2026
EMPLOYEE BENEFITS GUIDE

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WELCOME TO CITY OF RIPON!

At City of Ripon, we are committed to offering a comprehensive employee benefits program that helps our employees stay healthy, feel secure and maintain a work/life balance.

STAY HEALTHY

- Medical
- Dental
- Vision
- Flexible Spending Accounts

FEELING SECURE

- Life Insurance and Accidental Death & Dismemberment (AD&D)
- Long Term Disability Insurance

WORK/LIFE BALANCE

- Employee Assistance Programs

This booklet will answer some of the questions you have about your employee benefits. This document is a high-level summary of the major points of our benefit plans and is for informational purposes only. It does not cover all provisions, limitations, and exclusions. The official plan documents, policies, and certificates of insurance govern in all cases and are available for your review at any time. Guidance and interpretations relating to healthcare are being released on a regular basis. City of Ripon is not providing legal advice. If you have any questions about any of the benefits mentioned in this booklet, please contact Human Resources or visit the Intranet Café at www.cityofripon.org/cafe.

ELIGIBILITY & ENROLLMENT

ELIGIBILITY

All Full-time employees are eligible for coverage. Full-time employees are those scheduled to work a minimum of 30 hours per week.

Waiting Period

Your effective date for all benefits is the first of the month following date of hire.

Who Else Is Eligible?

If you enroll in benefits program, you may also enroll your eligible dependents.

Eligible dependents include:

- Your spouse to whom you are legally married
- Your registered domestic partner
- Children up to age 26

PLEASE NOTE:

Open Enrollment for 2026 benefits occurs October 1st through October 31st for a January 1st effective date. During this time, full-time employees may terminate, add, or change coverage.

Changing coverage does not apply to Blue Shield members.

OPEN ENROLLMENT

Each year during Open Enrollment, you have the opportunity to re-evaluate your benefit needs and adjust your coverage for the upcoming plan year. Once you make selections, you may not change your benefits during the year unless there is a qualifying life event. This Open Enrollment is for your benefits effective January 1, 2026.

ELECTION CHANGES

You may not change your benefit elections during the year unless you have a qualifying life event. When one of the following events occurs, you have 30 days from the date of the event to request changes to your coverage and provide documentation to support your qualifying life event. Your change in coverage must be consistent with your change in status.

QUALIFYING LIFE EVENTS INCLUDE:

- A change in your legal marital status (marriage, divorce, or legal separation).
- A change in the number of your dependents (through birth, adoption, or if a child is no longer an eligible dependent).
- A change in your spouse's or registered domestic partner's employment status (resulting in a loss or gain of coverage).
- A change in your benefit eligibility status (part-time to full-time, or full-time to part-time).

MEDICAL - CSAC/BLUE SHIELD & KAISER PERMANENTE

The chart below is a brief side by side benefit comparison of the medical plans offered by City of Ripon. Please see policy for complete benefit details. See chart below for employee monthly costs for 2026. Premiums will be a tax-free, FSA deduction twice a month. A completed form will be sent to you by end of year for your signature.

Please Note: If enrolling with Blue Shield, your enrollment is locked in for the duration of the plan. This means that if the City continues to offer the Blue Shield plan, you will be unable to change to a different insurance carrier at any time – even during open enrollment.

