2025-2026

New Hire Benefits Guide

Effective August 1, 2025 - July 31, 2026

Caraday Healthcare

C3

TABLE OF CONTENTS

Important Notice
Caraday Healthcare has made every attempt to ensure the accuracy of the information described in this enrollment guide. Any discrepancy between this guide and the insurance contracts or other legal documents that govern the plans of benefits described in this enrollment guide will be resolved according to the insurance contracts and legal documents. Caraday Healthcare reserves the right to amend or discontinue the benefits described in this enrollment guide in the future, as well as change how eligible team members and Caraday Healthcare share plan costs at any time. This enrollment guide creates neither an employment agreement of any kind nor a guarantee of continued employment with Caraday Healthcare.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 31 for more details.

The Caraday Way

From the moment anyone – residents, families, or team members – walk through the doors of a Caraday Healthcare community, there is a noticeable and distinct difference.

Our vision in everything we do is to convey a shared value of compassion, a commitment to excellence, open communications, motivation to be the best, and a sense of personal integrity. We are honored to care for our residents and share a passion to make their days enriching and fulfilling.

Quite simply, that is The Caraday Way.

Mission:

To provide the best care and environment so that our residents look forward to each day and our team members enjoy a sense of pride and purpose.

Shared values:

- Compassion
- Motivation
- Personal integrity
- Operational excellence
- Communication

WELCOME

As a team member of Caraday Healthcare enjoying your work and making valuable contributions to business are equally vital. The health, satisfaction and security of you and your family are important, not only to your well-being, but ultimately, in terms of achieving the goals of our organization. For the 2025-2026 plan year, Caraday Healthcare has worked hard to offer a competitive total rewards package that includes valuable and competitive benefits plans. These programs reflect our commitment to keeping our staff healthy and secure. We understand that your situation is unique, and Caraday Healthcare is offering an overall benefits package that can be shaped and molded by you to fit your needs. This benefits booklet is a summary description of your Caraday Healthcare benefit plans. If there is a discrepancy between these summaries and the written legal plan documents, the plan documents shall prevail. This booklet and plan summaries do not constitute a contract of employment. We hope this benefits booklet, along with our additional communication and decision-making tools, will help you make the best health care choices for you and your family.

Review this guide to choose which benefits are right for you. If after reading this guide you need more information, please contact Human Resources.

[1] You can change your coverage during the year if you experience a "Qualified Status Change," including but not limited to marriage, common law marriage, divorce, birth or adoption of a child or death of spouse or child.

ELIGIBILITY

Full-time team members (working a minimum of 30 hours per week) and their eligible dependents can participate in Caraday Healthcare benefits. Eligible dependents include:

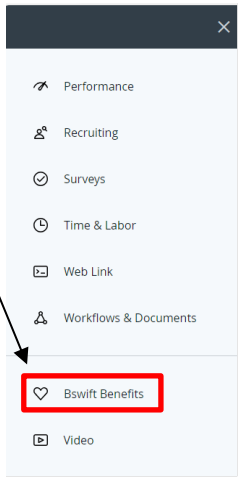
- Your legal spouse
- Child(ren) up to age 26
- Child(ren) of any age if you support the child and he or she is incapable of self-support due to disability

PROOF OF DEPENDENT ELIGIBILITY

You may be required to provide proof of eligibility for your dependents. Note that attempting to enroll an ineligible dependent could lead to discipline. If your dependent becomes ineligible for coverage during the year, you must contact Human Resources within 30 days. Failure to provide notification may lead to discipline.

Enrolling in Benefits

If you're eligible for Caraday Healthcare benefits, you can enroll by visiting **Login (bswift.com)** or from the Paylocity menu bar as you can see to the right. If using the link, you must know your username and password, whereas access from the Paylocity menu bar will put you straight into the application without a username or password needed. Continue each step until all elections are complete. If after reading this guide you have enrollment questions, please contact HR.



BENEFITS TERMS

Before reviewing your benefit choices for this year, here's a refresher on some key health insurance vocabulary that will help you better understand your options.

Coinsurance	The percentage you pay for the cost of covered health care services **after** you've met your deductible. For example, if the coinsurance under your plan is 30%, you would pay 30% of the cost of the service and your insurance would pay the remaining 70%.
Copayment (Copay)	A fixed amount (for example, $25) you pay for a covered health care service, usually when you receive the service (as specified by your plan).
Deductible	The amount you pay in a calendar year before your health plan begins to pay benefits.
PCP	If you elect the Base HMO plan you will be required to choose a PCP (Primary Care Physician) who participates in the Blue Essentials HMO. This PCP will need to provide a referral to a specialist when you need to see a specialist.
Network	A group of doctors, hospitals, labs, and other providers that your health insurance contracts so you can make visits at a pre-negotiated discounted rate.
Out-of-Pocket Maximum	The cap on your out-of-pocket costs for the calendar year. Once you've reached this amount, your plan will cover 100% of your qualified medical expenses for the plan year.
Premium	The amount of money that's paid for your health insurance every month. Caraday Healthcare pays a portion of this amount, and you pay a portion.

TEAM MEMBER CONTRIBUTIONS

The values below indicate how much you're responsible for contributing towards coverage. Amounts are taken directly from your paycheck each pay period.

CONTRIBUTION SUMMARY

Benefit	Team members Only	Team members + Spouse	Team members + Child(ren)	Team members + Family
Medical- Base HMO Plan	$74.52	$374.54	$249.01	$419.94
Medical- Buy Up Plan 1	$158.71	$576.14	$389.87	$843.11
Medical- Buy Up Plan 2	$232.26	$763.58	$531.45	$1,094.49
Dental Base Plan	$11.07	$23.23	$20.46	$33.18
Dental Buy-up Plan	$20.90	$43.88	$38.65	$62.67
Vision Plan	$3.96	$7.51	$7.91	$11.63
Basic Life and AD&D	Employer Paid			
Voluntary Life and AD&D	**Age-specific rates are available when you enroll in bswift**			
Voluntary Short-Term Disability (STD)	**Age-specific rates are available when you enroll in bswift**			
Voluntary Long-Term Disability (LTD)	**Age-specific rates are available when you enroll in bswift**			
Voluntary Accident	$3.43	$5.76	$6.43	$10.17
Voluntary Critical Illness Plan	See page 21			

MEDICAL & PRESCRIPTION DRUG BENEFITS

You have the opportunity to enroll in one of three medical plans through Blue Cross Blue Shield. The Base HMO plan does not offer out of network care except in a true emergency. Buy Up plan 1 and 2 offer out of network care but you will want to stay in network for lowest cost and no balance billing. To find an in-network provider visit https://www.bcbs.com/ and click on "Find a Doctor".

MEDICAL PLANS SUMMARY

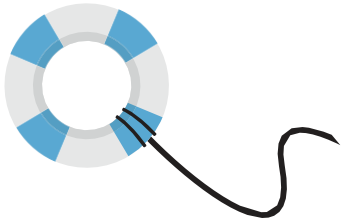
Key Features	Medical Base HMO Plan	Medical Buy-Up Plan 1	Medical Buy-Up Plan 2
	Blue Essentials HMO	Blue Choice PPO [BCA]	Blue Choice PPO [BCA]
	In-Network	In-Network	In-Network
Calendar Year Deductible Individual / Family	$6,000/ $12,000	$3,000/ $6,000	$1,500/ $3,000
Out-of-Pocket Maximum (includes deductible) Individual / Family	$6,600/ $13,200	$6,600/ $13,200	$5,000/ $10,000
Lifetime Maximum	No Limit	No Limit	No Limit
Coinsurance (portion you pay)	30%	20%	20%
Preventive Care	Covered 100%	Covered 100%	Covered 100%
Primary Care Physician (PCP) Office Visit	$25	$35	$30
Virtual Visit (MDLive)	$25	$35	$30
PCP Required	Yes	No	No
Specialist Office Visit	$70	$60	$50
Referral needed by PCP to access a specialist	Yes	No	No
Urgent Care Copay	$100	$75	$75
Emergency Room Copay (waived if admitted)	$200 copay + 30% after deductible	$200 copay + 20% after deductible	$300 copay + 20% after deductible
Inpatient Hospital (per admission)	30% after deductible	20% after deductible	20% after deductible
Lab and X-Ray Services In-office/Outpatient	Inpatient: $25 Copay Outpatient: 30% after deductible	Inpatient: $35 Copay Outpatient: Covered 100%	Inpatient: $30 Copay Outpatient: Covered 100%
Advanced Imaging (MRI, PET Scan, CT Scan, etc)	30% after deductible	20% after deductible	20% after deductible
MEDICAL OUT-OF-NETWORK BENEFITS			
Annual Deductible (Individual/Family)	Not Available	$15,000/ $45,000	$15,000/ $45,000
Out of Pocket Max (Individual/Family)	Not Available	$30,000/ $90,000	$30,000/ $90,000
Plan Coinsurance	Not Available	50%	50%
RETAIL PRESCRIPTIONS (30-DAY SUPPLY)	**NO RX DEDUCTIBLE – COPAYS APPLY**		
Generic	$5	$10	$10
Preferred Brand	$50	$35	$35
Non-preferred Brand	$100	$70	$70
Specialty	$250	$200	$200
MAIL-ORDER PRESCRIPTIONS (90-DAY SUPPLY)- 2.5 TIMES 30 DAY COPAY			

NOTE: Copays do not count toward a health plan's deductible, but do count toward your Out-of-Pocket Maximum.
Mandatory generic: If you chose a brand over a generic, you will pay the brand copay plus the cost difference in the medication unless your doctor writes dispense as written. *The information above is a summary of coverage only. For more information, visit https://www.bcbs.com/ or contact HR.

