benefits@alumus.com
Online Enrollment Vendor: Dayforce			Dayforce Home Page
Medical Coverage			
BlueCross BlueShield Prosano Health Center (AZ Only)	042778	602.864.4400 855.776.7266	www.azblue.com prosanohealth.com
Dental Coverage			
Delta Dental	1529	602.938.3131	www.deltadentalaz.com
Vision Coverage			
Vision Service Plan (VSP)	30106794	800.877.7195	www.vsp.com
Life, AD&D, Short-Term Disability and Long-Term Disability			
Mutual of Omaha	G000BM4F	800.877.5176	www.mutualofomaha.com
Flexible Spending Accounts			
HealthEquity	60622	866.382.3510	www.healthequity.com
401(k) Retirement Plan Adviser			
Foster & Wood Investment Fiduciaries Jeremy Six Tim Wood		 971.366.3513 971.266.3134	https://sante401k.fosterandwood.com/ jeremy@fosterandwood.com tim@fosterandwood.com
Employee Assistance Plan			
Mutual of Omaha	G000BM4F	800.316.2796	www.mutualofomaha.com/eap
Accident, Critical Illness, and Hospital Indemnity			
Mutual of Omaha	G000BM4F	800.877.5176	www.mutualofomaha.com
COBRA			
Wage Works	CXT102601	888.678.4861	https://cobrabenefits.wageworks.com
Benefits Broker / Claims Questions			
Marsh & McLennan Insurance Agency LLC Claims Advocate - Maureen Wigham	Claims Advocate	602.385.7066	www.MarshMMA.com maureen.wigham@marshmma.com

Glossary of Terms

Ambulatory Patient Services

Medical care provided without need of admission to a health care facility. This includes a range of medical procedures and treatments such as such as blood tests, X-rays, vaccinations, nebulizing and even monthly well-baby checkups by pediatricians.

Annual Household Income

The total amount of income for a family in a calendar year.

Annual Limit

A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance plan. These caps are sometimes placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered. To have your claim reviewed or to dispute the claim if you think there has been an error, refer to the Plan Document or Summary of Benefits or Coverage.

Coinsurance

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

Copayment

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

Cost-sharing

The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes deductibles, coinsurance and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost-sharing in Medicaid and Children's Health Insurance Program also includes premiums.

Deductible

The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you have met your deductible for covered health care services. The deductible may not apply to all services.

Essential Health Benefits

Health care service categories that must be covered by certain plans. These service categories include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, behavioral health treatment, prescription drugs, rehabilitative and habilitation services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including dental and vision care. Insurance policies must cover these benefits in order to be certified and offered in the marketplace, and all Medicaid state plans must cover these services.

Federal Poverty Level

A measure of income level issued annually by the Department of Health and Human Services. Federal poverty levels are used to determine your eligibility for certain programs and benefits. In 2024, the federal poverty level for an individual was $15,060 per year and $31,200 for a family of four.

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium

Health Insurance Marketplace (Exchange)

The Health Insurance Marketplace (Exchange) is a way to compare and purchase health insurance plans. Every state will have one, and it will provide you with choices of insurers and plans that are affordable and in a way that makes it easy to understand and compare them.

Health Insurance Requirement (Individual Mandate)

As a part of the health care law, most Americans will need to have health insurance. If you do not have health insurance, you may need to pay a penalty. You won't have to pay a penalty if you have a very low income and coverage is unaffordable for you, or for other reasons including your religious beliefs. You can also apply for a waiver asking not to pay a penalty if you aren't automatically exempt.

Medi-Cal

California's Medicaid health care program. This program provides free medical services for children and adults with limited income and resources. Your local County Welfare/Social Services Department manages Medi-Cal eligibility determinations. You can get Medi-Cal as long as you meet the eligibility requirements.

Open Enrollment

A designated period of time each year – usually a few months – during which insured individuals or employees can make changes in health insurance coverage.

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. In Medicaid and CHIP, the limit includes premiums.

Policy

The contract (agreement) between the person buying health insurance and the company providing it, describing specific health care services that will be covered, any coverage limitations and any out-of-pocket costs (copays) that might be required.

Pre-existing Medical Condition

Any illness or condition a patient has prior to obtaining insurance. Most health insurance plans can't refuse to cover an individual or change more simply due to a pre-existing condition.

Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly.

Special Enrollment

The opportunity for people who experience a life-changing event, such as the loss of a job, death of a spouse or birth of a child, to sign up immediately in an employer's health plan, even if it is outside of the plan's specified enrollment period.

