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GROUP BENEFIT ADVISORS

Benefits Guide

GOLD STAR MORTGAGE FINANCIAL GROUP

PLAN YEAR 2024

NMLS #3446
Gold Star
Mortgage Financial Group

Table of contents

This booklet is intended for illustrative and informational purposes only. The plan documents, insurance certificates, and policies will serve as the governing documents. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.

Opening letter

Choose the best benefits for you and your family

Gold Star Mortgage Financial Group strives to provide you and your family with a comprehensive and valuable benefits package. This guide will outline the different benefits offered during this open enrollment period. Each year, we review the benefit strategy and analyze our plans to manage our healthcare costs.

Open enrollment is an annual process that provides Gold Star Mortgage Financial Group's employees the opportunity to make changes to their existing benefit elections or enroll in new benefit plans for you and your family. This is also a good time to verify your current employment, dependent, and beneficiary information with Gold Star Mortgage Financial Group.

Any elections you make during this open enrollment period will become effective January 1, 2024. If you have questions about any of the benefits in this guide, please don't hesitate to contact Human Resources.

Use this booklet to:

- *Learn about our new medical concierge tool: HealthJoy*
- *Learn about the exciting new Life and Disability carrier: Guardian*
- *IRS Increase to the HSA and FSA maximum contribution amounts*

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General information

Open enrollment dates

Open enrollment period is from November 13 – November 27, 2023.

To make elections via Paycor:

- Log into Paycor with your employee role.
- Go to Me.
- Click on **Benefits**.
- **Start Enrollment**.
- **Review** current benefit elections and make any applicable changes.
- **Review** and **submit**.

How to enroll

Are you ready to enroll? The first step is to review your current benefits in the Paycor enrollment site. Contact Human Resource if you need assistance obtaining your current enrollment information. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all of your information is up to date, it's time to make your benefit elections. The enrollment decisions you make can have a significant impact on your life and finances, so it's important to weigh your options carefully.

Who is eligible?

If you're a full-time employee at Gold Star Mortgage Financial Group, you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who are regularly scheduled to work 30 or more hours per week. Benefits begin on the 1st of the month following 30 days for new hires, and if you are rehired within a year, 1st of the month after your rehire date.

Your dependents may also be covered under the medical/pharmacy, dental, vision, and voluntary life plans. Eligible dependents include:

- Legal spouse, as defined by federal law
- Dependent children under age 26:
    - Medical coverage: Until the end of the year in which the child turns age 26
    - Vision coverage: Until the end of the year in which the child turns age 26
    - Dental coverage: Until the end of the year in which the child turns age 26
    - Voluntary life coverage: Until the child's 26th birthday

How to make midyear changes (qualifying events)

Unless you experience a qualifying life event, you can't make changes to your benefits until the next open enrollment period. Qualifying events include:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse or child
- Change in employment status or a change in coverage under another employer-sponsored plan within 30 days of the qualifying event

If you experience a qualifying life event, you must notify Human Resources that you wish to make changes to your benefit plan options within 30 days of the qualifying event and will be effective in accordance with the event.

In the event of employment termination, Medical, Dental and Vision coverage will end of the last day of the month in which you were an active employee. All other coverages will end of your last day worked.

Healthcare benefits

Gold Stars' medical plans are insured by Meritain Health with access to the Aetna Choice POS II PPO provider network. Our plans offer comprehensive coverage to help keep you and your family healthy. You and Gold Star share in the cost of medical coverage. For 2024, Gold Star is sponsoring three medical plans for you and your family:

- Meritain Health HSA HDHP
- Meritain Health $2500 PPO
- Meritain Health $4000 PPO

Your Meritain Health medical plan has a network of providers but also allows for the use of providers outside the plan's network. The Aetna Choice POS II PPO provider network is the largest in the nation. You may access a list of participating network providers through Meritain Health's website or by chatting with HealthJoy.

On the following pages are summaries of your medical plan options. Please refer to your summary plan description for a more detailed explanation of benefits. Please note that the deductible and out-of-pocket maximum requirements accumulate on a calendar-year basis.

PPO in-network versus out-of-network costs

"PPO" refers to a Preferred Provider Organization from which you will receive the highest level of benefits when you utilize a participating provider in the PPO network. Providers participating with the PPO network must accept the network-approved amount. In-network providers can't balance bill you for more than your deductible and coinsurance.

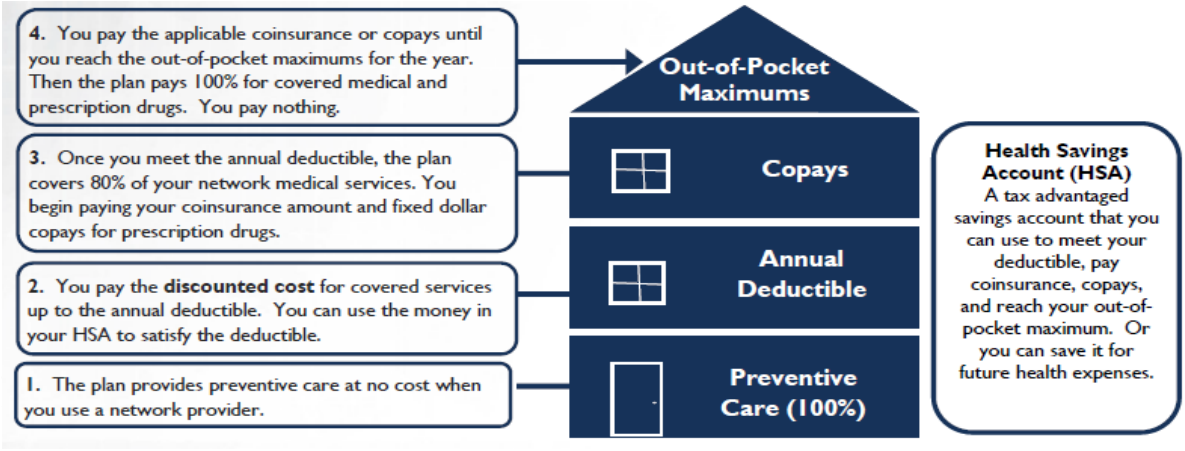
Your PPO plans offer services through a network of providers but also allow for the use of providers outside of the plan's network. When members use a nonparticipating provider, the level of benefits is reduced, and members will pay more out-of-pocket expenses. Nonparticipating providers can balance bill you for any amount they request for their services.