Employee Assistance Program

Extra Help When It's Needed Most

When personal problems arise, many people may choose to cope alone, resulting in negative consequences at home and the workplace. This is why we have teamed with ComPsych® Corporation to offer the Employee Assistance Program to team members covered by our Basic Life and AD&D insurance. The Employee Assistance Program provides convenient resources to help address emotional, legal and financial issues.



Face-to-Face Sessions

The Employee Assistance Program provides Basic Life and AD&D insured team members with three face-to-face sessions in a geographically accessible location to address behavioral issues.

Unlimited Telephonic Counseling

The Employee Assistance Program also provides Basic Life and AD&D insured team members with unlimited telephonic counseling (24 hours a day, 7 days a week) to help address behavioral issues. Master's degree level counselors use a conversational approach to identify issues, assess needs and refer participants to specialists to help resolve their issues.

Web-Based Services

GuidanceResources® Online (guidanceresources.com) is a secure, password-protected website that contains self-assessments, extensive content on personal health and powerful tools to help with personal, relational, legal, health and financial concerns. This service is free of charge to team members who are insured with us for Basic Life and AD&D insurance. It covers many topics and personal concerns, such as:

- Alcohol and drug abuse
- Depression
- Divorce and family law
- Estate planning
- Getting out of debt
- Grief and loss
- Job pressures
- Managing debt obligations
- Marital and family conflicts
- Retirement planning
- Saving for college
- Stress and anxiety
- Tax questions
- Real estate buying and selling

Employee Assistance Program

In the U.S. and Canada call

866-899-1363

TDD: 800-697-0353

guidanceresources.com

Enter Your Company ID: DISRES

BlueCross BlueShield of Texas

To Access Your Services

Call: 866-899-1363

- You will be asked what type of insurance policy you have: LTD, STD or life insurance. If you are unsure, consult with your HR representative.

Online: GuidanceResources.com

- Click "Register" to create a new account.
- Enter Your Company ID: DISRES

Insurance products issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148.

Your Guide to GuidanceResources® Online

GuidanceResources.com

What about financial concerns?

Financial issues can arise at any time, from dealing with debt to saving for college. Guidance Resources® Online is available to provide you with the tools and information you need to help solve your personal money management concerns.

How can I manage all of my life's little details and the issues my family faces?

Whether you are a new parent, giving care to an elder, sending a child off to college, buying a car or doing home repairs, you're bound to come across concerns that need to be addressed. Let GuidanceResources® Online help you explore your options.

Where can I get answers to all my legal questions?

GuidanceResources® Online provides access to practical, understandable information and tools to help address your concerns about divorce, bankruptcy, buying real estate and other issues.

Guide to using GuidanceResources.com

1. Once on the **GuidanceResources.com** home page, click on the tab at the top labeled **"Register."**
2. Enter your **company ID: DISRES**. Create a **username and password**. The username has to be at least six characters long and should have no spaces (for example: joesmith). Make sure that you **complete all required fields, noted with red asterisks**.
3. Read the Terms of Use and click inside the checkbox to indicate your agreement to those terms.
4. When you've finished, **click on the "Submit" button** at the bottom of the page.

GuidanceResources® Online offers web-based services designed to help address the personal concerns and life issues you may be facing. Whether it's depression, alcohol and drug abuse, or grief and loss, these services are available to you and members of your family at no cost—24 hours a day, 7 days a week.

ONLINE ACCESS:
GuidanceResources.com

- Click "Register" to create a new account.
- Enter Your Company ID: DISRES
- FOR FUTURE LOGINS, just go to the member login section and enter your username and password. This will take you directly to **GuidanceResources.com**.

If you have any problems logging in, you can contact: **memberservices@guidanceresources.com or 877-595-5289**.

The Employee Assistance Program

In the U.S. and Canada call
866-899-1363

TDD: 800-697-0353

guidanceresources.com
Enter Your Company ID: DISRES

BlueCross BlueShield of Texas

Blue Cross and Blue Shield of Texas is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association.

750129.0919

BCBSTX IMPORTANT INFORMATION

1. Get connected with Blue Access for Members (BAM) before you need assistance. With BAM, you can:

- Find care – search for in-network doctors, hospitals, pharmacies
- and other health care providers
- Get your digital member ID card
- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Sign up for text or email alerts

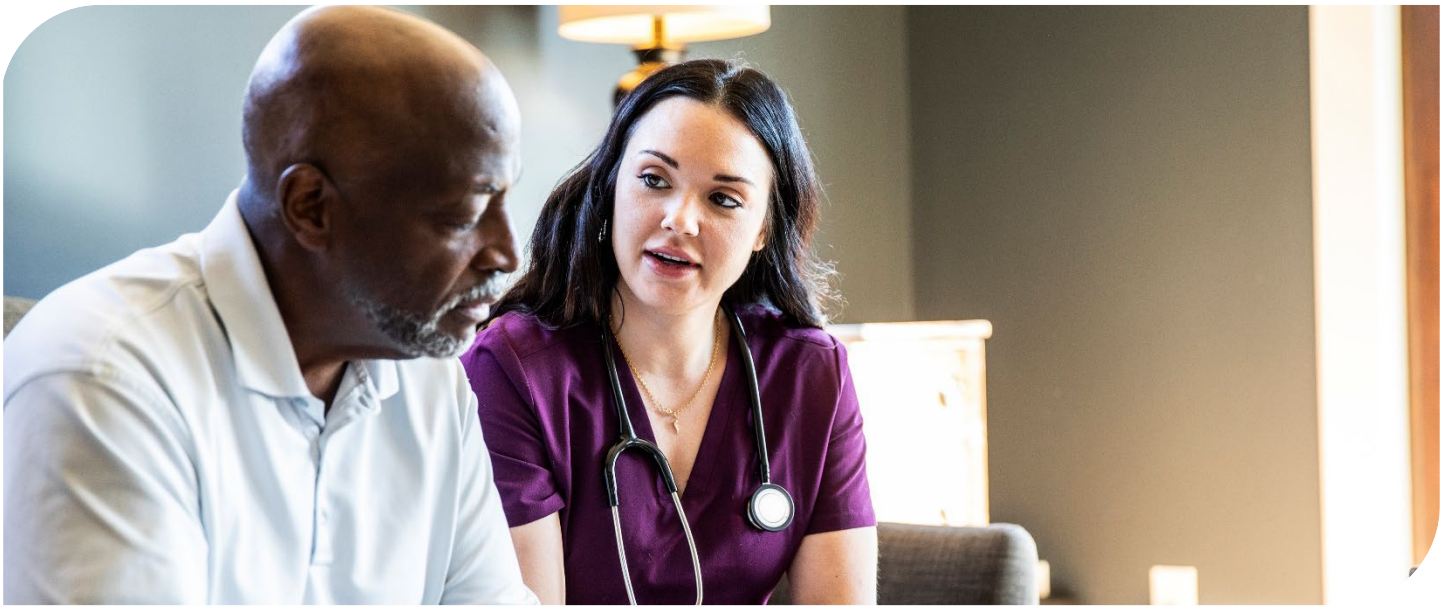
SCAN ME

Scan this QR code to visit bcbstx.com.

Use your member ID card to create a BAM account at **www.bcbstx.com**, or text* **BCBSTXAPP** to **33633** to download the mobile app.

2. How to search for a provider or facility in your network if you are not on the BAM app, or logged in to BCBSTX as a member:

- Step 1- Go to www.bcbstx.com
- Step 2- Select 'Find Care'
- Step 3- Select 'Find a Doctor or Hospital'
- Step 4- Search as Guest to find providers when shopping for a health plan
- Step 5- Enter the location for where you want to search for a provider
- Step 6- Select plan/network
- Step 7- Search for specific names or specialties



BCBSTX IMPORTANT INFORMATION

Please Note: If you select the **Medical- Base HMO Plan** you must select a Primary Care Provider (PCP). All services are coordinated through your PCP in order to get in-network benefits.

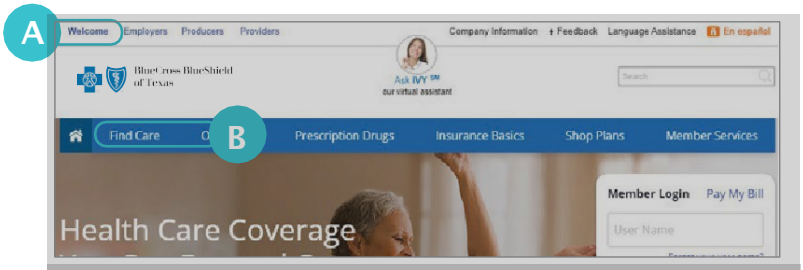
How to Find Providers as a Guest

To get the most accurate results based on your plan, use the **Member Login**.

