nuehealth

SPONSORED BY BLUE CROSS AND BLUE SHIELD OF KANSAS CITY

For employees of NueHealth, LLC

MyHealthToolkitKC.com

Greetings,

As a valued employee, you help shape and impact the quality of life for people throughout our company and our communities.

You play an important role in our mission to lead healthcare transformation. Our company's high-quality, comprehensive benefits are among the rewards you receive in return. These benefits are an important part of your total compensation, and our benefits program provides choice and value to meet the needs of our diverse workforce.

Choosing benefits can be overwhelming. We have equipped you with a 2023 Benefits Guide that includes tools and information to help you make the right choices for you and your family. The guide offers a comprehensive overview of your health and welfare benefits and options, including details about eligibility, enrollment, and the plans available to you and your covered dependents.

We would like to call your attention to important program details for 2023.

- **MyHealth Toolkit** – This is a concierge tool that allows members to take full advantage of their BCBS benefits. By logging on to MyHealth Toolkit (www.MyHealthToolkitKC.com), members can access Teladoc, print their BCBS ID card, find providers, check the status of claims, receive cost estimates on specific services, get access to resources related to various types of care, BCBS member perks, and so much more.
- **Teladoc** – Members have access to board-certified physicians through the convenience of phone or video consults 24/7/365. Teladoc providers can treat many common medical conditions and write prescriptions according to the guidelines in your state. Log on to My Health Toolkit to register for Teladoc and start utilizing services starting January 1st. Until then, please continue to use HealthJoy for virtual providers for the remainder of 2022.
- **Domestic Partners** – Domestic Partners became eligible to participate in our benefits in 2022 with the same access as spouses. As a reminder when adding a domestic partner, teammates must provide a notarized 'Domestic Partner Certification', which is provided within the electronic UKG enrollment tool as well as on the UKG website under the benefits section of 'Myself/My Company'. The Domestic Partner Certification is also available through the benefits website: nuehealthbenefits.com.
- **SpouseSaver HRA** – This plan offers an incentive to spouses who opt-out of our medical plan by enrolling in their company's medical insurance plan. To participate in the SpouseSaver program, spouses of participants in the medical plan must have participated in one of our medical plans or in the SpouseSaver HRA during the preceding plan year. This requirement does not apply to new hires, newly eligible teammates, or those experiencing a qualifying life event, such as marriage. Re-enrolling in this program must be done on an annual basis.
- **Virta Disease Health Coaching** – Do not forget about our physician-led disease management and coaching program for participants of the medical plan who are at risk for pre-diabetes, diabetes, and obesity. This is at no cost to the teammate or eligible dependent.

Your well-being is about more than just physical health. It includes your emotional, financial, and social wellness too. No matter where you are on your health and wellness journey, we are here to support you.

Your Benefits Team

In this guide

Summary of Benefits and Coverage

The Health section of this guide provides an overview of your medical plan options. You can find detailed information about each plan, including a breakdown of costs, in each plan's Summary of Benefits and Coverage (SBC). The SBCs summarize important information about your health coverage options in a standard format to help you compare costs and features across plans. The SBCs are available on UKG Menu under Myself / My Company / Company Info.

nueHealth

2023 Open Enrollment November 7th - 18th

New teammates must complete their benefit enrollment within 31 days of their eligibility date.

Open Enrollment is your chance to make changes for the plan year starting 1-1-23. If you do not complete your enrollment before 12 Midnight CST on the last day of open enrollment, your benefits will carry forward for the new plan year.*

BenManage Benefit Counselors are available
Monday-Friday 8am - 5pm
(314) 442-0058

Important Reminders

*FSA, DCA, HSA & Spouse HRA contributions won't carry forward, you must re-enroll in the flexible spending plans.

Our partners at BenManage are available to help you get logged into and explain the benefits found on UKG.

If you have any questions, call 314-442-0058.

Review your benefits by scanning this QR code or go to: https://nuehealthbenefits.com

BenManage

enroll

Carefully consider your benefit options and your anticipated needs. Follow the instructions to enroll yourself and any eligible dependents in health and insurance benefits for 2023.

How to enroll

- Benefits are effective the first of the month following the date of hire or a change in status that qualifies you for benefits.
- You must complete the enrollment process within 31 days of your date of hire or effective date of your status change.
- We invite Spouses/Domestic Partners and children to participate in our plans. Dependent children are eligible to participate through December 31st of the year they reach age 26.
- If you miss the opportunity to enroll, you will be unable to enroll again until Annual Enrollment, which occurs in the fall.
- Enrollment changes for qualifying events such as marriage, divorce, birth, loss or gain of coverage must be made within 31 days of the event. In the case of birth, coverage will retro to the date of the birth as long as the baby is added to the plan within the 31-day timeframe.
- If you choose not to participate in the benefits plans, you will still need to complete the enrollment process so that you can designate beneficiaries for the employer paid life insurance plans. This will also allow you to confirm your decision to 'decline' other benefits.

To Complete your enrollment, we have provided an enrollment guide on the UKG Home Page under Myself/My Company/General Job Aids. You may also enroll through the benefits website: nuehealthbenefits.com, which will connect you to the UKG benefits enrollment website.

Please be certain to print out your enrollment confirmation for your personal records.

Contacts

Benefit Plan	Provider	Phone Number	Website
Benefit Enrollment Counselors	BenManage	314.442.0058	https://NueHealthbenefits.com
Medical	Blue Cross and Blue Shield	888.495.9340	www.MyHealthToolkitKC.com
Prescription (OptumRx)			
Medical Precertification			
Teladoc			
Spending Accounts (HSA, FSA, HRA)	NueSynergy	855.890.7239	https://nuesynergy.wealthcareportal.com/Authentication/Handshake
Dental	MetLife	800.942.0854	www.metlife.com/?mybenefits
Vision	MetLife	855.638.3931	www.metlife.com/?mybenefits
Wellness program	Vitality	877.224.7117	www.PowerofVitality.com
Long Term Care	Trustmark	833.996.3280	https://schedapple.com/appointment/12104
Employee assistance program (EAP)	LifeWorks (through MetLife)	888.319.7819	metlifeeap.lifeworks.com; Username: metlifeeap, Password: eap)
Life and Disability insurance	MetLife	800.638.6420	www.metlife.com/?mybenefits
Voluntary benefits	MetLife	800.438.6388	www.metlife.com/?mybenefits
Virta – Diabetes Management Program	Virta	844.847.8216	https://apply.virtahealth.com/bi/get-started
401(k) savings plan	Principal Financial Group	800.986.3343	www.principal.com

MAKE THE MOST OF YOUR BENEFITS

Health issues are in the news more than ever. It's a good thing you have access to top-quality care from the largest provider network in the nation!

Please use this guide to make the most of your benefits. We appreciate having you as a member and will do all we can to serve you.

For your health,
Blue Cross and Blue Shield of Kansas City

These topics are included in this guide:

- Using your member ID card
- Finding doctors and cost details on our website
- Discounts on health products and services
- Connecting in ways that work for you — including texts, phone calls, emails, web inquiries and our app
- Tips on the benefits available with your health plan — including telehealth, if applicable

Symbols in this guide:

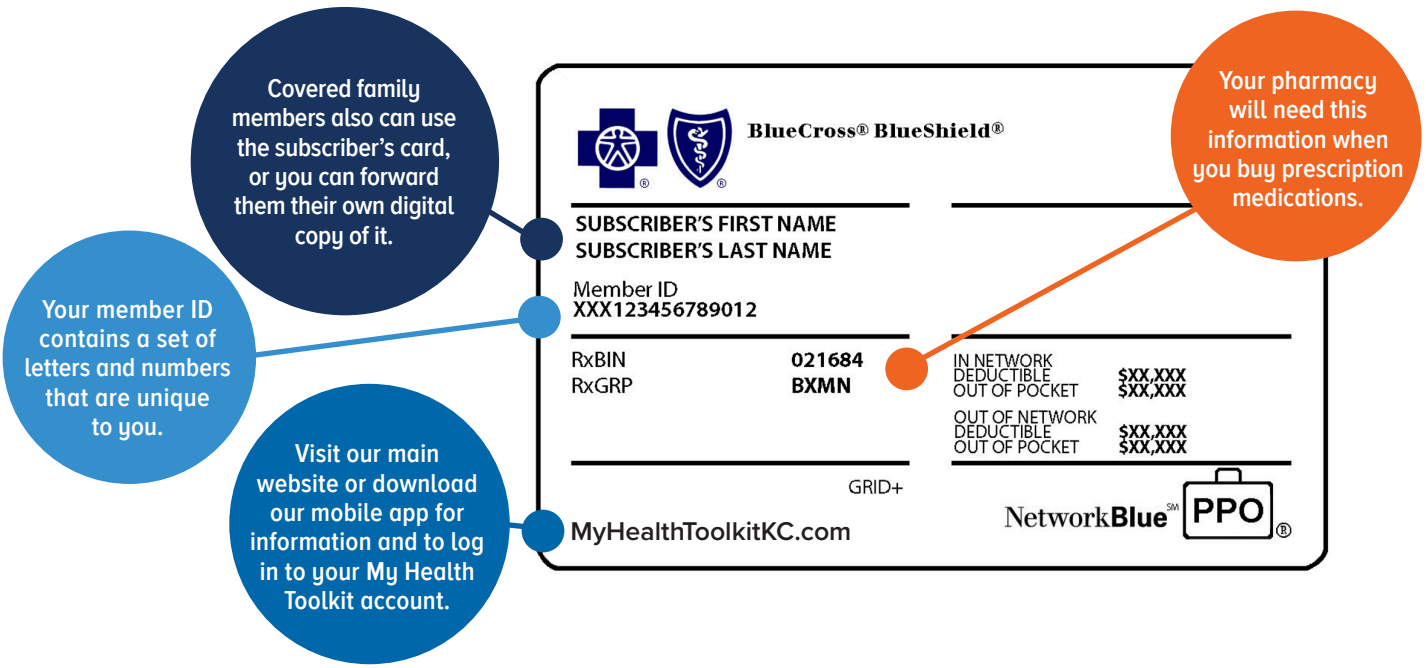
Log in to your **My Health Toolkit®** account.

Call the number on the back of your membership ID card to speak to a **customer service advocate**.

Kansas City

WE'VE GOT YOU COVERED WITH YOUR MEMBERSHIP CARD

Your Blue KC membership card contains important information that helps providers and pharmacists apply your benefits correctly. Keep it with you at all times or download a digital ID card to keep on your smartphone. A health care provider usually will ask to see your insurance card at the beginning of your visit.



Convenient option: your digital ID

It's all about convenience! Your digital ID card has the same information as the card you receive in the mail, but you can:

- View the digital ID on a smartphone, tablet or computer.
- Email the card to a spouse, child, doctor's office or pharmacy.
- Print the card from a smartphone, tablet or computer and use the printout just like a plastic card.

Accessing your digital ID

- From a computer or mobile device, log in to My Health Toolkit.
- Follow the prompts to select/view your insurance ID card.

QUALITY CARE ... ANYTIME AND ANYWHERE WITH TELADOC®

Why wait for the care you need now? Teladoc gives you 24/7/365 access to a board-certified physician through the convenience of phone or video consults. Teladoc is an independent company that provides telehealth consultation services on behalf of your health plan.

The care you need

Teladoc doctors can treat many of the most common medical conditions, including:

- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infections
- Respiratory infections
- Sinus problems
- Behavioral health and dermatology services may also be covered.

They can also write prescriptions, according to the regulatory guidelines of your state.

When you need it

Teladoc has a national network of doctors ready to answer your call. With an average call-back time of only eight minutes, you can forget about spending hours in the waiting room. Now, you can quickly and easily consult an experienced doctor from the comfort of your home.

It's easy to get started

Register for Teladoc now — don't wait till you are sick! Call **866-789-8155**, or start by logging in to **My Health Toolkit**.

1. Under the **Resources** tab, select **Teladoc**. This will take you to the Teladoc site.
2. Your insurance information will appear so you can easily complete your registration.

Want to know more? Please visit your health plan's My Health Toolkit website to learn more about using Teladoc.

health

Quality health coverage is one of the most valuable benefits you can enjoy. Our benefits program offers plans to help keep you and yourfamily healthy and also provides important protection in the event of illness or injury.

Medical

You have a choice of medical plans with a range of coverage levels and costs. This gives you the flexibility to choose what's best for your needs and budget.

You and the company share the cost of your medical benefits. The company pays a generous portion of the total cost and you pay the remainder. The amount you pay is deducted from your paycheck on a before-tax basis. Your specific cost is determined by the plan you choose and the coverage level you select.

Key features

All medical plan options offer:

- Comprehensive, affordable coverage for a wide range of healthcare services.
- Flexibility to see any provider you want, although you'll save money when you stay in-network.
- 100% covered in-network preventive care.
- Prescription drug coverage.
- Financial protection through annual out-of-pocket maximums that limit the amount you'll pay each year.

1 **Preventive care covered at 100%**	You pay nothing for in network preventive care.
2 **Deductible**	You pay your medical expenses up to the annual deductible amount. Use your FSA or HSA to plan ahead for these costs and save money by paying with tax-free dollars.
3 **Coinsurance**	After meeting your deductible, the plan starts to pay coinsurance. You'll only pay a percentage of each bill.
4 **Out-of-pocket Maximum**	You're protected by an annual limit on costs. The plan starts to pay 100% if you reach this amount during the year.

Preventive care benefits

Good preventive care can help you stay healthy and detect any "silent" problems early, when they're most likely to be treatable. Most in-network preventive services are covered in full, so there's no excuse to skip them.

Have a routine physical exam each year. You'll build a relationship with your doctor and can reduce your risk for many serious conditions.

Get regular dental cleanings. Numerous studies show a link between regular dental cleanings and disease prevention, including lower risks of heart disease, diabetes, and stroke.

See your eye doctor at least once every two years. If you have certain health risks, such as diabetes or high blood pressure, your doctor may recommend more frequent eye exams.

Don't have a primary care physician (PCP)? You should. Here'swhy.

Better health. Getting the right health screenings each year can reduce your risk for many serious conditions. And remember, preventive care doesn't cost you anything.

A healthier wallet. A PCP can help you avoid costly trips to the emergency room. Your doctor will also help you decide when you really need to see a specialist and can help coordinate care.

Peace of mind. Advice from someone you trust - it means a lot when you're healthy, but it's even more important when you're sick.

Compare medical plans

The chart below provides a comparison of key coverage features of our 2023 medical plan options with Blue Cross and Blue Shield of South Carolina. Please refer to the applicable Summary of Benefits and Coverage (SBC) for additional plan details.