Meritain Health HSA HDHP

The High Deductible Health Plan (HDHP) is offered with a tax-free Health Savings Account (HSA) that reimburses you for current and future medical expenses. All services, including prescriptions and office visits, are subject to the benefit year deductible, with the exception of certain preventive care services. Preventive care services are covered at 100% with no deductible when performed by a network provider.

It's important to note that the annual deductible under the HDHP works differently than the other PPO plans. Under the HDHP two-person or family coverage, benefits for an individual will be payable only when the FULL family HDHP deductible has been met. This means that services for an individual are not covered after they have satisfied the individual deductible as they are under the other PPO plans.

How the High Deductible Health Plan Works



Healthcare benefits

HSA HDHP		
	IN NETWORK	OUT OF NETWORK
DEDUCTIBLES		
Individuals	$1,600	$3,000
Family (2 or more enrolled)	$3,200	$6,000
COINSURANCE		
Plan Pays	80%	60%
You Pay	20%	40%
OUT-OF-POCKET MAXIMUM (PER CALENDAR YEAR)	Deductible, coinsurance & copays included	
Individual	$4,000	$8,000
Family	$8,000	$16,000
HEALTHCARE SERVICES		
Primary Care Physician	80% after deductible	60% after deductible
Specialist	80% after deductible	60% after deductible
Urgent care	80% after deductible	60% after deductible
Emergency room	80% after deductible	80% after deductible
Inpatient Hospital	80% after deductible	60% after deductible
Outpatient Hospital	80% after deductible	60% after deductible
Chiropractic Care- combined 12 visit max per year	80% after deductible	60% after deductible
Physical, occupational, and speech therapy- combined 30 visit max per year	80% after deductible	60% after deductible
Preventive care	100%	Not covered
Diagnostic X-Ray & Lab	80% after deductible	60% after deductible
PRESCRIPTION DRUGS		
Generic and Specialty	$15 copay after deductible	Deductible and in-network copay apply + 20% of the approved amount
Preferred Brand and Specialty	$50 copay after deductible	
Nonpreferred Brand and Specialty	Greater of $70 copay or 50% coinsurance ($100 max) after deductible	
Mail Order (90-day supply)		
Generic	$35 copay after deductible	Not Covered
Preferred Brand	$140 copay after deductible	
Nonpreferred Brand	Greater of $200 copay or 50% coinsurance ($290 max) after deductible	

Healthcare benefits

$2,500 PPO		
	IN NETWORK	OUT OF NETWORK
DEDUCTIBLES		
Individuals	$2,500	$5,000
Family (2 or more enrolled)	$5,000	$10,000
COINSURANCE		
Plan Pays	80%	60%
You Pay	20%	40%
OUT-OF-POCKET MAXIMUM (PER CALENDAR YEAR)	Deductible, coinsurance & copays included	
Individual	$6,350	$12,700
Family	$12,700	$25,400
HEALTHCARE SERVICES		
Primary Care Physician	$30 copay	60% after deductible
Specialist	$50 copay	60% after deductible
Urgent care	$60 copay	60% after deductible
Emergency room	$150 copay	$150 copay
Preventive care	100%	Not covered
Inpatient Hospital	80% after deductible	60% after deductible
Outpatient Hospital	80% after deductible	60% after deductible
Chiropractic care - combined 12 visit max per year	$30 copay	60% after deductible
Physical, occupational, and speech therapy combined 30 visit max per year	80% after deductible	60% after deductible
Preventative Care Services	100% coverage	Not covered
Diagnostic X-Ray & Lab	80% after deductible	60% after deductible
PRESCRIPTION DRUGS		
Retail generic	$15 copay	In-network copay applies + 20% of the approved amount
Retail preferred brand and specialty	$50 copay	
Retail nonpreferred brand and specialty	Greater of $70 copay or 50% coinsurance (max $100)	
MAIL ORDER 90-DAY SUPPLY SPECIALTY NOT COVERED	2x retail	Not Covered

Healthcare benefits

$4,000 PPO		
	IN NETWORK	OUT OF NETWORK
DEDUCTIBLES		
Individuals	$4,000	$4,000
Family (2 or more enrolled)	$8,000	$8,000
COINSURANCE		
Plan Pays	70%	60%
You Pay	30%	40%
OUT-OF-POCKET MAXIMUM (PER CALENDAR YEAR)	Deductible, coinsurance & copays included	
Individual	$6,600	$13,200
Family	$13,200	$26,400
HEALTHCARE SERVICES		
Primary Care Physician	$30 copay	60% after deductible
Specialist	70% after deductible	60% after deductible
Urgent care	70% after deductible	60% after deductible
Emergency room	70% after deductible	70% after deductible
Preventive care	100%	Not covered
Inpatient Hospital	70% after deductible	60% after deductible
Outpatient Hospital	70% after deductible	60% after deductible
Chiropractic care - combined 12 visit max per year	70% after deductible	60% after deductible
Physical, occupational, and speech therapy combined 30 visit max per year	70% after deductible	60% after deductible
Preventative Care Services	100% coverage	Not covered
Diagnostic X-Ray & Lab	70% after deductible	60% after deductible
PRESCRIPTION DRUGS		
Retail generic	$20 copay	Deductible and in-network copay apply + 20% of the approved amount
Retail preferred brand and specialty	$60 copay	
Retail nonpreferred brand and specialty	Greater of $80 copay or 50% coinsurance (max $100)	
MAIL ORDER 90-DAY SUPPLY SPECIALTY NOT COVERED	2x retail	Not Covered

Healthcare benefits (continued)

CancerCARE

It's estimated that 1 in 2 men and 1 in 3 women face a cancer diagnosis during their lifetimes. To control costs and optimize outcomes, it's important to ensure that the cancer diagnosis is confirmed, properly staged, and the best evidence-based treatment protocol is implemented quickly. The CancerCare program is tailored to members and immediately pairs a plan participant with a care coordinator to help navigate all aspects of treatment and care. Patients will be placed into appropriate treatment protocols with access to the Cancer Centers of Excellence Network, access to clinical trials, and oversight by oncology experts. Call **877.640.9610**

KISCard
Keep It Simple Surgery

The KISx Card is a surgery and imaging program that's available to you for the most common surgical and imaging elective procedures. Some of the most common procedures through The KISx Card include orthopedic, general surgery, colonoscopies, MRIs, and CT and PET scans. If you utilize the program, you will receive your procedure at no cost to you. Call **877.GET.KISX** or email **info@getKISx.com**