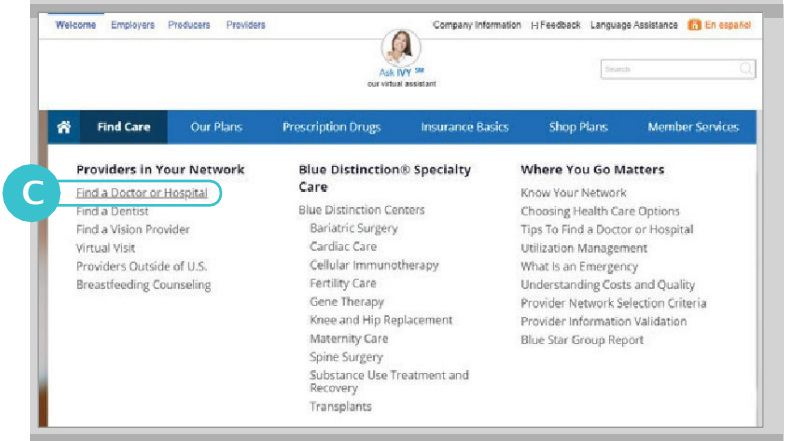
Where to Start

A. Go to **bcbstx.com**

B. Select **Find Care**



C. Select **Find a Doctor or Hospital**

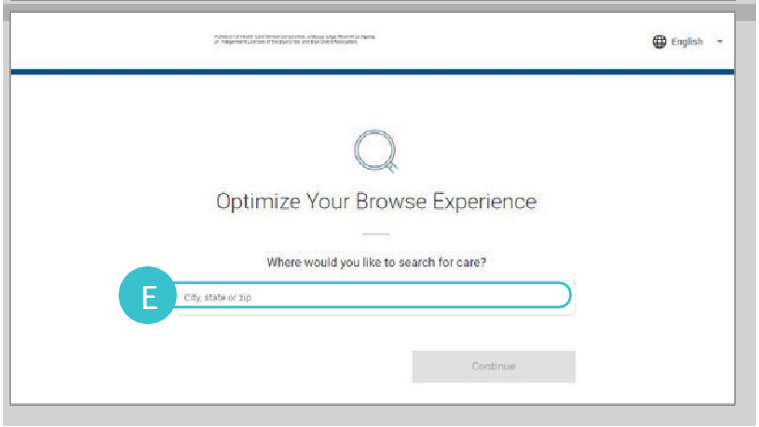


D. **Search as Guest** to find providers when shopping for a health plan

Enter the Location Where You Want to Search for a Provider

E. Enter any of the following under **Optimize Your Browse Experience**:

- City
- State
- ZIP Code

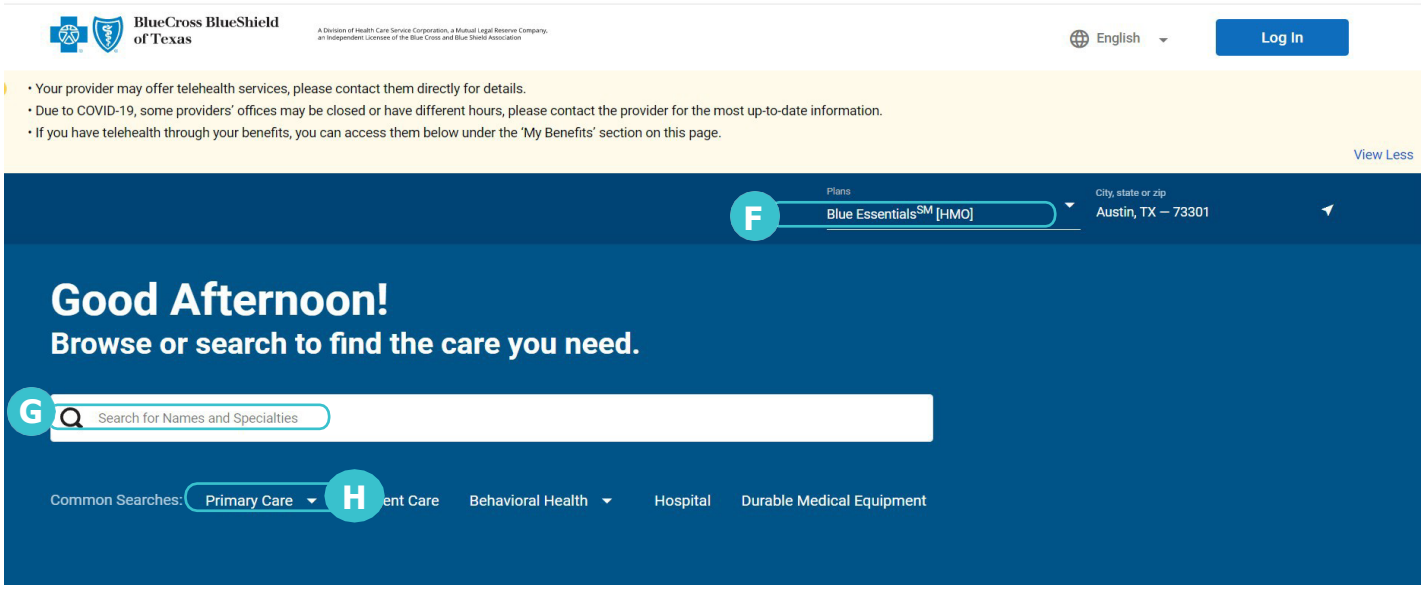


If you are enrolling in a PPO plan - Medical Buy Up Plan 1 or Medical Buy Up Plan 2 your Network is **Blue Choice PPO [BCA].**

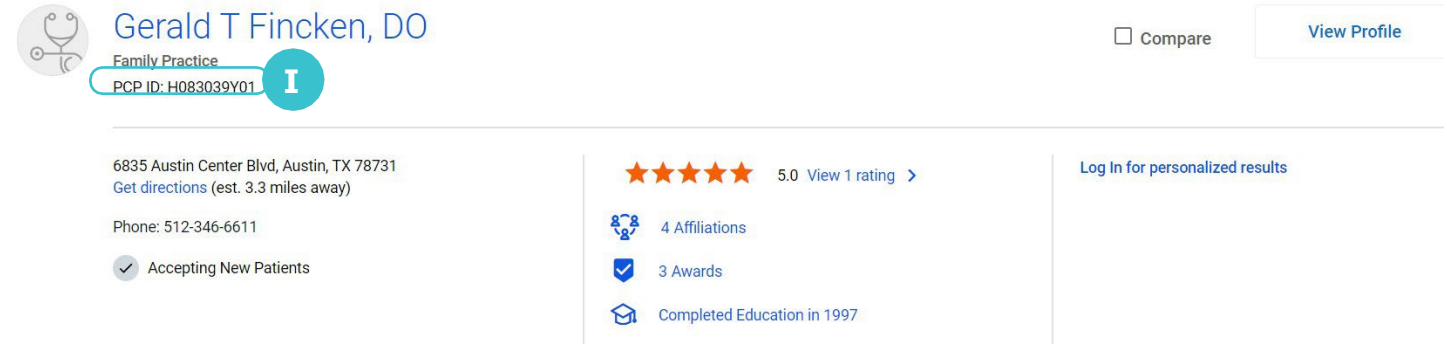
If you are enrolling in the **Medical Base HMO Plan** your Network is **BlueEssentials**, and your Plan is **Blue Essentials [HMO].**

F. Select your plan/network from the drop down list

*As previously mentioned, if you select the **Medical BASE HMO Plan**, you must select a **Primary Care Provider** (PCP). Please continue to follow the instructions below to select a PCP.



G. Search for **specific names or specialties** **OR**
H. Select **Primary Care Option** from the drop-down list
I. PCP ID should be listed under Providers name. Remove the H0 at the beginning of the PCP ID and the 01 at the end. The PCP ID to put in the ATL Enrollment Spreadsheet would be 83039Y (example: ~~H0~~83039Y~~01~~)



BCBSTX ADDITIONAL SERVICES

Express Scripts - Mail Order Pharmacy

With this program, you can order from the comfort of your home — through your mobile device, online or over the phone. Your doctor can fax, call or send your prescription electronically to Express Scripts® Pharmacy for up to a 90-day supply of long-term medicines.

Accredo- Specialty Medications

Accredo carries roughly 99% of specialty drugs, which means you're more likely to get all of your specialty drugs from one pharmacy. Through Accredo, you can have your covered, self-administered specialty drugs delivered straight to you. When you get your specialty drugs through Accredo, you get:

- One-on-one counseling from 500+ condition specific pharmacists and 600+ nurses
- Simple communication, including refill reminders, by your choice of phone, email, text or web4
- An online member website to order refills, check order status and track shipments, view order and medication history, set profile preferences and learn more about your condition
- A mobile app that lets you refill and track prescriptions, make payments and set reminders to take your medicine4
- Free standard shipping
- 24/7 support

To start using Accredo**, call 833-721-1619.** An Accredo representative will work with your doctor on the rest. Once registered, you can manage your prescriptions on **accredo.com** or through the mobile app.

