nuehealth

Employee **Benefits Guide**

2025 ENROLLMENT

Welcome to Open Enrollment 2025

Greetings,

Welcome to the new plan year! We are excited to have you as a valued member of our benefits plan for 2025. Your well-being and that of your family is our top priority, and we are committed to providing you with the resources and support you need to make the most of your benefits.

As we embark on this new year together, we encourage you to take a moment to review your benefit options carefully. Thoughtful elections can greatly impact your health and financial security, so we urge you to consider your individual and family needs as you make your selections. Remember, your choices shape your experience and can help us all thrive together.

At NueHealth, we believe in partnership. We understand that it takes all of us working together to create a supportive environment that fosters health, wellness, and satisfaction. Each of us has a responsibility to contribute to a successful year, and we are here to support you every step of the way.

Let's make 2025 the best year ever! If you have questions or need assistance, please don't hesitate to reach out to our benefits team at BenefitsSupport@nuehealth.com. We are here to help you navigate your options and ensure you have a rewarding experience.

Thank you for being an essential part of our community. We look forward to a fantastic year ahead.

Your NueHealth 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 the NueHealth benefits website at nuehealthbenefits.com.

REDUCING YOUR HEALTHCARE EXPENSE

NueHealth encourages all participants to take an active role in their healthcare. How? By learning about treatment options, the total cost of the medication and doing all we can to prevent health problems in the first place.

Below are programs that are designed to help participants save money while providing tools and resources that help maintain good health.

1. ACCESS CARE THROUGH PREFERRED FACILITIES

Members may qualify for a richer benefit when seeking services through preferred in-network facilities for outpatient surgery procedures. Utilize the Provider Finder at www.MyHealthToolkitKC.com to locate the preferred facilities below.

- Tier 1: NueHealth ASCs– Deductible Only (Plan pays 100% of coinsurance)
- Tier 2: Blue Centers of Distinction – Deductible + 10% Coinsurance (Plan pays 90% of coinsurance)
- Tier 3: All other In-Network Surgery Facilities – Deductible + 20% Coinsurance (Plan pays 80% of coinsurance)

2. ENROLL IN A COACHING PROGRAM THROUGH BCBS MY HEALTH NOVEL OR VIRTA

The programs connect participants with a specially trained coach to give guidance, support and education. The coach will work collaboratively with members to promote medical and pharmacy management through virtual coaching sessions, mobile apps, and other resources to help set goals and stay on track.

***As a reward for participating in one of the coaching programs mentioned below, members taking qualified maintenance medications will benefit from reduced copays for medications and supplies related to their condition**.

My Health Novel– Sign up for BCBS My Health Novel at www.MyHealthToolkitKC.com and access health coaching, nutrition guidance, digital tools, group support and more to keep you on track. Through My Health Novel, members can access support for conditions related to weight management, healthy bones and joints, behavioral health, and women's health.

CareCore+ - Sign up for CareCore+ by calling 1-855-838-5897, select option 2, to access a personal health coach who can help create a personalized, member-centered plan to manage weight, prevent and manage stress, quit tobacco products and prevent and manage back pain.

Virta - Sign up for Virta at https://apply.virtahealth.com/bi/get-started to access research-backed treatment that can help reverse type 2 diabetes, prediabetes and lose weight.

3. CHOOSE GENERIC MEDICATIONS WHEN AVAILABLE

Generic medications are cheaper than their branded counterparts. It is estimated that you could save at least 2/3 of your prescription costs if you elect to use generic medications.

4. PARTICIPATE IN THE VITALITY WELLNESS PROGRAM

Receive quarterly financial rewards by earning points while completing wellness activities and challenges on your way to a healthy lifestyle. Rewards include gift cards, shopping trips to the Vitality Mall and financial incentives up to $1,000.

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2025 Open Enrollment October 28th – November 8th

Employees **MUST** complete their enrollment between 10/28 – 11/8. This is your chance to make changes for the plan year starting 1-1-25. If you do not complete your enrollment by 12 midnight CT on the last day of open enrollment, your medical and flex benefits will **NOT** carry forward for the new plan year.

BenManage Benefits Counselors are available
Monday-Friday 8am - 7pm CT
(314) 442-0058

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

If you have 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 2025.

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 30 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 30 days of the event. In the case of birth, coverage will be retro to the date of the birth as long as the baby is added to the plan within the 30-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 Self-Service Portal 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 save 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	Blue Cross and Blue Shield	1.800.Teladoc	www.MyHealthToolkitKC.com
MyHealthNovel CareCore+ (Care Management)	Blue Cross and Blue Shield	800.288.2227 855.838.5897	www.MyHealthToolkitKC.com
Flexible Spending & Dependent Care Accounts	NueSynergy	855.890.7239	https://nuesynergy.wealthcareportal.com/Authentication/Handshake
Spouse HRA			
Health Savings Account (HSA)	UMB	866.520.4472	HSA.UMB.com
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/12896
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	Empower	866.467.7756	https://participant.empower-retirement.com/participant/#/login

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.

MEET US ON MY HEALTH TOOLKIT

Whether you join us from your smartphone or on your computer, Blue Cross and Blue Shield of Kansas City looks forward to meeting you on My Health Toolkit.

Registration is easy.
All you need to get started with My Health Toolkit is the member ID located on your insurance card or subscribing member's Social Security number and your date of birth. If you share a health plan with family members ages 16 and over, they can register for individual accounts, too.

Enjoy the security and convenience of facial recognition.
We never forget a face. If you are accessing My Health Toolkit on your smartphone, make sure to enable facial recognition to make logging in safe, quick and easy.

Download the My Health Toolkit app from your app store or register at www.MyHealthToolkitKC.com.

