THE KADGROUP®

2023-2024 Benefits at a Glance

November 2023 - October 2024

This brochure provides an overview of the benefits package provided by The KAD Group® and powered by Lone Star Benefits. Actual benefits are subject to provisions and limitations of the agreement between The KAD Group® and its benefit providers.

Except where otherwise indicated, employees must work 32 hours per week, or meet the requirements for continuing eligibility during an approved leave of absence, to be eligible for the health and welfare benefits of this package. Certain individuals are excluded from participation. Please refer to the Summary Plan Description (SPD) for each plan for full eligibility requirements.

Questions about your KAD Benefits?

The KAD Group® has partnered with Lone Star benefits to provide a robust benefit package for the employees of KAD! For any questions on health, dental, vision, FSA, HSA, disability, life and AD&D benefits, please call the Lone Star Contact Center from 8am - 5pm CT, Monday through Friday. The Lone Star team will offer personal assistance with everything from choosing a medical coverage option to enrolling online and more. The personal representative for KAD employees is Kimberly Brown with Lone Star at 214-619-0934 or email to kbrown@LSBinc.com. KAD employees can also reach out to The KAD Group® at 972-294-5254.

Our KAD Brands

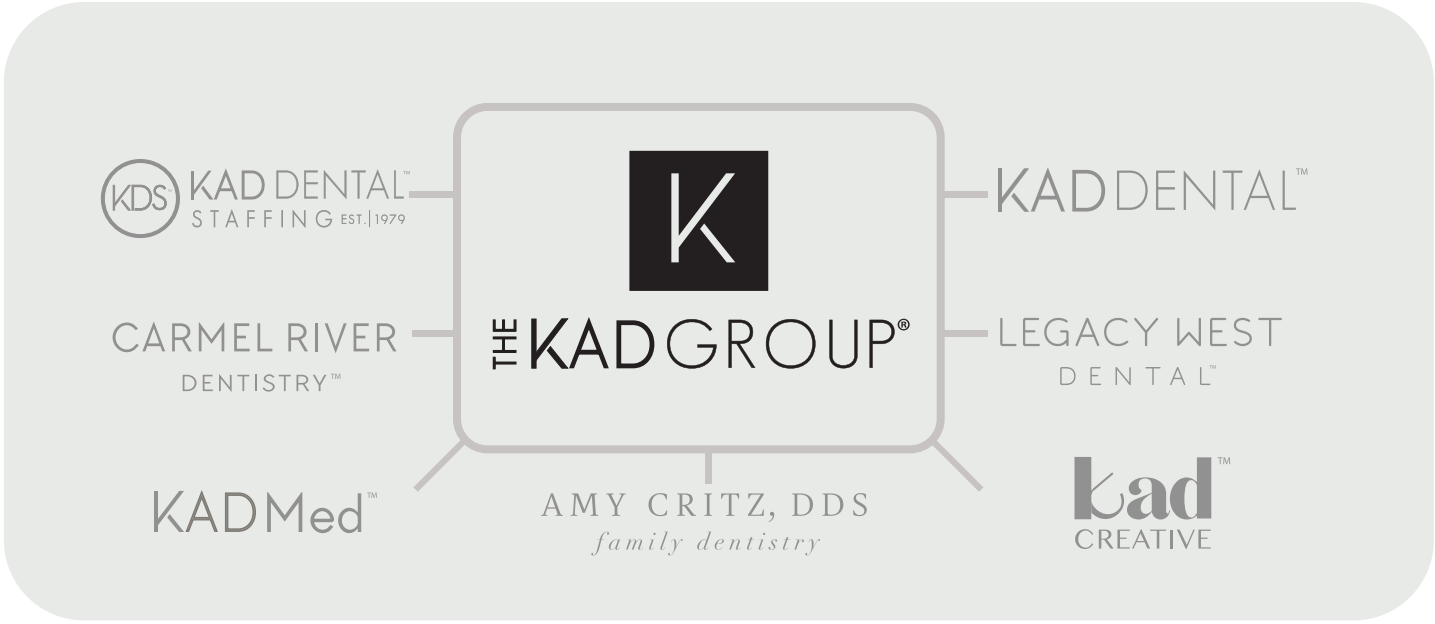


Table of Contents

Your benefits program overview

Who is Eligible

If you are a full-time employee who works a minimum of 32 hours per week, you are eligible to participate in the benefits program. You may also elect coverage for your eligible dependents. Eligible dependents are defined as:

- your legal spouse;
- domestic partner;
- eligible children up to age 26 (children are defined as your natural children, stepchildren, legally adopted children and children under your legal guardianship);
- physically or mentally disabled children of any age who are incapable of self-support.