Well on Target - Member Wellness Portal

The Fitness Program is available exclusively to you and your covered dependents (age 16 and older).* The program gives you access to a nationwide network of fitness locations. Choose one location close to home and one near work, or visit locations while traveling.

The Suite of programs and tools include:

- Digital Self-management Programs: Learn about nutrition, fitness, weight loss, quitting smoking, managing stress and more!
- Health and Wellness Library: The health library has useful articles, podcasts and videos on health topics that are important to you.
- Tools and Trackers: These interactive resources help keep you on track while making wellness fun.
- Personal Challenges: Join a personal challenge to help you reach your goals. There are over 30 challenges, so you can choose the best one to fit your wellness journey. Topics include stress, sleep, physical activity and more!

Go to **bcbstx.com** and log in to Blue Access for Members, select **Wellness** tab on the top navigation bar of the Dashboard page. Then scroll down to the **Fitness Program** section and click on **Learn More** to complete registration form. Questions? If you have any questions about Well onTarget, call Customer Service at 877-806-9380.

Blue Points - Rewards for Healthy Living

With the Blue Points program, you will be able to earn points for regularly participating in many different healthy activities. You can redeem these points in the online shopping mall, which provides a wide variety of merchandise. Log on to **wellontarget.com** today to find all the interactive tools and resources you need to start racking up Blue Points. Keep yourself motivated to earn more points by heading over to the online shopping mall and checking out all the rewards you can earn for adopting — and continuing —healthy habits.

BCBSTX ADDITIONAL SERVICES CONT.

Blue365 - Discount Program

With this program, you may save money on health and wellness products and services from top retailers that are not covered by insurance. There are no claims to file and no referrals or preauthorization's.
Once you sign up for Blue365 at **blue365deals.com/bcbstx**, weekly **"Featured Deals"** will be emailed to you.
These deals offer special savings for a short period of time.

SmartER- Care Options

When having an emergency, knowing where to go for medical care may save you on cost and time. You have options for where you can get care depending on your symptoms- these are called SmartER Care options. Visit the "Control Costs with SmartER Care" web page at bcbstx.com for more details.

Special Beginnings- Maternity Program

The Special Beginnings maternity program supports you from early pregnancy until six weeks after delivery.
An experienced Blue Cross and Blue Shield of Texas staff member will contact you and:

- Ask you questions to determine what support you will need
- Send you information about having a healthy pregnancy and baby
- Answer any questions you have and help you plan your care with your doctor
- Assist you with managing high-risk conditions such as gestational diabetes and preeclampsia

Visit the Special Beginnings website to view a video library and week-by-week pregnancy information. To access the site, log into **Blue Access for MembersSM (BAMSM)** by visiting **bcbstx.com** and click on the "**My Health"** tab. Call **888-421-7781**, 8 a.m. – 6:30 p.m., CT, to enroll or ask questions about the program

Wondr

Wondr is a skills-based digital weight loss program that teaches you how to enjoy the foods you love to improve your overall health. This science-based program was created by a team of doctors and clinicians and is clinically-proven for lasting results. *To learn more and join the waitlist, visit: **wondrhealth.com/BCBSTX**. Questions? Visit **support.wondrhealth.com**

Assist America- Travel Resource Services

Assist America, offers around-the-clock emergency and information services that can help you access emergency assistance when you are traveling 100 or more miles away from home. Access a wide range of global emergency assistance services from your phone by downloading the FREE Assist America Mobile App. Enter your Assist America Reference Number to set up the App: **01-AA-TRS-12201**.

24/7 Nurseline

The 24/7 Nurseline allows you to talk to registered nurses anytime you need them. They can answer your health questions and try to help you decide whether you should go to the emergency room or urgent care center or make an appointment with your doctor. You can also call the 24/7 Nurseline whenever you or your covered family members need answers to health questions about:

- Asthma
- Dizziness or severe headaches
- Cuts or burns
- Back pain
- High fever
- Sore throat
- Diabetes
- A baby's nonstop crying
- And much more

Call **800-581-0393 to** reach the 24/7 Nurseline and talk to a nurse. Hours of Operation: **Anytime**

BCBSTX ADDITIONAL SERVICES CONT.

Omada

An easy-to-follow program that provides support for healthier living. Through Omada members enrolled in BCBSTX have access to a personal health coach, expert advice to manage food, activity, sleep and stress with personalized support. Visit **omadahealth.com/bcbstx.**

Hinge Health

Hinge Health provides all the tools you need to get moving again from the comfort of your home. You'll get exercise therapy tailored to your needs, technology for instant feedback in the app, a personal coach and a physical therapist . Best of all, it ?s no cost ? 100%covered by Blue Cross and Blue Shield of Texas (BCBSTX) for you and eligible family members. Hinge Health will reach out to eligible members with details and next steps.

Livongo

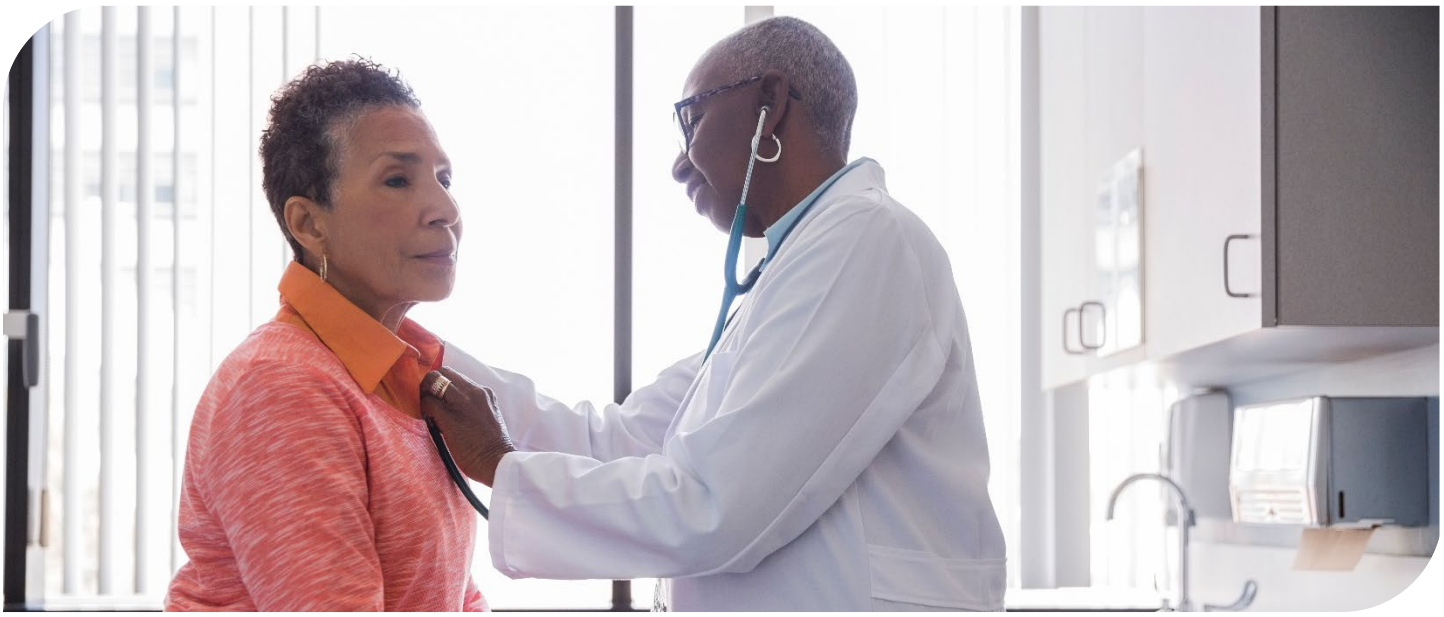
This program is provided to you and your family members through BCBSTX at no cost to you to help with Diabetes Management and Blood pressure management. To get started- **visit get.livongo.com/well-bcbstx/register or call 800-945-4355 and use registration code: WELL-BCBSTX** to receive unlimited strips & lancets, connected blood sugar meter, one on one coaching, or a connected blood pressure monitor.

Mental Health

Your health plan includes access to mental health care like therapy and medicines that might help. You and your family members can get support for issues such as:

- Depression
- Anxiety and panic attacks
- Substance use
- Attention deficit (ADHD/ADD)
- Autism
- Bipolar
- Eating disorders

Mental health is just as important as physical health. Don't be afraid to reach out – call the Customer Service or behavioral health number on the back of your member ID card.



TELEMEDICINE – MDLIVE

Why Virtual Visits?

