



2025-2026 **BENEFITS** GUIDEBOOK



PRESENTED BY



2025-2026



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WELCOME TO YOUR **2025-2026 BENEFITS GUIDEBOOK**

Dear Employees,

This 'Employees Benefit Guidebook' is provided to you as a quick reference guide to address all of your benefit questions. We encourage you to share this guidebook with your family members and dependents to help you gain better understanding of the benefits available to you through our company. Based on eligibility, you are only able to join or make changes to your benefit elections during either the annual Open Enrollment period or due to a qualifying life event, such as starting a new job, getting married/divorced, loss of other coverage or for the birth of a child. In the case of qualifying life event, you will have 48 hours from the date of the event to join the plan otherwise you may join the plan during the designated Open Enrollment period.

You are eligible for benefits if you work 30 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include: Your legally married spouse; Your registered domestic partner (RDP) and/or his/her children, where applicable by state law; your children who are your natural children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply); Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

The Open Enrollment period generally occurs during the month of November, with benefit renewals becoming effective the 1st of December. The Benefit Waiting Period is 365 days following date of hire.

Sincerely,
TeleSearch, Inc.

Highlights



- **TeleSearch will be renewing our health plan with the AmeriHealth EPO Value Plus \$20/\$50 \$2,000 plan.** We will continue to pay 50% of the employee-only rate for our permanent staff. This plan will continue to have no referrals and access to the AmeriHealth Value Plus network.
 - o **Provider Finder and Hospital Finder** help you find the participating doctors and hospitals that are equipped to handle your needs. When you select your health plan type, your results are customized based on your network, making it easy to locate a participating doctor, specialist, hospital, or other medical facility nearby.
 - o **Treatment Cost Estimator** helps you estimate your costs within certain geographic areas for hundreds of common conditions, including tests, procedures, and health care visits, so that you can plan and budget for your expenses.
 - o Find these and more at www.amerihealthnj.com

2025-2026

MEDICAL PLAN



TeleSearch
Group Medical Benefit and Rate Summary
Effective Date: December 1, 2025



Insurance Carrier	AmeriHealth
Plan Type	EPO Value Plus \$20 / \$50 \$2,000 \$25 / \$50 / \$75
In Network	
Referrals	No
Primary / Specialist	\$20 / \$50
Telemedicine	\$0
Wellness Visits	\$0
Deductible (Ind/Family)	\$2,000 / \$4,000
Inpatient Hospital	30% (After Deductible)
Outpatient Surgery	30% (After Deductible)
Xray	\$50
Complex Imaging (MRI)	\$75
Lab	\$0
Urgent Care / ER	\$50 / \$100
Out of Pocket Max (Ind/Fam)	\$4,000 / \$8,000
Lifetime Maximum	Unlimited
Network Link	https://www.amerihealth.com/tpa/providerfinder
Out of Network	
Deductible (Ind/Family)	No Coverage
Coinsurance	No Coverage
Out of Pocket Max (Ind/Fam)	No Coverage
Lifetime Maximum	No Coverage
Prescription	
Deductible	\$0
Generic	\$25
Brand / Non-Form / Specialty	50% up to \$250 Max
Mail Order (90 Day Supply)	50% up to \$250 Max
Prescription Formulary	Main Formulary Search (formularynavigator.com)
Total Monthly Premium	
Employee	\$781.64
Employee + Child(ren)	\$1,535.26
Employee + Spouse	\$1,868.15
Family	\$2,767.04

National and New York Network access through Cigna HealthcareSM PPO



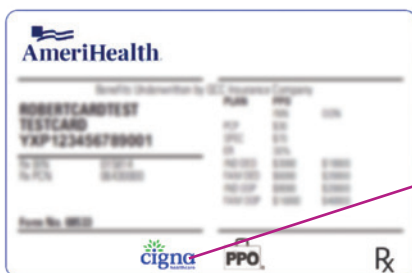
Members have access to quality and affordable health care nationwide

As an AmeriHealth member, you have nationwide access to the Cigna Healthcare Preferred Provider Organization (PPO) Network¹ outside the AmeriHealth service area.²

The Cigna Healthcare PPO Network includes more than 1.5 million health care providers and 6,400 hospitals nationwide.³ AmeriHealth members can easily find providers in their region using the Cigna Healthcare provider search tool.