Download on the App Store | GET IT ON Google Play

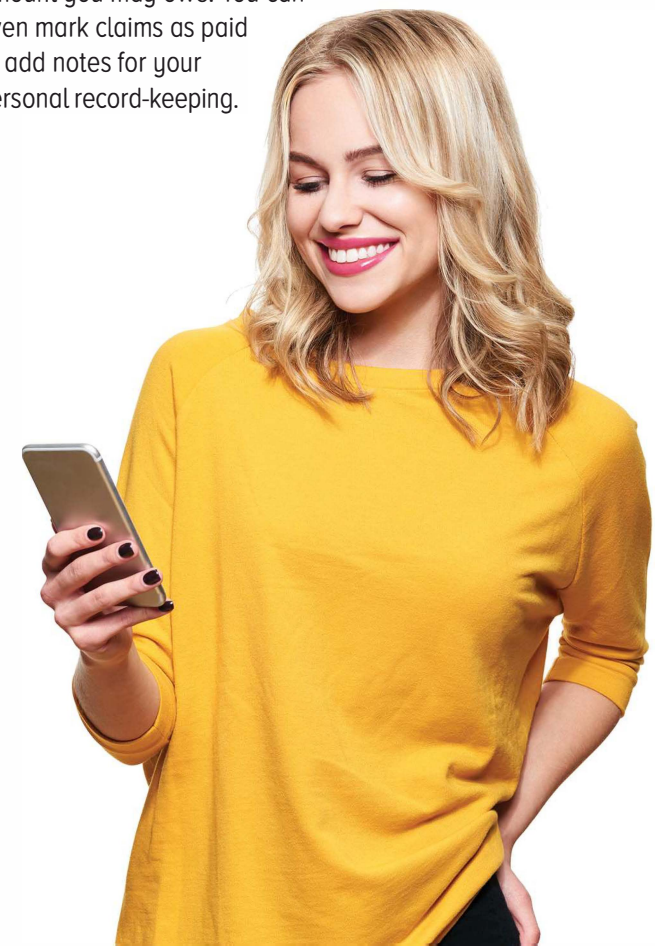
Access your digital ID card.
There's no need to dig through your wallet. We keep a digital copy of your ID card at the ready so you can access it whenever and wherever you need it. You can also order a replacement card if you misplace yours.

Manage your contact preferences.
Choose how you want to hear from us. Whether it's by text, mail or email, you can select how you want to receive important health information.

Learn more about your coverage.
We want to make sure you are up to speed on all the features of your plan. Meet us on My Health Toolkit to look up your medical coverage, deductible and out-of-pocket spending.

Shop for care.
Let us introduce you to our crew. Using the Find Care link, you can view a list of network doctors and medical facilities in your area. Make sure you check out features like patient reviews, provider quality information and a list of doctors who are accepting new patients.

Check the status of your claims.
All of your details are at your fingertips. You can view the status of a current or previous medical claim, the dates of services, the amount charged by your provider and the amount you may owe. You can even mark claims as paid or add notes for your personal record-keeping.



Kansas City

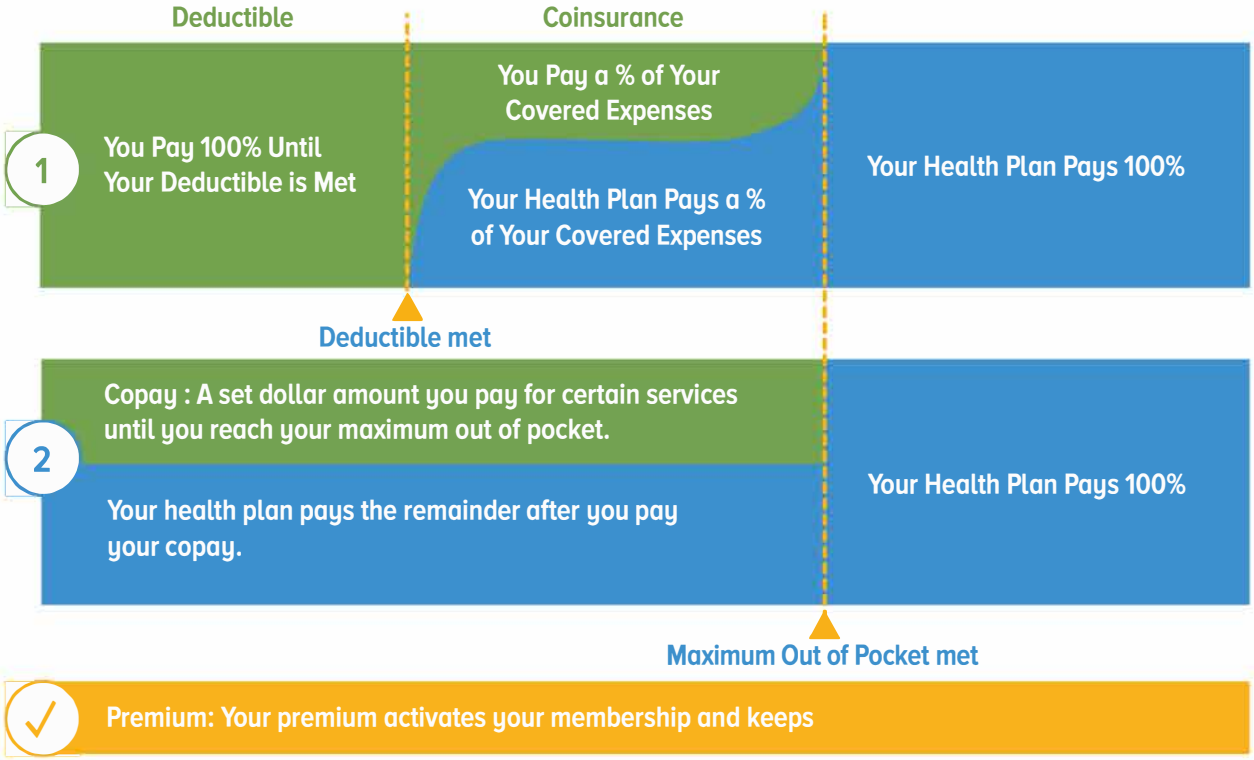
KC-EE-1417-3-2022

HOW YOU AND YOUR PLAN SHARE HEALTH CARE COSTS

Health insurance helps cover the cost of your medical expenses.

How your annual insurance benefits work: what you can expect to pay

Each service you receive gets paid through path 1 or path 2.



Terms you need to know

Your **deductible** is the set total amount you pay for medical services before your coinsurance kicks in. For example, you would meet your $1,000 deductible after your payments for covered medical services add up to $1,000. For most health plans, your copay does not count toward your deductible.

Coinsurance is the percentage of medical costs you pay after you've met your deductible. For example, you might pay 20 percent once you've met your deductible. Your health plan would pay 80 percent.

A **copay**, or copayment, is a set rate you pay for doctor visits, prescriptions and some other types of care. For example, you might pay $20 for an in-network doctor visit and $15 for a prescription.

Your **maximum out-of-pocket amount** is the most you have to pay for covered services in one plan year. For example, let's say your maximum out-of-pocket amount is $4,000. Once your in-network payments for deductibles, copays and coinsurance add up to $4,000, your health plan then will pay 100 percent of the costs for covered services for the rest of that benefit year.

For more terms you'll see and hear in health insurance and health care, please see the Helpful Terms page near the end of this benefits guide.