CVS minute clinic

CVS Minute Clinic is a walk-in clinic at 40% less than the cost on average of urgent care. The Minute Clinic provides treatment for illnesses and infections such as sore throat, flu-like symptoms, bug bites, sprains, strains, urinary tract and bladder infections, health screenings, vaccinations, and more 7 days a week for your convenient care as well as provides telehealth options. Find a nearby clinic at **https://www.cvs.com/minuteclinic/clinic-locator/**

HUSK

Husk is an online platform that allows you to access discounted gym memberships at popular fitness, weight loss, and wellness programs nationwide. marketplace.huskwellness.com/paretohealth
Eligibility ID: HS00113

SmartConnect
POWERED BY SMARTMATCH

SmartMatch Insurance Agency is an independent Medicare insurance agency that helps consumers research, compare, and purchase Medicare insurance plans. SmartConnect is an exclusive program created specifically for working or retiring adults (and family members) who are Medicare-eligible and may not have fully explored the benefits of Medicare coverage. Their concierge service helps explore Medicare supplemental plans and Medicare Advantage plans for you. Call **855-810-8938**

Virtual mental health support

Gold Star Mortgage offers several options for leveraging virtual therapy services in-network.

Here are some quick facts:

- All Meritain medical plans include coverage for mental health support through virtual mental well-being providers like Talkspace.
- Virtual mental health support is covered at the same level as an in-office visit, meaning members are responsible for the applicable copays and/or coinsurance. However, how services are billed can vary by virtual support platform.

Ages	Provider	Contact
18 months to 17 years	Brightline	**https://www.hellobrightline.com/meritain**
5 and up	Telemynd	**1.866.991.2103** **https://Telemynd.com/meritain**
13 and up	Talkspace	**https://www.talkspace.com/Meritain**
18 and up	Meru Health	**https://www.meruhealth.com/sign-up/meritain/**

HealthJoy

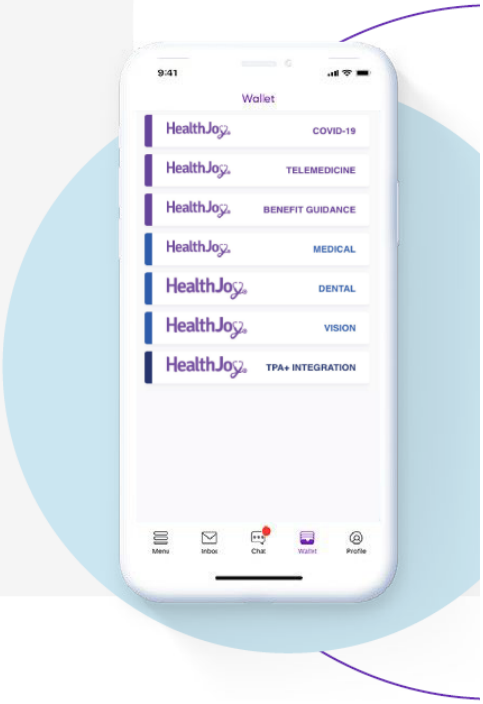
Available January 1, 2024

HealthJoy Makes it Easier to be Healthy and Well.

HealthJoy is the virtual access point for all your healthcare navigation and employee benefits needs. We're provided free by your employer to help understand and make the most of your benefits. We connect you and your family with the right benefits at the right moment in your care journey, saving you time, money, and frustration.

Help For Your Healthcare Journey.

With 24/7 access to our dedicated healthcare concierge team, visits, and care navigation tools, you never have to walk alone. HealthJoy helps you locate in-network doctors, find extra savings on your prescriptions, and navigate your benefits. Our mobile app and dedicated member support team are always on hand to help make it easier to stay healthy and well.



BENEFITS WALLET

HEALTHCARE CONCIERGE

RX SAVINGS REVIEW

APPOINTMENT BOOKING

PROVIDER RECOMMENDATIONS

Chat with us today by logging into the HealthJoy app or call (877) 500-3212

Download on the App Store

GET IT ON Google Play

SCAN ME

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Health savings accounts

Individuals who are enrolled in the qualified high deductible health plan (QHDHP) $1,600 PPO option are eligible to contribute to a Health Savings Account. The HSA custodian for 2024 is WEX.

Health savings account (HSA)

A health savings account is a tax-favored account an employee can contribute to for the purposes of paying qualified medical expenses such as deductibles, coinsurance, and copays. An HSA provides a triple tax advantage to those who participate in the plan. Contributions, investment earnings, and amounts used to pay for qualified medical expenses are exempt from federal income tax, FICA tax, and most state income taxes. The money in your HSA is carried over from year to year and is yours to keep, even if you retire, change medical plans, or experience a change in employment.

Who is eligible to contribute to an HSA?

Any individual who:

- Is covered by a qualified high-deductible health plan (the $1,600 PPO option qualifies).
- Is not covered by any other insurance, including a healthcare FSA; you may participate in a limited-purpose FSA (see page 15 for details).
- Is not enrolled in any portion of Medicare. If you become eligible for Medicare within the next six months, please contact Human Resources to discuss your options further.
- Can't be claimed on someone else's tax return.

How much can I contribute to the health savings account?

The IRS sets the maximum contributions; these limits are set on a calendar-year basis. For the 2024 calendar year, the total maximum allowed contribution, including amounts contributed by your employer, are:

SINGLE: $4,150 **TWO-PERSON OR FAMILY: $8,300**

Employees age 55 and older can contribute an extra $1,000 to their HSA in 2024.

Using funds in your HSA

The HSA should be used to pay for qualified medical expenses. If you use the account for nonqualified medical expenses, and you are audited, you will be taxed on the amount and you will be charged a 20% tax penalty if you are under age 65. Once age 65, you can use the account for any expense and you will be taxed on any nonqualified medical expense, but you won't be charged the penalty. It's the member's responsibility to keep track of your deposits and expenditures with your HSA. Keep all receipts for HSA expenses in the event you are audited by the IRS. See the IRS publication 502 for details on qualified medical expenses at: irs.gov/publications/p502.

Dental benefits

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings, X-rays, restorative services like fillings, crowns, bridges, and dentures, as well as orthodontic coverage for your dependent children up to age 19.