BRIEF BENEFIT COMPARISON		
BENEFITS	**CSAC - BLUE SHIELD**	**KAISER PERMANENTE**
DEDUCTIBLE		
Employee Only	$2,000 *	N/A
Employee + Dependents	$4,000 *	N/A
MAXIMUM OUT OF POCKET		
Employee Only	$5,000	$1,500
Employee + Dependents	$10,000	$3,000
PHYSICIAN SERVICES		
Primary Care Physician / Specialist	$30 Co-pay / $30 Co-pay	$20 Co-pay / $20 Co-pay
Preventive Care / Well Baby Care	$0 Co-pay	$0 Co-pay
Chiropractic – Plan payment max $50	20% after ded / 26 Visits Per Year	$10 Co-pay / 30 Visits Per Year
OUT-PATIENT SURGERY		
Hospital / Surgical Center	20% Co-ins after deductible	$100 Co-pay
IN-PATIENT HOSPITALIZATION		
Semi-private Room	20% Co-ins after deductible	$250 Co-pay
EMERGENCY CARE		
Emergency Room	$100 + 20% Co-ins after deductible	$50 Co-pay
OTHER SERVICES		
Laboratory & X-ray	$25 + 20% Co-ins after deductible	$10 Co-pay
Specialized	$100 + 20% Co-ins after deductible	$50 Co-pay
Hospital Facility - Laboratory & X-ray	20% Co-ins after deductible	$10 Co-pay
Hospital Facility - Specialized	20% Co-ins after deductible	$50 Co-pay
PRESCRIPTION BENEFIT		
Deductible: Namebrand & Non-Formulary	$200 Individual / $500 Family	$0
Generic Formulary	$10 Co-pay	$15 Co-pay
Namebrand Formulary	$20 Co-pay	$35 Co-pay
Non-Formulary	$45 Co-pay	N/A
Specialty Medication	30%; Max $150 Co-pay	$35 Co-pay
EMPLOYEE – MONTHLY COST	**CSAC – BLUE SHIELD**	**KAISER PERMANENTE**
Employee Only	$0.00	$0.00
Employee + Spouse	$0.00	$0.00
Employee + 1 Child	$0.00	$0.00
Employee + 2 or more Children	$347.87	$0.00
Employee + Family	$347.87	$400.97

*See Human Resources on deductible reimbursement program.

For Blue Shield Members –

ACCOLADE

Get virtual care and explore your benefits all in one place. The Accolade web portal and mobile app make it easy to:

- Speak to an online doctor or therapist – anytime, anywhere
- Explore your employee benefits
- Send a message to your Care Team
- Assist members with how to use outside programs such as,
  - Digbi Health
  - Carum Health
  - Hinge Health
  - Rx' n Go

VIRTUAL CARE (Replaces Teladoc)

See a doctor or therapist – day or night! With Accolade Care, you can see and speak with a board-certified doctor or therapist right from your phone, tablet or computer. You have access to:

- Doctors trained at top-tier medical institutions
- Same and next day virtual primary care visits

What we treat

- **Urgent Medical Issues**
  - Cold and flu
  - Urinary tract infections
  - Sinus and bacterial infections
  - Rashes
- **Ongoing Conditions**
  - Diabetes
  - High blood pressure
  - Anxiety or depression
  - Asthma
  - Thyroid Disorders
- **Everyday Care**
  - Prescriptions and refills
  - Birth control
  - HIV prevention (PrEP)
  - Preventive care and screenings

ACTIVATE YOUR ACCOLADE ACCOUNT TODAY

- Download the Accolade mobile app
  - Find us in the App Store or Google Play
  - Text ACCD to 67793* to get a download code or
  - Visit member.accolade.com on your computer
  - Or Scan the QR Code

Accolade

FOR KAISER MEMBERS –

MANAGE YOUR HEALTH ONLINE

With Kaiser Permanente, kp.org is your connection to great health and great care. Once you register, you'll have easy access to time saving tools and resources that help you stay on top of your health and keep you feeling great. Go to www.kp.org/register now and follow the sign on instructions. You'll need your medical record number which you can find on your Kaiser Permanente ID card.

MANAGE YOUR HEALTH ANYTIME, FROM ANYWHERE

Sign on anytime to:

- View most lab results
- Refill most prescriptions, Email your doctor's office with non-urgent questions
- Schedule and cancel routine appointments
- Use tools to help you manage your coverage and costs
- Download the Kaiser Permanente app: Once you've registered, you can download the Kaiser Permanente app to your smartphone to access these tools on the go.

VIDEO VISITS

Doctors are available 24/7/365 to resolve many of your non-emergency medical issues through phone or video consultations.

- See a physician for urgent health concerns by video visit – wherever you need
- Video visits are easy, secure, and part of you coordinated care, so you can always get the care you need
- There is no co-pay or coinsurance to pay or a deductible to meet
- Video visits are for certain conditions, such as:
    - Cold and flu symptoms
    - Allergies /Sinus problems
    - Bronchitis / Respiratory infections
    - Urinary Tract Infections
    - And more!

Schedule an appointment online from your kp.org account today!