	Buy-Up Plan PPO		**Base Plan** HDHP/HSA* (See below)		**Buy-Down Plan** HDHP/HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible						
Individual	$1,000	$2,000	$2,000	$4,000	$3,000	$6,000
Family	$3,000	$6,000	$4,000	$8,000	$6,000	$12,000
Out-of-pocket maximum						
Individual	$6,500	$19,500	$6,500	$13,000	$6,500	$13,000
Family	$12,000	$36,000	$12,000	$24,000	$12,000	$24,000
Medical coverage						
PCP office visits	Ded. + 20%	Ded. + 40%	Ded. + 20%	Ded. + 50%	Ded. + 20%	Ded. + 50%
Specialist office visits	Ded. + 20%	Ded. + 40%	Ded. + 20%	Ded. + 50%	Ded. + 20%	Ded. + 50%
Preventive care	Covered at 100%	Ded. + 40%	Covered at 100%	Not covered	Covered at 100%	Not covered
Outpatient surgery	Ded. + 20%	Ded. + 40%	Ded. + 20%	Ded. + 50%	Ded. + 20%	Ded. + 50%
Inpatient hospital	Ded. + 20%	Ded. + 40%	Ded. + 20%	Ded. + 50%	Ded. + 20%	Ded. + 50%
Urgent care	Ded. + 20%	Ded. + 40%	Ded. + 20%	Ded. + 50%	Ded. + 20%	Ded. + 50%
Emergency room	$200 copay + Ded. + 20%		Ded. + 20%		Ded. + 20%	
Rx (retail)						
Generic	$15 copay	50%	Ded. + 20%	Ded. + 20%	Ded. + 20%	Ded. + 20%
Preferred brand	50%	50%	Ded. + 20%	Ded. + 20%	Ded. + 20%	Ded. + 20%
Non-preferred brand	50%	50%	Ded. + 20%	Ded. + 20%	Ded. + 20%	Ded. + 20%
Specialty	50%	Not covered	Ded. + 20%	Not covered	Ded. + 20%	Not covered

* BASE PLAN DEDUCTIBLES

- Employee Only Deductible = $2,000 INDIVIDUAL deductible met before insurance carrier pays for non-preventative expenses.
- Employee + Dependent Deductible = $4,000 COMBINED FAMILY deductible before insurance carrier pays for non-preventative expenses.

Money-Saving Tips

To stretch your healthcare dollars, remember to:

- **See in-network providers** – They've agreed to the plan's negotiated rates. Log in to www.MyHealthToolkitKC.com to search for in-network providers near you.
- **Use the mail-order pharmacy** – It will save you time and money when refilling long-term prescriptions.

closer look at the HDHP

HEALTH

The Base and Buy-Down high deductible health plans (HDHP) cost you less from your paycheck, so you keep more of your money. These plans reward you for taking an active role as a healthcare consumer and making smart decisions about your healthcare spending. As a result, you could pay less for your annual medical costs.

HDHP advantages

1. Lower paycheck costs

Your per-paycheck costs are lower compared to the Buy-Up plan, giving you the opportunity to contribute the cost savings to a tax-free Health Savings Account (HSA). You pay foryour initial medical costs until you meet your annual deductible, and then you pay a percentage of any further costs until you reach the annual out-of-pocket maximum.

2. Tax-advantaged savings account

To help you pay your deductible and other out-of-pocket costs, a HDHP lets you open a Health Savings Account (HSA) and make before-tax contributions directly from your paycheck.

All withdrawals from your HSA are tax-free, as long as you use the money to pay for eligible healthcare expenses. In addition, all the money in the account is yours and will never be forfeited. It rolls over from year to year, and you can take it with you if you leave the company or retire. After age 65, you can withdraw funds for any reason without a tax penalty — you pay ordinary income tax only if the withdrawal isn't for eligible healthcare expenses.

Look for additional information regarding the HSA later in this guide.

Note: You won't pay federal taxes on HSA contributions; however, you may pay state taxes depending on your residence. Consult your tax advisor to learn more.

3. 100% covered in-network preventive care

As with all of our health plans, preventive care is fully covered under the HDHPs. You pay nothing as long as you receive care from in-network providers. Preventive care includes annual physicals,wellness exams, immunizations, flu shots, and cancer screenings, etc.

4. Extensive provider network

The Base and Buy-Down HDHPs use the Blue Cross and Blue Shield large network of doctors and other healthcare providers.

Money-Saving Tips

If you enroll in a HDHP, put the money you save through lower paycheck deductions into your tax-free HSA so you'll have money available when you need to pay out-of-pocket costs.

NueSynergy SPOUSE/DOMESTIC PARTNER SAVER HRA
AN INCENTIVE PLAN TO HELP COVER SPOUSAL EXPENSES

Your employer has chosen to offer the Spouse/Domestic Partner (SP/DP) Saver Health Reimbursement Arrangement (HRA), an innovative company incentive that can pay up to 100%of your dependent's out-of-pocket expenses such as deductibles, copays, and coinsurance.

When you enroll in our group health insurance plan, you have the opportunity to add your spouse/domestic partner and dependents to your coverage. However, if your spouse/ domestic partner enrolls in health insurance through their employer or through another organization (i.e., an alternate group plan), you may take advantage of SpouseSaver HRA.

SpouseSaver HRA is a great choice that could have a huge impact on your family's bottom line. This means you can save on your spouse/partner's premiums, plus our company will make contributions to your SpouseSaverHRA to cover 100% of your spouse/domestic partner's in-network, out- of-pocket expenses from his/her medical plan. In turn, we have fewer claims costs and an overall reduction in premiums.

What do I need to do when I enroll?

The SpouseSaver HRA is only available if your spouse/domestic partner has access to a group health plan through an employer or another organization.

- Your spouse enrolls in his/her company's group healthinsurance (instead of through your plan) and provides proof of qualifying health insurance.
- You elect Employee Only or Employee + Child when enrolling in one of our group health plans, taking advantage of the benefits and coverage it offers.
- You elect SpouseSaver HRA during the enrollment process.
- SpouseSaver HRA employer contribution is added to your plan to help cover up to 100% of your spouse/domestic partner's in-network, out-of-pocket expenses.
- An HRA smart debit card is provided to cover the HRA expenses.

Who can participate?

The SpouseSaver Health Reimbursement Account is an account set-up by and 100% funded by the our company's Self-insured Medical Plan. HRA Funds can be used to pay for eligible medical expenses which will reduce the amount you pay out-of-pocket.

- You must be enrolled in one of the company's Medical Plans as Employee Only or Employee & Child(ren).
- Your spouse/domestic partner must enroll in alternate group health insurance (instead of the our medical plan). You must provide our Benefits team with proof of your spouse/domestic partner's enrollment and a plan summary of their health insurance for 2022.
- If you elect for your dependent(s) to move to your spouse/domestic partner's group health plan, proof of qualifying health insurance must be provided as well.
- In order to participate in the SpouseSaver program, spouses of participants in the company's medical plan must have participated in one of the our medical plans or in the SpouseSaver HRA during the preceding plan year. This requirement does not apply to new hires, newly eligible teammates, or those experiencing a qualifying life event, such as marriage. Re-enrolling in this program must be done on an annual basis.

  ***The Spouse Saver HRA may impact the ability to contribute to an HSA if your spouse enrolls in an HSA-qaulified high deductible health plan. Consult a tax professional for regulations and restrictions**.

Health Plan Enrollees:
We are pleased to continue offering SurgerySavings, a surgical savings program administered by ValueHealth for medical Plan members, as one of your benefits. This program is available to you as an added benefit. IMPORTANT NOTE: only employees and dependents enrolled in one of the ValueHealth medical plans are eligible.

What is SurgerySavings

SurgerySavings is a program that lowers the cost of surgery. Program research has identified surgeries that generally can be shifted safely from a hospital setting to an ambulatory surgery center save money for the health plan **and** its participating plan members. SurgerySavings pays a cash incentive to enrolled plan members when their qualified procedure is performed at any in-network independent ambulatory surgery center (ASC).

How it Works

If you or a family member are considering surgery or if you have been told you need surgery, you should take advantage of SurgerySavings. It can put power back into your hands by providing you with information to make smart healthcare choices for surgery and decrease your out-of-pocket cost.

Getting Your Share of the Savings

Costs vary by surgical procedure and the savings vary too. The incentives are aligned accordingly.

SurgerySavings will pay $200, $400 or $600 for ambulatory surgery center procedures. These SurgerySavings incentives are paid via direct deposit to the employee's bank account. (As a reminder, these payments to you are taxable).

SurgerySavings Member Engagement Communications

ValueHealth is working to more effectively to communicate and share information about the benefits plans.

To support these efforts, we are launching 'member-preferred' methods of communication in order to provide better access and opportunities for you to engage with the SurgerySavings Program and Portal. The goal is to boost your understanding about the program and benefits. Look out for messages from ValueHealth Benefits in your email inbox or SMS text.

If You Need Surgery

If you or an enrolled family member need a surgical procedure, go to the SurgerySavings Portal to browse program-covered procedures and find in-network surgeons and/or facilities participating in the SurgerySavings program. Next, there'll be a meeting with the surgeon, and a decision made together whether a surgical procedure is needed and whether the procedure can safely be performed at an ASC.

If you already have a surgeon in mind, that's great! Before scheduling, speak with your physician about whether you and your surgical procedure can be done at an ASC.

After the procedure, return to the SurgerySavings Portal to fill out a brief claim form and SurgerySavings will process your reward.

Get started now, register and create an account at **www.surgerysavings.com** and then learn more about how SurgerySavings can work for you.

Register with SurgerySavings now and receive 100 Vitality Bonus Points!

If you have questions, please call us 833-858-4584 and speak live with a member experience representative or ask us at info@surgerysavings.com.

Remember, your personal health information is CONFIDENTIAL and is not shared with your employer.

virta

Yes. You *can* lose weight and reverse type 2 diabetes and prediabetes.

In only one year, Virta patients see an average of[1]:

63% medication reduction | **1.3pt** HbA1c reduction | **12%** weight loss

No matter the season or time of year, if you are part of an eligible plan,* you can enroll in Virta. Virta is a research-backed treatment that can help you reverse your type 2 diabetes and prediabetes and lose weight. Take back control of your health.

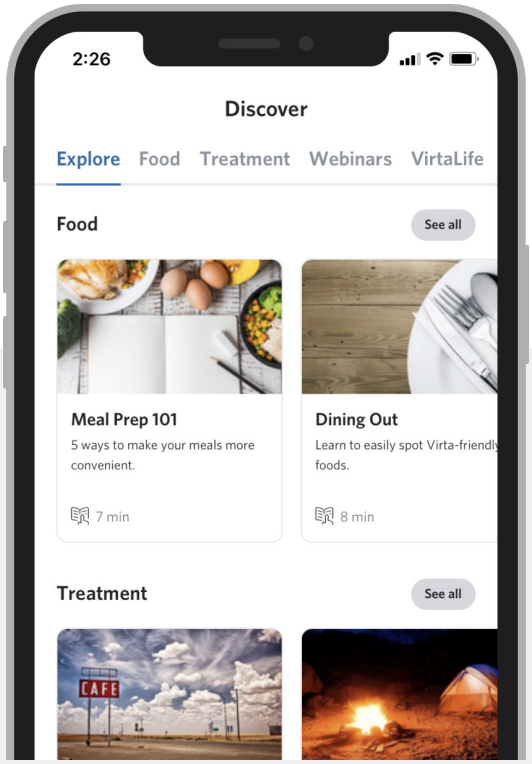
The Virta difference

Unlike other diabetes (or weight loss) treatments/management programs, Virta goes beyond just treating the symptoms of the disease. On Virta, you learn how to change how you eat so that your body burns fat for energy, instead of sugar/carbohydrates. This can help you naturally lower your blood sugar and reduce the need for diabetes medication. It also can help you lose weight and live a healthier life.

Your company is fully covering the cost of Virta for all benefits-enrolled employees and dependents with type 2 diabetes, prediabetes, and those with a BMI of 30 or above[1].

*Virta is available to employees, spouses and adult dependents between the ages of 18 and 79 who are enrolled in the company health plan. Some exclusions may apply. Scan the code below to verify eligibility.

1 Note that those on high-deductible health plans (HDHPs) may need to pay a small fee to participate in Virta.



info.virtahealth.com/join

Text "ENROLL" to 57005 to receive periodic alerts about better health through Virta.

Msg&data may apply. Text HELP for help, STOP to quit. Privacy Policy: www.virtahealth.com/privacypolicy

1 Hallberg SJ, McKenzie AL, Williams P, et al. Effectiveness and Safety of a Novel Care Model for the Management of Type 2 Diabetes at One Year: An Open Label, Non-Randomized, Controlled Study. Diabetes Ther. 2018.

dental & vision benefits

HEALTH

Dental plan

Healthy teeth and gums are important to your overall wellness. That's why it's important to have regular dental checkups and maintain good oral hygiene. Learn about the dental plans available to help you maintain your oral health.

	MetLife PDP Network
Annual deductible (employee only/family)	$50/$150
Calendar-year maximum	$1,500 per person
Preventive/diagnostic services	100%
Basic services	80%
Major services	50%
Orthodontia	50% $1,000 lifetime max

Benefits shown are for in-network providers and are based on negotiated fees. The MetLife network is comprehensive, but keep in mind if you go to an out-of-network provider, you may pay more for your services.

To make the most of your dental coverage, seek treatment from a MetLife provider. To find in-network providers, please visit https://mybenefits.metlife.com and click on the "PDP Plus" network option.

Vision plan

Having vision coverage allows you to save money on eligible eye care expenses, such as periodic eye exams, eyeglasses, contact lenses, and more for yourself and your covered dependents.

	MetLife Vision
Exam (once per calendar year)	$10 copay
Lenses (once per calendar year) • Single, Lined Bifocal, Lined Trifocal or Lenticular	Covered in full after $25 copay
Lens options • Ultraviolet coating, polycarbonate, standard progressive	Covered in full after $25 copay (Additional lens options available at a discount)
Frames (once every other calendar year)	Up to $160
Contact lenses (instead of glasses)	Elective: up to $160 Necessary: covered in full

PLEASE NOTE: MetLife does not provide dental or vision cards. When you, or a covered dependent, visit your dental and/or vision provider, the provider will need the employee's SSN to verify coverage.

Money-Saving Tip

Remember, you can use your HSA or FSA for qualified out-of-pocket dental and vision expenses.

Health Savings Account (HSA)

If you enroll in the Base or Buy-Down HDHP, you are eligible to open an HSA. An HSA is a tax-free savings account you can use to pay for eligible health expenses anytime, even in retirement.