Dependents must enroll in the same plan as the employee.

When to Enroll

Eligible employees may review and change their benefit elections during the annual Open Enrollment period which is October of each year. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, or if you experience a family status or other qualifying event. Please refer to the following page for examples of "Qualified Events."

How to Enroll

If you are a new employee, this guide will help you make your initial benefit elections.

If you are not a new employee and have previously made benefit elections, you may do the following during the Open Enrollment period:

1) Review your current benefit elections.
2) Verify your personal information and make changes, if necessary.
3) Utilize this guide to make benefit elections during the Open Enrollment period.

All Employees: Once you have made your elections, you will *not be able to change them until the next Open Enrollment period*, unless you incur a Qualifying Event.

How to Make Changes

If you experience any of the events listed below, you must notify Human Resources within 30 days of the event to make the necessary adjustments. Unfortunately, changes reported after the 30-day window are not able to be accepted. Members who do not report a qualifying event within the 30-day window will be required to wait until the next Open Enrollment period to make any changes. Qualified Events include:

- Marriage
- Divorce or legal separation
- Birth of a child
- Adoption of a child or placement for adoption
- Gain or loss of legal custody of a child
- Dependent child turns 26 years old
- Death of a dependent
- Medicare eligibility
- Dependent becomes disabled
- Termination of spouse's employment
- Spouse loses healthcare benefits
- Loss or gain of another group coverage
- Employment termination
- Death of the person upon whom you or your dependents depend for coverage
- Change in employment status (i.e. part-time, full-time) of the employee

What Documents are Required

Supporting documentation may be required to process a change related to a qualifying event. Examples of acceptable forms or documents include, but not limited to:

- Marriage Certificate
- Divorce Decree
- Birth Certificate
- Legal Adoption Paperwork
- Death Certificate
- Certificate of Creditable Coverage
- Documents indicating loss or gain of another group coverage
- Copy of insurance ID card

It is your responsibility to notify Human Resources of any qualifying event within 30 days of the qualifying event. Conact KAD at (972) 294 – 5254 or HR@thekadgroup.com.

KAD has a special way of making employees feel like family. We, as a company, value and show appreciation for one another and our clients on a daily basis. When my dad was sick in 2021, I had endless support and resources from my team members and leaders. They were there for everything from time off to helping me access legal and other advice. Not only are the people of KAD great, but the benefits are, too! From PTO to health and other insurances, and getting to build my own 401K, I feel so supported! I'm thankful for this company and love that I get to be part of it!

- Cailee T.

The KAD Health Care Flexible Spending Account Plan (FSA)

General Purpose FSA:

Available to full-time employees who work 32 hours per week (20+ hours in Hawaii) on average

When you enroll in a general purpose healthcare FSA plan, you can make pre-tax contributions up to the annual maximum through payroll deduction for qualifying health care expenses incured during the plan year. The limits for 2023 and 2024 are $3,050 for medical FSA and $5,000 for dependent care FSA.

Eligible expenses include, health plan deductibles, copays, coinsurance, prescription drug costs, certain medically necessary supplies and equipment, dental deductibles and coinsurance, and vision care services and supplies, such as exam copays, glasses, contacts and contact lens solution. See IRS 502 for a current list of qualified expenses.

Elect to contribute a monthly amount, up to a maximum annual contribution of $3,050.

An election to contribute to a healthcare FSA is generally irrevocable during the plan year (January 1, 2024 to December 31, 2024) and can only be changed in limited circumstances, called Qualifying Life Events. Please note that most life events do not allow a change to your FSA elections, so it is important to estimate your FSA needs carefully.

The funds you contribute to a healthcare FSA are subject to the "use-it-or-lose-it" rule. The KAD Group Health Care FSA will allow you to rollover a maximum of $610 into the next year, should you have a balance of funds remaining at the end of the 2024. To determine how much money you should put into your Health Care FSA, try to estimate as closely as possible the amount of qualified health care expenses you will have in 2024. The amount you choose to contribute into your account annually will then be divided and deducted equally from each of your weekly paychecks.