The dental insurance through Delta Dental provides you with access to an extensive network of dentists, utilizing the Delta Dental network, one of the largest in the nation. With the flexibility of this network, you have the option of visiting any provider. If you choose a network dentist, you'll receive the highest level of benefits and save on out-of-pocket costs. To locate a network dentist or review your claim history, create your member account at: www.deltadentalmi.com website.

	BUY-UP PPO PLAN			BASE EPO PLAN
	PPO DENTIST	PREMIER DENTIST	*NONPARTICIPATING DENTIST	PPO DENTIST IN NETWORK ONLY
Diagnostic & Preventative services Cleanings, oral exams, bitewing X-rays, brush biopsy, fluoride treatment for children, and sealants	100% covered	100% covered	100% covered	100% covered
Basic services Fillings, crown repair, root canals, periodontic services, extractions and dental surgery, prosthetics appliances	80% covered	80% covered	80% covered	80% covered
Major services Crowns, bridges & dentures, implants	50% covered	50% covered	50% covered	50% covered
Orthodontic services braces up to the 19th birthday Deductible does not apply	50% covered	50% covered	50% covered	50% covered
ANNUAL DEDUCTIBLE	(Except diagnostic & preventive services)			
Individual	$25			$25
Family	$75			$75
MAXIMUM ANNUAL BENEFIT — CALENDAR YEAR				
Diagnostic & Preventive, Basic and Major services (per person per year)	$1,000			$1,000
Orthodontic services (per person lifetime)	$1,000			$1,000
COMMON PROCEDURE FREQUENCY LIMITATIONS				
Oral exam and cleaning bitewing	Twice per calendar year			Twice per calendar year
X-rays (bitewings)	Once per calendar year			Once per calendar year
Full mouth x-rays	Once in any five-year period			Once in any five-year period
LATE ENTRANT WAITING PERIODS	None			None
* When you receive services from a nonparticipating dentist, the percentages in this column indicate the portion of Delta Dental's fee that will be paid for those services. This amount may be less than what the dentist charges and you are responsible for that difference.				

Vision benefits

Driving to work, reading a news article, and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Our vision benefits, provided by EyeMed cover routine eye exams and provide specified coverage or discounts for the purchase of eyeglasses and/or contact lenses.

If you seek services through an EyeMed network provider, you will receive the greatest benefit for your vision care needs. To locate an EyeMed doctor, visit EyeMed.com

EYEMED VISION PLAN	IN NETWORK	OUT OF NETWORK
Eye exam	$10 copay	Reimbursement up to $40
Lenses		
• Single Vision	$25 copay	Reimbursement up to $30
• Bifocal	$25 copay	Reimbursement up to $50
• Trifocal | Lenticular	$25 copay	Reimbursement up to $70
Lens enhancements		
• Standard Progressive	$80 copay	Reimbursement up to $50
• Premium Progressive tier 1-4	$110-$200 copay	Reimbursement up to $50
Lens options		
• Anti-reflective coating standard	$45 copay	Reimbursement up to $23
• Anti-reflective coating premium tier 1-3	$57 - $85 copay	Reimbursement up to $23
• Polycarbonate- std < 19 yrs of age	$0 copay	Reimbursement up to $20
Frames	$0 copay; 20% discount off the balance over $130	Reimbursement up to $91
Contact lenses		
Medically necessary contact lenses-individuals who are not able to wear glasses due to a physical condition.	$0 copay; paid in full	Reimbursement up to $300
• Elective contact lenses - conventional	$0 copay; 15% discount off the balance over $130	Reimbursement up to $91
• Elective contact lenses - disposable	$0 copay; $130 allowance	Reimbursement up to $91
ANNUAL DEDUCTIBLE	None	None
FREQUENCY LIMITATIONS		
Eye exam	Once every plan year	
Lenses	Once every plan year (in lieu of contacts)	
Frames	Once every two years (in lieu of contacts)	
Contact lenses	Once every plan year (in lieu of glasses)	

Flexible spending accounts

All eligible employees may participate in a Flexible Spending Account (FSA) program administered through WEX.

A Flexible Spending Account allows you to set aside money from your paycheck before income taxes to be used to pay for IRS-approved medical expenses and dependent care expenses. There are three types of FSAs:

- **Healthcare FSA**. You can use this account to pay for medical, dental, and vision expenses that you or your dependents incur, even if they are not enrolled in the company-sponsored health plans.
- **Limited-Purpose Healthcare FSA**. You can use this account to pay for dental and vision expenses that you or your dependents incur. This option is only available to individuals contributing to a Health Savings Account.
- **Dependent Care FSA**. This account is for daycare expenses only and can't be used for medical expenses. You are able to participate in the Dependent Care FSA even if you contribute to the Health Savings Account.

How does an FSA work?

First, estimate the amount of out-of-pocket expenses you expect to incur in the upcoming year (known as your election amount). This is divided by the frequency of pay periods, then deducted from your paycheck each pay period on a pretax basis. When you incur expenses during the plan year, you can swipe your FSA debit card at the point of sale or you can submit a receipt for reimbursement. You can save approximately 25% of each dollar spent when you participate in an FSA.

What is the plan year?

The plan year is Jan 1, 2024, to Dec 31, 2024. To participate in the plan, you must actively enroll each year.

How much can I contribute to the FSA plan?

The maximum that you can contribute to the Healthcare FSA for 2024 is $3,200. This applies to both the full Healthcare FSA and Limited-Purpose FSA.

Dependent Care FSA annual maximum contribution

The maximum that you can contribute to the Dependent Care FSA is $5,000 if you're a single employee or married filing jointly, or $2,500 if you're married and filing separately.

Carryover provision

Gold Star Mortgage Financial Group has adopted the "carryover" provision. This allows up to $640 of unused Healthcare FSA funds to be carried over from the 2024 Plan Year to the 2025 Plan Year. This option requires that the plan provider hold the unused money for three months to apply toward any claims that may come through from the past year. Once that period is over, the funds will be transferred into your account balance for the following year. Any amount above the $640 carryover allowance that remains unused in your FSA at the end of the plan year will be forfeited. Dependent Care FSA funds may not be carried over into the next plan year.

Please note, if you are currently participating in the Healthcare FSA, have funds remaining in your account, and elect to enroll in the HSA HDHP plan for the upcoming year, you must transfer those funds into the Limited-Purpose Healthcare FSA to be eligible to contribute to the Health Savings Account.