How does an HSA work?

- **Build tax-free savings for health care.** You can make before-tax deductions from your paycheck into your HSA, allowing you to save money by using tax-free dollars to pay for eligible medical, prescription, dental, and vision expenses. The total amount that can be contributed to your HSA each year is limited by the IRS. The following limits for 2023 include any company contributions you may receive from participation in the Wellness Program:
  - Up to $3,850 for employee-only coverage.
  - Up to $7,750 if you cover dependents.
  - Add $1,000 to these limits if you're age 55 or older.
- **Receive company contributions.** If your facility participates in the wellness plan, you may be eligible to receive HSA contributions.
- **Use it like a bank account.** Pay for eligible medical, prescription, dental, and vision expenses for yourself and your family by swiping your HSA debit card or submit a claim to reimburse yourself for payments you've already made.

  Keep in mind that you may only access money that is in your HSA when making a purchase or withdrawal. There's no need to turn in receipts but keepthem for your records.
- **Keep your money.** Unlike an FSA, the money in your HSA is always yours to keep and is rolled over from year to year. You can take your unused balance with you when you retire or leave ValueHealth.
- **Earn interest and invest for the future.** Once your interest- bearing HSA reaches a minimum balance, you can start an investment account, which offers a variety of no-load mutual funds similar to 401(k) investments. You can learn more about this option by contacting NueSynergy's customer service at 855.890.7239.
- **Never pay taxes.** Contributions are made on a before-tax basis, and your withdrawals will never be taxed when used for eligible expenses. Any interest or earnings on your HSA balance build tax-free, too. *

- *Money in an HSA grows tax-free and can be withdrawn tax-free if it is used to pay for qualified healthcare expenses (for a list of eligible expenses, see IRS Publication 502, available at **www.irs.gov**). If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn plus a 20% penalty tax if you withdraw the money for ineligible expenses before age 65. After age 65, withdrawals for ineligible expenses are only subject to ordinary income tax. Please review your state regulations as you may have to pay state taxes depending on your residency.*

HSA eligibility

- Must be enrolled in a high deductible health plan, like one of our HDHP plans.
- Cannot be covered by any other medical plan that is not a HDHP. This includes a spouse/domestic partner's medical coverage unless it's a HDHP.
- Cannot be enrolled in a traditional healthcare FSA in 2023.
- Cannot be enrolled in Medicare, including Parts A or B, Medicaid, or Tricare.
- Cannot be claimed as a dependent on another person's tax return.
- Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months.

flexible spending accounts (FSAs)

HEALTH

Tax-advantaged FSAs are a great way to save money. The money you contribute to these accounts comes out of your paycheck without being taxed, and you withdraw it tax-free when you pay for eligible healthcare and dependent care expenses.

Our benefits package offers the following FSAs:

Healthcare FSA

- Pay for eligible healthcare expenses, such as plan deductibles, copays, and coinsurance.
- Contribute up to $3,050.

Dependent Care FSA

- Pay for eligible dependent care expenses, such as day care for a child so you and/or your spouse/domestic partner can work, look for work, or attend school full time. Elder care may be eligible for reimbursement as well.
- Contribute up to $5,000* in 2023, or $2,500* if you are married and filing separate tax returns.

Estimate Carefully

Keep in mind, FSAs are "use-it-or-lose-it" accounts. It is important that you use your funds by March 15, 2024, and file your claims by March 31, 2024, or your funds will be forfeited.

Managing your FSA(s)

When you enroll in an FSA, you will receive a debit card, which you can use to pay for eligible expenses. Depending on the transaction, you may need to submitreceipts or other documentation to NueSynergy.

HSA vs. Healthcare FSA: What's the difference?

	HSA	FSA
Available if you enroll in a…	**Base or Buy-Down**	**Any Medical Plan***
Eligible for company contributions	Yes	No
Change your contribution amount anytime	Yes	No
Access your entire annual contribution amount from the beginning of the plan year	No	Yes
Access only funds that have been deposited	Yes	No
"Use it or lose it" at year-end	No	Yes
Money is always yours to keep	Yes	No

Note: If you enroll in the Base or Buy-Down HDHP **and have an HSA, you are not eligible to open a Healthcare FSA.*

What's an eligible expense?

- **Healthcare FSA –** Plan deductibles, copays, coinsurance, and other healthcare expenses for you and your family. To learn more, see IRS Publication 502 at **www.irs.gov**.
- **Dependent Care FSA –** Child daycare, babysitters, elder care, and related expenses. To learn more, see IRS Publication 503 at **www.irs.gov**.

For employees who continue to have HRA funds in their NueSynergy account:

Your HRA funds are still available to you; however, if you participate in the Health Savings Account, you will only be able to use the HRA for limited purpose such as dental and vision expenses. You will not be able to use HRA dollars for medical plan expenses. Please remember that you have 90 days after the end of the calendar year to request reimbursements for the previous year medical expenses.

**Current IRS limits; the 2023 plan year limits may not have been available when this guide was created*

WHERE SHOULD YOU GO WHEN YOU NEED CARE?

Your primary care physician should be your first call for routine medical care. But what if your doctor's office is closed? Or it may be an emergency?

Here are tips to help you choose the right type of care for various situations:

Doctor's Office

Your primary care physician, or regular doctor, is the best option for routine medical care like:

- Annual checkups, physicals
- Health screenings, immunizations
- Prescription refills

And unexpected health issues, if they can wait a day, like:

- Sprained muscles
- Minor cuts and bruises
- Cold and flu symptoms, including fever, coughing, sore throat and mild nausea
- Sinus or respiratory infections
- Urinary tract infections
- Seasonal allergies
- Pinkeye
- Migraines
- Rashes, insect bites, sunburn, other skin irritations

Urgent Care Center

If you can't wait for an appointment with your regular doctor, an urgent care center may be your best option for unexpected health issues like:

- Minor fractures and sprains, especially if an X-ray is required
- Minor cuts and animal bites, especially if stitches may be required
- Cold and flu symptoms, including fever, coughing, sore throat and mild nausea
- Sinus or respiratory infections
- Urinary tract infections
- Seasonal allergies
- Pinkeye
- Migraines
- Rashes, insect bites, sunburn and other skin irritations

Emergency Room

Go to the ER or call 911 for potentially life-threatening conditions like:

- Heavy, uncontrolled bleeding
- Signs of a heart attack, like chest pain that lasts more than two minutes
- Signs of stroke, such as numbness, sudden loss of speech or vision
- Loss of consciousness or sudden dizziness
- Major injuries such as broken bones or head trauma
- Coughing up or vomiting blood
- Severe allergic reactions

EXPLANATION OF BENEFITS

Savvy health care consumers check their EOBs!

Keep track of your medical and dental services by checking each Explanation of Benefits, or EOB. You also can choose whether to receive your EOBs by text, email or regular mail.

What is an EOB?

Whenever you use your health insurance, we send you an Explanation of Benefits. It shows you:

- How much the doctor charged.
- How much your health plan paid.
- The amount applied toward your deductible.
- How much you may still owe.

Why look at your EOB?

When you eat out, you at least glance at the bill before paying, right? Double-checking your medical expenses is even more important. You can:

- Compare your doctor and hospital bills with the EOB to make sure you're being billed — and paying — the correct amount.
- Share your EOB with your provider if you notice any differences.

PRESCRIPTION DRUG PROGRAM

Your prescription drug plan gives you and your doctor many choices. Understanding your choices can help you make the most of your benefits and save money.

Where To Find Details

On our website, you'll find lists of covered and excluded drugs, along with lists related to our various drug management programs.

Select **Prescription Drugs** from the menu at the top of the page, and then choose the option with the information you're looking for.

Prescription Drug Coverage

With almost 70,000 network pharmacies to choose from, it's easy to find one near you. When you use a network pharmacy, you'll have no claim forms to file and no waiting for reimbursement. Prescription drugs under your integrated medical or pharmacy benefit may be subject to deductible and coinsurance. At network pharmacies, the pharmacist will use a computer to check your eligibility for benefits and to provide the amount you will pay for prescriptions. If you don't present your member ID card or don't use a network pharmacy, you'll have to file a claim and you may not be reimbursed for the full amount you paid. Please see the benefits summary listed in this booklet to determine the amounts you pay for your prescriptions.

Specialty Drugs

Specialty drugs treat conditions such as cancer, hepatitis, multiple sclerosis or rheumatoid arthritis, just to name a few. They often require special administration, dosing and monitoring. You may pay more for specialty drugs than non-specialty drugs for each 30-day supply. Your plan requires you to have specialty drug prescriptions filled at our preferred specialty pharmacy, Optum Specialty Pharmacy. The Optum Specialty Pharmacy is a specialty pharmacy service provided by OptumRx, an independent company that provides pharmacy benefit management services on behalf of your health plan.

Mail (Standard/Voluntary)

Mail service is convenient and can save you money on prescriptions you take regularly. You'll receive up to a 90-day supply of your prescription drugs at one time with free standard shipping. To download the mail service form, visit your health plan's website. Select **Forms** from the menu bar, then click **Claims Forms**. Select **Mail Service Order Form**.

Quantity Management

For drugs in this program, your plan will cover only a set amount within a set time frame. Your doctor can request an override to allow a larger amount, if he or she determines it's necessary for you.

Prior Authorization

Prior authorization is a quality and safety program that promotes the proper use of certain medications. If your doctor prescribes a medication that is included in our Prior Authorization program, you must get approval before your plan will cover it.

Step Therapy

Step therapy requires you to try an alternative, cost-effective medication before trying (or "stepping up to") the more expensive name-brand medication. Many people find the alternative medications work just as well for them. If you have not tried the less-expensive medication and you and your doctor want to skip that step, your doctor must request an exception before your plan will cover the more expensive drug.

Excluded Drug List

From time to time, our committee of doctors and pharmacists may decide to no longer cover some drugs when other safe, effective, less costly alternatives are available. To view the latest excluded drug list for your health plan, go to your health plan's My Health Toolkit website. Select **Prescription Drugs** from the top menu and then **Drug Lists**.

LOWEST NET COST FORMULARY

Your prescription benefit is based on a list of covered drugs called the Lowest Net Cost Formulary. We want to make sure you understand the role of the formulary so you and your doctor can make the best choices for you. Here are answers to the most frequently asked questions.

What is a formulary?

A formulary is a list of medications covered under your prescription benefit. Drugs on the formulary are chosen for their safety, cost and effectiveness by an independent panel of physicians and pharmacists. Since there may be more than one drug available for your medical condition, we encourage you to use generic or preferred brand-name drugs on the formulary whenever possible to help manage your prescription costs.

Where can I find the formulary?

Go to your health plan's My Health Toolkit website. Select **Prescription Drugs** from the top menu and then **Drug Lists**.

How do I find a pharmacy?

Log in to **My Health Toolkit** and select the **Benefits** tab. Select the **Pharmacy Benefits** link, and then select **View Your Pharmacy Benefits**.

How can I save money?

To save money, ask your doctor to prescribe a generic or preferred brand-name drug if one is right for you. Generic drugs must meet the same U.S. Food and Drug Administration quality standards as brand-name drugs. When you use a generic drug, you get the same quality as the brand-name drug at a lower cost.

Note: When a generic becomes available, the brand-name drug usually moves to the nonpreferred drug tier.

What if my drug is not listed on the formulary document?

The formulary contains most commonly prescribed drugs. If your drug is not listed, it may be that:

1. Your drug is available over the counter. For many conditions, an over-the-counter medication may be the most appropriate treatment. Talk to your doctor about over-the-counter alternatives. They may be a good choice for you and may cost you less.
2. Your drug is excluded from coverage. Ask your doctor if a covered alternative may be right for you.

If your drug is not on the formulary and you have more questions, use the searchable tool through **My Health Toolkit**. You can also call the customer service number on the back of your membership card.

PRIOR AUTHORIZATION FOR SPECIALTY MEDICAL BENEFIT DRUGS

Your health plan requires prior authorization (PA) for most specialty drugs covered under your medical benefit. This applies to specialty drugs administered and dispensed by a medical professional.

What are specialty drugs?

Specialty drugs treat conditions such as cancer, hepatitis, multiple sclerosis or rheumatoid arthritis, just to name a few. They often require special administration, dosing and monitoring.

How are specialty drugs covered under my medical benefit?

Most specialty drugs covered under the medical benefit require prior authorization through the medical prior authorization system.

How do I get prior authorization under the medical benefit?

Your doctor can request prior authorization by calling **877-440-0089**.

Site of care

Prior authorization for some specialty drugs may only be granted for administration in certain locations (sites of care), such as an infusion center or in your home.

Self-administered drug block

Most specialty drugs that are typically self-administered are “blocked” from coverage under the medical benefit and are covered only under your pharmacy benefit. See the **Prescription Drug Program** section of this guide for more information on specialty drug coverage under the pharmacy benefit.

voluntary benefits

FINANCIAL WELFARE

Accident insurance

MetLife's accident insurance supplements your primary medical plan and disability programs by providing cash benefits directly to you in cases of accidental injuries. You can use this money to help pay for uncovered medical expenses, such as your deductible or coinsurance, or for ongoing living expenses, such as your mortgage or rent.

Critical illness insurance

When a serious illness strikes, such as a heart attack, stroke, or cancer, MetLife's critical illness insurance can provide a lump-sum benefit to cover out-of-pocket expenses for your treatments that are not covered by your medical plan. You can also use the money to take care of your everyday living expenses, such as housekeeping services, special transportation services, and day care. Benefits are paid directly to you, unless assigned to someone else.

Hospital indemnity insurance

A trip to the hospital can be stressful, and so can the bills. Even with a major medical plan, you may still be responsible for copays, deductibles, and other out-of-pocket costs. MetLife's hospital indemnity plan provides supplemental payments directly to you for expenses that your medical plan doesn't cover for hospital stays.

Auto & homeowner's insurance

You can receive exclusive employee-only rates on your home and auto insurance coverage. Through the program with Farmers, you can apply to insure your auto, home, and other property against loss, and yourself against personal liability.

This program gives you access to special group discounts, and you benefit from these program features:

- 24-hour claim reporting
- Extended customer service hours, including weekdays, evenings, and Saturdays
- Coverage you take with you should you retire or leave the company

Learn More

Visit UKG Menu under Myself / My Company / Company Info for more information about your accident, critical illness, hospital indemnity, and legal insurance options.

Legal plan through MetLife Legal

The legal services plan through MetLife offers participants and their eligible dependents access to legal advice and services from a nationwide network of attorneys with coverage for many personal legal issues. Services include telephone advice and office consultations on an unlimited number of legal matters, in addition to full representation for covered matters.