Tax considerations

IRS rules prohibit individuals with general purpose health care FSA coverage (including an eligible spouse or dependents) from contributing to a health savings account HSA. If you are covered by a Qualified High Deductible Health Plan, also known as an HSA plan, you are not eligible to contribute to a general purpose healthcare FSA. You may, however, contribute to a limited purpose healthcare FSA.

The General Purpose Healthcare FSA is administered by Paylocity. Participants will have access to an online portal and a mobile app from which you can view your account balance, request reimbursements, and more.

Limited Purpose Health Care FSA:

A limited health FSA allows you to pay for eligible vision and dental expenses that are not covered by another health plan. A limited health FSA is a great option if you (or your spouse, if you're married) contribute to a Health Savings Account (HSA) because you can participate in both of these plans at the same time.

NOTE: Only for those currently enrolled in an HSA plan can contribute to a limited purpose healthcare FSA.

(FSA) Continued:

Dependent Care FSA:

A Dependent Care FSA allows you to set aside pre-tax funds to pay for daycare expenses for children or other eligible dependents. You (and your spouse, if you're married) must be working, looking for work, or be a full-time student to use this account. When you enroll in this plan, you choose how much pre-tax money you would like to contribute to the FSA, up to the $5,000.

When you enroll in a Dependent Care FSA, you pay for your eligible daycare expenses out-of-pocket and then are reimbursed after completing a claim form. Claims for reimbursement can be submitted through your online account or on the mobile app.

NOTE FOR MARRIED PARTICIPANTS: The $5,000 annual contribution maximum is a family maximum. If you and your spouse will file a joint federal tax return for this year, you may only contribute a combined total of $5,000 to a Dependent Care Account between both of your employers. If you and your spouse will file separate federal tax returns for this year, you may only contribute a maximum of $2,500 to a Dependent Care Account, even if your spouse does not contribute to, or is not offered, a Dependent Care Account at his or her employer.

Remember with FSA funds, you "use it or lose it." To determine how much money you should put into your Dependent Care FSA, try to estimate as closely as possible the amount of money you will spend on qualified dependent care (such as daycare, after school care, and more… see the "Dependent Care Eligible Expenses" flyer). The amount you choose to contribute into your account annually will then be divided and deducted equally from each of your weekly paychecks.

» **All Health Care FSA members will receive a Benefit Card which is a debit card that you can use when paying for your qualified health care expenses.**

I really appreciate the way KAD cares about its team members. A great example is that KAD offers the same benefit package to everyone who works full-time, no matter your role in the company. To me, this is just one of the ways KAD shows a truly human touch to its operation.

-Cara F.

The KAD Health Savings Account Plan (HSA)

Available to full-time employees who work 32 hours per week (20+ hours in Hawaii) on average
You have the option to enroll in a medical plan considered Health Savings Account (HSA). Qualified members that enroll in this plan may open their own HSA bank account and contribute funds that can be used for qualified medical, dental, and vision expenses. The HSA contributions that members make may either be deducted from their taxable income on their annual income tax return or your employer can make pre-tax deduct employees' contributions from your paychecks and deposit those funds directly into members' HSA account. Members may only contribute up to the annual contribution max set by the IRS.

For 2023, the annual contribution max for a member enrolled on an HSA qualified plan with Self-only coverage is $3,850 and for Family coverage is $7,750. For, 2024, the annual contribution max for a member enrolled on an HSA qualified plan with Self-only coverage is $4,150 and for Family coverage is $8,300.

Any member age 55 and older can make an additional annual catch-up contribution up to $1,000 in 2023. If you enroll in Medicare, you are no longer eligible per IRS regulations to make contributions to your HSA account. Unused funds remain yours and rollover year after year. Please refer to IRS guidelines for further details.