Your cost

Employees regularly scheduled to work 30 or more hours per week may participate in Gold Star Mortgage Financial Group medical, dental, and vision plans. The vision plan is voluntary, and employees pay 100% of the monthly premium amount through payroll deduction.

MEDICAL PLAN COSTS PRE-TAX SEMI-MONTHLY			
COVERAGE LEVEL	**QHDHP $1,600 PLAN**	**$2,500 PPO**	**$4,000 PPO**
Single	$211.54	$211.54	$175.80
Employee + 1	$501.14	$501.14	$409.77
Family	$700.26	$700.26	$586.02

	DENTAL PLAN COSTS		VISION PLAN COSTS
COVERAGE LEVEL	**DELTA DENTAL PPO PLAN PRE-TAX SEMI-MONTHLY**	**DELTA DENTAL EPO PLAN PRE-TAX SEMI-MONTHLY**	**EYEMED VISION PRE-TAX SEMI-MONTHLY**
Single	$13.71	$9.14	$2.66
Employee + spouse	$27.41	$18.26	$5.32
Family	$47.95	$31.96	$8.83

Premium conversion

Gold Star Mortgage Financial Group has established a medical Premium Conversion Plan through IRC (Internal Revenue Code) Section 125. The Premium Conversion Plan allows you to make your medical, dental, and vision contributions for yourself, your legal spouse, and your dependents on a pretax basis. Your contribution is withheld from your pay before federal, state, local, and FICA taxes are calculated.

Disability income benefits

Gold Star Mortgage Financial Group offers full-time employees both voluntary short-term and long-term disability income benefits insured through Guardian. We want to do everything we can to protect you and your family.

In the event that you become disabled from a nonwork-related injury or sickness, disability income benefits will provide a partial replacement of lost income. Any benefit that is payable due to your disability will be subject to income taxes.

SHORT-TERM DISABILITY	
Weekly benefit	60% of your covered earnings up to $1,250 weekly benefit
Elimination period	Later of 15 days accident or 15 days sickness or accumulated sick leave
Maximum benefit duration	11 weeks
Definition of disability	Disabled means you are: 1) unable to do the material duties of your job, 2) no doing any work for payment; and 3) under the regular care of a physician.
Pre-existing condition limitation	coverage is not paid for any pre-existing conditions during the first 12 months of coverage. A pre-existing condition is one you received treatment for within 3 months prior to your effective date.

LONG-TERM DISABILITY	
Monthly benefit	60% of your covered earnings up to $5,000 monthly benefit
Elimination period	90 consecutive days
Benefit duration	Up to Social Security's normal retirement age
Definition of disability	Total Disability means, that as a result of an injury or sickness: 1) during the elimination period and for the first 24 months of receiving benefits, you cannot perform the material duties of your regular occupation; 2) after 24 months of receiving benefits, you cannot perform the material duties of any occupation.
Pre-existing condition limitation	Coverage is not paid for any pre-existing conditions during the first 12 months of coverage. A pre-existing condition is one you received treatment for within 12 months prior to your effective date.

Basic Life and AD&D

All full-time employees are provided with a Life and Accidental Death and Dismemberment (AD&D) benefit at no cost to you. This coverage is insured by Guardian. For more information, contact Human Resources.

LIFE AND AD&D BENEFITS		
Life insurance	$15,000	
Accidental death and dismemberment	$15,000	
Benefit Reduction (of original amount)	**Age**	**Reduction**
	65	35%
	70	60%
	75	75%
	80	85%

Voluntary Life

We're pleased to offer you the ability to purchase additional life insurance protection for you and your dependents. This coverage offers important financial security for your family members. Coverage is offered through Guardian. Please note, coverage does not become effective until approved by Guardian.

All voluntary life elections include an accidental death and dismemberment rider, which would pay an additional life insurance benefit if the covered individual's death is the direct result of an accident.

Employee

You have the ability to purchase additional life and accidental death and dismemberment benefits in $10,000 increments to a maximum of $500,000. During the annual enrollment period, you can increase your coverage amount by up to $10,000, even if you did not previously elect this coverage. Evidence of insurability wouldn't apply unless the new election results in a voluntary life coverage amount exceeding $100,000, you waived coverage when first eligible and later elect coverage by more than $10,000, or you increase your coverage by more than $10,000.

Spouse

If you elect coverage for yourself, you may also purchase coverage for your spouse. Spouse coverage is available in $10,000 increments to a maximum of $500,000. During the annual enrollment period, you may increase coverage for your spouse by up to $10,000, even if coverage was not previously elected. Evidence of insurability would apply to the increase only if the additional coverage amount increases your spouse's total life insurance coverage to over $20,000, you waived spousal coverage when first eligible and later elect coverage by more than $10,000, or you increase your spousal coverage by more than $10,000. Coverage terminates at age 70.

Child

If you elect coverage for yourself, you may also purchase coverage for your child(ren) in the amount of $10,000. There is an Infant benefit, birth to 14 days old, in the amount of $1,000. Regardless of when it's purchased, all child life amounts are guaranteed.

Voluntary Life

	Voluntary Life Coverage
Voluntary Life Insurance	
Employee	Can be elected in $10,000 increments
Spouse	Can be elected in $10,000 increments
Dependent children	Birth to 14 days: $1,000 14 days to 26 years: $2,500 increments
Maximum benefit elections	
Employee	$500,000
Spouse	$500,000, not to exceed 100% of Employee's amount
Dependent children	$10,000, not to exceed 100% of Employee's amount
Guaranteed Issue Amounts	
Employee	$100,000
Spouse	$20,000
Dependent children	$10,000
Age reductions	Benefits reduce at the employee age of 65

Costs and limitations

The cost of coverage for yourself and your spouse is based on your age as of your last birthday. Please see the Paycor site for additional details regarding the cost that would apply to you based on the election amount and your age.

Guardian will not pay any benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit.

Additional benefit offerings

Guardian Employee Assistance Program (EAP)

When life gets tough, it's helpful to have someone in your corner to listen, offer advice, and point you in the right direction. Your Employee Assistance Program (EAP) is here to help with expert guidance when you need it most.

Guardian's Employee Assistance Program provides confidential counseling, expert guidance, and valuable resources to help you handle any of life's challenges, big or small. These services are included at no cost to you.