To find your deductible, coinsurance, copay and maximum out-of-pocket amounts, review your summary of benefits or log in to **My Health Toolkit®**.

Compare medical plans

The chart below provides a comparison of key coverage features of our 2025 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.

	PPO Plan		Base Plan* HDHP/HSA		Buy-Down Plan** HDHP/HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible						
Individual	$2,000	$4,000	$2,000	$4,000	$3,000	$6,000
Family	$4,000	$8,000	$4,000	$8,000	$6,000	$12,000
Out-of-pocket maximum						
Individual	$9,200	$18,400	$6,500	$13,000	$6,500	$13,000
Family	$18,400	$36,800	$12,000	$24,000	$12,000	$24,000
Medical coverage						
PCP office visits	$30 Copay	Ded. + 40%	Ded. + 20%	Ded. + 50%	Ded. + 20%	Ded. + 50%
Specialist office visits	$60 Copay	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

HDHP Deductibles

* Base Plan: Employee Only Enrollment: $2,000 deductible / Emp+Dependent(s) Enrollment: $4,000 combined family

** Buy-Down Plan: Employee Only Enrollment: $3,000 deductible / Emp+Dependent(s) Enrollment: $3,300 per individual / $6,000 family max

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 2024.
- 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.**

UMB Healthcare Services

Quick Guide to HSAs

You own it!

The money in your HSA is always yours, even if you:

- ✓ change jobs
- ✓ switch health plans
- ✓ become unemployed
- ✓ retire

Your unused balance rolls over from year to year so you never lose the money.

Pay for the unexpected...

HSAs not only cover planned out-of-pocket costs but allow you to be better prepared financially when an unexpected injury or illness comes along.

HSA funds can be used for a variety of medical, dental, vision expenses and more.

See list of eligible expenses.

Ways to Save on Taxes[1]

1. **Tax-free deposits**[1] Money contributed to your HSA is not taxed.
2. **Tax-free earnings** Interest and any investment earnings grow tax-free.
3. **Tax-free withdrawals** for qualified medical expenses.

How it works

To make HSA contributions you must:

- Be covered by an HSA Qualified High Deductible Health Plan (QHDHP)
- Not be enrolled in Medicare (any part)
- Not be claimed as a tax dependent on someone else's taxes
- Have no other non-permissible coverage

HSA Contributions

PLAN TYPE	2024	2025
Individual	$4,150	$4,300
Family	$8,300	$8,550

If you are age 55 or older, you may contribute an additional $1,000.

Invest[2] for the future

Learn more about UMB HSA investments[2].

HSAs can be used similar to traditional retirement accounts, allowing you to invest money in mutual funds,[2] like a 401(k) or traditional IRA.

You can invest in your HSA when:

Deposit balance = $1,000 + purchased investment amount for fund(s)

FOR MORE INFORMATION:
UMB.com/HSA
866.520.4HSA (4472)

[1] All mention of taxes is made in reference to federal tax law. States can choose to follow the federal tax-treatment guidelines for HSAs or establish their own; some states tax HSA contributions. Please check with each state's tax laws to determine the tax treatment of HSA contributions or consult your tax adviser. Neither UMB Bank, n.a., nor its parent, subsidiaries, or affiliates are engaged in rendering tax or legal advice. Withdrawals for non-qualified expenses are subject to income taxes and a possible additional 20% penalty (penalty not applicable if you are over age 65).

[2] INVESTMENTS IN SECURITIES THROUGH AN HSA INVESTMENT ACCOUNT ARE: NOT FDIC-INSURED · MAY LOSE VALUE · NO BANK GUARANTEE

Funds in an HSA Deposit Account are held at UMB Bank, n.a., Member FDIC.

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 $3,200*, or $6,400* if you are married and filing separate tax returns.

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 2025, 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, 2025, and file your claims by March 31, 2025, 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 2025 plan year limits may not have been available when this guide was created.*

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.

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.

** 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).
    - Guarantee Issue: $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).
    - Guarantee Issue: $50,000
- **Child supplemental life –** $10,000
    - Guarantee Issue: full amount

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 https://participant.empower-retirement.com/ 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.

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

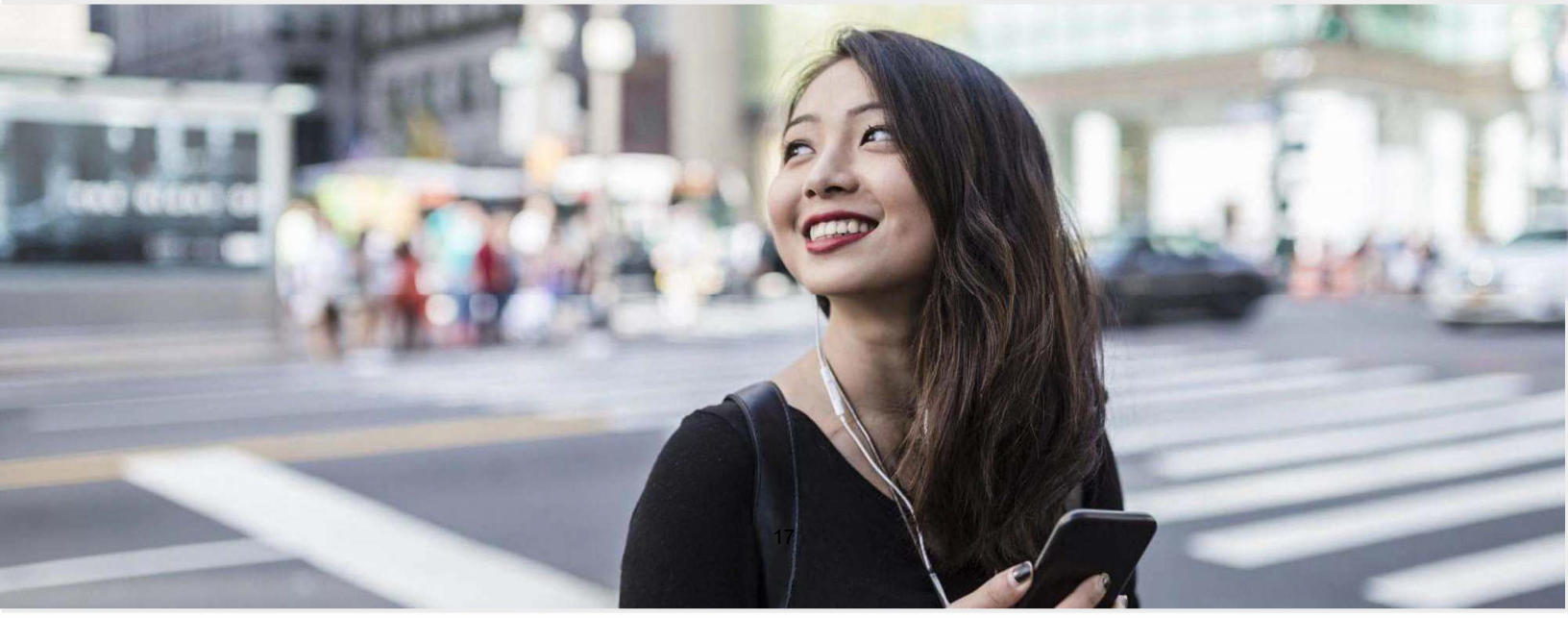
You can receive exclusive employee-only rates on your home and auto insurance coverage. Through the program with Farmers, you can apply to insure your auto, home, and other property against loss, and yourself against personal liability.