Examples of Eligible HSA Expenses

- Acupuncture
- Fertility Enhancement
- Optometrist
- Ambulance
- Guide Dog or Service Animal
- Osteopath
- Birth Control Pills
- Hearing Aids
- Prosthesis
- Body Scan
- Home Care
- Psychologist & Psychiatric Care
- Breast Pumps and Supplies
- Hospital Services
- Special Education
- Insurance Premiums - see IRS list
- Sterilization
- Chiropractor Laboratory Fees
- Stop-Smoking Programs
- Christian Science Practitioner
- Lifetime Care-Advance Payments
- Surgery
- Crutches
- Dental Treatment (not teeth whitening)
- Medical Services
- Vasectomy
- Diagnostic Devices Medicines (many over-the-counter)
- Vision Correction Surgery
- Drug/Alcohol Addiction Treatment
- Drugs (including some over-the-counter)
- Nursing Services & Home Care
- Wheelchair
- Eye Exam/Glasses/ Contacts/Surgery
- Operations
- X-Ray
- Transportation/Trips - for medical care
- Long-term care
- Capital Expenses - ramps, rails, etc.
- Nursing Home
- Weight-Loss Program

Questions?
Call Lone Star Benefits at
(214) 619 - 0934 or
The KAD Group® at (972) 294 - 5254

Voluntary Short-term and Long-term Disability Benefits

Available to full-time employees who work 32 hours per week (20+ hours in Hawaii) on average
Voluntary (100% employee-paid) disability insurance provides income protection if you are unable to perform your job due to illness or injury (including pregnancy/childbirth).

Disability benefits pay you up to 60% of your covered earnings.

• **Short-term disability insurance pays up to 60% of covered monthly earnings up to $1,900 per week.** There is a 14-day elimination/waiting period for short-term disability benefits. Benefits begin on the 15th day of disability and continue for up to 24 weeks following the elimination period or the end of the disability, whichever comes first.

• Long-term disability insurance pays up to 60% of covered weekly earnings up to $8,000 per month. Benefits begin after 180 days of continuous disability. The duration of long-term disability payments will depend on the circumstances of the disability and the age you become disabled. Refer to the Certificate of Coverage for details.

How are covered earnings calculated for disability, life and AD&D insurance?

For full-time employees, covered earnings will generally be your base annual salary plus actual earnings for the previous 12 months. Actual earnings include commisions, piece-work and fee based work. It does not include bonuses, overtime pay, special pay or another form of extra compensation. (If the employee has been employed for less than 12 months, actual earnings will be annualized.) Refer to the Certificate of Coverage for full details.

Principal Voluntary Disability Benefits

Disability coverages offer income protection and will pay a portion of your earnings if you are unable to work.

Principal Short Term Disability (STD)

Benefit Percentage	60% of your weekly earnings up to $1,900
Maximum Weekly Benefit	$1,900
Benefit Waiting Period:	
Accident	14 Days
Sickness	14 Days
Benefit Duration	24 Weeks
Pre-existing Condition	
(look-back period/treatment period)	3/12
Rate per $10 of weekly benefit:	
<20	$0.520
20-24	$0.520
25-29	$0.690
30-34	$1.190
35-39	$0.700
40-44	$0.420
45-49	$0.340
50-54	$0.420
55-59	$0.490
60-64	$0.600
65-69	$0.660
70-99	$0.790

Principal Long Term Disability (LTD)