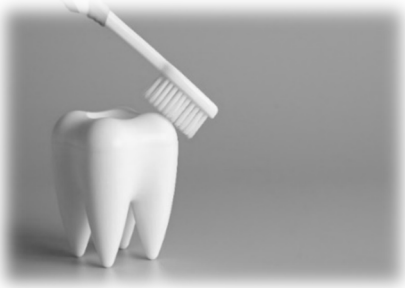
TOOLS AND RESOURCES FOR GOOD HEALTH

Included with your Kaiser Permanente Medical Insurance are wellness benefits, such as:

- Online wellness tools: visit kp.org/healthyliving for wellness information, health calculators, fitness videos, podcasts, and recipes from world-class chefs
- Healthy lifestyle programs: connect to better health with programs to help you lose weight, quit smoking, reduce stress, and more – all at no cost. Learn more at kp.org/healthylifestyles
- Health classes: sign up for health classes and support groups at many of our facilities. See what's available near you at kp.org/classes
- Special rates for members: enjoy reduced rates on products and services that can help you stay healthy – like gym memberships, massage therapy, and more. Explore your options at kp.org/choosehealthy

KAISER PERMANENTE®

DENTAL – CYPRESS



Taking care of your teeth can be expensive. That's why the right dental insurance is so important – it not only pays for preventive care that can keep you and your family healthy, but it also helps pay for more extensive, costly and often unexpected expenses. With this plan, you may see any dentist you wish for dental care. However, non-participating dentists can bill you for charges above the amount covered by your Cypress dental plan. To ensure you do not receive additional charges, visit a participating PPO network dentist. Out of network dentists may bill you for charges above the amount covered by your plan.

To locate in-network providers in your area, please visit the employee website at www.cityofripon.org/cafe.

This is a brief summary of benefits. Please see policy for complete benefit details.

Plan Features	In-Network (PPO)	Non-Network
Deductible		
Employee Only	$25	$25
Family Coverage	$75	$75
Deductible Waived for preventive?	Yes	Yes
Annual plan maximum (per individual) ***Preventive Services not Applicable***	$1,500	$1,500
Type I – Preventive Services	100%	100%
Type II - Basic Services	100%	80%
Type III - Major Services	60%	50%
Type IV - Orthodontia Services **Lifetime Maximum**	50% $1,000	50% $1,000
Waiting Periods – Major/Ortho	No waiting period for timely applicants	

Type I – Preventive Services, including, but not limited to:

- Routine oral exam (2 per year), Bitewing x-rays, Routine cleanings (3 per year), Fluoride treatment, Sealants, Fluoride (2 per 12 months for dependents under age 16), Full-mouth x-rays (once every 36 months)

Type II – Basic Services, including but not limited to:

- Restorative Fillings, Simple Extractions, Emergency Treatment, Endodontics, Periodontics, oral Surgery

Type III – Major Services, including, but not limited to:

- Crowns, Bridges, Dentures

Type IV – Child Orthodontia

Preventive Rewards

- Preventive services do not apply to the Calendar Year Maximum

VISION – SUN LIFE / VSP

Vision care benefits include coverage for eye exams, standard lenses and frames, and contact lenses.

Protect Your Eyes. You can help protect your eyesight by visiting an eye doctor regularly. Vision insurance includes an annual comprehensive eye exam with an eye care doctor. Taking care of your eyes today can lead to a better quality of life later.

Prevents Other Health Issues. Just annual preventive care alone can help detect signs of chronic health conditions such as high blood pressure and diabetes. Early detection can be key before costly symptoms arise.

Lowers Out-of-Pocket Expenses. Seeing an in-network eye care provider can reduce your expenses with savings on frames, lenses, contacts, eye exams and more. In-Network benefits are shown.

Please see benefit summary or Human Resources for complete plan details.

BENEFIT	DESCRIPTION	COST / ALLOWANCE	FREQUENCY
Vision Exam	Exam Co-pay	$25.00 Co-pay	12 Months
Frames	Frame Allowance	$130.00 for Frame and 20% off the amount over your allowance	24 Months
Lenses	Standard Lenses	$0.00 Co-pay	12 Months
Contact Lenses ***Contact lenses are in place of lenses and frame***	Exam, Fitting & Evaluation Allowance	$60.00 Co-pay $130.00	12 Months

How do I use my vision benefit?

Once enrolled, simply tell your doctor you are a VSP member, and they will handle the rest. If you visit an in-network doctor, you do not need an ID card or have forms to complete.