24/7 live assistance: Call 855-2390743 or Visit guidanceresources.com

Confidential emotional support

- Anxiety, depression, stress

Work and lifestyle support

- Child, elder and pet care

Financial resources and legal guidance

- Retirement planning, taxes
- Wills, trusts and estate planning

Guardian TravelAid Services

TravelAid provides an emergency response network around-the-clock and around-the-world (domestic and international) to ensure that business travelers are not left on their own when they need help the most, whether for a medical emergency or to replace travel documents.

Travel Planning

• Travel intelligence, alerts and destination information

• Pre-travel immunization information, health planning, and travel medical kits

• International medical insurance and claims administration

• Preventive security training, assessments, and contingency planning

• Executive protection services

Specialized Security Resources

• Available for sensitive and complex emergency security situations

• Available at all times for a safe and speedy response

• Embassy and consular assistance

Medical Transportation Services

• Qualified and responsive personnel worldwide

• Up-to-date equipment and technology

• International and regional providers

Worldwide Physician and Hospital Referrals

- Qualified hospitals and facilities
- Multi-lingual services at medical facilities
- Patient accommodations and accessibility

Emergency Response

- 24/7 multi-lingual assistance operations
- Emergency travel arrangements
- Emergency prescription replacement
- Lost document assistance

Accident Insurance

No matter how healthy or careful you are, accidents happen, and sometimes they hurt more than just your body. The unexpected medical care you'll need can hit your wallet hard as well.

Accident insurance helps protect your finances if you suffer an accident on or off the job. A lump-sum benefit is paid directly to you, and you can use that money in any way you like. For example, imagine you fall at home and break a limb. You will need to visit the emergency room which may require surgery and physical therapy. You can use the accident benefit to pay your medical bills, or you could use it to pay your mortgage or car loan.

If you are enrolled for HDHP coverage, you can still contribute to an HSA if you receive an accident benefit. In addition, the accident benefit will not be used to offset (and therefore reduce) any disability payments you may receive.

Guardian insures our Accident Insurance. You receive a different lump-sum payment when you have these covered medical services/treatments as a result of an accident.

You will not have to answer any health questions. Your post-tax contributions will be deducted from your paycheck. Coverage can be elected for you, your spouse, or your dependent children. You must elect coverage for yourself, in order to elect coverage for your dependents. (Some restrictions apply). If you leave Gold Star, you can take the coverage with you, and pay the premium directly to Guardian. You can use this coverage multiple times. For example, if you break your leg, you will receive a benefit payment. If you suffer a concussion a few months later, you will receive another benefit.

Please see the Guardian enrollment materials for more information about the accident insurance.

Monthly Rates	
Employee Only	$11.76
Employee + Spouse	$19.10
Employee + Children	$26.02
Family	$33.36

Accident Insurance cont'd

Type of Benefit	Accident Insurance
Ambulance Transportation	$300 Ground, $1,500 Air
Blood/Plasma/Platelets	$300
Burns	9 sq inches to 18 sq inches: $0 / $2,000 18 sq inches to 35 sq inches: $1,000 / $4,000 Over 35 sq inches: $3,000 / $12,000 Skin Graft: 50% of burn benefit
Chiropractic Services Limit 6 per calendar year per family	$50 per session, 6 sessions maximum
Coma	$12,500
Concussion	$300
Dental Injury	$400 for Crown; $100 for Extraction
Diagnostic Examination	$300 per CT/MRI scan
Dislocations	Schedule up to $7,000
Emergency Treatment	$250
Epidural Anesthesia Pain Management	$100, 2x per accident
Eye Injury	$300
Family Care	$30 per day up to 30 days
Fractures	Schedule up to $8,000
Gun Shot Wound	$1,00
Hospital Admission	$1,500
Hospitalization due to covered accident Hospital Confinement ICU Confinement	$300 per day, 365 days maximum $600 per day, 15 days maximum
Joint Replacement (hip, knee, shoulder)	$3,000/$1,750/$1,750
Lacerations	Schedule up to $500
Lodging	$150 per day up to 30 days for companion hotel stay
Medical Appliance	Schedule up to $600
Outpatient Therapies	$50 per day up to 10 days
PTSD	$500
Prosthetic Device/Artificial Limb	1: $1,000 2 or more: $2,000
Rehabilitation Unit Confinement	$150 per day up to 15 days
Ruptured Disc with Surgical Repair	$750
Surgery (cranial, open abdominal, thoracic)	Schedule up to $1,500 Hernia: $300
Surgery – Exploratory or Arthroscopic	$500
Tendon/Ligament/Rotator Cuff	1: $750 2 or more: $1,500
Transportation	$0.50 per mile, limited to $600/round trip, up to 3x per accident
Traumatic Brain Injury	$5,000
X-Ray	$50

Critical Illness

While financial experts recommend having 3-9 months of living expenses set aside to help in an emergency situation like undergoing a serious illness, with today's economy, many families don't have that kind of money in reserve. Critical Illness insurance can help safeguard your finances by providing you with a lump-sum payment when your family needs it most. The payment you receive is yours to spend as you see fit and in addition to any other insurance you may have.

Payments will be made directly to you, not to the doctors, hospitals or other health care providers. You will receive a check mailed directly to your home.

If you are enrolled for HDHP coverage, you can still contribute to an HSA if you receive a critical illness benefit. In addition, the critical illness benefit will not be used to offset (and therefore reduce) any disability payments you may receive.

Guardian insures our Critical Illness benefits.

Your post-tax contributions will be deducted from your paycheck. Coverage can be elected for you, your spouse and dependent children. You must elect coverage for yourself in order to elect coverage for your dependents. (Some restrictions apply.) If you leave Gold Star, you can take the coverage with you, and pay the same premium directly to Guardian. You can use this coverage multiple times.

Please see the Guardian enrollment materials for more information about the critical illness insurance.