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	

Trustmark Life + Care® Insurance

Take charge of your tomorrow.

Open Enrollment dates are October 28,2024 - November 8, 2024

If ever there's a time you **can't care for yourself**, things may get difficult – and expensive. Finding caregiving can be a challenge, and care can cost **hundreds of dollars a day**.

It can happen at any age, to anyone: something goes wrong and you start needing **help with the basics of everyday life**, like eating, dressing or going to the bathroom. When that happens, Trustmark Life + Care® pays **cash benefits** that can help you afford the comfort and quality of care that you deserve. Plus, it **doubles as life insurance**, with a death benefit payable to those who rely on you.

Why Trustmark Life + Care?

1. Two-in-one coverage: get both **permanent life insurance** (death benefit) **and care benefits** for one affordable rate.
2. **Benefits can help with the cost of care** when the time comes, so you can avoid depleting your retirement savings or overburdening family members.
3. Care benefits are paid to you when you receive caregiving services **from either a professional or a family member**.
4. Coverage is available to you on a **guaranteed issue** basis – **no medical questions** asked, and you can't be turned down – up to benefit amount limits.[1]
5. Guaranteed to last a lifetime: once you have coverage, your rate **doesn't increase as you get older**.

nuehealth

Trustmark
benefits beyond benefits

How Care Benefits Work

Trustmark Life + Care pays benefits in cash, directly to you, when you **require help with at least two of six activities of daily living** (for example, eating, bathing or dressing) or have a **severe cognitive impairment** (such as Alzheimer's Disease) and receive caregiving services for more than 90 days.[2]

When you receive professional caregiving services, you can collect **4% of your benefit amount per month**, up to two times the face amount of your certificate. (Or you may elect a one-time lump sum of 20% of your face amount.)

Professional Caregiving benefits example for a $100,000 certificate:

$4,000 per month up to a **$200,000** maximum

Plus, with your Family Caregiving benefit, you can get benefits **when care is provided by a family member or friend** rather than by a professional! For family caregiving, collect **2% of your benefit per month**, up to two times the face amount of your certificate. (Or you may elect a one-time lump sum of 10% of your face amount.)

Family Caregiving benefits example for a $100,000 certificate:

$2,000 per month up to a **$200,000** maximum

You can even **switch between family caregiving and professional caregiving** and keep collecting benefits, up to the maximum of twice your certificate's face amount.

Plus, care benefits paid **do not reduce the death benefit**, so a full death benefit is available to your beneficiaries even after you receive care benefits! This can dramatically increase the maximum value of your coverage:

Benefit type	Maximum Amount ($100,000 certificate)
Care benefits	$200,000
Death benefit	+ $100,000
Total maximum benefit	**= $300,000**

Note: because your condition **does not have to be permanent** to receive benefits, the money you receive can help you recover your independence.

Additional Plan Features

Guaranteed Issue – Apply for yourself with **no medical questions asked**, no exams, and no evidence of insurability required. You **can't be turned down** for coverage! (Applies up to benefit amount limits.)[1]

Spouse Coverage – Apply for **Trustmark Life + Care coverage for your spouse** (or domestic partner/civil union partner) as well as for yourself. Your spouse's plan will include the same features as yours. (Spouse coverage amount is capped at a portion of employee amount.)

Interim Coverage – Your Life + Care coverage **begins as soon as you apply**, as long as you meet eligibility requirements.

Terminal Illness Benefit – **Advance up to 50%** of your death benefit if you're diagnosed with having less than 24 months to live.

Options to Convert – After you have had coverage for at least 10 years, you may elect to **pay no additional premiums** and **convert your plan** into either Extended Term or Reduced Paid-Up life insurance (death benefit only). Details will depend on your plan, age, benefit amount and how long you have had coverage.

Portability – Keep your coverage at the same rate and benefits if you change jobs or retire.

You can manage your coverage or easily file online claims 24/7 at TrustmarkVB.com!

Scan the QR Code to schedule your appointment today!
Or call (833) 996-3280

Note: if you have previously elected Trustmark life insurance coverage, your existing policy may differ from what is described here.

This is a brief description of the benefits under forms GTL 121 C MET, GTL 121 C ERG and applicable riders CTR 121 and STR.121. ***This is a life insurance benefit that also gives you the option to accelerate some of the death benefit in the event that you meet the criteria for a qualifying event in the certificate. This certificate does not provide long-term care insurance and is not subject to long-term care insurance law. This certificate is also not a long-term care partnership policy or a Medicare supplement certificate. The accelerated death benefit will terminate with the certificate.*** *Benefits provided by this certificate are designed with the intent to qualify for favorable tax treatment under Section 101(g) of the Internal Revenue Code. Unlike the benefits provided by traditional or stand-alone long-term care insurance, the benefits provided by this certificate do not include coverage for the reimbursement of long-term care services. A maximum issue age applies to certain benefits; coverage issued at age 69 or later may differ from what is described here. Limitations on pre-existing conditions may apply. Benefits, definitions, exclusions and limitations and form numbers may vary by state. Please consult your certificate for complete information. For costs, coverage details and terms, see your agent or write the company. Underwriting conditions may vary, and determine eligibility for the offer of insurance. Trustmark® is a registered trademark of Trustmark Insurance Company. Trustmark Life + Care® is a trademark of Trustmark Insurance Company.*

[1]Maximum issue age for guaranteed issue is 70. Employees who have previously been offered this coverage may not be eligible for guaranteed issue. Refer to the sample-rate sheet or speak to an enroller for details. [2]Care benefits are payable after 90 days of qualifying care has been received; to qualify you must meet the conditions for payment.