Look for the logo

You will find the Cigna logo on your AmeriHealth member ID card if you have access to the Cigna Healthcare PPO Network.⁴



Search for a provider

Visit [amerihealth.com](https://www.amerihealth.com) or scan the QR code to access the provider finder.

Select *Find a Doctor*, then the *Find a provider* button in the "Through my job" box.



Questions?

Call the number on the back of your AmeriHealth member ID card.

The Cigna Healthcare PPO Network includes more than **1.5 million health care providers and 6,400 hospitals** nationwide.³



Scan to search for providers



- 1 The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of the Cigna Healthcare PPO for Shared Administration.
- 2 The service area includes all New Jersey and Delaware counties and nine Pennsylvania counties in the Philadelphia area including: Berks, Bucks, Chester, Delaware, Lancaster, Lehigh, Montgomery, Northampton, and Philadelphia.
- 3 Cigna Healthcare analysis of actual providers contracted as part of the Cigna Healthcare PPO for Shared Administration as of July 2024. Data is subject to change.
- 4 The Cigna Healthcare PPO network is only available to members whose employer purchased this network. Cigna Healthcare is an independent company and not affiliated with AmeriHealth. Access to the Cigna Healthcare PPO Network is available through the contractual relationship between AmeriHealth and Cigna Healthcare. All Cigna Healthcare products are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company. The Cigna name, logo, and other marks are owned by Cigna Intellectual Property, Inc.


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Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

EPO \$20/\$50 \$2,000 \$25/\$50/\$75 Rx (Full Mandate)

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.**
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.amerihealth.com/tpa or by calling 1-844-352-1706 (TTY:711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-844-352-1706 (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network providers \$2,000 person / \$4,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care , Primary care services, Specialist services and Emergency room services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network providers \$4,000 person / \$8,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums , out-of-network balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain precertification for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See www.amerihealth.com/tpa/providerfinder or call 1-844-352-1706 (TTY:711) for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20/Visit. Deductible does not apply.	Not covered.	Telemedicine is a covered benefit: See your benefit booklet for coverage details.
	Specialist visit	\$50/Visit. Deductible does not apply.	Not covered.	None
	Preventive care/screening/immunization	No charge. Deductible does not apply.	Not covered.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: \$50/Visit. Deductible does not apply. Blood Work: No charge. Deductible does not apply.	Not covered.	None
	Imaging (CT/PET scans, MRIs)	\$75/Scan. Deductible does not apply.	Not covered.	Prior authorization is required. *Visit https://www.amerhealth.com/tpa/precertification .
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.amerhealth.com/tpa/formulary4v .	Generic Drugs	Retail/Mail Order (1-30 days supply) \$25/Fill. Mail Order (31-90 days supply) \$50/Fill. Deductible does not apply.	Not covered.	Prior authorization may be required on some drugs. Covers up to a 30 day supply. Value Formulary , not all drugs covered.
	Preferred Drugs	Retail/Mail Order (1-30 days supply) \$50/Fill. Mail Order (31-90 days supply) \$100/Fill. Deductible does not apply.	Not covered.	
	Non Preferred Drugs	Retail/Mail Order (1-30 days supply) \$75/Fill. Mail Order (31-90 days supply) \$150/Fill. Deductible does not apply.	Not covered.	

*For more information about limitations and exceptions, see plan or policy document at www.amerhealth.com/tpa.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty Drugs	Retail (1-30 days supply) 50% coinsurance (\$250 max/fill). Deductible does not apply.	Not covered.	This applies to oral or injectable self-administered Specialty Drugs which are covered under the Prescription Drug Plan . Covers up to a 30 day supply. Prior authorization and/or dispensing limits may apply. Other Specialty Drugs and infusion therapy drugs may be covered under your medical benefits plan as stated within your Policy and/or Drug Rider information. A complete list of drugs requiring Prior authorization is available, *visit https://www.amerhealth.com/tpa/formulary4v .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance .	Not covered.	Prior authorization is required. *Visit https://www.amerhealth.com/tpa/precertification .
	Physician/surgeon fees	30% coinsurance .	Not covered.	
If you need immediate medical attention	Emergency room care	\$100/Visit. Deductible does not apply.	Covered at In-Network level.	None
	Emergency medical transportation	30% coinsurance .	Covered at In-Network level.	
	Urgent care	\$50/Visit. Deductible does not apply.	Covered at In-Network level.	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance .	Not covered.	Prior authorization is required. *Visit https://www.amerhealth.com/tpa/precertification .
	Physician/surgeon fees	30% coinsurance .	Not covered.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50/Visit. Deductible does not apply.	Not covered.	Telemedicine is a covered benefit. See your benefit booklet for coverage details.
	Inpatient services	30% coinsurance .	Not covered.	Prior authorization may be required. *Visit https://www.amerhealth.com/tpa/precertification .