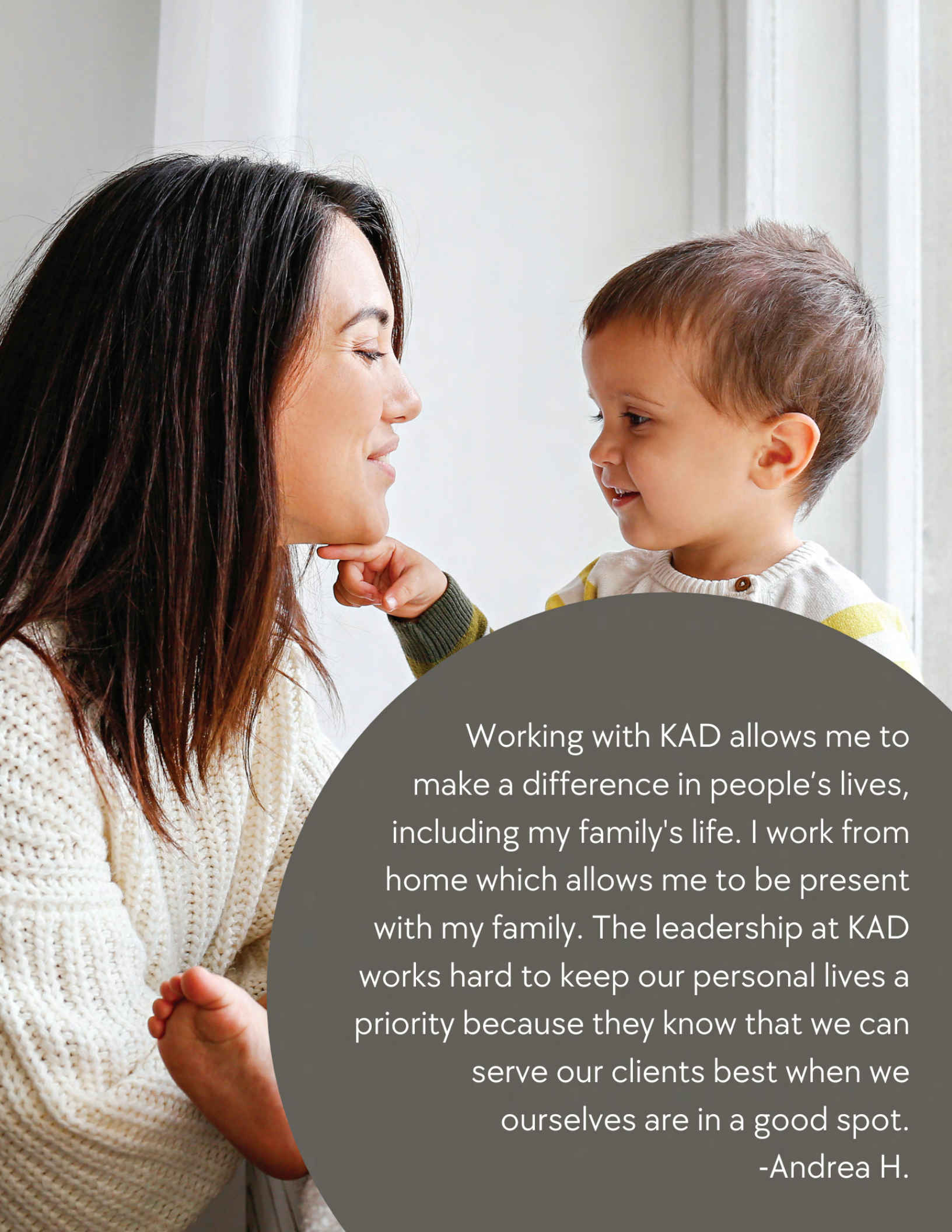
Benefit Percentage	60% of your monthly earnings up to $1,900
Maximum Monthly Benefit	$8,000
Elimination Period	180 Days
Own Occupation Period	24 Months
Survivor Benefit	3 Months
Benefit Duration	To Age 65
Pre-existing Condition	
(look-back period/treatment period)	12/12
Rate per $100 of weekly benefit:	
<20	$0.170
20-24	$0.170
25-29	$0.210
30-34	$0.360
35-39	$0.480
40-44	$0.680
45-49	$0.840
50-54	$0.920
55-59	$1.630
60-64	$0.770
65-69	$0.320
70-99	$0.580

Life and Accidental Death & Dismemberment Insurance

Available to full-time employees who work 32 hours per week (20+ hours in Hawaii) on average

Basic (100% employer-paid) life and AD&D insurance is provided automatically at no cost to eligible employees (no enrollment required). You may also elect voluntary (employee-paid) life and voluntary (100% employee-paid) AD&D insurance for yourself and eligible dependents. Coverage in excess of the guaranteed issue amounts indicated below is subject to proof of good health.