How do I locate an in-network VSP doctor?

You will have access to the largest national network of private-practice eye care doctors in the industry through VSP. There are three ways to find an in-network doctor:

1. Visit vsp.com and select the Choice Network
2. Call VSP at 800-877-7195
3. Download the VSP mobile app, Benefit Tools, and search for a doctor near you.

What happens if I use an out-of-network doctor?

You will be required to pay the full amount to the doctor at time of service. You can then submit a claim for reimbursement.

How can I get more information about my coverage?

Visit www.sunlife.com/account to create a Sun Life account. Once you are logged in, you'll be able to see your plan details and more. Or you can call VSP Customer Service at 800-877-7195.

LIFE INSURANCE & LONG TERM DISABILITY – SUN LIFE

TERM LIFE AND AD&D INSURANCE

Protect your family – Life insurance provides the people you love with financial support when you can't be there – and when they need it most.

How it works – City of Ripon is providing employee and dependent coverage at no cost to you!

Benefits:

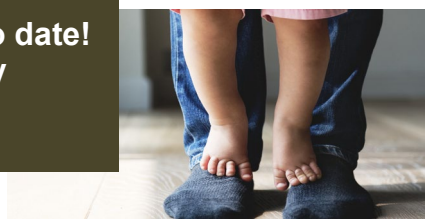
- **For you** - $25,000, with no medical questions asked.
  - Benefits are reduced to 65% at age 65 and to 50% at age 70.
  - Coverage ends at termination of employment or retirement.
- **For your spouse** - $5,000, with no medical questions asked.
  - Benefit may be reduced when the employee benefit amount is reduced.
- **For your child/ren** - $1,000
  - A full benefit is payable for a dependent child who is 24 days to 26 years old.
  - Benefit may be reduced when the employee benefit amount is reduced.

The policy includes an equal amount of AD&D insurance, which provides a benefit if you suffer a covered accidental injury or die from a covered accident.

Please see benefit summary for complete benefit details.

Don't forget!

Make sure your beneficiary information is up to date! Open Enrollment is a good time to make any necessary changes or updates.



LONG TERM DISABILITY

An accident or illness can put your life on hold. It may even mean you can't work. How do you pay your bills? Long-term disability replaces part of your income if you can't work due to a covered disability. You can use this money to help you pay everyday expenses, like your mortgage or rent, utilities, childcare and groceries.

How it Works - City of Ripon is providing this coverage at no cost to you!

- **Monthly benefit after your claim is approved** – you will receive a check for your benefits on a monthly basis. It will cover 60% of your Total Monthly Earnings, up to $6,000 each month.
- **When Benefits Begin** – Benefits begin as soon as 90 days.
- **Benefits may be paid for** – Until you reach the Social Security Normal Retirement Age, as long as you are still unable to work due to a covered disability.

Please see benefit summary for complete benefit details.

Sun Life

FLEXIBLE SPENDING ACCOUNT (FSA) - NAVIA

What is an FSA? Sometimes referred to as a Cafeteria Plan, Flex Plan, or Section 125 Plan – a Flexible Spending Account (FSA) allows you to set aside a certain amount of your earnings into an account before paying income taxes. If you are one of many people who spend money on out-of-pocket medical expenses, an FSA can make those expenses more affordable. During the year you have access to this account for reimbursement of expenses you regularly pay out of pocket. When you use tax-free dollars to pay for these expenses, you realize an increase in your spending power and substantial tax savings.

How it works. When you participate, you will elect to have a specified amount of money deducted on a pre-tax basis from your paycheck for 24 pay periods. The 2026 annual limit on salary reduction contributions to a health FSA offered under a cafeteria plan is $3,400. This limit is subject to change in subsequent years. Some examples of eligible expenses include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives
- Visit FSAstore.com to confirm if your claim is eligible for reimbursement

Use-it or Lose-It. All contributions must be used by the end of the plan year. However, City of Ripon does offer a $680 roll-over amount to the next year. This limit is subject to change in subsequent years. For complete FSA benefit details, please contact Navia at 800-669-3539.