*For more information about limitations and exceptions, see plan or policy document at www.amerhealth.com/tpa.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge. Deductible does not apply.	Not covered.	Office visit cost share applies to the first OB visit only. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested.
	Childbirth/delivery professional services	30% coinsurance .	Not covered.	
	Childbirth/delivery facility services	30% coinsurance .	Not covered.	
If you need help recovering or have other special health needs	Home health care	30% coinsurance .	Not covered.	Prior authorization is required. *Visit https://www.amerhealth.com/tpa/precertification .
	Rehabilitation services	\$50/Visit. Deductible does not apply.	Not covered.	Physical, Occupational, and Speech: 60 visits/Calendar Year (combined).
	Habilitation services	\$50/Visit. Deductible does not apply.	Not covered.	Physical, Occupational, and Speech: 60 visits/Calendar Year (combined). Visit limits do not apply for the treatment of Autism.
	Skilled nursing care	30% coinsurance .	Not covered.	Precertification is required. *Visit https://www.amerhealth.com/tpa/precertification . 120 days/Calendar Year.
	Durable medical equipment	50% coinsurance .	Not covered.	Precertification required for certain items. *Visit https://www.amerhealth.com/tpa/precertification .
	Hospice services	30% coinsurance .	Not covered.	Prior authorization is required. *Visit https://www.amerhealth.com/tpa/precertification .
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	None
	Children's glasses	Not covered.	Not covered.	None
	Children's dental check-up	Not covered.	Not covered.	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery Dental care (Adult) 	<ul style="list-style-type: none"> Long-term care Non-emergency care when traveling outside the U.S. Routine eye care (Adult) 	<ul style="list-style-type: none"> Routine foot care Weight loss programs

*For more information about limitations and exceptions, see plan or policy document at www.amerhealth.com/tpa.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric surgery
- Chiropractic care (30 Visits per Calendar Year)
- Hearing aids (1 Device Per Ear Every 2 Years)
- Infertility treatment (covered for artificial insemination and assisted reproductive technology; requires pre approval)
- Private-duty nursing (covered under Home Health Care)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. To contact the [plan](#) call 1-844-352-1706 (TTY: 711), or the contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; For non-federal governmental group health [plans](#), contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Church [plans](#) are not covered by the Federal COBRA continuation coverage rules. Coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for non-federal governmental group health [plans](#) and church [plans](#) that are group health [plans](#), contact us at 1-844-352-1706.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet Minimum Value Standards?

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

*For more information about limitations and exceptions, see plan or policy document at www.amerhealth.com/tpa.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#), and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
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Deductibles	\$2,000
Copayments	\$100
Coinsurance	\$1,900

<i>What isn't covered</i>	
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Limits or exclusions	\$20
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The total Peg would pay is	\$4,020
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Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
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Deductibles	\$0
Copayments	\$1,600
Coinsurance	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$20
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The total Joe would pay is	\$1,620
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
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Deductibles	\$1,200
Copayments	\$500
Coinsurance	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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The total Mia would pay is	\$1,700
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Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-844-352-1706 (TTY:711)

Fixed Funding Mandate Lite exclusion guide

Benefits not covered under Fixed Funding Mandate Lite:

- Autologous bone marrow transplant
- Bariatric surgery
- Continuation of coverage due to total disability of employee or member
- Hearing aids
- Infertility treatment (including diagnosis, testing, and treatment)
- New Jersey's Surprise Out-of-Network Act
- 12-month fill of oral contraceptives
- Prosthetics/Orthotics mandated appliances
- Temporomandibular joint dysfunction (TMJ)
- Wilms' tumor

Full Mandate plan disclaimer

Unlike fully insured plans, Full Mandate plans do not cover hearing aids at the Primary Care Physician (PCP) cost share. Cost-share for hearing aids will continue to be covered at 50% coinsurance (deductible applies on applicable plans).