- 24/7 access to an independently contracted, board-certified doctor or therapist
- Access via phone, online video or mobile app from almost anywhere
- Average wait time of less than 20 minutes
- Doctors can send e-prescriptions to your local pharmacy

The Virtual Visits benefit is a convenient alternative for treatment of more than 80 health conditions, including:

- Allergies
- Cold/Flu
- Fever
- Headaches
- Nausea
- Sinus infections

Virtual Visits sessions with licensed behavioral health therapists are available by appointment. Get virtual care for:

- Depression
- Eating disorders
- ADHD
- Substance use disorders
- Trauma and PTSD
- Autism spectrum disorder

First, call your doctor's office; they may also offer telehealth consultations by phone or online video. If you have any questions about this or any other BCBSTX benefit, please call the number on the back of your ID card.

*See page 7 for the cost of Virtual Visits.

Virtual Visits may be limited by plan. For providers licensed in New Mexico and the District of Columbia, Urgent Care service is limited to interactive online video; Behavioral Health service requires video for the initial visit but may use video or audio for follow-up visits, based on the provider's clinical judgment. Behavioral Health is not available on all plans.

MDLIVE is a separate company that operates and administers Virtual Visits for Blue Cross and Blue Shield of Texas. MDLIVE is solely responsible for its operations and for those of its contracted providers. MDLIVE® and the MDLIVE logo are registered trademarks of MDLIVE, Inc., and may not be used without permission.

9100009.1222

DENTAL BENEFITS

Caraday Healthcare offers dental coverage through Blue Cross Blue Shield of Texas (BCBSTX). You have the opportunity to choose from two PPO dental plan options.

Plan	Plan Features
PPO	• Allows you to receive care from a dentist in the network or outside the network • Pays a portion of your expenses after you meet your calendar year deductible, except for preventive care which is covered at 100%

DENTAL PLAN SUMMARY

Key Features	Dental Base Plan		Dental Buy-Up Plan	
	In-Network Only	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible (Individual / Family)	$50/ $150		$50/ $150	
Preventive Services (no deductible)	100%		100%	
Basic Services	80%		80%	
Major Services	50%		50%	
Endo/Periodontal	Major Service		Basic Service	
Orthodontics (children up to age 19)	Not Covered		50% (lifetime max $2,000)	
Annual Calendar Year Maximum	$1,000		$3,000	

The information above is a summary of coverage only. For more information, visit https://www.bcbstx.com/ or contact HR.

VISION BENEFITS

You and your dependents have access to vision coverage through Blue Cross Blue Shield of Texas (BCBSTX). The plan pays benefits for both in-network and out-of-network services. However, you will receive maximum value from your vision benefits when you choose in-network providers. If you see a network provider, you will pay copays for most services. If you receive care outside the network, you will need to pay the full cost and file a claim to be reimbursed for a portion of the costs.

VISION PLAN SUMMARY

Key Features	In-Network	Out-of-Network	Frequency
Exam	$10	Up to $30	Once every calendar year
Lenses Single/Bifocal/ Trifocal/Lenticular	$25	Up to $25/$40/$55/$55	Once every calendar year
Frames	$150 Allowance	Up to $75	Once every calendar year
Contact Lenses (instead of glasses)	Elective: Up to $150 allowance Medically Necessary: Covered 100%	Elective: Up to $120 allowance Medically Necessary: Up to $210	Once every calendar year

For more information, visit https://www.bcbstx.com/ or contact HR.

INCOME PROTECTION BENEFITS

In addition to health benefits, Caraday Healthcare also offers eligible team members income protection benefits. These benefits are intended to provide financial assistance for you and your beneficiaries in the event of disability, accident, or death. For more information, visit https://www.bcbstx.com/employer/products/ancillary-products/overview or contact HR.

Caraday Healthcare offers the following benefits:

- Basic Life and Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Short-Term Disability (STD)
- Voluntary Long-Term Disability (LTD)

BASIC LIFE AND AD&D

Caraday Healthcare provides you with Basic Life insurance, up to $15,000, at no cost to you. If your death is the result of an accident, you will receive an additional Accidental Death & Dismemberment (AD&D) benefit. If you lose a limb or your eyesight as the result of an accident, the AD&D plan will pay a percentage of your AD&D benefit amount.

Basic Life/ AD&D Insurance	
Life Insurance Benefit	$15,000
AD&D Benefit	$15,000
Benefits reduce by 50% at age 70	

VOLUNTARY LIFE AND AD&D

You have the option to supplement your company-paid coverage by purchasing additional Life and AD&D insurance for yourself, your spouse and your children. You are required to purchase coverage for yourself in order to enroll your family members.

Voluntary Life/AD&D Insurance	
Maximum Voluntary Life/AD&D Insurance Benefit (Benefits reduce by 50% at age 70)	$400,000 team members (5x salary max) **Spouse limited to 50% of team member election** $20,000 child(ren)
Guarantee Issue amount when 1st eligible for benefits as a fulltime team member	$200,000 team members $30,000 spouse $20,000 child(ren)
Age specific rates are available when you enroll in bswift.	

PLEASE NOTE:

- The amount you purchase on your spouse cannot exceed 50% of what you purchase for yourself
- If you waive this benefit during your New Hire enrollment, and chose to enroll at Open Enrollment, you will be required to complete an Evidence of Insurability(EOI) form which may be approved or denied by BCBSTX

INCOME PROTECTION BENEFITS

DISABILITY

Caraday Healthcare offers Short-Term Disability (STD) and Long-Term Disability (LTD) insurance through Blue Cross Blue Shield of Texas (BCBSTX). For more information, visit https://www.bcbstx.com/employer/products/ancillary-products/overview or contact HR.

- **Voluntary Short-Term Disability (STD)**
  STD coverage replaces a portion of your income if you are unable to work due to an illness, pregnancy, or non-work-related injury. Benefits begin after 14 days and continue for 13 weeks or until you are certified to return to work. You receive 60% of your pay, up to a maximum benefit of $1,000 per week. You pay for the cost of this coverage.

  Pre-existing condition limitation (3/6): -- Any conditions that you have received medical attention in the 3 months prior to your effective date of coverage will not be covered under the STD plan until you are actively and work and covered for 6 months.

  PLEASE NOTE:
  - If you waive this benefit during your New Hire enrollment, and chose to enroll at Open Enrollment, you will be subject to a 60-day benefit waiting period for sickness or pregnancy during the first 12 months of coverage. Any claim filed within the first 60 days will be denied by BCBSTX.
  - EOI is not required

Plan Features	
Team Member Benefit	60% of salary
Maximum Weekly Benefit	$1,000
Elimination Period (Accident/Illness)	14 Days
Benefit Duration	13 weeks

- **Voluntary Long-Term Disability (LTD)**
  After you have been disabled for 90 days, LTD benefits begin and you receive 60% of your income, up to a maximum of $5,000 per month. Benefits continue until you are no longer disabled or until you reach Social Security Normal Retirement Age, whichever comes first. Your LTD benefits will be offset by any other disability payments you may receive, such as Social Security or Workers' Compensation. You pay for the cost of this coverage.

  Pre- existing condition limitation (3/12): -- Any conditions that you have received medical attention in the 3 months prior to your effective date of coverage will not be covered under the LTD plan until you are actively and work and covered for 12 months.

  PLEASE NOTE: If you waive this benefit during your New Hire enrollment, and chose to enroll at Open Enrollment, you will be required to complete an EOI form which may be approved or denied by BCBSTX

Plan Features	
Team Member Benefit Amount	60% of salary
Maximum Monthly Benefit Amount	$5,000
Elimination Period	90 Days
Benefit Duration	SSNRA

VOLUNTARY BENEFITS

As a supplement to the income protection benefits, Caraday Healthcare also offers additional voluntary benefits. These benefits can help pay for out-of-pocket expenses not covered by your medical plan. You can enroll yourself and your eligible family members. You pay the full cost of these benefits.

VOLUNTARY ACCIDENT

Voluntary Accident Insurance helps cover the cost of emergency medical care, physical therapy and other unexpected expenses that result from an accidental injury. Coverage for this plan ends at the end of the month in which you are 70.

Plan Features	
Emergency Treatment	Urgent Care - $75, Physician - $50, X-Ray - $25, Ambulance - $120 (ground) $800 (air), Emergency Room - $75
Follow Up Treatments	$25
Physical Therapy	$25
Appliances	$50
Fractures / Dislocations	$75 - $2,000 / $150 - $2,000
Initial Hospitalization	$400
Hospital Confinement	$150
Lodging / Transportation	$75 per day / $200

VOLUNTARY CRITICAL ILLNESS

Voluntary Critical Illness Insurance pays a benefit if you are diagnosed with a serious illness covered by the plan. The benefit is paid to you and can be used to pay medical costs or living expenses such as childcare or mortgage payments. Covered illnesses include:

	Benefit Percentage
• Invasive Cancer	100%
• Carcinoma in-situ	25%
• Heart Attack	100%
• Major Heart Surgery	25%
• Stroke	100%
• Major Organ Transplant	100%

	Benefit Percentage
• End Stage Renal Failure	100%
• Paralysis	100%
• Benign Brain Tumor	100%
• Coma	100%
• Loss of Sight, Speech or Hearing	100%
• Major Burns	100%
• Severe COVID-19 Infection	100%

Available Coverage Levels	
Employee	$10,000 or $20,000
Spouse	$5,000 or $10,000
Child(ren)	$2,500 or $5,000

Cost Per $1,000 of Coverage (monthly premiums shown)	
Under 30	$0.370
30 - 39	$0.560
40 - 49	$1.140
50 - 59	$2.360
60 – 69	$4.530
70+	$9.140

Dependent Child(ren) Rates per $1,000: $0.210

Pre-Existing Condition 12/12: Illness or injury for which you received advice or care in the 12 months prior to effective date are not covered for the first 12 months of coverage. For invasive cancer, you must first be cancer free and then a new cancer diagnosis would be covered if you have been on the plan for 12 months.