DEPENDENT CARE FSA

A "DCAP" is a dependent care assistance program that is also an FSA. An employee can use a DCAP to be reimbursed for employment-related expenses that allow the employee and his or her spouse to be "gainfully employed." Common DCAP expenses are those incurred to have a babysitter or day-care provider take care of employee's children (only under the age of 13) while the employee and spouse are both working or to take care of a spouse or other tax dependent who lives with the employee and is incapable of self-care.

The annual maximum amount you may contribute to the Dependent Care FSA is $7,500 for single filers and married couples filing jointly or $3,750 if married and filing separately per calendar year. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Please Note: A valid Tax ID number from provider is required to file for reimbursement.

Use-it or Lose-It. If you do not use all the dollars contributed to the reimbursement account by the end of the plan year, remaining funds will be forfeited to the plan.

Tax Credit & DCAP Spending Accounts. If you participate in this plan, you cannot claim credits on your tax return for the same expenses. Any amount reimbursed under this plan will reduce the amount of dependent care expenses you can claim on your taxes. Before signing up, be sure to evaluate what will be more beneficial for you.

navia benefit solutions

EMPLOYEE ASSISTANCE PROGRAM –
SIMPLE EAP AND GUIDANCE RESOURCES

SIMPLE EAP

SimpleEAP offers expert guidance to help you and your family address and resolve everyday issues.

- In-the-moment support – reach a licensed clinician by phone 24/7/365
- Short-term counseling
- Coaching
- Work-life benefits
- Confidentiality – strict confidentiality standards ensure no one will know you have accessed the program without your written permission except as required by law.

Your web portal and mobile app

- Create a personal profile to quickly access support from a licensed clinician
- Receive recommendations and care options based on your unique needs
- Exchange text messages with a Coach
- Attend anonymous group support sessions on a variety of topics
- Strengthen your mental health and wellbeing at your own pace with self-guided digital therapy
- Discover flash courses, self-assessments, financial calculators, career resources, articles, tip sheets and videos

Access your Employee Assistance Program (EAP) any time at 1-888-425-4800 or visit www.simpleeap.com
Username: csjvrma

GUIDANCE RESOURCES

Through Guidance Resources you are entitled to three (3) phone sessions per incident, per plan period. Guidance Resources also offers legal, financial, wellness, family and relationships and work/life services. There is no charge for covered services. Contact Guidance Resources at 1-800-460-4374 or visit their website at www.guidanceresources.com
Company code: EAPEssential.

BENEFIT CONTACTS

RELATION INSURANCE SERVICES, INC.

Alan Jeppson, Broker: 209-653-9464
Debbie Pope, Account Manager: 209-554-4613

Resource	Phone Number	Website / E-Mail
MEDICAL INSURANCE		
CSAC/Blue Shield of CA Accolade – Customer Service	1-866-629-8769	www.blueshieldca.com member.accolade.com
Kaiser Permanente	1-800-464-4000	www.kp.org
DENTAL INSURANCE		
Cypress Dental PPO	1-800-350-3989	www.cypressadmin.com
VISION INSURANCE		
Sun Life -VSP	1-800-877-7195	www.vsp.com
FLEXIBLE SPENDING ACCOUNT		
Navia Benefit Solutions	1-800-669-3539	www.naviabenefits.com
LONG TERM DIABILITY, LIFE AND AD&D		
Sun Life Insurance	1-800-247-6875	www.sunlife.com/us
EMPLOYEE ASSISTANCE PROGRAM		
SIMPLE EAP	1-888-425-4800	www.simpleeap.com company code: csjvrma
Guidance Resources	1-800-460-4374	www.guidanceresources.com company ID: EAPEssential

QUESTIONS?

Remember, the information provided in this booklet is only a brief overview of the benefits offered to you by City of Ripon. Please see policy for complete benefit details.If you have any questions or would like additional information about any of the content in this booklet, please reach out to City of Ripon Human Resources at 209-599-0219 or Relation Insurance Services at 209-529-4530 Ext. 32958.

2026 FEDERAL NOTICES (ANNUAL)

HIPAA Special Enrollment Rights Notice

Loss of Other Coverage:

If you have declined or will be declining enrollment for yourself and/or your dependents because of other in force health plan coverage, you may be able to enroll yourself and/or your dependents in this plan in the future. If you or your dependents lose eligibility for that other coverage, or if the employer stops contributing towards other group health plan coverage, it may trigger a special enrollment right.