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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 the 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 "TELUS Health" 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 TELUS Health — 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 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 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 one.telushealth.com, user name: metlifeeap and password: eap

MetLife

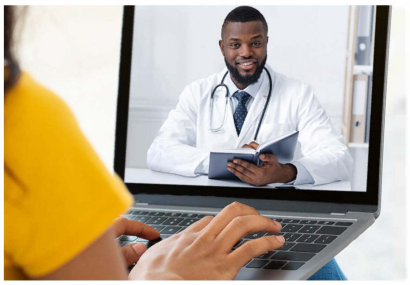
Navigating life together

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? Or you've been advised to stay home as much as possible?

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

Teladoc™



A Teladoc virtual visit is a great option if your doctor's office or urgent care center is closed, you're traveling, or you're not up to driving.

With a virtual visit, you can:

- Use your computer or mobile device.
- See a doctor who can diagnose your symptoms.
- Get a prescription if needed.

Use Teladoc for nonemergency health issues, such as:

- Cold and flu symptoms, including fever, coughing and sore throat.
- Sinus or respiratory infections.
- Urinary tract infections.
- Seasonal allergies.
- Pinkeye.
- Migraine.
- Rashes, insect bites, sunburn or other skin irritations.

Doctor's Office

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

- Annual checkups and physicals.
- Health screenings and immunizations.
- Prescription refills.

Your regular doctor can also help with unexpected health issues that can wait a day or so. These might include:

- 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.
- Migraine.
- Rashes, insect bites, sunburn or other skin irritations.

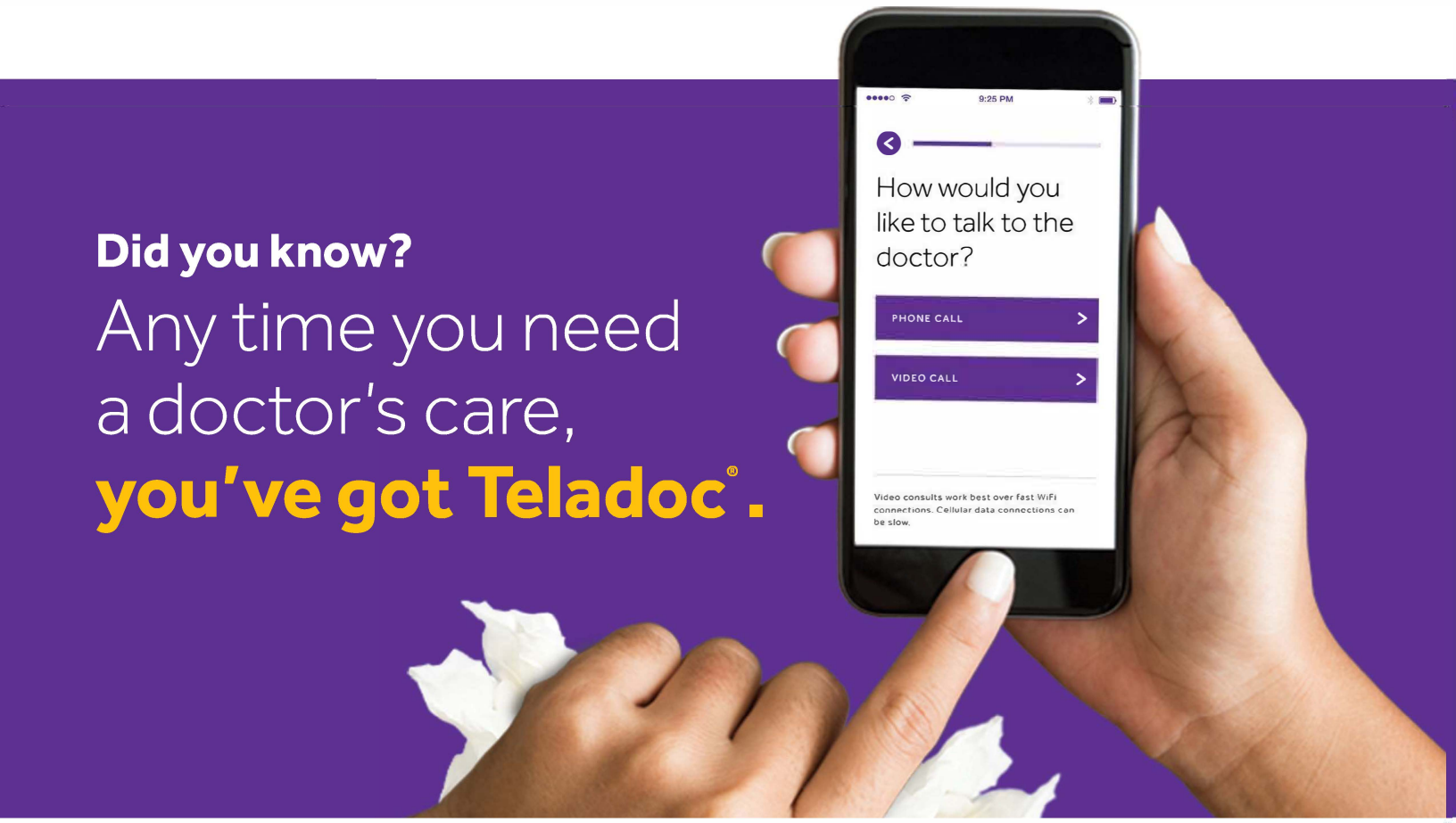
Emergency Room

Go to the emergency room or call 911 for potentially life-threatening conditions, such as:

- Heavy, uncontrolled bleeding.
- Signs of a heart attack, like chest pain that lasts more than two minutes.
- Signs of a stroke, such as numbness or 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.

Kansas City

TELADOC®



Did you know?

Any time you need a doctor's care, you've got Teladoc®.

24/7/365 care for:
Cold & flu, allergies, rash and much more!

Licensed doctors
U.S. board-certified doctors average 20 years of experience

In minutes
Connect with a doctor by phone or video

Get a diagnosis
Our doctors recommend treatment and prescribe medication (when medically necessary)

Register for Teladoc now!

Visit My Health Toolkit® to complete your Teladoc registration.

1. Visit www.MyHealthToolkitKC.com and log in.

2. Under the Resources tab, select Teladoc. This will take you to the Teladoc site.

3. Your insurance information will appear so you can easily complete your registration.

Available on the iPhone App Store

ANDROID APP ON Google Play

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KC-EE-1343-12-2019

MY HEALTH NOVEL℠

The Next Chapter in Health Solutions

Everyone's life story has some plot twists — and when it comes to your health, you have a lot to say about how the story develops.