Saving HealthCare Dollars



Medical

- Make sure providers you are seeing are in your network.
- Use your Carrier's Cost of Care Estimator Tool to compare pricing.
 - You can get pricing on MRI's, Lab Tests, Surgeries and much more at providers and hospitals in your area.
- Use your plan's Telemedicine to access a doctor virtually, 24 hours/day.
- Ask questions:
 - *Can I try Physical Therapy before having surgery?"*
 - *"What other options are available?"*
 - *"Can you confirm my carrier will cover this & at what cost to me?"*
 - *"Is there a discount if I pay full balance now?"*
- If your plan offers a tax deferred account, such as an FSA or HSA, use it.
- Use medical cost negotiation services such as AblePay (<https://www.ablepayhealth.com/>)

Prescriptions

- Ask for generic medications.
- Ask if condition can be treated with diet and exercise before using prescriptions.
- Use Mail Order to get a 90-day prescription for less than three copays.
- Check Drug Manufacturer's website for discounts on brand name medications.
- Go to www.GoodRx.com (or use app) to check prices. Good Rx can be used as often as needed, often reducing costs by 80%.

Insurance Card FAQ's



Question	Answer
When will I receive my Medical Insurance ID Card?	You should receive your Medical Insurance ID Card within 15 business days of accurately completing and submitting enrollment.
What if my coverage effective date is here but my Medical Insurance ID Card is not?	You can print a Medical Insurance ID Card by going to www.amerhealthnj.com . Click "Register" at the top right. After registering you will have an option to print an ID Card. This card can be used at the provider's office and the pharmacy.
What if I lose my Medical Insurance ID Card? How do I get another one?	You can print a Medical Insurance ID Card by going to www.amerhealthnj.com . Click "Register" at the top right. After registering you will have an option to print an ID Card. This card can be used at the provider's office and the pharmacy.
Can I get a copy of my ID Card online?	Yes, you are able to download a copy of your ID Card at www.amerhealthnj.com . This is also available through your carrier's app.

2025-2026

WHAT'S NEXT?



Consider your options

Make sure you get the coverage that best suits your needs. Discuss with your spouse, partner or other family members to consider all sources of benefit coverage.



Keep this guide handy

Refer to the information in this guide and online at our website to help you make wise benefit choices.


If you still have unanswered questions, please contact:

Karrie Rank
251 US Highway 206
Flanders, NJ 07836

Phone: 973-927-7870
Email: Karrie@telesearch.com
Website: www.telesearch.com

Notice of Privacy for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is required by the health insurance portability and accountability act (“HIPAA”) as amended by the health information technology for economic and clinical health act (“HITECH”).

 Please review it carefully.

SECTION 1

Effective Date of Notice: Effective October 15, 2018, the Plan is required to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan’s uses and disclosures of Protected Health Information (PHI);
- your privacy rights with respect to your PHI
- the Plan’s duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and

Uses and disclosures that require your written authorization.

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during counseling session. They do not include summary information about your mental health

treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you.

Your authorization will also be obtained in the event your PHI is released for sale or other marketing activities. The plan may not disclose any PHI that is genetic information for underwriting purposes. Finally, any other uses and disclosures of your PHI not mentioned or otherwise covered in this privacy notice will require your written authorization.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend’s involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosure for which consent, authorization or opportunity to object is not required.

Use and disclosure of your PHI is allowed without consent, authorization or request under the following circumstances:

1. When required by law.
2. When permitted for purpose of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease condition, if authorized by law.
3. Complaints against providers and other activities necessary for appropriate oversight of government benefit programs (for example to investigate Medicare or Medicaid fraud).
4. The Plan may disclose your PHI when required by judicial or administrative proceedings.
5. When required for law enforcement purposes (for example, to report certain types of wounds).
6. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate

law enforcement activity would be material and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

7. When required to be given to the coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
8. The Plan may use or disclose PHI for research, subject to certain conditions.
9. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes that use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
10. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law. Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

SECTION 2 - Rights of Individuals

Right to Request Restrictions of PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures only to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. However, we may not refuse a request to restrict the disclosure of PHI to health plans where you pay in full the out-of-pocket expenses for the services to which that PHI relates.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to the following officer:

Karrie Rank
251 US Highway 206
Flanders, NJ 07836
Phone: 973-927-7870
Email: Karrie@telesearch.com
www.telesearch.com

Rights to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Plan maintains the PHI.