	Critical Illness Options
Employee	$5,000 increments to a maximum benefit of $20,000
Spouse	$5,000 increments to a maximum benefit of $20,000 Not to exceed 50% of employee coverage
Dependent Children	25% of employee coverage

MONTHLY PREMIUM						
Employee (Spouse same premium)						
Benefit Amounts	<30	30-39	40-49	50-59	60-69	70+
$5,000	$1.20	$2.15	$5.10	$10.90	$22.30	$61.10
$10,000	$2.40	$4.30	$10.20	$21.80	$44.60	$122.20
$15,000	$3.60	$6.45	$15.30	$32.70	$66.90	$183.30
$20,000	$4.80	$8.60	$20.40	$43.60	$89.20	$244.40

BENEFITS			
Covered Conditions (Lump Sum Payments)	Condition	First Occurrence	Second Occurrence
	Cancer		
	Invasive Cancer	100%	50%
	Carcinoma In Situ	30%	0%
	Benign Brain Tumor	75%	0%
	Skin Cancer	$250	Not Covered
	Vascular		
	Heart Attack	100%	50%
	Stroke	100%	50%
	Heart Failure	100%	50%
	Coronary Arteriosclerosis	30%	0%
	Other		
	Organ Failure	100%	50%
	Kidney Failure	100%	50%
Group 2 Covered Conditions	First Occurrence of these additional illnesses: • 100% Benefit: ALS, Coma, Loss of Speech, Sight or Hearing, Parkinson's • 50% Benefit: Alzheimer's Disease • 30% Benefit: Addison's Disease, Huntington's Disease, MS • Permanent Paralysis: 50% for 1 limb; 100% for 2 limbs		
Group 3 Childhood Covered Conditions	100% of Child Benefit for the First Occurrence of Cerebral Palsy, Cleft lip/palate, Club Foot, Cystic Fibrosis, Down's Syndrome, Muscular Dystrophy, Spina Bifida, and Type 1 Diabetes.		
Benefit Reduction	Age: 70 Reduction: 50%		

Hospital Indemnity

A sudden or unexpected hospitalization can be very expensive, especially if you are enrolled in a high deductible health plan. It can be difficult to come up with the hundreds or even thousands of dollars needed to pay these bills.

Hospital indemnity insurance pays a lump-sum benefit directly to you if you are admitted to the hospital for a covered stay. It supplements your medical plan and can help you pay the claims you may incur. For example, if you are enrolled in the HDHP and must meet the entire annual deductible for a hospital stay, the hospital indemnity benefit may cover most or all of the deductible.

If you are enrolled for HDHP coverage, you can still contribute to an HSA if you receive a hospital indemnity benefit. In addition, the hospital indemnity benefit will not be used to offset (and therefore reduce) any disability payments you may receive.

You will not have to answer any health questions and there is no evidence of insurability (EOI) required. Your post- tax contributions will be deducted from your paycheck.

MONTHLY RATES	
Employee Only	$15.81
Employee + Spouse	$30.26
Employee + Children	$22.07
Family	$36.11

Coverage can be elected for you, your spouse and dependent children. You must elect coverage for yourself in order to elect coverage for your dependents. (Some restrictions apply.) If you leave Gold Star, you can take the coverage with you, and pay the same premium directly to Guardian.

Please see the Guardian enrollment materials for more information about the hospital indemnity insurance.

Hospital Indemnity Insurance	
Hospital Admission Benefit	
Hospital Admission Benefit Receiving treatment for a sickness or injury in a hospital, in- including an observation room or ICU, for a period of more than 23 hours	$1,000 per occurrence one admission benefit per year
Hospital/ICU Confinement	$100 per day up to maximum of 360 days per year
Hospital Indemnity Additional Provisions	
Pre-Existing Limitation	3 month look back period, 12 month exclusion period, Continuity of Coverage

Discount Program

Perk9

Introducing: My PerkSpot!

Exclusive Discounts from Your Favorite Brands | 30,000 National and Local Offers | Designed for Your Device of Choice

Start by signing up or logging in at **my.perkspot.com**.

Access at work, home, or on the go and browse thousands of discounts!

Keep an eye out for new featured discounts in your weekly email.

TRAVEL | GYMS | CELL PHONES | RESTAURANTS | AUTO | APPAREL | ELECTRONICS

Get Started Today!

my.perkspot.com

Contact information

GENERAL CLAIMS AND BENEFIT INFORMATION			
Medical Benefits	Meritain Health	888.324.5789	www.meritainhealth.com
Prescription Benefits	SmithRx	844.454.5201	www.smithrx.com
Medical Concierge	HealthJoy	877.500.3212	groups@healthjoy.com
Dental	Delta Dental	800.524.0149	www.deltadentalmi.com
Vision	EyeMed	866.939.3633	www.eyemed.com
Health Savings Account	WEX	866.346.5800	www.healthequity.com
Flexible Spending Accounts	WEX	877.924.3967	www.healthequity.com
Basic Life/AD&D Voluntary Life Short & Long-term Disability	Guardian	888.482.7342	www.guardiananytime.com
Voluntary Accident Insurance Critical Illness Hospital Indemnity	Guardian	888.482.7342	www.guardiananytime.com
EAP	Guardian	855.239.0743	www.guidanceresources.com
Discount Program	Perk Spot	866-606-6057	my.perkspot.com
Benefits Team	Benefit Questions		humanresources@goldstarfinancial.com

When contacting any of the companies above, it's important to have the insurance card or ID number(s) of the subscriber for the coverage you are calling about, as well as any appropriate paperwork, such as an explanation of benefits, a denial letter, receipts, etc.

Required notices

IMPORTANT NOTICE FROM EMPLOYER ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE UNDER THE EMPLOYER MEDICAL AND PHARMACY PLAN(S)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the employer 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 costs, 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. Employer has determined that the prescription drug coverage offered by the Meritain Health plan(s) 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 during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday (including the month you turn 65) and continues for the ensuing three months. You may also enroll each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current employer coverage will not be affected. For most persons covered under the plan, the plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the plan's summary plan description or contact Medicare at the telephone number or web address listed herein. If you do decide to join a Medicare drug plan and drop your current employer coverage, be aware that you and your dependents will 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 the employer and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher

than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

Contact the person listed at the end of these notices 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 your employer 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 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 socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Medicare Part D 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 are required to pay a higher premium (a penalty).

Date: October 15, 2023

Name of entity/sender: Gold Star Mortgage Financial Group

Contact: Human Resources

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 was signed into law on Oct. 21, 1998. The Act requires that all group health plans providing medical and surgical benefits with respect to a mastectomy must provide coverage for all of the following:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce asymmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient and will be subject to the same annual deductibles and coinsurance provisions which apply for the mastectomy. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description or contact Human Resources.

WOMEN'S PREVENTIVE SERVICES

Under the Affordable Care Act, many insurers are required to cover certain preventive services at no cost to individuals. This list will expand to include additional services for women, including annual well-woman visits, screening for gestational diabetes, human papillomavirus testing, also known as HPV testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus (HIV), contraceptive methods and counseling, breastfeeding support, supplies and counseling, and screening and counseling for interpersonal and domestic violence.