If you're basically healthy, you can put in some effort to stay that way. If you need to make changes, you can do that, too.

That's the simple idea behind **My Health Novel**, a free program offered by your health plan. Using innovative mobile apps and other tools and resources, you can set your own goals to stay on track.

You'll also save on medical costs when you take steps to reduce your risks!

How it works:

1. Log in to **My Health Toolkit®**.
2. Select **Wellness & Care Management**, **Wellness Programs**, then **My Health Novel**.
3. Take a one-minute assessment.
4. You'll get details about your recommended program and resources available to you.

Get healthy and stay healthy with My Health Novel.

When Weight Management Is Part of Your Story

MY HEALTH NOVEL℠

The weight management chapter of My Health Novel is designed to match you with helpful resources and tools based on your specific health needs.

It lets you access health management mobile apps at no cost to you.

When you qualify and sign up, you'll get access to health coaching, nutrition guidance, digital tools, group support and more to keep you on track.

How it works:

1. Log in to **My Health Toolkit®**.
2. Select **Wellness & Care Management**, **Wellness Programs**, then **My Health Novel**.
3. Take a quick, one-minute assessment.
4. You'll receive your recommended programs and resources available to you.

Find support to help you reach and stay at a healthy weight!

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

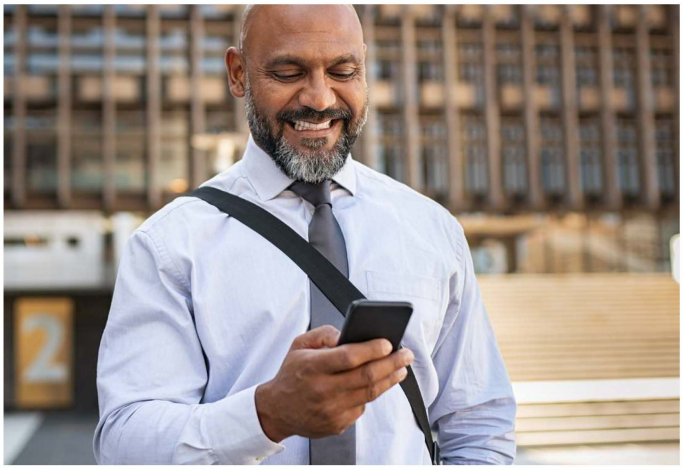
- Attention-deficit hyperactivity disorder (adults)
- Asthma (adults and children)
- Bipolar disorder
- Heart disease and heart failure
- Chronic obstructive pulmonary disease
- Depression
- Diabetes (adults and children)
- High blood pressure and high cholesterol
- Metabolic health (metabolic syndrome 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℠** 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**.

virta

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

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

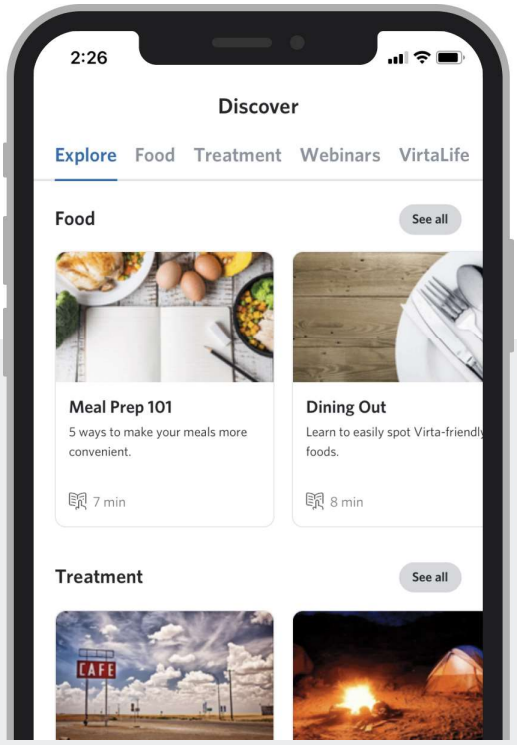
63% medication reduction | **1.3pt** HbA1c reduction | **12%** weight loss

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

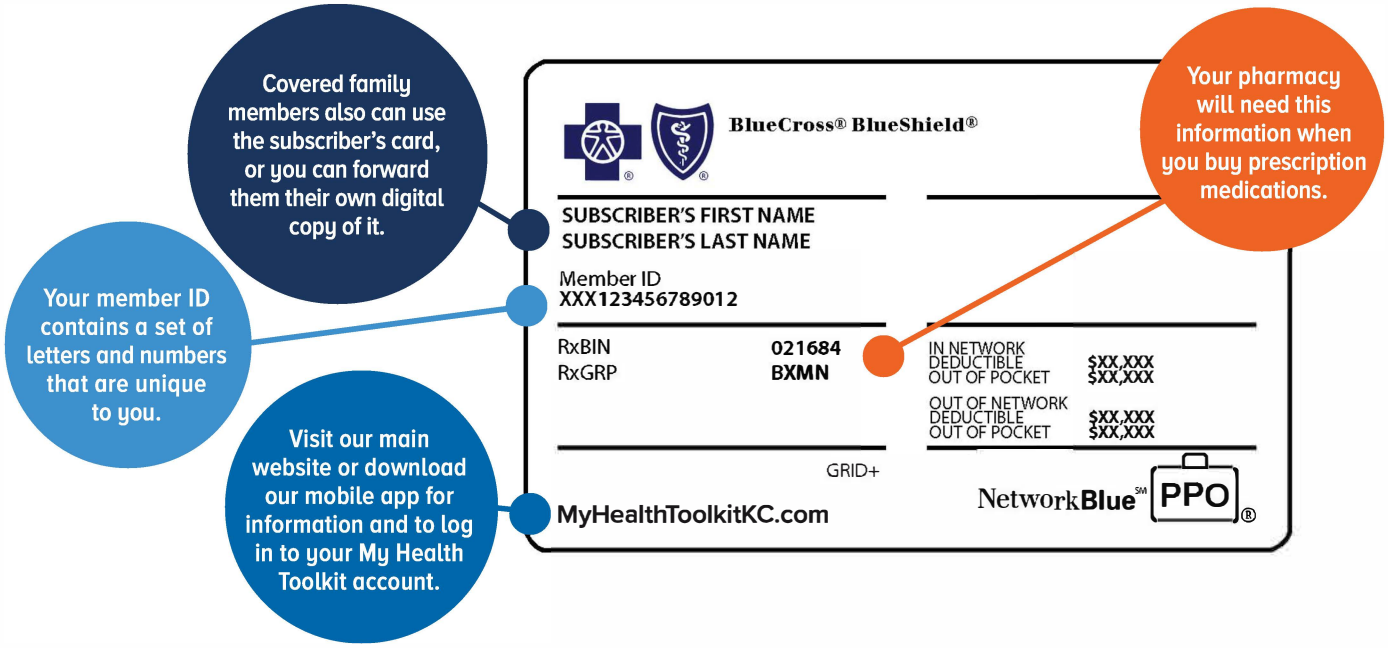
Text "ENROLL" to 57005 to receive periodic alerts about better health through Virta.