PLEASE NOTE: EOI is not required

ADDITIONAL BENEFITS

401(k) SAVINGS PLAN

Caraday Healthcare 's 401(k) Plan is a great way to start planning for retirement. You can contribute to your account on a pre-tax basis through automatic payroll deductions, up to the IRS annual maximum ($23,500 for 2025). If you are age 50 or older, you can make an additional catch-up contribution of $7,500.

Ready to set yourself up for retirement? Enroll here.

Click:
myretirementbenefit.voya.com/1n3u

Plan Number: 862346

Plan verification number: 86234699

Scan:

Need help enrolling? : Call us at 888-311-9487
Our hours are Mon-Fri from 8:00 AM to 9:00 PM ET

If you would like general information on financial wellness as you consider your plan, visit voya.com/VoyaLearn. Our informative education will help you on your journey to financial wellness. Sign up today for a live session or browse our library of on-demand videos.

Why is it important to get started now?

Be good to yourself.

We want to help you plan the retirement you envision. You deserve to feel good about your future and confident in your plan to get there. The first step? Enroll in your retirement savings plan.

70% of your current income

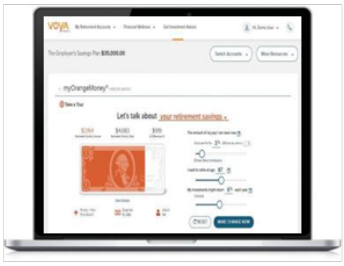
How much retirement income is enough?

Although it is different for everyone, you will likely need to replace at least 70% of your current income annually in retirement. After you enroll, you can determine how much income you might need by using myOrangeMoney®, an interactive online experience, that will show you how your current retirement assets may translate into future potential monthly income in retirement so you know when you can retire.

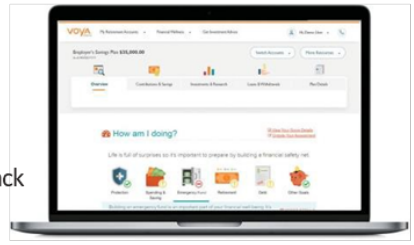
2

Access your retirement plan account today

Did you know your employer-sponsored retirement plan offers online tools and resources to help you plan your financial future? Gain access to information about your account, including statements, fund performance, transaction history and alerts, as well as financial education and investment updates.



Take advantage of myOrangeMoney®,* an interactive educational experience to help you estimate savings scenarios and make sure you're on track for the future you envision.



For a comprehensive view of your finances, we invite you to start your journey with the Financial Wellness Experience. This personalized and guided experience helps you think about your financial priorities and learn how to take meaningful actions.

You will receive a unique Personal Identification Number (PIN) in the mail after your account is set up. Your PIN is required to register and view your account online or to access your account information by phone.

First time users

voyaretirementplans.com

1. Click *Register now.*
   - Select the way you would like to create your online access.
   - If you prefer to use the PIN option, but have not received or cannot locate your PIN, you can request a PIN on the website or by calling customer service.
2. Set up a unique username and password for use on the website and the Voya Retire mobile app.
3. Provide your mobile number or an alternate email address to ensure the security of your account. We will use this for the future recovery of your username or password, as needed, or if you login using a computer or device that is not recognized.

Hint: Please retain your PIN. If using the phone services you will need that same Voya-issued PIN for detailed account information and to perform certain transactions. If helpful, you can customize your PIN through the automated system to something you will more easily remember.

View the website in Spanish! Select "Español" in the language selector at the bottom of the website to view all of your account information in Spanish.

ADDITIONAL BENEFITS

Previously registered users

voyaretirementplans.com

Enter your username and password to access your account.

If you have forgotten your username or password, select the appropriate link and follow the instructions to recover your credentials.

To access your statements online, click on the Statements & Documents tab at the top of the page and select Statements.

Tap the app to save in a snap

The Voya Retire mobile app is an easy, secure and convenient way to access and manage your retirement account all in one place – so you can help boost your retirement savings and manage your money all while on the go.

Access your account by phone

1-800-584-6001

You can access your account by phone 24 hours a day, seven days a week.

Keep in mind when calling you may need your PIN. If you've lost or misplaced your PIN, request a PIN reminder through the automated system or hold for a Customer Service Associate.

You may also access the following (if available):

- Account balance
- Loans
- Investments
- Contributions and fund elections
- Other plan information
- Other options

Questions? Need help? At any time, just press 0 and a Customer Service Associate can help you. They're available Monday through Friday, 8:00 a.m. to 9:00 p.m. Eastern Time

Search Voya Retire in your mobile app store. You will log in with the same Username and Password used for the Plan website. If your device allows, you can establish fingerprint security.

***IMPORTANT**: The illustrations or other information generated by the calculators are hypothetical in nature, do not reflect actual investment results, and are not guarantees of future results. This information does not serve, either directly or indirectly, as legal, financial or tax advice and you should always consult a qualified professional legal, financial and/or tax advisor when making decisions related to your individual tax situation.

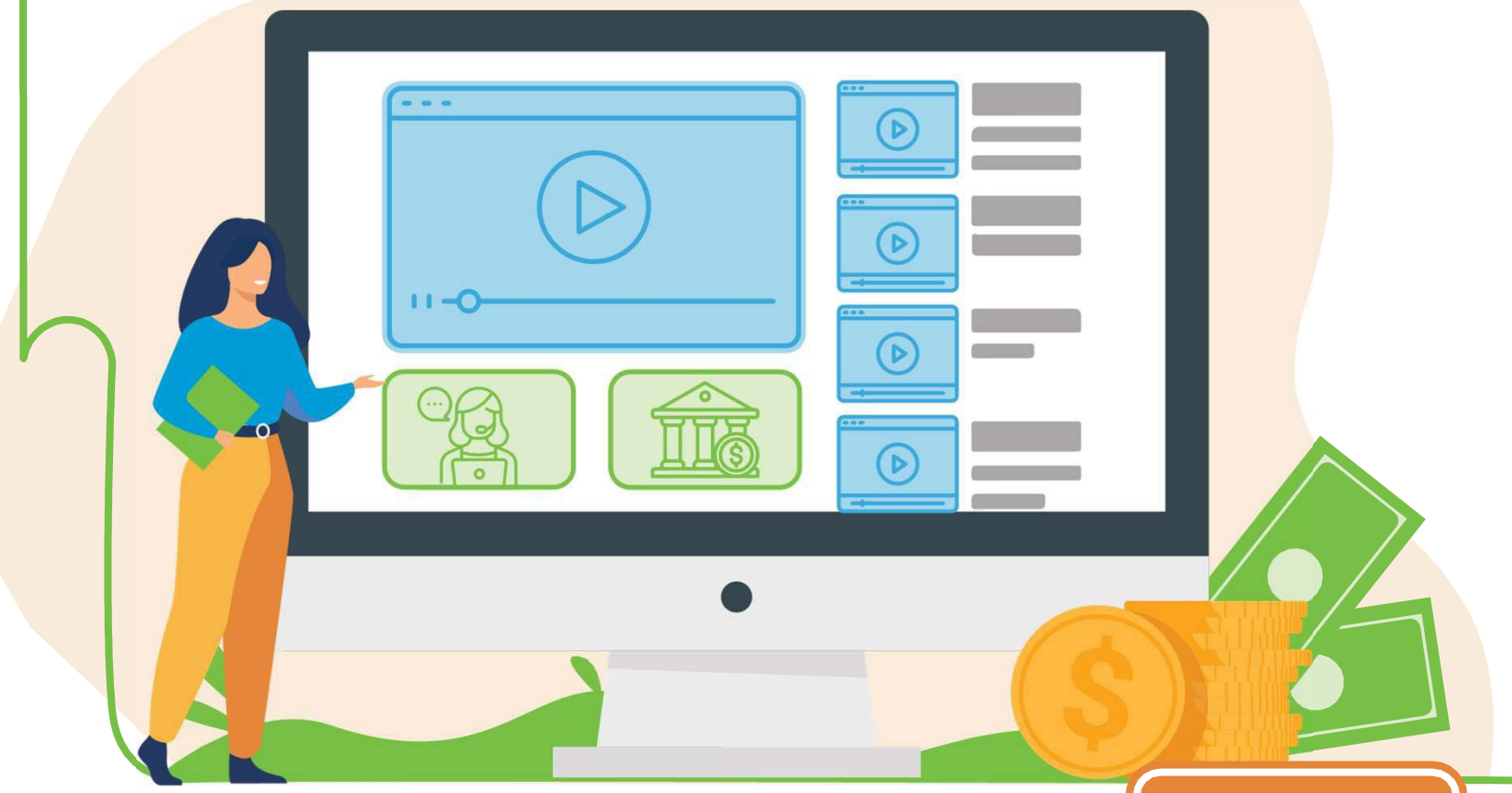
PLAN
INVEST
PROTECT

VOYA FINANCIAL

SMARTMap®
FINANCIAL WELLNESS

Welcome to your Pensionmark

Financial Wellness Hub



Learn about your retirement plan & financial wellness benefits

Get financial guidance from registered professionals

Access courses, calculators, financial trackers, and more

Scan QR Code to access or visit:

Caraday Healthcare 401(k) Plan (venrollment.com)

Email Us:
smartmap@pensionmark.com

Call Us:
(888) PEN-401K (736-4015)
M-F 8:30 am - 8:00 pm EST

Visit Us:
smartmap.pensionmark.com

ADDITIONAL BENEFITS

Need to take a leave of absence?