Note: You don't pay an hourly rate if you use a network attorney.

Key features

- **No deductibles,** claim forms, or copays
- **No usage limits** – full service on an unlimited number of some of the most common personal legal matters
- **Access to experienced,** credentialed network attorneys in person or by telephone
- **Access to services in all 50 states**, most U.S. territories, and worldwide
- **Convenience** of payroll deduction

Your cost per month is only $18.00, and it covers you, your spouse/domestic partner and dependents. Parents are also eligible for this plan, as a separate plan, available at the group rate. They are responsible for their own enrollment and premium payments. Employees without access to a legal plan can easily spend an average of $338 an hour for legal counsel.

Sample covered benefits		
Money matters • Identify theft • Negotiating with creditors • Tax audit representation	**Family and personal** • Adoption • Prenuptial agreement • Personal property issues	**Vehicle and driving** • Defense of traffic tickets • License suspensions • Repossession
Home and real estate • Sale, purchase, or refinancing of a primary or vacation home • Property tax assessment • Foreclosure	**Civil lawsuits** • Civil litigation defense • Small claims assistance • Pet liabilities	**Estate planning documents** • Simple or complex wills • Living wills • Revocable or irrevocable trusts
Elder care issues • Medicare • Nursing home agreements • Power of attorney	**Learn More** For more information, call 1-800-821-6400 or go to info.legalplans.com	

financial welfare

Our company offers programs to help ensure financial security for you and your family. We also provide access to voluntary benefits designed to help you save money on valuable supplemental insurance coverage.

Basic life and AD&D insurance

You automatically receive basic life and accidental death and dismemberment (AD&D) insurance so that you can protect those you love from the unexpected. There is no cost to you for this coverage. See your company provided Life/AD&D benefit in UKG during enrollment. **The life insurance plans have an age reduction provision within the policy starting at age 65.**

** Federal tax law requires the company to report the cost of company-paid life insurance in excess of $50,000 as imputed income.*

**** AD&D benefits are paid in addition to any life insurance if you die in an accident or become seriously injured or physically disabled.*

Employee paid

Full-time and part-time employees may also purchase supplemental life insurance for yourself, your spouse/domestic partner, and/or your dependent children.

- **Employee supplemental life –** $10,000 increments up to $500,000 or 5x your annual salary (whichever is lower). The Guarantee Issue is $100,000.
- **Spouse/Domestic Partner supplemental life** – $5,000 increments up to $250,000 (can't exceed 50% of the employee's supplemental life amount). The Guarantee Issue is $50,000.
- **Child supplemental life –** $10,000
- **The life insurance plans have an age reduction provision within the policy starting at age 65.**

PLEASE NOTE: If you do not elect to enroll in employee and/or spouse/domestic partner supplemental life insurance when you are first eligible, you may be required to submit Evidence of Insurability (EOI), also known as Statement of Health.

There are two scenarios when you may be required to submit EOI:

1) If you increase your supplemental life coverage over the allowed $10k Annual Enrollment increment AND/OR
2) If you increase your supplemental life coverage over the Guarantee Issue amount

After your enrollment period has closed, MetLife will contact you to provide instructions for the submission of your EOI.

Disability insurance

The loss of income due to illness or disability can cause serious financial hardship for your family. Our disability insurance programs work together to replace a portion of your income when you're unable to work and is provided to full-time employees at no cost to you. The disability benefits you receive allow you to continue paying your bills and meeting your financial obligations during this difficult time.

Short-term disability benefits pay 60% of salary up to a maximum payment of $1,500 per week after a seven-day waiting period.

Long-term disability (LTD) also pays 60% of salary up to a maximum payment of $7,500 per month. LTD benefits are payable after a 90-day waiting period.

Please see your facility's Benefit Highlights for additional information.

401(k)

The company cares about your financial well-being and proudly offers a 401(k) plan to help you meet your retirement goals. After the Plan eligibility period, we offer a company match. While you can enroll or make contribution changes throughout the year, the Annual Enrollment period provides a great opportunity for you to set aside time to review your financial goals and objectives and to take action to alter your strategy if needed. Log on to www.login.principal.com/login to review your financial goals and/or make changes. Consult your facility's 401(k) plan for specific details.

Have You Named a Beneficiary?

Be sure you've selected a beneficiary for all your life and accident insurance policies. The beneficiary will receive the benefit paid by a policy in the event of the policyholder's death. It's important to designate a beneficiary and keep that information up-to-date. Visit UKG to add or change a beneficiary.

Available for employees and spouses age 18-64

Trustmark Universal Life Insurance with Long-Term Care Benefit

Two important coverages in one to help protect you for life.

Financial security even after a loss

Protecting your loved ones is one of life's greatest responsibilities. When a family loses someone, in addition to grief, survivors may suddenly be faced with costly expenses and debts, and even a loss of income. **Universal LifeEvents can help**.

Universal LifeEvents provides a **higher death benefit during your working years**, when your needs and responsibilities are the greatest. (See reverse for more on how Universal LifeEvents works.) You can choose a plan and benefit amount that provides the **right protection for you**.

Universal LifeEvents insurance can mean those left behind are still able to pursue their own dreams, and help ensure that the **ending** of one story won't stop the **beginning** of another.

valueHealth EMPLOYEES

GO TO:
https://schedapple.com/appointment/12104
to schedule your counselor assisted appointment to learn about this valuable new benefit and enroll.

CALL:
833-996-3280 if you need help scheduling an appointment.

OPEN ENROLLMENT DATES ARE:

November 7 - November 18, 2022

Note: your rate is "locked in" at your age at purchase!
Once you have a policy, your rate will never increase due to age.

Solving the long-term care issue

At any point in your life, you may need long-term care services, which could cost hundreds of dollars per day. Universal LifeEvents includes a **long-term care (LTC)** benefit that can help pay for these services at any age. This benefit **remains at the same** level throughout your life, so the full amount is always available when you most need it.

Here's how it works:

4% You can **collect 4% of your Universal LifeEvents death benefit per month** for up to 25 months to help pay for long-term care services.

Flexible features available:

2x **PLUS:** if you collect a benefit for LTC, your **full death benefit** is still available for your beneficiaries, as much as **doubling** your benefit.

3x **PLUS:** you can collect your LTC benefit for an **extra 25 months**, as much as **tripling** your benefit.

The LTC Benefit is an acceleration of the death benefit and is not Long-Term Care Insurance (except in LA and VA, where the LTC benefit is Long-Term Care Insurance). It begins to pay after 90 days of confinement or services, and to qualify you must meet conditions of eligibility for benefits. The LTC benefits provided by this policy may not cover all of the policyholder's LTC expenses. Pre-existing condition limitation may apply. Your policy will contain complete details. You should consult a financial advisor to determine if the long-term care benefits and the retirement benefits provided by this policy are right for you.

Universal LifeEvents is **flexible permanent** life insurance designed to last a lifetime.

The younger you are when you enroll, the **more benefit** you receive for the same premium.

No medical exams or blood work – just answer a few simple questions.

See reverse side for more information on Universal LifeEvents insurance from Trustmark Insurance Company.

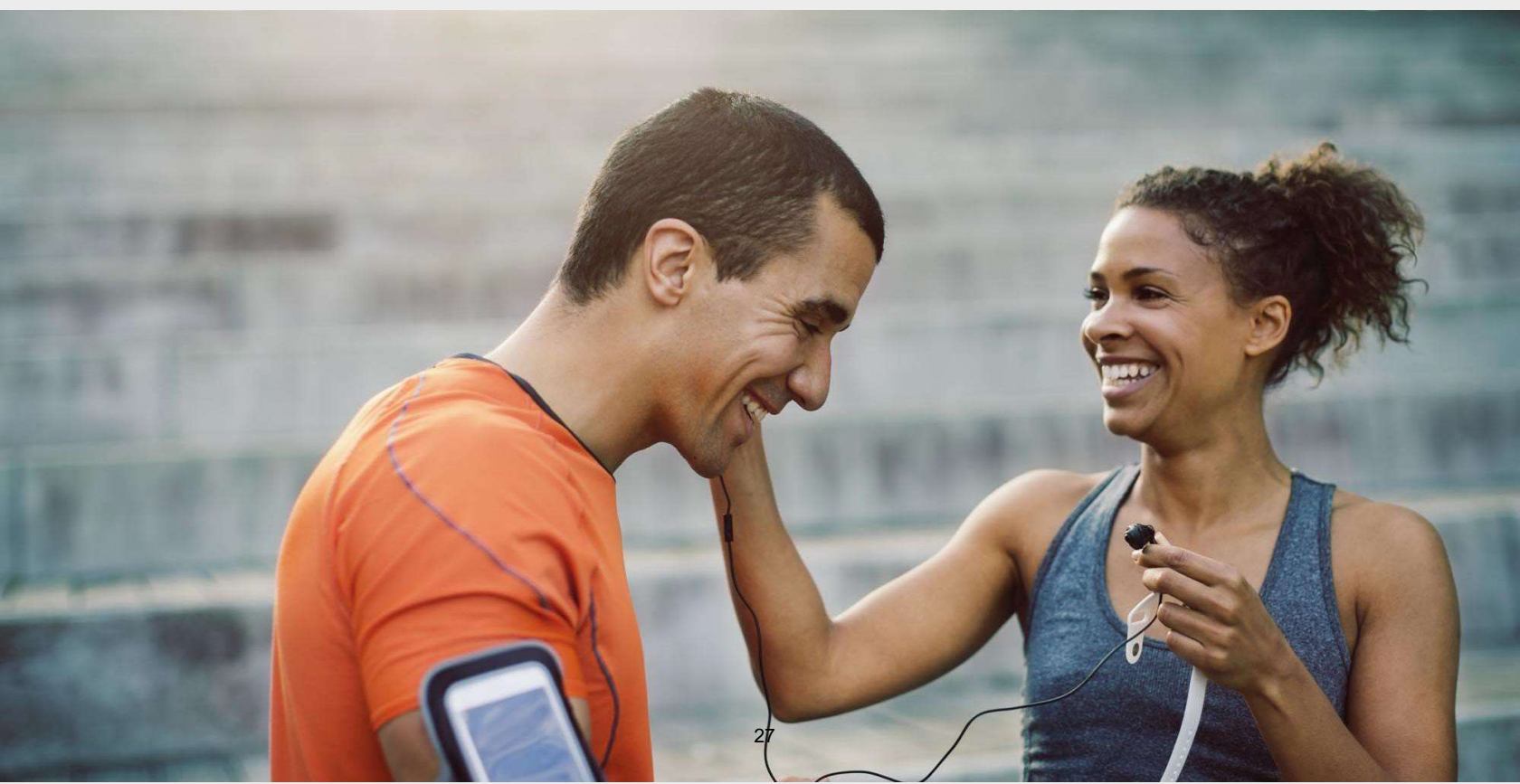
focus on wellness

Our wellness program is designed to help you maintain or move toward a healthy lifestyle. You have access to tools and resources you can use to learn more about your personal health and monitor your progress toward your health goals.

Vitality

Partner with Vitality to work toward becoming a more educated, healthy, and proactive consumer of health care. You will also have opportunities to earn Vitality bucks to use toward gift cards and incentives that focus on overall well-being.

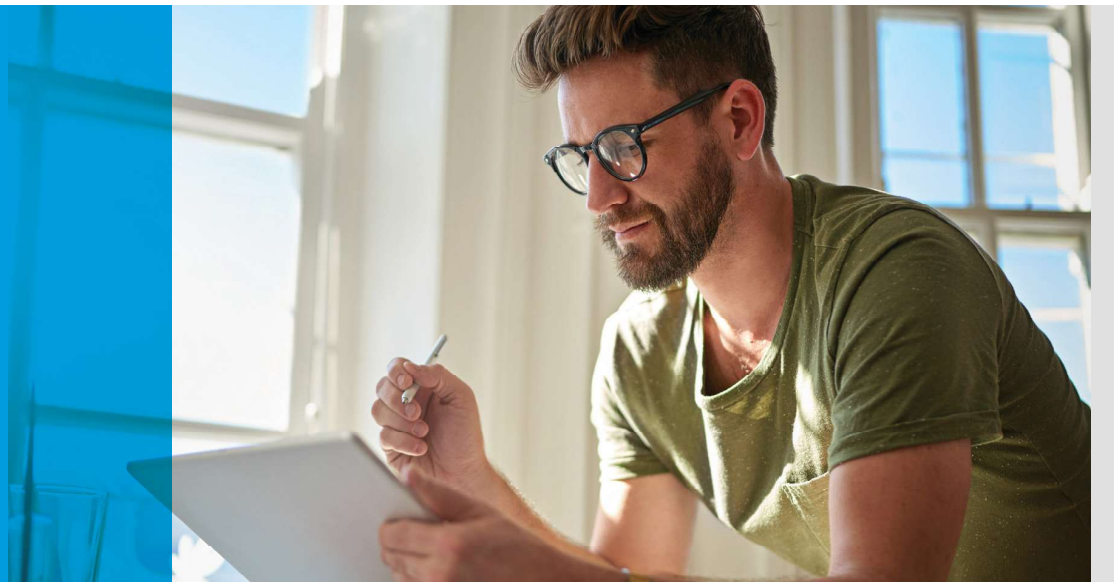
Any employee and his or her spouse/domestic partner enrolled in one of our medical plans can participate in the wellness activities. If your facility chooses to incentivize participation in the wellness program and you are enrolled in one of our qualified high deductible medical plans, your earned incentives will be deposited into your HSA which can help you meet your maximum allowed annual contribution more quickly. If you do not participate in an HSA but participate in wellness activities as an eligible plan member, your incentives will be paid to you via payroll, less applicable taxes.



Professional support and guidance for everyday life

Life doesn't always go as planned. And while you can't always avoid the twists and turns, you can get help to keep moving forward.

We can help you and your family, those living at home, get professional support and guidance to make life a little easier. Our Employee Assistance Program (EAP) is available to you in addition to the benefits provided with your MetLife insurance coverage. This program provides you with easy-to-use services to help with the everyday challenges of life — at no additional cost to you.



Help is always at your fingertips.

Our mobile app makes it easy for you to access and personalize educational content important to you.

Search "LifeWorks" on iTunes App Store or Google Play. Log in with the user name: **metlifeeap** and password: **eap**

Expert advice for work, life, and your well-being

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

- **Family:** Going through a divorce, caring for an elderly family member, returning to work after having a baby
- **Work:** Job relocation, building relationships with co-workers and managers, navigating through reorganization
- **Money:** Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues
- **Legal Services:** Issues relating to civil, personal and family law, financial matters, real estate and estate planning
- **Identity Theft Recovery:** ID theft prevention tips and help from a financial counselor if you are victimized
- **Health:** Coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking
- **Everyday Life:** Moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, training a new pet

Convenient and confidential help when you want it, how you want it

Your program includes up to 5 phone or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year. You can call **1-888-319-7819** to speak with a counselor or schedule an appointment, 24/7/365.