Benefit	Available coverage amounts	Coverage details
Basic Life & AD&D Insurance (100% employer-paid)	**Employee** $50,000	Provided automatically to eligible employees. No enrollment is required. Reduces to 65% at age 65/ Reduces to 50% at age 70.
Voluntary Life Insurance (100% employee-paid)	**Employee** Up to $300,000, with minimum amount of coverage at $10,000, and guaranteed amount at $150,000.	Guaranteed issue amount for employee is up to $150,000 for employees under 70 and $10k for employees 70 and over.
	Spouse Maximum amount of $100,000 Minimum amount of $5,000 Guaranteed Issue Amount $30,000	Guaranteed issue amount for spouse is $30,000 for spouses under 70 and $10k for spouses 70 and over.
Rate per $1000 of Coverage:		
0-24		$0.075
25-29		$0.075
30-34		$0.089
35-39		$0.143
40-44		$0.215
45-49		$0.323
50-54		$0.531
55-59		$0.849
60-64		$1.288
65-69		$2.189
70-74		$3.947
75-79		$3.947
80 & Over		$3.947
AD&D Rate		$0.019
Child Benefit		
Child Benefit **Voluntary Life Insurance** (100% employee-paid)	Live Birth to 14 Days 14 Days to 6 Months 6 Months and Older	$1,000 $10,000 $10,000
Child Life Rate		$2 per Family
Child Life Rate Rate Guaranteed		$2.00 per Family 24 Months



Working with KAD allows me to make a difference in people's lives, including my family's life. I work from home which allows me to be present with my family. The leadership at KAD works hard to keep our personal lives a priority because they know that we can serve our clients best when we ourselves are in a good spot.

-Andrea H.

National Medical Coverage Options

Medical (in-network)

Coverage options		UHC Choice Plus PPO HSA DDYP 3,000	UHC Choice Plus PPO BCY4 1,500	UHC Choice Plus PPO BCY5 2,000	UHC Choice Plus PPO ANDL 5,000	UHC Choice Plus PPO BMDN 6,000
Coinsurance UHC pays after deductible		80%	50%	50%	80%	80%
Medical calendar-year deductible	individual	3,000	1,500	2,000	5,000	6,000
	family	6,000	3,000	4,000	10,000	12,000
Annual out-of-pocket maximum*	individual	6,350	5,000	6,000	6,500	7,150
	family	12,700	10,000	12,000	13,000	14,300
Office visit		20%**	$25	$30	$0	$15
Specialist visit		20%**	$50	$60	$100	$100
Virtual visit		$49	$0	$0	$0	$0
Urgent Care		20%**	$75	$75	$50	$25
Annual preventative care		Covered 100%	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Diagnostic Lab & X-Ray		20%**	Covered 100%	Covered 100%	20%**	20%**
Imaging (CT, PET Scans, MRI)		20%**	50%**	50%**	20%**	20%**
Hospital Services						
Inpatient		20%**	50%**	50%**	20%**	20%**
Outpatient Surgery		20%**	50%**	50%**	20%**	20%**
Emergency Room		20%**	$250***	$250**	$250***	$300***
Prescriptions (CVS not in network)		For the HSA, DDYP plan, copays applied after deductible is met.				
Tier 1		$10	$10	$10	$10	$10
Tier 2		$35	$35	$35	$35	$35
Tier 3		$70	$85	$85	$85	$85

* Out-of-Pocket Maximums include all applicable deductibles, co-pays, and coinsurance paid by the member.

** Deductible must be met before coinsurance will apply.

*** Plus all applicable deductibles and coinsurance paid by the member.

National Medical Coverage Options

Medical (out-of-network)

Coverage options		UHC Choice Plus PPO HSA DDYP 3,000	UHC Choice Plus PPO BCY4 1,500	UHC Choice Plus PPO BCY5 2,000	UHC Choice Plus PPO ANDL 5,000	UHC Choice Plus PPO BMDN 6,000
Coinsurance UHC pays after deductible		50%	50%	50%	50%	50%
Medical calendar-year deductible	individual	$5,000	$5,000	$5,000	$10,000	$10,000
	family	$10,000	$10,000	$10,000	$20,000	$20,000
Annual out-of-pocket maximum*	individual	$10,000	$10,000	$10,000	$20,000	$20,000
	family	$20,000	$20,000	$20,000	$40,000	$40,000
Office visit		50%**	50%**	50%**	50%**	50%**
Specialist visit		50%**	50%**	50%**	50%**	50%**
Virtual visit		$49	$0	$0	$0	$0
Urgent Care		50%**	50%**	50%**	50%**	50%**
Annual preventative care		50%**	50%**	50%**	50%**	50%**
Diagnostic Lab & X-Ray		50%**	50%**	50%**	50%**	50%**
Imaging (CT, PET Scans, MRI)		50%**	50%**	50%**	50%**	50%**
Hospital Services						
Inpatient		50%**	50%**	50%**	50%**	50%**
Outpatient Surgery		50%**	50%**	50%**	50%**	50%**
Emergency Room		50%**	$250***	$250***	$250***	$300***
Prescriptions (CVS not in network)		For the HSA, DDYP plan, copays applied after deductible is met.				
Tier 1		$10	$10	$10	$10	$10
Tier 2		$35	$35	$35	$35	$35
Tier 3		$70	$85	$85	$85	$85