Subsidy

Cost-sharing subsidies and tax credits have lowered the cost of premiums and out-of-pocket expenses for health coverage that qualifying families purchase through Covered California.

Tax Credit

One of the largest subsidy programs for health insurance, to help consumers pay health insurance premiums. Tax credits will also be available to small businesses with no more than 25 full-time equivalent employees to help offset the cost of providing coverage.

For other general definitions of common terms, see the "Glossary of Health Coverage and Medical Terms" located at www.healthcare.gov/sbc-glossary/ or call 1-877-475-8440 to request a copy.

Thanks for Reading

This guide contains just a few (or a few more than a few) words about your benefits, but it represents a network of resources and support. Now it's time to get back to living—knowing that this guide is here when and if you ever need it. If questions slow you down, keep in mind that the Alumus HR Team would be happy to help.

Here's to a happy, healthy year ahead!

Sante Operations LLC Health & Welfare Benefit Plan Annual Notice Packet

For the 2025 plan year

Dear Valued Employee,

Enclosed is a packet of notices and disclosures that pertain to your employer-sponsored health and welfare plans, as required by federal law.

Enclosures:

- ☐ Medicare Part D Creditable Coverage Notice
- ☐ HIPAA Special Enrollment Rights Notice
- ☐ HIPAA Notice of Privacy Practices
- ☐ Children's Health Insurance Program (CHIP) Notice
- ☐ Women's Health and Cancer Rights Act (WHCRA) Notice
- ☐ Newborns' Mothers Health Protection Act (NMHPA) Notice
- ☐ General Notice of COBRA Continuation Rights
- ☐ Fixed Indemnity Policy Notice
- ☐ HIPAA Wellness Program Reasonable Alternative Standards (RAS) Notice – Medical plans with wellness programs that offer health contingent incentives
- ☐ EEOC Wellness Program Notice
- ☐ Surprise Billing Notice – "Your Rights and Protections Against Surprise Medical Bills"

Should you have any questions regarding the content of the notices, please contact us at benefits@alumus.com.

Medicare Part D
Creditable Coverage Notice

Important Notice from Alumus
About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan while enrolled in Alumus coverage as an active employee, please note that your Alumus coverage will be the primary payer for your prescription drug benefits and

Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Alumus coverage as a former employee.

You may also choose to drop your Alumus coverage. If you do decide to join a Medicare drug plan and drop your current Alumus coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2025
Name of Entity/Sender: Alumus
Contact-Position/Office: Corporate Benefit Office
Address: 8502 E. Princess Drive Suite 200, Scottsdale, AZ 85255
Phone Number: 480-563-2402

HIPAA Special Enrollment Rights Notice

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact the Corporate Benefit Office at 480-563-2402.

HIPAA Notice of Privacy Practices

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

Alumus sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Alumus, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

(1) your past, present or future physical or mental health or condition;
(2) the provision of health care to you; or
(3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Alumus, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Alumus HIPAA Privacy Officer:

Alumus
Attention: HIPAA Privacy Officer
8502 E. Princess Drive Suite 200,
Scottsdale, AZ 85255
480-563-2402

Effective Date

This Notice as revised is effective January 1, 2025.

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and

- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment
We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment
We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

(1) the individual identifiers have been removed; or
(2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

(1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
(2) treating such person as your personal representative could endanger you; or
(3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

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

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period ABC Company has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA**.**

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting https://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: 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: masspremiumassistance@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**
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-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

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

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

Women's Health Cancer Rights Act (WHCRA) Notice

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

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, contact your plan administrator.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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

Model General Notice of
COBRA Continuation Coverage Rights

** Continuation Coverage Rights Under COBRA**

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children

getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

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

If you have questions

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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start. These rules are different for people with End Stage Renal Disease (ESRD).

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

Plan contact information
Alumus
Corporate Benefit Office
8502 E. Princess Drive Suite 200,
Scottsdale, AZ 85255
480-563-2402
benefits@alumus.com

Fixed Indemnity Policy Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

HIPAA Wellness Program Reasonable Alternative Standards Notice

Your group health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 480-563-2402 or benefits@alumus.com and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

EEOC Wellness Program Notice

Notice Regarding Wellness Program

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

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

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Corporate Benefit Office at 480-563-2402 or benefits@alumus.com.

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

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Alumus may use aggregate information it collects to design a program based on identified health risks in the workplace, Alumus will never disclose any of your personal information either publicly or to the employer, except as

necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Corporate Benefit Office at 480-563-2402 or benefits@alumus.com.

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

1. You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

2. Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills.

Notes:

Notes:

Prepared by: **Marsh & McLennan Insurance Agency LLC**

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