When you call, just select "Employee Assistance Program" when prompted. You'll immediately be connected to a counselor.

If you're simply looking for information, the program offers easy to use educational tools and resources, online and through a mobile app. There is a chat feature so you can talk with a consultant to guide you to the information you are looking for or help you schedule an appointment with a counselor.

Log on to metlifeeap.lifeworks.com, user name: metlifeeap and password: eap

MetLife

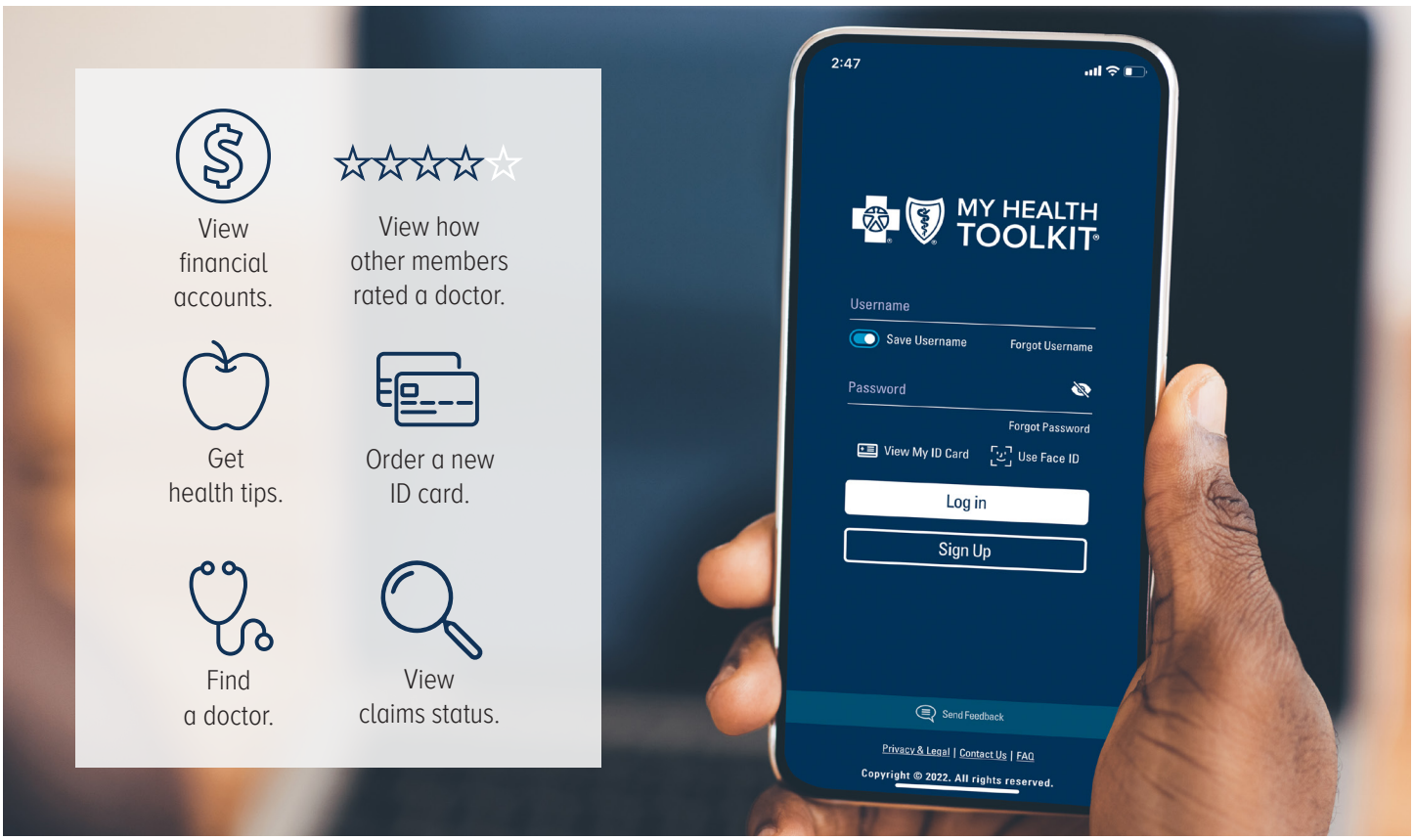
Navigating life together

TRY THIS SHORTCUT

Get easy access to your benefits information by downloading the My Health Toolkit® mobile app today! It's free on the App Store or Google Play.

Download on the App Store | GET IT ON Google Play

Register quickly through the app using your member ID number. Or just log in if you're already a My Health Toolkit user.



Your account homepage will link you to all of the helpful resources included with your health benefits plan.

Now you have anywhere, anytime access to your benefits information, including claims, discounts and how you prefer to be contacted.

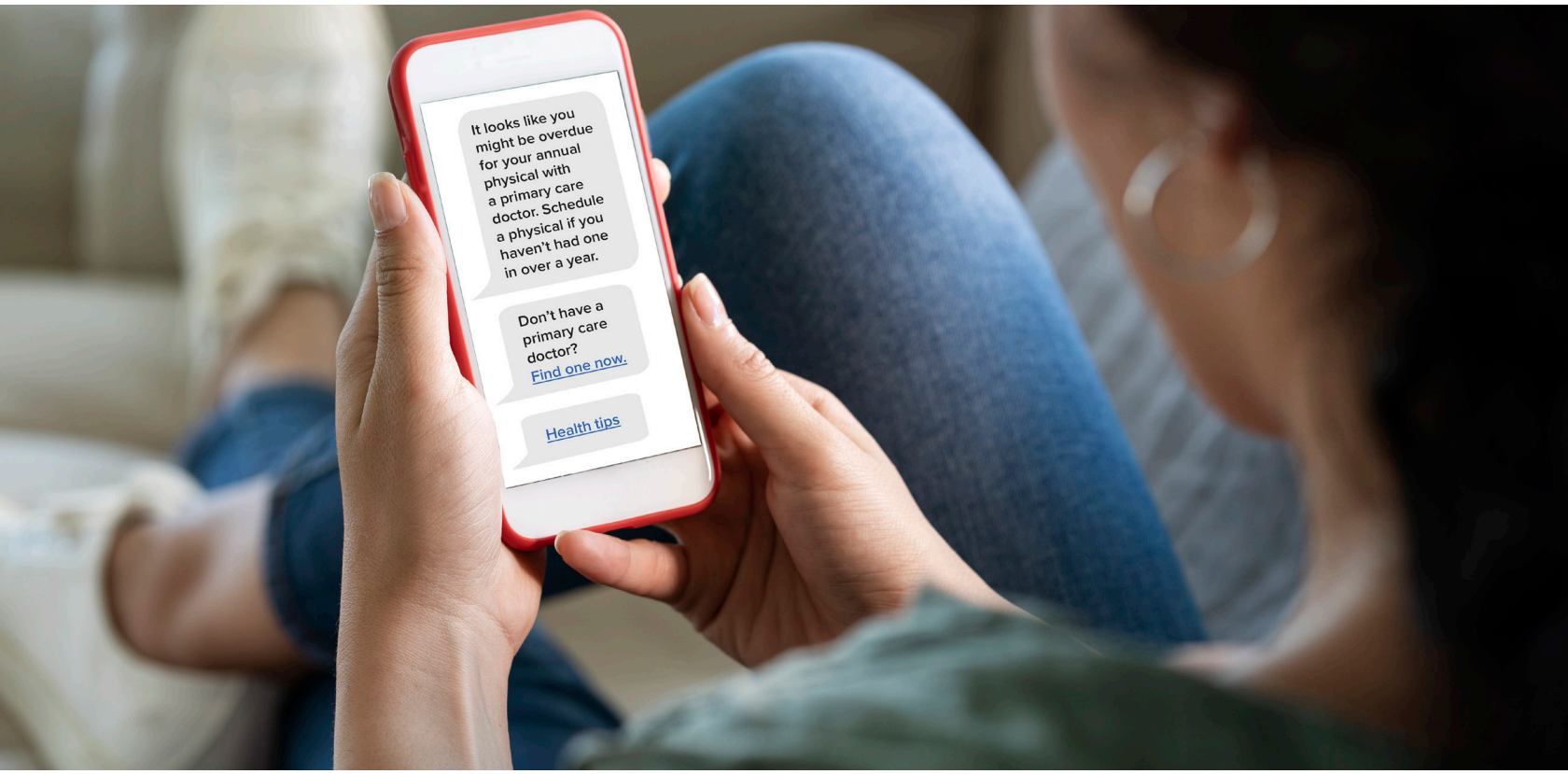
Rather get My Health Toolkit from a desktop or laptop computer?

Go to **www.MyHealthToolkitKC.com** and then:

- Select **Create An Account** within the **Member Login** section.
- Enter your **member ID** (from your ID card).
- Follow the instructions to **create your profile**.

TELL US THE BEST WAY TO REACH YOU

Occasional communications from your health plan help you stay on top of your health, save money and make the most of your benefits. Just let us know which contact option is most convenient. We'll send a brief message when it's time for your annual checkup, for example, or there's an update on a prior authorization request.



Personalized member messages — by text, mail, app notification or email — help us keep in touch by providing useful information and tips. These could include wellness reminders or news on benefit changes.

You have great benefits; make sure you use them! Please take a minute to update your contact preferences in My Health Toolkit. Just let us know which channels and contacts you prefer. Check out the easy opt-in tips below.

Log in to My Health Toolkit, and under My Profile, select My Contact Preferences. Update your contact information and tell us the best way to reach you.

You also can opt in to receive text messages by calling 844-206-0624.

SHOPPING FOR CARE

Find the best health care options just like you check out your choices in cars, hotels or restaurants.

"Know before you go." It's a smart idea before you make any important decision, including finding a new doctor or choosing a location for surgery.

Your health plan makes these decisions easier with Shopping for Care. Find it at your health plan's **My Health Toolkit®** website.

- Find health care providers and services within our vast provider network.
- Check out cost information to make sure you're getting the care you need at the best possible price.*
- See reviews from other patients who have rated a provider you're considering.
- Identify the highest-quality providers in your area, with Total Care and Blue Distinction® Specialty Care designations.
- View a detailed map to help you get where you need to go.

After you've registered with My Health Toolkit®:

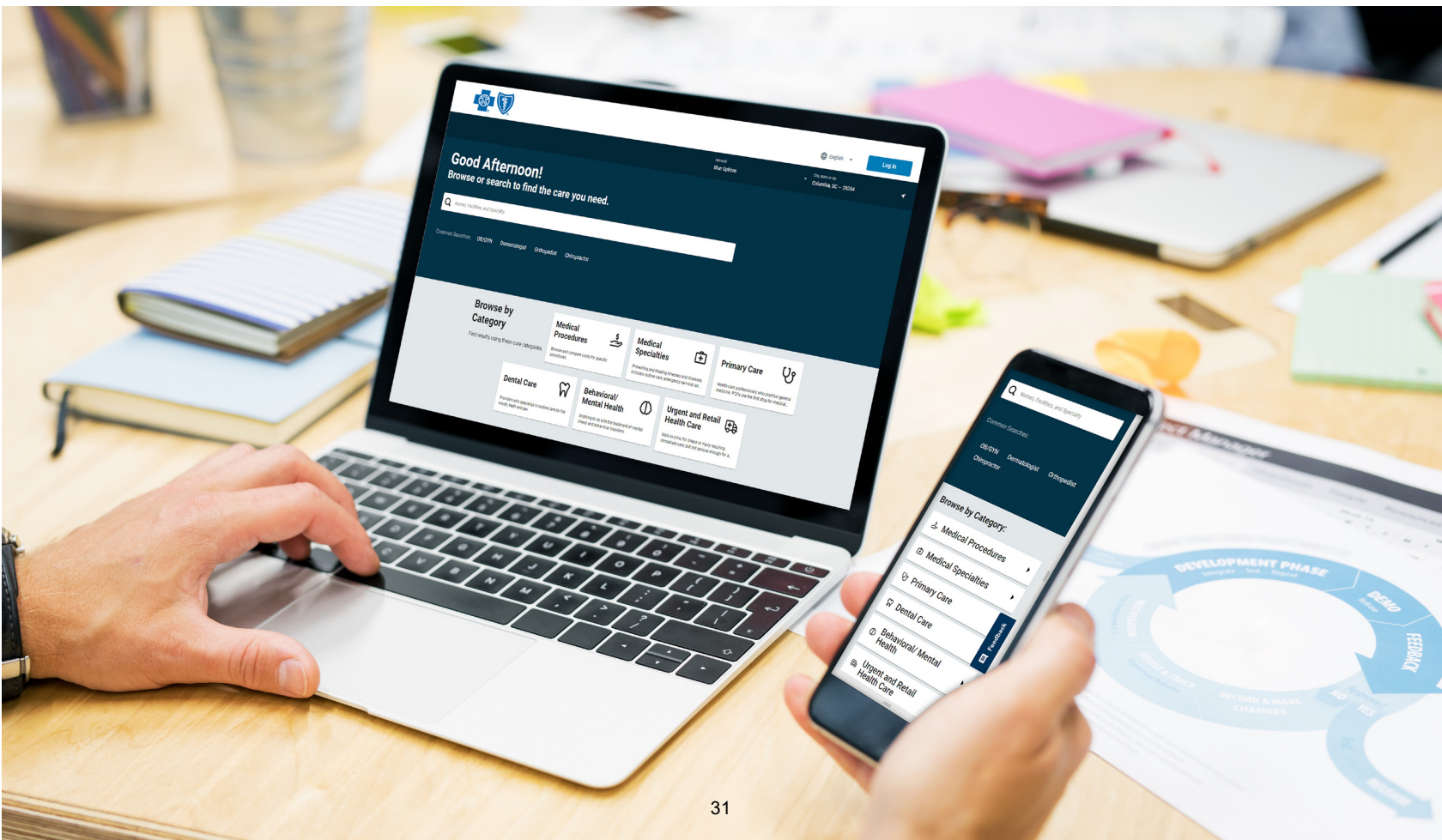
Access Shopping for Care from your computer:

- Visit your health plan's **My Health Toolkit** site.
- Log in to your account, select **Resources**, and then choose **Find Care**.
- We'll walk you through each step!