* Out-of-Pocket Maximums include all applicable deductibles, co-pays, and coinsurance paid by the member.

** Deductible must be met before coinsurance will apply.

*** Plus all applicable deductibles and coinsurance paid by the member.

Payroll Deductions

$250.00 monthly will be contributed toward the cost of coverage for your dependents. This amount and your remaining portion will be split across all of your monthly payroll payments. The amounts below do not include the $250.00 dependent care contributions so you will need to subtract that amount from the premium paid by member amount shown below.

2023-2024 Medical Rates

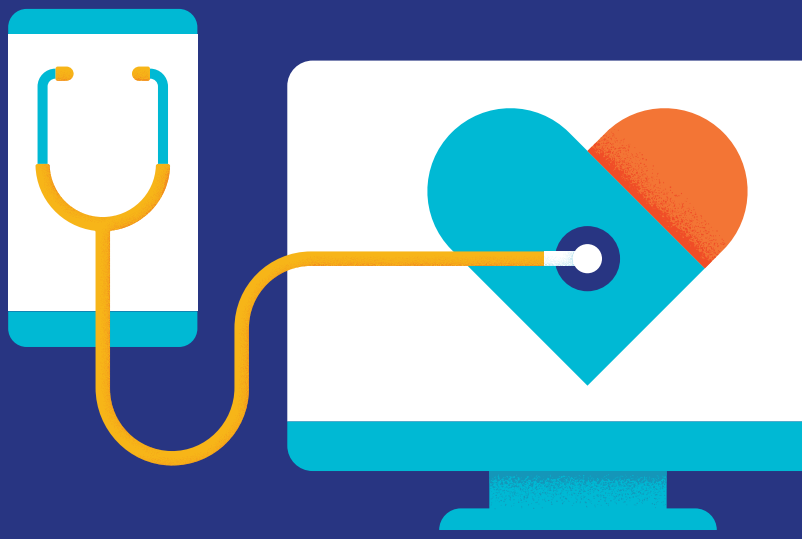
DDYP - HSA	Total Monthly Premium	Monthly Premium Paid by Member	ER covers 100% of the EO premium
Employee Only	**$593.63**	**$0.00**	**$593.63**
Employee + Spouse	$1244.34	$650.71	
Employee + Children	$1126.03	$532.40	
Employee + Family	$1836.69	$1243.06	
BCY4	Total Monthly Premium	Monthly Premium Paid by Member	ER covers 100% of the EO premium
Employee Only	**$769.34**	**$0.00**	**$769.34**
Employee + Spouse	$1612.66	$843.32	
Employee + Children	$1459.33	$689.99	
Employee + Family	$2380.34	$1611.00	
BCY5	Total Monthly Premium	Monthly Premium Paid by Member	ER covers 100% of the EO premium
Employee Only	**$742.67**	**$0.00**	**$742.67**
Employee + Spouse	$1556.76	$814.09	
Employee + Children	$1408.74	$666.07	
Employee + Family	$2297.82	$1555.15	
ANDL	Total Monthly Premium	Monthly Premium Paid by Member	ER covers 100% of the EO premium
Employee Only	**$655.80**	**$0.00**	**$655.80**
Employee + Spouse	$1374.66	$718.86	
Employee + Children	$1243.96	$588.16	
Employee + Family	$2029.04	$1373.24	
BMDN	Total Monthly Premium	Monthly Premium Paid by Member	ER covers 100% of the EO premium
Employee Only	**$646.59**	**$0.00**	**$646.59**
Employee + Spouse	$1355.36	$708.77	
Employee + Children	$1226.49	$579.90	
Employee + Family	$2000.55	$1353.96	

2023-2024 Dental & Vision Rates (An EE must elect vision & dental combined.)