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.

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.

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.

nuehealth

Special Notices

Please note that there are important notices for your review that are list on UKC 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

About This Guide

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual Summary Plan Descriptions (SPDs), plan document, and/or certificate of coverage for each plan. Your SPDs can be obtained at **www.nuehealthbenefits.com**; you may also request a copy free of charge by emailing benefitssupport@nuehealth.com.

Enclosed are important notices about your rights under your health and welfare plan (NueHealth Health & Welfare Benefits Plan), the "Plan". The information in the accompanying guide provides updates to your existing SPDs as of 01/01/2025 and is intended to be a Summary of Material Modification.

If any discrepancy exists between this guide and the official documents, the official documents will prevail. NueHealth reserves the right to right to amend or terminate any of its plans or policies, make changes to the benefits, costs, and other provisions relative to benefits at any time with or without notice, subject to applicable law.

Reminder of Availability of Privacy Notice

This is to remind plan participants and beneficiaries of the NueHealth Health & Welfare Benefits Plan (the "Plan") that the Plan has issued a Health Plan Privacy Notice that describes how the Plan uses and discloses protected health information (PHI). You can obtain a copy of the NueHealth Health & Welfare Benefits Plan Privacy Notice upon your written request to the Human Resources Department, at the following address:

NueHealth, Human Resources
11350 Tomahawk Creek Parkway
Leawood, KS 66211

If you have any questions, please contact the NueHealth Human Resources Office by emailing benefitssupport@nuehealth.com**.**

Patient Protection Notice

NueHealth Health & Welfare Benefits generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

For information on how to select a primary care provider, and for a list of the participating primary care providers, refer to "Find Care" on the Blue Cross Blue Shield website at myhealthtoolkit.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from NueHealth Health & Welfare Benefits Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in-network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, refer to "Find Care" on the Blue Cross Blue Shield website at myhealthtoolkit.com.

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Newborns' and Mothers' Health Protection 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

USERRA

Your right to continued participation in the Plan during leaves of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act (USERRA). Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted, and you will continue to pay the same amount as if you were not absent.

If the absence is for more than 31 days and not more than 24 months, you may continue to maintain your coverage under the Plan by paying up to 102% of the full amount of premiums. You and your dependents may also have the opportunity to elect COBRA coverage. Contact the plan administrator for more information.

Also, if you elect not to continue your health plan coverage during your military service, you have the right to be reinstated in the Plan upon your return to work, generally without any waiting periods or pre-existing condition exclusions, except for service-connected illnesses or injuries, as applicable.

Important Notice from NueHealth About Your Prescription Drug Coverage and Medicare

Medicare Part D Notice of Creditable Coverage

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 coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. NueHealth has determined that the prescription drug coverage offered by the NueHealth Health & Welfare Benefits Plan 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 (or are losing) your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current NueHealth coverage will not be affected.

Your NueHealth coverage pays for other medical expenses in addition to prescription drugs. This coverage provides benefits before Medicare coverage does (i.e., the plan pays primary). You and your covered family members who join a Medicare prescription drug plan will be eligible to continue receiving prescription drug coverage and these other medical benefits. Medicare prescription drug coverage will be secondary for you or the covered family members who join a Medicare prescription drug plan.

If you do decide to join a Medicare drug plan and voluntarily drop your current medical and prescription drug coverage from the plan, be aware that you and your dependents may not be able to get this coverage back until the next annual enrollment or you experience a qualifying life event.

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

You should also know that if you drop or lose your current coverage with 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 join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage:

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

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

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

- Visit **www.medicare.gov**
- Call your State Health Insurance Assistance Program for personalized help. See the inside back cover of your copy of the "Medicare & You" handbook for their telephone number.
- 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.ssa.gov**, or
- Call **1-800-772-1213**. TTY users should call **1-800-325-0778**.

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

required to pay a higher premium (a penalty).

Date: January 1, 2025
Name of Entity/Sender: NueHealth
Contact: Lynnette Morris
Address: 11350 Tomahawk Creek Parkway, Leawood, KS 66211
Email: LMorris@nuehealth.com

Your ERISA Rights

As a participant in the NueHealth benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

ERISA provides that all plan participants shall be entitled to receive information about their plan and benefits, continue group health plan coverage, and enforce their rights. ERISA also requires that plan fiduciaries act in a prudent manner.

Receive Information About Your Plan and Benefits

You are entitled to:

- Examine, without charge, at the plan administrator's office, all plan documents—including pertinent insurance contracts, trust agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the plan's administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary report of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continued Group Health Plan Coverage

You are entitled to:

- Continued health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Summary Plan Description governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the plans. The people who operate your plans are called "fiduciaries," and they have a duty to act prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to:

- Know why this was done;
- Obtain copies of documents relating to the decision without charge; and
- Appeal any denial.

All of these actions must occur within certain time schedules.

Under ERISA, there are steps you can take to enforce your rights. For instance, you may file suit in a federal court if:

- You request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator;
- You have followed all the procedures for filing and appealing a claim (as outlined earlier in this summary) and your claim for benefits is denied or ignored, in whole or in part. You may also file suit in a state court;
- You disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order; or
- The plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if the court finds your claim frivolous.

Assistance With Your Questions

If you have questions about how your plan works, contact the Human Resources Department. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office listed on EBSA's website: **https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/regional-offices**.

Or you may write to the:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at: **1-866-444-3272**. You may also visit the EBSA's website on the Internet at: **https://www.dol.gov/agencies/ebsa**.

General Notice of Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA**

continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end.

For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What Is COBRA Continuation Coverage?

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

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

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

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

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

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

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

When Is COBRA Coverage Available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to NueSynergy, the third-party COBRA Administrator. The contact information is included below:

Name of Entity: NueSynergy/COBRA
Address: 4601 College Blvd
Leawood, KS 66211
Phone: 913-521-2310
Email: COBRA@NueSynergy.com

How Is COBRA Continuation Coverage Provided?