Or take it with you:

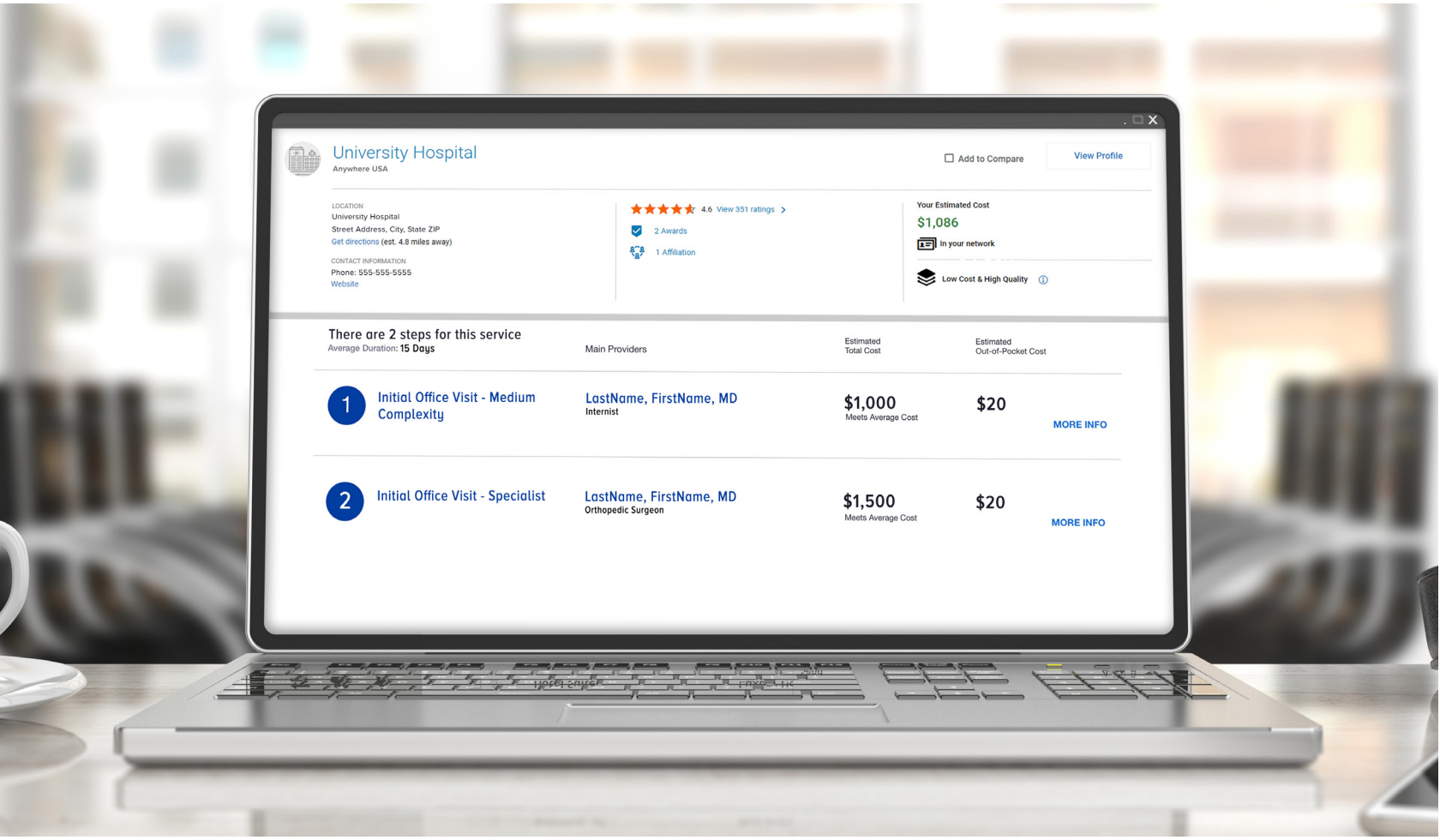
- Log in to the **My Health Toolkit** app from your mobile device.
- Select **Find Care**.

*Cost details might not be included with all plans.



“How much will it cost?”

Estimates help you avoid surprises when the bills come.



Costs for a medical procedure — like an ultrasound, a checkup, X-rays or joint replacement — can vary by hundreds of dollars. Our Shopping for Care feature includes cost estimates to help you find the right care at the right price. (Cost information might not be included for all plans.)

Estimate your out-of-pocket expenses for medical procedures — and compare pricing details that show you the most cost-efficient providers.

- At your health plan’s **My Health Toolkit** website, log in to your **My Health Toolkit** member account.
- Under **Resources**, select **Find Care** under **Shopping for Care**.

As you explore the **Find Care** categories further, you’ll see a **Cost Estimates** tab that’s loaded with price information about hundreds of procedures, from mammograms and MRIs to allergy testing, sleep studies, physical therapy and various types of surgery.

TIP: When you get your member ID card, use your ID number to create your My Health Toolkit account. Then you’ll see cost information about copays and other details specific to your health plan.

TOTAL CARE

Better care, outcomes and costs

Total Care is a national Blue Cross Blue Shield program that recognizes doctors and hospitals that are committed to improving health care for patients.

What's different about Total Care doctors?

Doctors and hospitals with Total Care designation have access to enhanced technology and information that can improve the way they care for patients. A Total Care team might include a primary care doctor, pharmacist, care coordinator and a dietitian.

Who should use a Total Care doctor?

Anyone can choose a doctor with Total Care designation. The team-based approach is especially helpful for people with chronic health conditions like high blood pressure, heart failure or diabetes.

How does Total Care benefit you?

- Care is personalized and consistent. You will see a member of your care team who knows you and your medical history.
- Results of your medical procedures are shared with members of your team so they have a complete picture of your health.
- Total Care's improved screenings, medication management and other programs help provide better outcomes and lower costs for patients.

To find Total Care doctors and hospitals:

- Log in to My Health Toolkit and select the **Resources** tab
- Click **Find a Doctor or Hospital**
- Enter your location and the specialty type, then click **Search**
- On the left side, click **Total Care**

Or call the number on the back of your membership card to talk to a customer service advocate.

MEMBER PERKS

Discounts for you — just for being Blue!

In addition to superior health coverage, your membership provides access to exclusive discounts on a variety of products and services. The member discounts program includes items that generally are not covered byhealth insurance.

Log in to My Health Toolkit, select the **Resources** tab, then **Blue365® Discounts**. On a mobile device, select **Menu**, then **Blue365® Discounts**. You'll find details on discounts for:

Fitness

- Gym memberships
- Wearable fitness devices
- Activewear
- Magazine subscriptions
- 5K and obstacle course registration
- Home fitness equipment
- Vitamins and nutritional supplements

Personal care

- Allergy relief
- Acupuncture
- Chiropractic services
- Massage therapy
- Hair restoration
- Teeth whitening

Healthy eating

- Weight loss programs
- Cookbooks and recipes
- Online cooking classes

Hearing and vision

- Hearing aids
- Eyewear

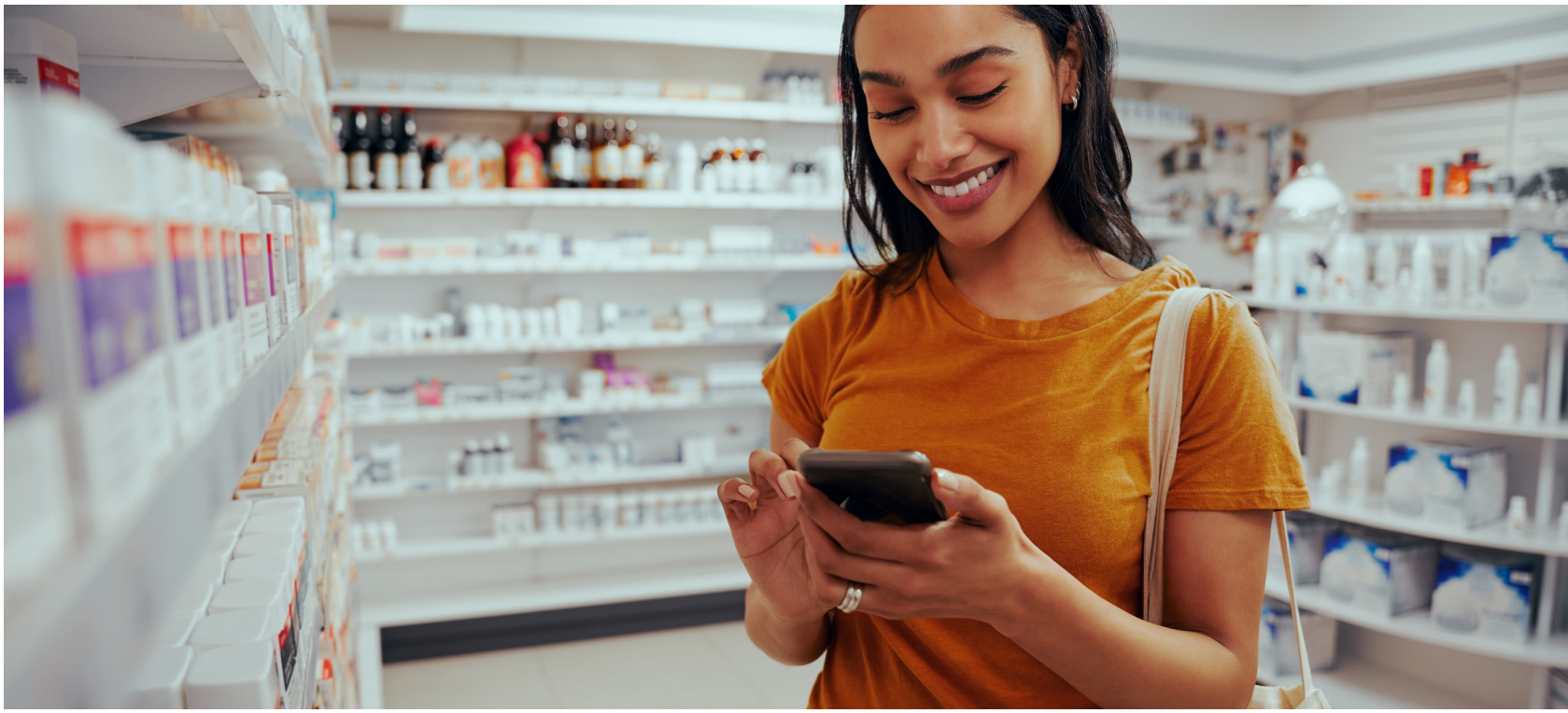
Lifestyle

- Travel clubs
- Vacation packages
- Pet care

KEEP UP WITH YOUR PRESCRIPTION DRUG BENEFITS FROM ANYWHERE

The My Rx Toolkit℠ app provides easy access to details you need

Need to know more about your prescription drug benefits? Often, questions come up when you're on the go, such as at the doctor's office or pharmacy. Now there's a mobile app to help you find the answers easily.



The **My Rx Toolkit** app lets you look up coverage information, copays and options for your medications, all with the convenience of using a mobile device. You can use the app to:

- Set up home delivery of medications. Fill, renew or transfer prescriptions for delivery directly to your door, often for less than you'd pay at a retail pharmacy.
- Look up cost information for your medications, including how much you can expect to pay out of pocket.
- See if lower-cost alternatives may be available.
- Find a network pharmacy near you.
- Initiate conversations with your health care providers.

Getting the app

You can download **My Rx Toolkit** from the App Store or Google Play. Log in with the same username and password you use for **My Health Toolkit®** — there's no need to create a new account.

Download on the App Store

GET IT ON Google Play

It's one more way to make the most of your health care benefits.

COULD YOU SAVE MORE ON YOUR PRESCRIPTIONS?

Get a personalized analysis with Rx Spending and Savings Insights

Many people rely on prescription medications to manage health conditions and live their best lives. But these medications can be costly, especially if you're not taking advantage of all the potential discounts.

Want to keep close track of your prescription drug spending — and save some money while you're at it? Check out Rx Spending and Savings Insights, a web-based tool you can access through **My Health Toolkit®**.

Rx Spending and Savings Insights offers a snapshot of your prescription drug spending based on your claims history. You can:

- See how much you've paid out of pocket for certain recurring prescriptions.
- See what your benefits plan has paid.
- Learn about possible cost savings, such as generic drug alternatives or mail-order delivery.
- View estimates of how much money you could save.

To access Rx Spending and Savings Insights:

- Log in to your **My Health Toolkit** account.
- Go to the **Benefits** tab and select **Pharmacy Benefits**.
- Select the **View Your Pharmacy Benefits** button to access the pharmacy benefits portal.

It only takes a few minutes to keep an eye on your prescription drug spending and be a savvy health care consumer!

MATERNITY CARE

Personalized care for you and your baby

They say a baby changes everything. They are right about that. You are bound to have questions about the transitions that lie ahead.

We're here to help!

Your health plan includes a free maternity care program designed to provide information and support during your pregnancy and postpartum period.

If you are pregnant, it is easy to get started.

- You may receive an invitation by phone, text message, email or postcard.
- You can call **855-838-5897** and let us know you are expecting.
- You can visit **My Health Toolkit®** and select the **Maternity** link in the **Wellness** menu.

You will be asked to take a short assessment online or by phone to complete your enrollment. Then you'll get access to **My Health Planner℠**, an interactive app that guides you through your customized pregnancy program. Through the app, you will receive educational information about each stage of pregnancy and be asked to check in periodically through quick 3 – 5 question surveys. Your care manager, a health care professional with experience in obstetrics, will review your progress and may reach out to you by phone to offer support. You can also use the app to send and receive secure messages to your care manager, set reminders, log medications, and more.

To learn more, log in to **My Health Toolkit**, select the **Wellness** tab, and then select **Maternity**. Or call the care management team at **855-838-5897**.

HELP ALONG THE WAY TO BETTER HEALTH

Whether you're ready to get on track with your health or looking for ways to maintain an already healthy lifestyle, you don't have to figure it out on your own. Your health plan includes free care management programs and resources to help you make positive, meaningful changes at your own pace.

What is care management?

It's a personalized approach that gives you support and lots of options. Our care team includes registered nurses, pharmacists, social workers, physicians, respiratory therapists, certified diabetes educators, licensed behavioral health specialists, and other health and well-being professionals. Connect online or by phone!