NOTICE REGARDING NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer to prescribe a length of stay not in excess of the above periods.

MICHELLE'S LAW

If a full-time student engaged in a postsecondary education loses their full-time student status due to a severe illness or injury, they will maintain dependent status until the earlier of (1) one year after the first day of a medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the plan. A medically necessary leave of absence or change in enrollment at that institution must be certified by the dependent's attending physician.

HIPAA PRIVACY AND SECURITY

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information, which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims, and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. A full copy of the notice of privacy practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 248-430-1068.

HIPAA SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later 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). Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

There is another way to buy health insurance: the health insurance marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new marketplace.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The marketplace is designed to help you find health insurance that meets your needs and fits your budget. The marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

The 2024 open enrollment period for health insurance coverage through the marketplace runs from Nov. 1, 2023, through to Jan. 15, 2024.

Individuals must enroll or change plans prior to Jan. 15, 2024, for coverage starting as early as Jan. 1, 2024. After Jan. 31, 2024, you can get coverage through the marketplace for 2024 only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer doesn't offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost sharing if your employer doesn't offer coverage to you at all or doesn't offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the year (9.61% for 2023), or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Human Resources department.

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the plan when they would otherwise lose their group health coverage. For additional 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.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific to 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 are an employee, you will become a qualified beneficiary if you lose your coverage under the plan due to either one of the following qualifying events: 1) your hours of employment are reduced, or 2) Your employment ends for any reason other than your gross misconduct. If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the plan due to any 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).
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the plan due to any 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.
- The child stops being eligible for coverage under the plan as a "dependent child."

WHEN IS COBRA COVERAGE AVAILABLE?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the plan administrator of the qualifying event.

YOU MUST GIVE NOTICE OF A QUALIFYING EVENT

For the other qualifying events (divorce, 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 written notice to: ABC Company, Human Resources Department. You will be required to provide a copy of the court document showing the date the divorce or legal separation occurred.

HOW IS COBRA COVERAGE PROVIDED?

Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which employment terminates, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPPA), 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 the EBSA website at dol.gov/agencies/ebsa. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.

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 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 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 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, 2023. Contact your state for more information on eligibility.

ALABAMA — MEDICAID

Website: myalhipp.com
Phone: 1-855-692-5447

ALASKA — MEDICAID

The AK Health Insurance Premium Payment
Program website: myakhipp.com/
Phone: 1-866.251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid eligibility:
dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS — MEDICAID

Website: myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA — MEDICAID

Website: 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: healthfirstcolorado.com
Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711
CHP+: colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
(HIBI): colorado.gov/pacific/hcpf/health- insurance-buy-program
HIBI Customer Service: 1-855-692-6442

FLORIDA — MEDICAID

Website:
flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA — MEDICAID

Website: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 1-678-564-1162, Press 1
GA CHIPRA Website:
medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization- act-2009-chipra
Phone: 1-678-564-1162, Press 2

INDIANA — MEDICAID

Healthy Indiana Plan for low-income adults 19–64
website: in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: in.gov/medicaid/
Phone 1-800-457-4584

IOWA — MEDICAID AND CHIP (HAWKI)

Medicaid website: dhs.iowa.gov/ime/members
Medicaid phone: 1-800-338-8366
Hawki website: dhs.iowa.gov/Hawki
Hawki phone: 1-800-257-8563
HIPP phone: 1-888-346-9562

KANSAS — MEDICAID

Website: kancare.ks.gov
Phone: 1-800-792-4884

KENTUCKY — MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) website:
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP website: kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid website: chfs.ky.gov

LOUISIANA — MEDICAID

Website: medicaid.la.gov or ldh.la.gov/lahipp
Phone: 1.888.342.6207 (Medicaid hotline) or 1.855.618.5488 (LaHIPP)

MAINE — MEDICAID

Website: maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium webpage:
maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740

MASSACHUSETTS — MEDICAID AND CHIP

Website: mass.gov/masshealth/pa
Phone: 1-800-862-4840

MINNESOTA — MEDICAID
Website: mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/otherinsurance.jsp
Phone: 1-800-657-3739

MISSOURI — MEDICAID
Website: dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA — MEDICAID
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA — MEDICAID
Website: ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 1-402-473-7000
Omaha: 1-402-595-1178

NEVADA — MEDICAID
Medicaid website: dhcfp.nv.gov
Medicaid phone: 1-800-992-0900

NEW HAMPSHIRE — MEDICAID
Website: dhhs.nh.gov/oii/hipp.htm
Phone: 1-603-271-5218
Toll-free number HIPP program: 1.800.852.3345, ext. 5218

NEW JERSEY — MEDICAID AND CHIP
Medicaid website: state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid phone: 609.631.2392
CHIP website: njfamilycare.org/index.html
CHIP phone: 1-800-701-0710

NEW YORK — MEDICAID
Website: health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA — MEDICAID
Website: dma.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA — MEDICAID
Website: nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA — MEDICAID AND CHIP
Website: insureoklahoma.org
Phone: 1-888-365-3742

OREGON — MEDICAID
Website: healthcare.oregon.gov/Pages/index.aspx
or oregonhealthcare.gov/index.es.html
Phone: 1-800-699-9075

PENNSYLVANIA — MEDICAID
Website: dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND — MEDICAID
Website: eohhs.ri.gov
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA — MEDICAID
Website: scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA — MEDICAID
Website: dss.sd.gov
Phone: 1-888-828-0059

TEXAS — MEDICAID
Website: gethipptexas.com
Phone: 1-800-440-0493

UTAH — MEDICAID AND CHIP
Medicaid website: medicaid.utah.gov
CHIP website: health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT— MEDICAID
Website: greenmountaincare.org
Phone: 1-800-250-8427

VIRGINIA — MEDICAID AND CHIP
Website: coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid phone: 1-800-432-5924
CHIP phone: 1-800-432-5924

WASHINGTON — MEDICAID
Website: hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA — MEDICAID
Website: dhhr.wv.gov/bms or mywvhipp.com
Medicaid phone: 1-304-558-1700

WISCONSIN — MEDICAID AND CHIP
Website: dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING — MEDICAID
Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Phone: 1-800-251-1269