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

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

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

Disability Extension of 18-Month Period of COBRA Continuation Coverage

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

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child.

This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

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

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

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

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

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

NOTE: https://www.medicare.gov/basics/get-started-withmedicare/sign-up/when-does-medicare-coverage-start

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/agencies/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

NueHealth Health & Welfare Benefits
Contact: Lynnette Morris
Address: 11350 Tomahawk Creek Parkway, Leawood, KS 66211
Email: LMorrris@nuehealth.com

Summaries of Benefits and Coverage (SBCs)

Availability Notice

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBC is available on the web at: **www.nuehealthbenefits.com**. A paper copy is also available, free of charge, by emailing benefitssupport@nuehealth.com.

Notice Regarding Wellness Program

Reasonable Alternative Standard Notice for Health Contingent Wellness Programs

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees.

If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us by emailing benefitssupport.com and we will work with you (and, if you wish, with your

doctor) to find a wellness program with the same reward that is right for you in light of your health status.

EEOC Notice Regarding Wellness Program

Vitality is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, will include screenings for body mass index (BMI), blood pressure, fasting glucose, total or LDL cholesterol and A1c levels. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will be eligible for an incentive (value established by the Wellness Committee on an annual basis. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so are eligible to receive the incentive.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by emailing benefitssupport@nuehealth.com.

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

Protections From Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and NueHealth may use aggregate information it collects to design a program based on identified health risks in the workplace, Vitality will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please email benefitssupport@nuehealht.com.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the NueHealth group health plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, divorce, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the qualifying event. To request special enrollment or obtain more information, email benefitssupport@nuehelath.com.

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

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

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

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

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

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

1. ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447
2. ALASKA – 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
3. ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
4. CALIFORNIA – Medicaid Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
5. COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/HIBI Customer Service: 1-855-692-6442
6. FLORIDA – Medicaid Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
7. GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/healthinsurance-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
8. INDIANA – Medicaid Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
9. IOWA – Medicaid and CHIP (Hawki) Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Phone: 1-800-338-8366 Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp HIPP Phone: 1-888-346-9562
10. KANSAS – Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
11. KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
12. LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
13. MAINE – Medicaid Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
14. MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

15. MINNESOTA – Medicaid Website:
    https://mn.gov/dhs/health-care-coverage/
    Phone: 1-800-657-3672
16. MISSOURI – Medicaid Website:
    http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
    Phone: 573-751-2005
17. MONTANA – Medicaid Website:
    http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
    Phone: 1-800-694-3084
    Email: HHSHIPPProgram@mt.gov
18. NEBRASKA – Medicaid Website:
    http://www.ACCESSNebraska.ne.gov
    Phone: 1-855-632-7633
    Lincoln: 402-473-7000
    Omaha: 402-595-1178
19. NEVADA – Medicaid Website:
    http://dhcfp.nv.gov
    Medicaid Phone: 1-800-992-0900
20. NEW HAMPSHIRE – Medicaid Website:
    https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
    Phone: 603-271-5218
    Toll free number for the HIPP program:
    1-800-852-3345, ext. 15218
    Email:
    DHHS.ThirdPartyLiabi@dhhs.nh.gov
21. NEW JERSEY – Medicaid and CHIP
    Medicaid Website:
    http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
    Phone: 1-800-356-1561
    CHIP Premium Assistance Phone:
    609-631-2392
    CHIP Website:
    http://www.njfamilycare.org/index.html
    CHIP Phone: 1-800-701-0710 (TTY: 711)
22. NEW YORK – Medicaid Website:
    https://www.health.ny.gov/health_care/medicaid/
    Phone: 1-800-541-2831
23. NORTH CAROLINA – Medicaid Website:
    https://medicaid.ncdhhs.gov/
    Phone: 919-855-4100
24. NORTH DAKOTA – Medicaid Website:
    https://www.hhs.nd.gov/healthcare
    Phone: 1-844-854-4825
25. OKLAHOMA – Medicaid and CHIP
    Website: http://www.insureoklahoma.org
    Phone: 1-888-365-3742
26. OREGON – Medicaid Website:
    http://healthcare.oregon.gov/Pages/index.aspx
    Phone: 1-800-699-9075
27. PENNSYLVANIA – Medicaid and CHIP
    Website:
    https://www.pa.gov/en/services/dhs/apply-formedicaid-health-insurance-premium-payment-program hipp.html
    Phone: 1-800-692-7462
    CHIP Website:
    https://www.pa.gov/en/agencies/dhs/resources/chip.html
    CHIP Phone: 1-800-986-KIDS (5437)
28. RHODE ISLAND – Medicaid and CHIP
    Website: http://www.eohhs.ri.gov/
    Phone: 1-855-697-4347, or
    401-462-0311 (Direct RIte Share Line)
29. SOUTH CAROLINA – Medicaid Website:
    https://www.scdhhs.gov Phone: 1-888-549-0820
30. SOUTH DAKOTA – Medicaid Website:
    http://dss.sd.gov
    Phone: 1-888-828-0059
31. TEXAS – Medicaid Website:
    https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
    Phone: 1-800-440-0493
32. UTAH – Medicaid and CHIP Medicaid
    Utah's Premium Partnership for Health Insurance (UPP) Website:
    https://medicaid.utah.gov/upp/
    Email: upp@utah.gov
    Phone: 1-888-222-2542
    Adult Expansion Website:
    https://medicaid.utah.gov/expansion/
    Utah Medicaid Buyout Program Website:
    https://medicaid.utah.gov/buyout-program/
    CHIP Website: https://chip.utah.gov/
33. VERMONT – Medicaid Website:
    https://dvha.vermont.gov/members/medicaid/hipp-program
    Phone: 1-800-250-8427
34. VIRGINIA – Medicaid and CHIP Website:
    https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select
    https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
    Medicaid/CHIP Phone:
    1-800-432-5924
35. WASHINGTON – Medicaid Website:
    https://www.hca.wa.gov/
    Phone: 1-800-562-3022
36. WEST VIRGINIA – Medicaid and CHIP
    Website: https://dhhr.wv.gov/bms/
    http://mywvhipp.com/
    Medicaid Phone: 304-558-1700
    CHIP Toll-free phone:
    1-855-MyWVHIPP (1-855-699-8447)
37. WISCONSIN – Medicaid and CHIP
    Website:
    https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
    Phone: 1-800-362-3002
38. WYOMING – Medicaid Website:
    https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
    Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

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

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