You must request enrollment in this **plan within 30 days** after the other coverage ends. You will be required to submit proof of prior coverage, such as a coverage termination letter from an insurance company or employer.

New Dependent:

If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and/or your dependents. This triggers a special enrollment right. However, you must request enrollment **within 30 days** after the marriage, birth, adoption, or placement for adoption. You will be required to submit proof of a newly eligible dependent, such as a marriage certificate or birth certificate.

Termination of Medicaid or CHIP Coverage:

If you and/or your dependents are covered under a Medicaid plan or a state child health insurance plan (CHIP), and coverage under such a plan is terminated because of loss of eligibility, you may be able to enroll yourself and/or your dependents in this plan, as it may trigger a special enrollment right.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan **within 60 days** after the date Medicaid or state sponsored CHIP coverage ends.

Eligibility for Premium Assistance Under Medicaid or CHIP:

If you and/or your dependents become eligible for premium assistance under Medicaid or a state CHIP, including under any waiver or demonstration project conducted under or in relation to such a plan, you may be able to enroll yourself and/or your dependents in this plan, as it may trigger a special enrollment right. This is usually a program where the state provides employed individuals with premium payment assistance for their employer's group health plan, rather than direct enrollment in a state Medicaid program.

To be eligible for this special enrollment opportunity you must request coverage under the group health plan within 60 days after the date you and/or your dependents become eligible for premium assistance under Medicaid or a state CHIP.

Please keep this notice in a secure place with your other health plan materials.

2026 FEDERAL NOTICES (ANNUAL)

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-KIDSNOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

CALIFORNIA – MEDICAID
Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
916.445.8322
Fax: 916.440.5676
Email: hipp@dhcs.ca.gov

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)

Please keep this notice in a secure place with your other health plan materials.

2026 FEDERAL NOTICES (ANNUAL)

Medicare Part D Disclosure Notice

Important Notice about your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about our company's group health plan prescription drug coverage, and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

Our company's group health plan is, on average for all plan participants, expected to pay as much as the standard Medicare prescription drug coverage will pay, and is considered "creditable coverage."

Because our plan is considered creditable coverage, you can enroll and/or stay enrolled in our plan and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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. All Medicare prescription 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.

Individuals (employees and/or their dependents) may enroll in a Medicare prescription drug plan when they first become eligible for Medicare, and each year from October 15th through December 7th, the annual Medicare Open Enrollment Period, with coverage effective on January 1st. Individuals leaving a group health plan during other times of the year may be eligible for a special enrollment period to sign up for a Medicare prescription drug plan.

If you do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you may not be able to get this coverage back. See below for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with your employer's group health plan and do not enroll in Medicare prescription drug coverage within 63 days after your current coverage ends, you may pay a higher premium (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium may go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may always be at least 19% higher than the regular premium. You will 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 Medicare Open Enrollment Period to enroll.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. You will receive a copy of the handbook in the mail from Medicare every year. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from these places:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov**, or call them at **(800) 772-1213; TTY (800) 325-0778**).

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare that offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you have maintained creditable coverage and are not required to pay a higher premium amount (a penalty).

2026 FEDERAL NOTICES (ANNUAL)

Women's Health and Cancer Rights Act Notice

This law requires group health plans providing coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies. We are pleased to inform you that your medical coverage follows this law.

As the Act requires, we have provided you this letter to inform you about the law's provisions. The law mandates that a member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed.
- surgery and reconstruction of the other breast to produce a symmetrical appearance.
- prostheses; and
- treatment of physical complications of all stages of mastectomy, including lymphedema

This coverage will be provided in consultation with the attending physician and the patient and will be subject to the same annual deductibles and coinsurance provisions applicable to the mastectomy.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on the back of your medical ID card.

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 insurers may not require that a provider obtain authorization from the plan or the insurer for prescribing a length of stay not more than 48 hours (or 96 hours).

HIPAA Notice of Privacy Practices Reminder

Our organization would like to communicate the availability of its Notice of Privacy Practices. At any time, a copy of the current Notice of Privacy Practices may be obtained by contacting Human Resources.

2026 FEDERAL NOTICES (ANNUAL)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

'Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

'Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

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

If you think you've been wrongly billed, *the federal phone number for information and complaints is: 1-800-985-3059*.

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