“Designated Record Set” includes the medical records and billing records about individuals maintained by or for a covered health care provider, enrollment, payment, billing, claims adjudication and care or medical management record systems maintained by or for a health plan, or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if The Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set.

Requests for access to PHI should be made to the following officer:

Karrie Rank
251 US Highway 206
Flanders, NJ 07836
Phone: 973-927-7870
Email: Karrie@telesearch.com
www.telesearch.com

You or your representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made:

1. to carry out treatment, payment or health care operations;
2. to individuals about their own PHI; or
3. prior to six (6) years before your request from accounting.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice contact the following officer:

Karrie Rank
251 US Highway 206
Flanders, NJ 07836
Phone: 973-927-7870
Email: Karrie@telesearch.com
www.telesearch.com

The Right to Opt-out of Receiving Certain Information

You have the right to opt-out of receiving certain types of communication from the plan including marketing, fundraising and treatment related communications.

The Right to Notice of Any Breach

If your unsecured PHI has been breached (within the meaning of HITECH), the plan is required to notify you of such breach.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public
- court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

SECTION 3 - The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective October 15, 2018 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date.

If a privacy practice is changed, a revised version of this notice will be provided to all past and present participants and beneficiaries for whom the Plan still maintains PHI in the same manner that this notice has been delivered.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or whenever requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosure to or request by a health care provider for treatment;

- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claim history, claim expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

SECTION 4 - Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following officer:

Karrie Rank
251 US Highway 206
Flanders, NJ 07836
Phone: 973-927-7870
Email: Karrie@telesearch.com
www.telesearch.com

You can complain if you feel we have violated your rights by contacting us using the information above.

- 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:
<http://www.hhs.gov/ocr/privacy/hipaa/complaints/>.
- The Plan will not retaliate against you for filing a complaint.

SECTION 5 - Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer:

Karrie Rank
251 US Highway 206
Flanders, NJ 07836
Phone: 973-927-7870
Email: Karrie@telesearch.com
www.telesearch.com

Conclusion

PHI use and disclosure by the Plan is regulated by HIPAA as amended by HITECH. You may find these rules 45 Code of Federal Regulations Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information notice and the regulations.

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

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

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

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

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

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

ALABAMA - Medicaid	Website: http://myalhipp.com/	Phone: 1 (855) 692-5447
ALASKA - Medicaid	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Phone: 1 (866) 251-4861 Email: CustomerService@MyAKHIPP.com
ARKANSAS - Medicaid	Website: http://myarhipp.com/	Phone: 1 (855) MyARHIPP - 1 (855) 692-7447
CALIFORNIA - Medicaid	Website: Health Insurance Premium Payment (HIPP) Program - http://dhcs.ca.gov/hipp	Phone: 1 (916) 445-8322 Fax: 1 (916) 440-5676 Email: hipp@dhcs.ca.gov
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	Health First Colorado Website: https://www.healthfirstcolorado.com/ CHP+: https://hcpf.colorado.gov/child-health-plan-plus Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/	Health First Colorado Member Contact Center: 1 (800) 221-3943 - State Relay 711 CHP+ Customer Service: 1 (800) 359-1991 - State Relay 711 HIBI Customer Service: 1 (855) 692-6442
FLORIDA - Medicaid	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html	Phone: 1 (877) 357-3268
GEORGIA - Medicaid	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	GA HIPP Phone: 1 (678) 564-1162, Press 1 GA CHIPRA Phone: 1 (678) 564-1162, Press 2
INDIANA - Medicaid	Website: http://www.in.gov/fssa/hip/ All other Medicaid Website: https://www.in.gov/medicaid/	Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA - Medicaid and CHIP (Hawki)	Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	Medicaid Phone: 1 (800) 338-8366 Hawki Phone: 1 (800) 257-8563 HIPP Phone: 1 (888) 346-9562
KANSAS - Medicaid	Website: https://www.kancare.ks.gov/	Phone: 1 (800) 792-4884 HIPP Phone: 1 (800) 967-4660
KENTUCKY - Medicaid	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KCHIP Website: https://kynect.ky.gov Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Phone: 1 (855) 459-6328 Email: KIHIPPPROGRAM@ky.gov Phone: 1 (877) 524-4718
LOUISIANA - Medicaid	Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp	Phone: 1 (888) 342-6207 (Medicaid hotline) or 1 (855) 618-5488 (LaHIPP)
MAINE - Medicaid	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms	Phone: 1 (800) 442-6003 - TTY: Maine relay 711 Phone: 1 (800) 977-6740 - TTY: Maine relay 711
MASSACHUSETTS - Medicaid and CHIP	Website: https://www.mass.gov/masshealth/pa	Phone: 1 (800) 862-4840 TTY: 711 Email: masspreassistance@accenture.com
MINNESOTA - Medicaid	Website: https://mn.gov/dhs/health-care-coverage/	Phone: 1 (800) 657-3672
MISSOURI - Medicaid	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	Phone: 1 (573) 751-2005
MONTANA - Medicaid	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP	Phone: 1 (800) 694-3084 Email: HSHIPPProgram@mt.gov
NEBRASKA - Medicaid	Website: http://www.ACCESSNebraska.ne.gov	Phone: 1 (855) 632-7633 Lincoln: 1 (402) 473-7000 Omaha: 1 (402) 595-1178