If you need to take a leave of absence, there is a two-step process to initiate the leave of absence.

1. Contact your Human Resources representative at your location to update your status in Paylocity to show that you are on leave of absence. HR can assist with questions you may have about taking a leave of absence.
2. Initiate your FMLASource request. If you have questions about your leave request, you can contact FMLASource. HR can assist with questions you may have about initiating your claim with FMLASource. There are a few ways to contact FMLA Source:

- Website: www.fmlasource.com
- Smartphone APP: FMLASource Now
- E-mail FMLACenter@fmlasource.com
- Phone: 1.877.GO2.FMLA (1.877.462.3652)
- Speak to a live rep from 7:30am – 9:30pm CT, Monday – Friday
- Automated (IVR) phone system available (24 hours)

FMLA Source will explain the leave process, open a request for you in their system, determine eligibility for FMLA or Personal leave of absence and request authorization to contact your health care provider if needed. You will receive a request letter along with next steps documentation within 5 days of reaching out. You will receive updates via phone or email of approaching deadlines throughout the leave.

If you have benefit coverage, you will transition to direct bill while out on leave. Information on the direct bill process will be mailed to your home. direct bill allows you to pay your benefit premiums online or through the mail in process. Be sure your address is current in Paylocity prior to going out on leave so that you receive communications timely.

ADDITIONAL BENEFITS

FMLASource®

FMLASource On The Go

With the new FMLASource mobile platform you now have anywhere, anytime access to FMLASource.com and its most important features. The mobile platform is free, easy to download, easy to navigate and simple to use. Download it today to:

- Open a new leave request
- View leave request details and decisions
- Generate absence reports
- Update current approved leaves
- Learn about federal FMLA regulations
- Contact FMLASource directly

To get started today, simply register on fmlasource.com and download the free mobile platform.

Check it out!

Register as a first-time user on fmlasource.com

- Go to fmlasource.com
- Click Register
- Enter Employee Number/Social Security Number and ZIP code
- Enter a Username (must be 6 characters and no spaces e.g., joesmith) and password
- Answer the other questions as accurately as possible

Download the app

- Search FMLASource (no space, one word)
- Select Install

For More Information

FMLASource provides you with quick access to experts who will answer questions, review guidelines and provide information regarding a job-protected medical or family leave of absence. Please contact FMLASource for information and forms required for your leave.

Call: 1.877.GO2.FMLA TDD: 800.697.0353
Fax: 877-309-0218 Online: fmlasource.com

Scan the QR code for easy access from your smartphone.

payactiv

Access money you've already earned

Access Anytime

- Get up to $500.00 of earned wages per pay period.
- Transfer to your bank or card
- Get cash at Walmart®[1]
- Use Uber® rides, Amazon Cash®

Spend Smarter

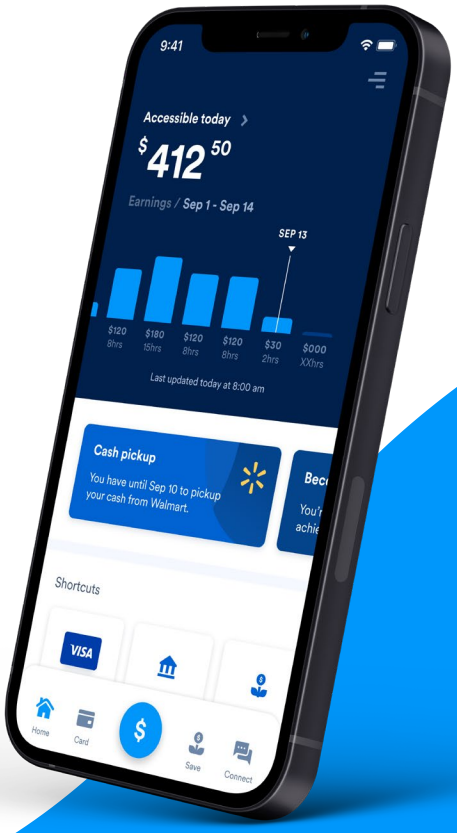
- Easily track earnings and spending in one place
- See what's safe to spend now
- Pay bills with earned wages

Save As You Go

- See what you can set aside safely
- Saving and budgeting tips
- Talk to financial coaches for advice
- Save up to 85% on Rx medicine

Getting Started

1. Create a Payactiv account with your employee ID.
2. When you access wages, the program fee is $1 for single or multiple transactions on the day you access funds.2
3. Additional fee of $1.99 per transaction may apply for instant deposit or Walmart cash pick up.



Want to learn more?

Scan the QR code or visit
payactiv.com/join-today

24/7/365 Customer Service: 1.877.937.6966
support@payactiv.com • www.payactiv.com/help

1 $1.99 processing fee for cash pick up at Walmart® or instant deposit to a debit card.

2 The program fee is capped at $3 for weekly and $5 for bi-weekly pay periods.

Control in Your Hands

Track and Pay Bills
Set reminders and schedule payments. Our built-in bill payment tool has over 80,000 billers.

Manage Your Card
Lock and replace your card if stolen or lost. Easily load it with direct deposit or by transferring your earned wages.

Save as You Go
Know what you could safely save and spend. Get discounts on prescription medications and other everyday items.

Stay in the Know
View your balance at any time. Track spending with transaction alerts and daily balance notifications.

Frequently Asked Questions

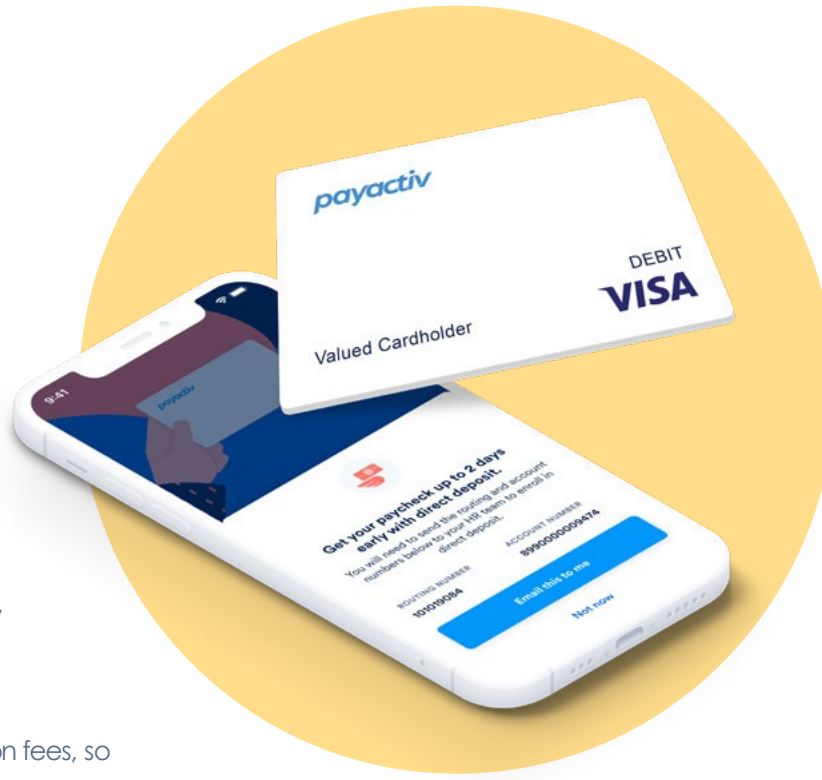
Is the Payactiv Visa® Payroll Card a credit card?
No. The Payactiv card is not a credit card.

Will using the Payactiv card affect my credit?
No. The Payactiv card is not a credit solution and will not affect your credit score in any way.

How long does it take to receive my Payactiv card?
At participating employers, you can get your card immediately. For cards ordered via the mobile app, allow 7-10 business days for the card to arrive at your place of residence.1

How can I check my balance on the Payactiv card?
You may check your card balance at any time by logging in to your Payactiv account through the app2, online, or by calling our customer service.