Chronic condition support

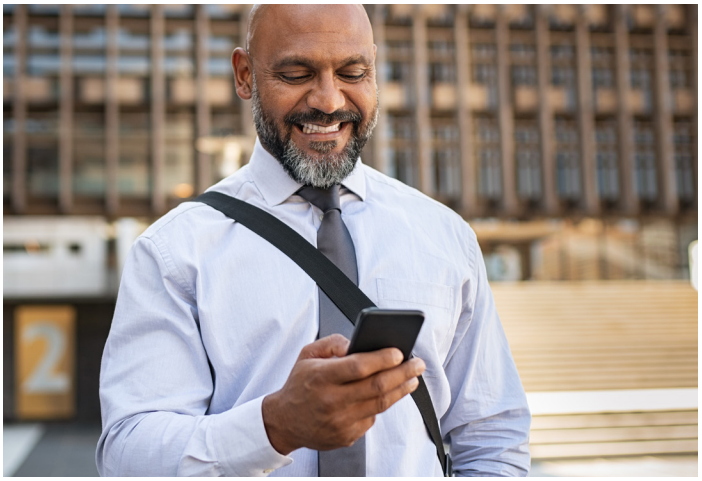
- Attention-deficit hyperactivity disorder (adults)
- Asthma (adults and children)
- Bipolar disorder
- Heart disease and heart failure
- Chronic obstructive pulmonary disease
- Depression
- Diabetes (adults and children)
- High blood pressure and high cholesterol
- Metabolic health (metabolic syndrome and prediabetes)
- Migraine
- Recovery support for substance use disorder

Case management

If you experience complex or difficult health issues, a registered nurse case manager will reach out to you to provide support. Things he or she can help with include cancer, transplants, trauma, end-stage renal disease and neonatal intensive care.

Prevention and wellness

- Maternity
- Back care
- Stress management
- Tobacco-free living
- Weight management (adults and children)
- Gaps in care — personalized reminders when you or your family member may be due for cancer screenings, diabetes care or a well-child visit



Connect with an app

The **My Health Planner**[SM] app is free for eligible members! It helps you keep track of what you need to do between doctor visits and stay in touch with your care team.

Ready to become a healthier you?

If you qualify for one of our care management programs, we will reach out to you with a phone call, email, text or letter to help you get started. To learn more, log in to **My Health Toolkit**®, select the **Wellness** tab, and then choose **Care Management**.

If you have questions, call the care management team at **855-838-5897**.

PRIOR AUTHORIZATION: WHAT YOU NEED TO KNOW

Your health plan requires prior authorization for certain medical tests and treatments. This is an extra step to ensure you receive the appropriate type of care for your condition. If your doctor does not receive authorization before he or she performs the service, it may not be covered by your health insurance.

What types of services require prior authorization?

Generally, prior authorization will be required for these types of services:

- Standard radiology and imaging services, such as magnetic resonance imaging (MRI) and computed tomography (CT) scans
- Radiation therapy for cancer treatment, such as brachytherapy, image-guided radiation and stereotactic therapy
- Spine treatments, such as lumbar decompression or fusion, cervical spine procedures and spinal epidural injections

What should you do?

Most providers will be knowledgeable about services that require prior authorization. You can ask your doctor to visit **www.RadMD.com** to request authorization for treatment.

What's the status of your prior authorization?

To check the status of your request:

Log in to **My Health Toolkit®**. Select the **Benefits** tab and then **Prior Authorization**. On a mobile device, find **Prior Authorization** under the **More** menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.

Or call the number on the back of your membership card to speak to a customer service advocate.

PRIOR AUTHORIZATION: STANDARD RADIOLOGY SERVICES

Your health plan requires prior authorization for certain radiology and imaging services in an outpatient setting. If you are in the emergency room or an inpatient setting, you don't have to get prior authorization.

What services require prior authorization?

- Magnetic resonance imaging (MRI)
- Magnetic resonance angiogram (MRA)
- Computed tomography (CT) scans
- Positron emission tomography (PET) scans
- Myocardial perfusion imaging — nuclear cardiology study
- Multigated acquisition scan (MUGA)

What should you do?

Ask your doctor to visit **www.RadMD.com** to request authorization for treatment. If your provider does not receive a prior authorization before you receive services, your health plan might not cover the treatment and you could be held liable for the payment.

What's the status of your prior authorization?

To check the status of your request:

Log in to **My Health Toolkit®**. Select the **Benefits** tab and then **Prior Authorization**. On a mobile device, find **Prior Authorization** under the **More** menu.

You also can sign up for paperless notifications when an authorization request has been submitted or a decision has been made.

Or call the number on the back of your membership card to speak to a customer service advocate.

What is the program designed to do?

- Promote patient safety by preventing unnecessary radiation exposure
- Help you avoid paying unnecessary out-of-pocket expenses

ADULT WELLNESS GUIDELINES

Adult health — for ages 18 and over

Preventive care is important for adults. By making healthier choices, you can improve your overall health and well-being. These healthy choices are a good start:

- Eat a healthy diet.
- Get regular exercise.
- Don't use tobacco products.
- Limit alcohol use.
- Strive for a healthy weight.
- Take medications as prescribed by your doctor.

Adult Recommendations

Screenings	
Physical Exam	Every year or as directed by your doctor
Body Mass Index (BMI)	Every year
Blood Pressure (BP)	At least every two years
Colon Cancer Screening	Screening beginning at age 45 in consultation with your doctor — You have three options: a colonoscopy every 10 years, a flexible sigmoidoscopy every five years or a blood test annually.
Diabetes Screening	Screening beginning at age 45 — If you have high blood pressure or high cholesterol, are overweight, or have a close family history of diabetes, you should consider being screened earlier.

Immunizations	19 – 21 years	22 – 26 years	27 – 49 years	50 – 64 years	65 and older
Influenza (Flu)*	Once each year				
Tetanus, Diphtheria and Pertussis (Tdap)*	One dose with a booster every 10 years				
Herpes Zoster (Shingles) — RZV*					Two doses RZV for those 60 and older
or Herpes Zoster (Shingles) — ZVL*					OR one dose ZVL for those 50 and older
Varicella (Chickenpox)*	Two doses				
Pneumococcal (Pneumonia)*					Two doses
Measles, Mumps and Rubella (MMR)*	One or two doses if no evidence of immunity				
Human Papillomavirus (HPV) — Female*	One or two doses if no evidence of immunity				
Human Papillomavirus (HPV) — Male*	Two or three doses depending on age at series initiation				
Hepatitis A**	Two or three doses for at-risk adults — Discuss with your doctor if this vaccine is right for you.				
Hepatitis B**	Three doses for at-risk adults — Discuss with your doctor if this vaccine is right for you.				
Meningitis**	One to three doses depending on indication — This vaccine is only recommended for specific groups of adults. Discuss the risks and benefits with your doctor.				
Haemophilus Influenzae Type B (Hib)*	One to three doses depending on health risks — This vaccine is only recommended for specific groups of adults. Discuss the risks and benefits with your doctor.				

*Recommended for most adults.

**Recommended for adults with certain health risks.

CHILDREN'S HEALTH

Put your children on the path to wellness by scheduling regular office visits with a doctor. The doctor will watch your baby's growth and progress and should talk with you about eating and sleeping habits, safety, and behavior issues.

According to the Bright Futures recommendations from the American Academy of Pediatrics, the doctor should:

- Check your child's body mass index percentile regularly beginning at age 6.
- Conduct a yearly wellness exam beginning at age 3.
- Test vision at least once between the ages of 3 and 5.

Routine Children's Immunization Schedule

Vaccine	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	1.5 – 3 years	4 – 6 years
Hepatitis B (HepB)	●	●			●					
Rotavirus (RV)			●	●	●*					
Diphtheria, Tetanus and Pertussis (DTaP)			●	●	●		●†			●
Haemophilus Influenzae Type B (Hib)			●	●	●*	●				
Pneumococcal Conjugate (PCV)			●	●	●	●				
Inactivated Polio Vaccine (IPV)			●	●	●					●
Influenza (Flu)	● Recommended **yearly** starting at age 6 months with two doses given the first year									
Measles, Mumps and Rubella (MMR)						●†				●
Varicella (Chickenpox)						●				●
Hepatitis A (HepA)						● First dose: 12 – 23 months ● Second dose: 6 – 18 months later				

● One dose ▢ Range of recommended dates

*Number of doses needed varies depending on vaccine used. Ask your doctor.

†12 months is minimum age for routine vaccination: two-dose series at 12 – 15 months and 4 – 6 years. Second dose may be given as early as four weeks after the first dose.

Sources: U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, U.S. Preventive Services Task Force

Some of these recommendations may not be covered by your health plan. Please refer to your summary of benefits to verify which services are covered.

The American Academy of Pediatrics is an independent organization that provides health information you might find helpful.

TWEEN AND TEEN HEALTH

Put your teen on the path to wellness. As your child grows into a teen, he or she should continue yearly doctor visits for exams and scheduled immunizations.

These visits give the doctor a chance to talk about:

- The importance of good eating habits and regular physical activity.
- Avoiding alcohol, smoking and drugs.
- The impact of sexual activity and sexually transmitted diseases.

Recommended Immunizations for Ages 7 to 18					
Vaccine	**7 – 10 years**	**11 – 12 years**	**13 – 15 years**	**16 years**	**17 – 18 years**
Tetanus, Diphtheria and Pertussis (Tdap)		●			
Human Papillomavirus (HPV) — females and males		●*			
Meningococcal (MCV)		●		●	
Influenza (Flu)	Yearly				

● One dose ▢ Range of recommended dates

*Routine at 11 – 12; may start at age 9 and through age 18. Whether a two- or three-dose series is recommended will depend on age at first vaccination. A three-shot series is needed for those with weakened immune systems and those 15 and older.

WOMEN'S HEALTH

**You play the role of a superwoman very well.
But that doesn't mean you're invincible.**

Ladies, your supernatural ability to keep everything and everyone in order is truly impressive. But remember that your powers have a limit. Before you can save the world, you must first take care of yourself.

Make sure everything is healthy underneath that cape by scheduling regular health screenings. These recommendations are in addition to the standard wellness guidelines for adults.

Women's Recommendations	
Mammogram	Women 40 and up should get checked yearly.
Cholesterol	Ages 30 – 35 should be tested if at high risk. Women 45 and older should be tested.
Pap Test	Women ages 21 – 65 should have a Pap test every three years. Another option for ages 30 – 65 is a Pap test and HPV test every five years. Women who have had a hysterectomy or are over age 65 may not need a Pap test.*
Osteoporosis Screening	Screenings should begin at age 65 or at age 60 if risk factors are present.*
Aspirin Use	At ages 50 – 79, talk with your doctor about the benefits and risks of aspirin use.
Pelvic Exam	Ages 21 and over should have an exam every year.

*Recommendations may vary. Discuss screening options with your doctor, especially if you are at increased risk.

Sources: American Cancer Society, U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, U.S. Preventive Services Task Force

MEN'S HEALTH

Even the toughest machines depend on regular maintenance.

Preventive care is important to men's health. If you're going to keep firing on all cylinders, you need to make time for tuneups. So, let's man up and schedule that appointment!

In addition to the standard wellness guidelines for adults, men should discuss these recommendations with their doctors.

Men's Recommendations	
Cholesterol	Ages 20 – 35 should be tested if at high risk. Men age 35 and over should be tested.
Abdominal Aortic Aneurysm	Get checked once between ages 65 and 75 if you have ever smoked.
Aspirin Use	At ages 50 – 79, talk with your doctor about the benefits and risks of aspirin use.

Sources: American Cancer Society, U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, U.S. Preventive Services Task Force

nuehealth

Special Notices

Please note that there are important notices for your review that are list on UKG under Myself / My Company / Company Info and starting on the next page of this benefit guide.

Please refer to these notices if you have questions regarding any of the below.

- HIPAA Special Enrollment Notice
- Women's Health and Caner Rights Ace Notice (WHCRA)
- Newborns and Mothers' Health Protection Act Notice (NMHPA)
- CHIP/Medicaid Notice
- HIPAA Privacy Notice
- Exchange Notice
- Wellness Program Notices

IMPORTANT NOTICES

YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with NueHealth and about your options under Medicare's prescription drug coverage.This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coveragein 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. NueHealth has determined that the prescription drug coverage offeredby Blue Cross and Blue Shield of South Carolina is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

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

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

- If you decide to join a Medicare drug plan, your current NueHealth coverage may be affected.
- If you do decide to join a Medicare drug plan and drop your NueHealth coverage, be aware that you and your dependents may not be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your coverage with NueHealth 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 joina Medicare drug plan later.

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2023
Name of Entity/Sender: NueHealth, LLC | Lynnette Morris |
Address: 11250 Tomahawk Creek Parkway | Leawood, KS 66211
Phone Number: *(888) 887-2619*

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). These benefits are subject to applicable terms and conditions under your health plan, including copayments, deductible, and coinsurance provisions. They are also subject to medical insurance limitations and exclusions. This notification is a requirement of the act. Those enrolled are to be notified of the WHCRA's coverage requirements to participants at the time of enrollment and on a yearly basis.

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

TELL US WHEN YOU'RE MEDICARE ELIGIBLE

Please notify your Human Resource Department when you or your dependents become eligible for Medicare. We are required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the health plan pays primary. You must also contact Medicare directly to notify them that you have health care coverage through an employer group. Privacy laws prohibit anyone other than the Medicare beneficiary, or their legal guardian, to update or change Medicare records. ***The toll-free number to contact Medicare Coordination of Benefits Contractor is 1-800-999-1118.***

SUMMARY OF BENEFITS AND COVERAGE

In addition, health plans are required to provide members with a Summary of Benefits and Coverage (SBC). The SBC is different from the standard summary, in that it provides members with improved standardized information designed to help better understand your coverage and compare the options available to you.

ERISA

The NueHealth employee benefit plans are generally subject to the federal law known as ERISA. Please see the SPD for each ERISA plan for a statement of participant rights under ERISA.

NueHealth Notice of Privacy Practices - This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

UNDERSTANDING YOUR HEALTH RECORD/ INFORMATION

Each time you visit a hospital, physician, dentist, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and helps you make more informed decisions when authorizing disclosure to others.

YOUR HEALTH INFORMATION RIGHTS

Unless otherwise required by law, your health record is the physical property of the health plan that compiled it. However, you have certain rights with respect to the information. You have the right to:

1. Receive a copy of this Notice of Privacy Practices from us upon enrollment or upon request.
2. Request restrictions on our uses and disclosures of your protected health information for treatment, payment, and health care operations. We reservethe right not to agree to a given requested restriction.
3. Request to receive communications of protected health information in confidence.
4. Inspect and obtain a copy of the protected health information contained in your medical or billing records and in any other of the organization's health records used by us to make decisions about you.
5. Request an amendment to your protected health information. However, we may deny your request for an amendment, if we determine that the protected health information or record that is the subject of the request:
   - Was not created by us, unless you provide a reasonable basis to believe that the originator of the protected health information is no longer available to act on the requested amendment;
   - Is not part of your medical or billing records;
   - Is not available for inspection as set forth above; or
   - Is accurate and complete.