NEVADA - Medicaid	Medicaid Website: http://dhcfp.nv.gov	Medicaid Phone: 1 (800) 992-0900
NEW HAMPSHIRE - Medicaid	Website: https://www.dhhs.nh.gov/programsservices/medicaid/health-insurance-premium-program	Phone: 1 (603) 271-5218 Toll free number for the HIPP program: 1 (800) 852-3345, ext 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY - Medicaid and CHIP	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP Website: http://www.njfamilycare.org/index.html	Medicaid Phone: 1 (800) 356-1561 CHIP Premium Assistance Phone: 1 (609) 631-2392 CHIP Phone: 1 (800) 701-0710 (TTY: 711)
NEW YORK - Medicaid	Website: https://www.health.ny.gov/health_care/medicaid/	Phone: 1 (800) 541-2831
NORTH CAROLINA - Medicaid	Website: https://medicaid.ncdhhs.gov/	Phone: 1 (919) 855-4100
NORTH DAKOTA - Medicaid	Website: https://www.hhs.nd.gov/healthcare	Phone: 1 (844) 854-4825
OKLAHOMA - Medicaid and CHIP	Website: http://www.insureoklahoma.org	Phone: 1 (888) 365-3742
OREGON - Medicaid	Website: http://healthcare.oregon.gov/Pages/index.aspx	Phone: 1 (800) 699-9075
PENNSYLVANIA - Medicaid and CHIP	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx	Phone: 1 (800) 692-7462 CHIP Phone: 1 (800) 986-KIDS (5437)
RHODE ISLAND - Medicaid and CHIP	Website: http://www.eohhs.ri.gov/	Phone: 1 (855) 697-4347, or (401) 462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA - Medicaid	Website: https://www.scdhhs.gov	Phone: 1 (888) 549-0820
SOUTH DAKOTA - Medicaid	Website: http://dss.sd.gov	Phone: 1 (888) 828-0059
TEXAS - Medicaid	Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	Phone: 1 (800) 440-0493
UTAH - Medicaid and CHIP	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Phone: 1 (888) 222-2542 Email: upp@utah.gov
VERMONT - Medicaid	Website: https://dvha.vermont.gov/members/medicaid/hipp-program	Phone: 1 (800) 250-8427
VIRGINIA - Medicaid and CHIP	Website: https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP Phone: 1 (800) 432-5924
WASHINGTON - Medicaid	Website: https://www.hca.wa.gov/	Phone: 1 (800) 562-3022
WEST VIRGINIA - Medicaid and CHIP	Website: https://dhhr.wv.gov/bms http://mywvhipp.com/	Medicaid Phone: (304) 558-1700 CHIP Toll-Free Phone: 1 (855) MyWVHIP (1 (855)-699-8447)
WISCONSIN - Medicaid and CHIP	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	Phone: 1 (800) 362-3002
WYOMING - Medicaid	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	Phone: 1 (800) 251-1269

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

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

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

Notice of Special Enrollment Rights

HIPAA applies to any employer that has two or more active employees. Under HIPAA group health plans are required to provide active employees, their dependents and COBRA qualified beneficiaries with special enrollment opportunities for certain situations.

The following are just some events that may trigger a Special Enrollment Event:

- Loss of eligibility under other coverage;
 - Due to divorce or legal separation;
 - Dependent loss of eligibility due to age under a parents plan;
 - Death of an employee's spouse which leaves the spouse with no coverage;
 - Spouse's employment ends, as does insurance coverage; and
 - Spouse no longer eligible due to hours being cut.
- Loss of eligibility under Medicaid/CHIP;
- 18/36 month exhaustion under COBRA;
- Birth/Adoption/Place for adoption of a child;
- Marriage of an employee; and
- Gain of eligibility for Medicaid/CHIP premium assistance.