How much does it cost to get the Payactiv card?
Zero. Payactiv does not charge any enrollment or activation fees, so there is no cost to get the card.



[1] Delivery to some areas may take up to 3 days longer. [2] Standard message and data rates from your wireless service provider may apply.

The Payactiv Visa® Payroll Card is issued by Central Bank of Kansas City, Member FDIC, pursuant to a license from Visa U.S.A. Inc. Certain fees, terms, and conditions are associated with the approval, maintenance, and use of the Card. You should consult your Cardholder Agreement and the Fee Schedule at Payactiv.com/MyCard. If you have questions regarding the Card or such fees, terms, and conditions, you can contact us toll-free at 877-747-5862, 24 hours a day, 7 days a week.

KEY CONTACTS

For Questions About	Carrier/Contact Name	Phone Number	Website/Email	Plan/Group ID
Medical & Prescription Drug	Blue Cross Blue Shield of Texas	General Information: 972-766-6900 HMO: 877-299-2377 PPO: 800-521-2227	General Information: https://www.bcbstx.com HMO Provider Finder: (providerfinderonline.com)	352944
Telemedicine	Blue Cross Blue Shield of Texas	972-766-6900	Find a Telehealth Provider https://www.bcbstx.com/find-care/find-virtual-care	352944
Dental	Blue Cross Blue Shield of Texas	800-521-2227	Find a Dental Provider: https://www.bcbstx.com/find-care/providers-in-your-network/find-a-dentist	352944
Vision	Blue Cross Blue Shield of Texas	877-973-3238	Find a Vision Provider: https://member.eyemedvisioncare.com/bcbstx/en	VF028239
Employee Assistance Program	Blue Cross Blue Shield of Texas	866-899-1363	GuidanceResources.com	VF028239
Life and AD&D Insurance	Blue Cross Blue Shield of Texas	877-442-4207	https://www.bcbstx.com/ancillary/employees **Email:** AncillaryQuestionsTX@bcbstx.com	VF028239
Voluntary Short-Term Disability (STD)	Blue Cross Blue Shield of Texas	877-442-4207		VF028239
Voluntary Long-Term Disability (LTD)	Blue Cross Blue Shield of Texas	877-442-4207		VF028239
Voluntary Critical Illness	Blue Cross Blue Shield of Texas	877-442-4207		VF028239
Voluntary Accident	Blue Cross Blue Shield of Texas	877-442-4207		VF028239
401(k) Savings Plan	VoyaFinancial	800-584-6001	voyaretirementplans.com	862346
Benefit Plan and Claims	Lauren Maas	832-675-9031	lauren.maas@epicbrokers.com	N/A
FMLA	FMLA Source	1.877.GO2.FMLA (1.877.462.3652)	www.fmlasource.com **Email:** FMLACenter@fmlasource.com	N/A
Financial Wellness Hub	Pensionmark	(888) PEN-401K (736-4015)	smartmap@pensionmark.com	N/A
Pay Advance	Payactiv	1-877-937-6966	www.payactiv.com/help **Email:** support@payactiv.com	N/A

Human Resources (HR)	Email	Phone Number
	humanresouces@caradayhealth.com	737-221-5059

Health Plan Notices

MEDICARE NOTICE OF CREDITABLE COVERAGE

Important Notice About
Your Prescription Drug Coverage and Medicare

Notice of Creditable Coverage

This Notice applies only if you and/or your dependent(s) are enrolled in a Caraday Healthcare, LLC medical plan and you are eligible for Medicare. If this does not apply to you, you may ignore this notice.

Please read this notice carefully and keep it where you can find it. This notice has information about your prescription drug coverage with Caraday Healthcare, LLC and 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 employer 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 employer 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. **Caraday Healthcare, LLC has determined that the prescription drug coverage offered under the Caraday Healthcare, LLC plan(s) are, 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 coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your 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.

Health Plan Notices

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

If you decide to join a Medicare drug plan, your employer coverage may be affected. Contact your employer to find out whether you can get your employer coverage back later if you or your dependents drop the coverage and join a Medicare drug plan.

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 employer coverage and don't join a Medicare drug plan within 63 continuous days after the coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Employer 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 changes. You also may request a copy of this notice at any time.

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

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

For More Information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on

the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

August 1, 2026
Caraday Healthcare, LLC
1101 Thorpe Lane San Marcos, TX 78666
512-641-8805

Notice of HIPAA Special Enrollment Rights

If an eligible employee declines enrollment in a group health plan for the employee or the employee's spouse or dependents because of other health insurance or group health plan coverage, the eligible employee may be able to enroll him/herself and eligible dependents in this plan if eligibility is lost for the other coverage (or because the employer stops contributing toward this other coverage). However, the eligible employee must request enrollment within **30** days after the other coverage ends (or after the employer ceases contributions for the coverage).

In addition, if an eligible employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents, provided that the eligible employee requests enrollment within **30** days after the marriage, birth, adoption, or placement for adoption.

Furthermore, eligible employees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan or being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan.

To request special enrollment or obtain more information, contact your health plan.

Newborns' and Mothers' Health Protection Act Notice

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

Health Plan Notices

length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, contact your health plan.

Women's Health and Cancer Rights Act Notice

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. If you would like more information on WHCRA benefits, contact your health plan.

Notice of Availability of HIPAA Privacy Practices

In accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the purpose of this communication is to notify you of our privacy practices that limit who in the organization may use, discuss, review, and transmit the Protected Health Information ("PHI") of our employees and their families. The Notice of Privacy Practices explains how PHI may be used, and what rights you have regarding this information. Please take time to read the notice. It provides details about how we may use and disclose your information. The Notice of Privacy Practices is provided by Caraday Healthcare, LLC through the benefits guide and can be found below.

Notice of HIPAA Privacy Practices

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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Caraday Healthcare, LLC Health Plan (the "Plan") sponsored by Caraday Healthcare, LLC ("Plan Sponsor") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and subsequent amending regulations ("HIPAA Privacy Rule"). Among other things, this Notice describes how your protected health information may be used

or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this HIPAA Privacy Notice to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- Your past, present, or future physical or mental health or condition;
- The provision of health care to you; or
- The past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the individual listed at the end of this notice.

Our Responsibilities

Caraday Healthcare, LLC is required by law to:

- Maintain the privacy of your protected health information;
- Provide you with certain rights with respect to your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your Protected health information; and
- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised HIPAA Privacy Notice electronically or by first class mail to the last known address on file.

How We May Use and Disclose Your Protected Health Information

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

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

Health Plan Notices

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. We may share or discuss your PHI with your family members or others involved in your care or payment for your care, unless you object in writing and provide the objection to the Plan's HIPAA contact listed at the end of this Notice. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments. In any of these cases, we will disclose only the information necessary to resolve the issue at hand.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

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

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

Health Plan Notices

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

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

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

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

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

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

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

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;

- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

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

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

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

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

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

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

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

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

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

Required Disclosures

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

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

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

Other Disclosures

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

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

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

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

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

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the individual listed at the end of this Notice. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the individual listed at the end of this Notice.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the individual listed at the end of this Notice. You must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

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

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

To request this list or accounting of disclosures, you must submit it in writing to the individual listed at the end of this Notice. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

***Right to Request Restrictions*.** You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person. To request restrictions, you must send your request in writing the individual listed at the end of this notice.
In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

Health Plan Notices

To request confidential communications, you must make your request in writing the individual listed at the end of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact to the individual listed below. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

HIPAA Contact

Ginger Provencher
Benefits Manager
Caraday Healthcare, LLC
1101 Thorpe Lane San Marcos, TX 78666
512-641-8805
www.caradayhealth.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 March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, 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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

COBRA COVERAGE CONTINUATION RIGHTS

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 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.

COBRA COVERAGE CONTINUATION RIGHTS

WHAT IS COBRA CONTINUATION COVERAGE? (CONTINUED)

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

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

WHEN IS COBRA CONTINUATION COVERAGE AVAILABLE?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

COBRA COVERAGE CONTINUATION RIGHTS

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, Medicaid, 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.

COBRA COVERAGE CONTINUATION RIGHTS

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/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.

.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2026. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2026, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2026, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

_____.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Caraday Healthcare, LLC		4. Employer Identification Number (EIN) 84-3394616
5. Employer address 1101 THORPE LANE		6. Employer phone number 512-641-8805
7. City San Marcos	8. State TX	9. ZIP code 78666
10. Who can we contact about employee health coverage at this job? Human Resources (HR)		
11. Phone number (if different from above) 737-221-5059	12. Email address humanresouces@caradayhealth.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ■ Some employees. Eligible employees are:

    Full-time team members (working a minimum of 30 hours per week)
- With respect to dependents:
  - ■ We do offer coverage. Eligible dependents are:

    •Your legal spouse
    •Child(ren) up to age 26
    •Child(ren) of any age if you support the child and he or she is incapable of self-support due to disability
  - ☐ We do not offer coverage.

■ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NOTES

Prepared By

EPIC®

Insurance Brokers &
Consultants