   In any event, any agreed upon amendment will be included as an addition to, and not a replacement of, already existing records.
6. Receive an accounting of disclosures of protected health information made by us to individuals or entities other than to you, except for disclosures:
   - To carry out treatment, payment and health care operations as provided above;
   - To persons involved in your care or for other notification purposes as provided by law;
   - To correctional institutions or law enforcement officials as provided by law;
   - For national security or intelligence purposes;
   - That occurred prior to the date of compliance with privacy standards (April 14, 2003, or April 14, 2004, for small health plans):
   - Incidental to other permissible uses or disclosures;
   - That are part of a limited data set (does not contain protected health information that directly identifies individuals);
   - Made to plan participant or covered person or their personal representatives;
   - For which a written authorization form from the plan participant or covered person has been received.
7. Revoke your authorization to use or disclose health information except to the extent that we have already taken action in reliance on your authorization, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer that obtained the authorization with the right to contest a claim under the policy.
8. Receive notification if affected by a breach of unsecured PHI.

INFORMATION WE COLLECT ABOUT YOU

We collect the following categories of information about you from the following sources: 1) Information that we obtain directly from you, in conversations or on applications or other forms that you fill out. 2) Information that we obtain as a result of our transactions with you. 3) Information that we obtain from your medical records or from medical professionals. 4) Information that we obtain from other entities, such as health care providers or other insurance companies, in order to service your policy or carry out other insurance-related needs.

GENETIC INFORMATION

We will not use genetic or disclose genetic information or results from genetic services for underwriting purposes, such as:

- Rules for eligibility or benefits under the health plan;
- The determination of premium or contribution amounts under the health plan; and
- Other activities related to the creation, renewal or replacement of a contract of health insurance or health benefits.

COVERAGE EXTENSION OPTION UNDER COBRA

The right to COBRA continuation coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). When you or a family member loses eligibility in health, dental, vision or the health care flexible spending account due to one of the qualifying status events listed herein, you may elect to continue your coverage through COBRA. You will receive the applicable COBRA communication and election materials from our third-party COBRA administrator, NueHealth following the qualifying event. COBRA continuation coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Those who elect to continue coverage under COBRA are responsible for the cost of the coverage.

OUR RESPONSIBILITIES

We are required to maintain the privacy of your health information. In addition, we are required to provide you with a notice of our legal duties and privacy practices with respect to information we collect and maintain about you. We must abide by the terms of this notice. We reserve the right to change our practices and to make the new provisions effective for all the protected health information we maintain. If our information practices change, a revised notice will be mailed to the address you have supplied upon request. If we maintain a website that provides information about our services or benefits, the new notice will be posted on that website.

Your health information will not be used or disclosed without your written authorization, except as described in this notice. The following uses and disclosures will be made only with explicit authorization from you: (i) uses and disclosures of your health information for marketing purposes, including subsidized treatment communications; (ii) disclosures that constitute a sale of your health information; and (iii) other uses and disclosures not described in the notice. Except as noted herein.

OUR PRACTICE REGARDING CONFIDENTIALITY AND SECURITY

We restrict access to nonpublic personal information about you to those employees who need to know that information in order to provide products or services to you. We maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard your nonpublic personal information.

OUR PRACTICE REGARDING CONFIDENTIALITY AND SECURITY FOR E-MAIL COMMUNICATION

If you choose to communicate with us via email, please be aware of the following due to the nature of email communication: (a) privacy and security of email messages are not guaranteed (b) we are not responsible for loss due to technical failures and (c) email communication should not be used for emergencies or time and content sensitive issues.

POTENTIAL IMPACT OF STATE LAW

In some circumstances, the privacy laws of a particular state, or other federal laws, provide individuals with greater privacy protections than those provided for in the HIPAA Privacy Regulations. In those instances, we are required to follow the more stringent state or federal laws as they afford the individual greater privacy protections. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of Protected Health Information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, and reproductive rights.

NOTICE OF PRIVACY PRACTICES AVAILABILITY

You will be provided a hard copy for review at the time of enrollment (or by the Privacy compliance date for this health plan). Thereafter, you may obtain a copy upon request, and the notice will be maintained on the organization's website (if applicable website exists) for downloading.

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

This organization may use and/or disclose your medical information for the following purposes:

- Treatment: We may use or disclose your health information without your permission for health care providers to provide you with treatment.
- Payment: We may use or disclose your health information without your permission to carry out activities relating to reimbursing you for the provision of health care, obtaining premiums, determining coverage, and providing benefits under the policy of insurance that you are purchasing. Such functions may include reviewing health care services with respect to medical necessity, coverage under the policy, appropriateness of care, or justification of charges.
- To Carry Out Certain Operations Relating to Your Benefit Plan: We also may use or disclose your protected health information without your permission to carry out certain limited activities relating to your health insurance benefits, including reviewing the competence or qualifications of health care professionals, placing contracts for stop-loss insurance and conducting quality assessment activities.
- To Plan Sponsor: Your protected health information may be disclosed to the plan sponsor as necessary for the administration of this health benefit plan pursuant to the restrictions imposed on plan sponsors in the plan documents. These restrictions prevent the misuse of your information for other purposes.
- Health-Related Benefits and Services: We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your protected health information for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing health plan coverage, and about health-related products and services that may add value to your existing health plan.
- Individuals Involved in Your Care or Payment for Your Care: Unless you object, we may disclose your protected health information to your family or friends or any other individual identified by you when they are involved in your care or the payment for your care. We will only disclose the protected health information directly relevant to their involvement in your care or payment. We may also disclose your protected health information to notify a person responsible for your care (or to identify such person) of your location,general condition or death.
- Business Associates: There may be some services provided in our organization through contracts with Business Associates. An example might include a copy service we use when making copies of your health record. When these services are contracted, we may disclose some or all of your health information to our Business Associate so that they can perform the job we have asked them to do. To protect your health information, however, we require the Business Associate to appropriately safeguard your information.
- Limited Data Sets: We may use or disclose, under certain circumstances, limited amounts of your protected health information that is contained in limited data sets. These circumstances include public health, research, and health care operations purposes.
- Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- Worker's Compensation: We may release protected health information about you for programs that provide benefits for work related injuries or illness.
- Communicable Diseases: We may disclose protected health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Health Oversight Activities: We may disclose protected health information to federal or state agencies that oversee our activities.
- Law Enforcement: We may disclose protected health information as required by law or in response to a valid judge ordered subpoena. For example in cases of victims of abuse or domestic violence; to identify or locate a suspect, fugitive, material witness, or missing person; related to judicial or administrative proceedings; or related to other law enforcement purposes.
- Military and Veterans: If you are a member of the armed forces, we may release protected health information about you as required by military command authorities.
- Lawsuits and Disputes: We may disclose protected health information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process.
- Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official. An inmate does not have the right to the Notice of Privacy Practices.
- Abuse or Neglect: We may disclose protected health information to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- Coroners, Medical Examiners, and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release protected health information about patients to funeral directors as necessary to carry out their duties.
- Public Health Risks: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose such as controlling disease, injury or disability.
- Serious Threats: As permitted by applicable law and standards of ethical conduct, we may use and disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person orthe public.
- Food and Drug Administration (FDA): As required by law, we may disclose tothe FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

For Purposes For Which We Have Obtained Your Written Permission: All other uses or disclosures of your protected health information will be made only with your written permission, and any permission that you give us may be revoked by you at any time

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions about this notice or would like additional information, you may contact our HIPAA Privacy Officer at the telephone or address below. If you believe that your privacy rights have been violated, you have the right to file a complaint with the Privacy Officer or with the Secretary of the Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints. The contact information for both is included below:

U.S. Department of Health and Human Services
Office of the Secretary
200 Independence Avenue, S.W.
Washington, D.C. 20201
Phone: 202-619-0257
Toll Free: 1-877-696-6775

NueHealth, LLC
Lisa Thacker
11250 Tomahawk Creek Parkway
Leawood, KS 66211
compliance@valuehealth.com
1-866-215-4363

HEALTHCARE REFORM – HEALTH INSURANCE MARKETPLACE

The Affordable Care Act (ACA) or healthcare reform requires you to have minimum essential health care coverage. If you do not have minimum essential healthcare coverage you may be subject to tax penalties. There are various sources through which you may get health coverage; your employer, Medicare, Medicaid or other similar government programs if you qualify; and the Health Insurance Marketplace (also known as healthcare exchanges). NueHealth continues to offer group health coverage to you as a benefit eligible employee. It is important for you to understand that the coverage offered under the NueHealth health plan does meet the federal criteriafor minimum value. Therefore, you will not qualify for the premium subsidy assistance within the insurance marketplace plans if you are eligible for a NueHealth Health Plan AND the required premium for employee-only coverage under the lowest cost health plan option does not exceed 9.12% (in 2023) of your household income.

The 2023 open enrollment period for health insurance coverage through the Marketplace runs from November 1, 2022, through January 15, 2023. Individuals must enroll or change plans prior to December 15, 2022, for coverage starting as early as January 1, 2023. After January 15, 2023, you can get coverage through the Marketplace for 2023 only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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 NueHealth benefits 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.

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.

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

US Department of Health & Human Services
Centers for Medicare Medicaid Services
www.cms.hh.gov
(877) 267-2323 Menu Option 4, Ext 6156

The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility.

ALABAMA – MEDICAID	FLORIDA – MEDICAID
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ALASKA – MEDICAID	**GEORGIA – MEDICAID**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2
ARKANSAS – MEDICAID	**INDIANA – MEDICAID**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
CALIFORNIA – Medicaid	**IOWA – MEDICAID and CHIP (Hawki)**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)	**NEW HAMPSHIRE – MEDICAID**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Website: https://www.dhhs.nh.gov/ombp/hhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KANSAS – MEDICAID	**NEW JERSEY – MEDICAID AND CHIP**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
KENTUCKY – MEDICAID	**NEW YORK – MEDICAID**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
LOUISIANA – MEDICAID	**NORTH CAROLINA – MEDICAID**
MISSOURI – MEDICAID	**PENNSYLVANIA – MEDICAID**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/ HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
MONTANA – MEDICAID	**RHODE ISLAND – MEDICAID**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/ HIPP Phone: 1-800-694-3084	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEBRASKA – MEDICAID	**SOUTH CAROLINA – MEDICAID**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEVADA – MEDICAID	**WASHINGTON – MEDICAID**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/ program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
SOUTH DAKOTA – MEDICAID	**WEST VIRGINIA – MEDICAID**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
TEXAS – MEDICAID	**VIRGINIA – MEDICAID AND CHIP**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Medicaid Website: http://www.coverva.org/programs_ premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_ assistance.cfm CHIP Phone: 1-855-242-8282
UTAH – MEDICAID AND CHIP	**WISCONSIN – MEDICAID AND CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– MEDICAID	**WYOMING – MEDICAID**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewardsfor participating in a wellness program are available to employees depending on facility. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 877-224-7117 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NEWBORN ACT DISCLOSURE

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

SUMMARY ANNUAL REPORT – GROUP INSURANCE PLAN OF VALUEHEALTH HEALTH AND WELFARE BENEFITS PLAN

This information summarizes the Form 5500 which is filed on an annual basis for each plan. If you are interested in receiving a copy of the full 5500 filing, please follow the instructions on the appropriate plan summary.

This is a summary of the annual report of the Group Insurance Plan of ValueHealth Health and Welfare Benefits Plan (Employer Identification Number 27-3585094, Plan Number 501), for the plan year 01/01/2021 through 12/31/2021. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

NueHealth has committed itself to pay certain medical and dental claims incurred under the terms of the plan.

Insurance Information

The plan has insurance contracts with MetLife to pay certain life, accidental death & dismemberment, vision, temporary disability, and long - term disability claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2021 were $2,932,414.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- Insurance information, including sales commissions paid by insurancecarriers.

To obtain a copy of the full annual report, or any part thereof, write or call the plan administrator, at 11250 Tomahawk Creek Parkway, Leawood, KS 66211 and phone number, (888) 887-2619.

You also have the legally protected right to examine the annual report at the main office of the plan: 11250 Tomahawk Creek Parkway, Leawood, KS 66211, and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is notrequired to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

NOTICE OF SPECIAL ENROLLMENT RIGHTS UNDER THE HEALTHINSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

If you are declining medical coverage under the Plan for yourself or your dependents (including your spouse) because of other medical insurance or group medical plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31days after your or your dependents' other medical coverage ends (or after the employer stops contributing towards the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in the Plan's medical coverage. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

In addition, you may be able to enroll yourself and your dependents in the Plan's medical coverage (1) if your or your dependent's coverage under a Medicaid plan or a State Children's Health Insurance Program ("CHIP") plan terminates due to loss of eligibility for such coverage, or (2) if you or your dependents become eligible for premium assistance with respect to the Plan's medical coverage under a Medicaid plan or a CHIP plan. However, you must request enrollment within 60 days after the date of termination of suchcoverage or the date you or your dependent is determined to be eligible for such assistance, whichever is applicable.

To request special enrollment or obtain more information, contact the Benefits department at benefits@nuehealth.com. If you are already enrolled in medical coverage for yourself, you may change your own medical coverage election in connection with enrolling a dependent child or spouse under the above special rules.

PATIENT PROTECTION DISCLOSURES

Certain medical options under the Plan may require the designation of a primary care provider. If a medical option requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the applicable network and who is available to accept you or your eligible dependent. For information on how to select a primary care provider, and for a list of the participating primary care providers, please review the medical option's summary plan description or contact the enrollment administrator. For children, you may designate a pediatrician as the primary care provider.

If you are enrolled in the Plan, you do not need prior authorization in orderto obtain access to obstetrical or gynecological care from a health care professional in the applicable network and who specializes in obstetrics or gynecology. The health care professional, however, may be required to complywith certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, review the medical option's summary plan description or contact the enrollment administrator.

NON-DISCRIMINATION STATEMENT AND FOREIGN LANGUAGE ACCESS

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or when we provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice **(TDD 711)**.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing **contact@hcrcompliance.com** or by calling our Compliance area at **800-832-9686** or the U.S. Department of Health and Human Services, Office for Civil Rights at **800-368-1019** or **800-537-7697 (TDD)**.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' ídíł kidgo, nihá'áhóót'i' nihí ká'a'doo wołgo kwii ha'át'íshíį́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)

NOTES

NOTES

We're glad to have you as a member of Blue Cross and Blue Shield of Kansas City. What did you think of this open enrollment guide? Please take a moment to scan this QR code and give us some feedback.

Kansas City

OE-KC-7-2022