You must notify us or your worksite employer within 30 days of the Special Enrollment Event taking place. Coverage will not be provided if the request is made after the 30 day period.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

Enrolling for the first time you must complete an enrollment form and provide the supporting documentation for your Special Enrollment Event. If you are currently enrolled and adding a dependent then a written request is required along with the supporting documentation.

If you have any questions about special enrollment eligibility please contact your HR Representative or Benefits Administrator.

Additional FAQs regarding HIPAA and Special Enrollment Rights can be found at:

<https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/hipaa-consumer.pdf>

The Women's Health and Cancer Rights Act of 1998 (WHCRA)

The Women's Health and Cancer Rights Act of 1998 requires us to notify you, as a participant or beneficiary of our Employee Benefit Plan ("Plan") of your rights related to benefits provided through the Plan in connection with a mastectomy. As a participant or beneficiary, you may have rights to the following coverage to be provided in a manner determined in consultation with your attending physician:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment of physical complications of the mastectomy including lymphedemas.

These benefits are subject to the Plan's regular deductible and co-pay.



Keep this notice for your records.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, health plans and insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan/issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans/issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, any issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, please contact your issuer.

This statement applies to any individual or group contract that provides coverage for maternity services.

Continuation Required by Federal Law for You and Your Dependents

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income. Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than your gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

Mental Health Parity Act

According to the Mental Health Parity Act of 1996, the lifetime maximum and annual maximum dollar limits for mental health benefits under the medical plan are equal to the lifetime maximum and annual maximum dollar limits for medical and surgical benefits under this plan. However, mental health benefits may be limited to a maximum number of treatment days per year or series per lifetime.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's co payments, 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" means 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're protected from balance billing for:

Emergency services

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

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

You're never required to give up your protections from balance billing. You also aren't required to get 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 these protections:

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

If you believe you've been wrongly billed or for more information, visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law.

No Surprises Help Desk: 800-985-3059 8am-8pm EST, 7 days a week

Glossary of Health Coverage and Medical Terms

When making decisions about health coverage, consumers should know the specific meanings of terms used to discuss health insurance. This Glossary defines many commonly used terms but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs.

Allowed Amount

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is \$200 and the allowed amount is \$100, the provider may bill you for the remaining \$90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not balance bill you for covered services.

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.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for

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

Complications of Pregnancy

Conditions due to pregnancy, labor and delivery, that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example \$20) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Cost-Sharing

Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out-of-pocket costs that you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost-sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention, you could reasonably expect one of the following: 1) Your health would be put in serious danger;

or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services

Health care services that your plan doesn't pay for or cover.

Formulary

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or plan.

Habilitation Services

Health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance

Your share (for example, 20%) of the allowed amount for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace

A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits, and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket

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

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

Minimum Value Standard

A basic standard to measure the percentage of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value, and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.

Network

The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider (Preferred Provider)

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the allowed

amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network Copayment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-network Provider (Non-Preferred Provider)

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Out-of-pocket Limit

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges, or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services Health Care

services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union, or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called “health insurance plan,” “policy,” “health insurance policy,” or “health insurance.”

Preauthorization

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called “prior authorization,” “prior approval,” or “precertification.” Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.

Premium

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

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage

Coverage under a plan that helps pay for prescription drugs. If the plan’s formulary uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you’ll pay in cost sharing will be different for each “tier” of covered prescription drugs.

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you

need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount is sometimes used to determine the allowed amount.

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

2025-2026

BENEFITS GUIDEBOOK

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This brochure summarizes the health care and income protection benefits that are available to employees and their eligible dependents. Official plan documents, policies, and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits. Please note: This enrollment guide is a summary of some of the benefits provided to eligible employees. We reserve the right to modify, amend, suspend, or terminate any plan at any time for any reason without prior notification. The plans described in this bulletin are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make explanations of the plans in this bulletin as accurate as possible. However, should there be any discrepancy between this bulletin and the provisions of the insurance contract or plan documents, the provisions of the insurance contract or plan documents will govern. The written descriptions in the insurance contracts or plan documents will always govern.