Dental	Total Monthly Premium	Monthly Premium Paid by Member	ER covers 100% of the EO premium
Employee Only	**$47.06**	**$0.00**	**$47.06**
Employee + Spouse	$91.55	$44.49	
Employee + Children	$93.26	$46.20	
Employee + Family	$142.03	$94.97	

As a mom of 3, my number one priority is my family, and working with KAD allows me to prioritize both career and family. Their benefit package and leadership offers opportunities to everyone, taking personal lives into account. Thanks to KAD, I can maintain my passion as a hygienist while still attending to my number one priority which is my family!

- Christina P.



Activate your myuhc.com account

Put your health plan at your fingertips

Get the most out of your benefits

Your personalized website, **myuhc.com®**, features tools designed to help you:

- **Find, price and save on care—**you can save with Virtual Visits* and other tools. You can save an average of 36%[1] when you compare costs for providers and services
- **Get care from anywhere** with Virtual Visits. A doctor can diagnose common conditions by phone or video 24/7
- **Understand your benefits** and the financial impact of care decisions
- **Find tailored recommendations** regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status
- **Access claim details,** plan balances and your health plan ID card quickly
- **Follow through on clinical recommendations** and access wellness programs
- **Order prescription refills,** get estimates and compare medication pricing**
- **Check your plan balances,** access financial accounts and more

Download the UnitedHealthcare® app

It's perfect for on-the-go access, help finding a nearby doctor and more.

*Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

**Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

continued

United Healthcare

Activation is quick

1. Go to **myuhc.com > Register Now**
2. Fill out the required fields and create your username/password
3. Enter your contact information and security questions
4. Agree to the website's policies and be sure to opt-in for email updates. We promise you'll only see our name in your inbox with relevant news and wellness updates

Get started at myuhc.com

United Healthcare

[1] UnitedHealthcare Internal Claims Analysis, 2019.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Visit with a doctor 24/7 — whenever, wherever

With a Virtual Visit, you can talk—by phone[1] or video—to a doctor who can diagnose common medical conditions and even prescribe medications, if needed.[2]

Virtual Visits may make it easier than ever to get treated by a doctor

Whether using **myuhc.com®** or the UnitedHealthcare® app, Virtual Visits let you video chat with a doctor 24/7—without setting up additional accounts or apps. But, if you'd rather just speak with a doctor, you can simply do a Virtual Visit over the phone. **With a UnitedHealthcare plan, your cost for a Virtual Visit is $0.[3]**

Use a Virtual Visit for these common conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- and more

$0 cost

An estimated 25% of ER visits could be treated with a Virtual Visit — bringing a potential $2,000[4] cost down to $0.

Get started

Sign in at **myuhc.com/virtualvisits** | Call **1-855-615-8335**
Download the UnitedHealthcare app

United Healthcare

[1] Data rates may apply.

[2] Certain prescriptions may not be available, and other restrictions may apply.

[3] The Designated Virtual Visit Provider's reduced rate for a Virtual Visit is subject to change at any time.

[4] Source 2019: Average allowed amounts charged by UnitedHealthcare Network Providers and not tied to a specific condition or treatment. Actual payments may vary depending upon benefit coverage. (Estimated $2,000.00 difference between the average emergency room visit and the average urgent care visit.) The information and estimates provided are for general informational and illustrative purposes only and is not intended to be nor should be construed as medical advice or a substitute for your doctor's care. You should consult with an appropriate health care professional to determine what may be right for you. In an emergency, call 911 or go to the nearest emergency room.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company and its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

Get more from your health plan with these programs

At UnitedHealthcare, we're continuing to make our health and wellness programs better and easier to use, helping improve how you interact with your care.

Virtual Visits

Whether on your computer via **myuhc.com®** or on your mobile device* via the UnitedHealthcare® app, Virtual Visits let you and your covered family members video chat with a doctor 24/7 — no additional accounts, passwords or apps. With Virtual Visits, doctors can diagnose a wide range of nonemergency medical conditions — and even prescribe medications, if needed.* *

UnitedHealthcare app

The UnitedHealthcare app helps you find care, review and manage claims, share your digital health plan ID card and more — all from the palm of your hand. Plus, you can log in with Touch ID®, and even video chat with a doctor 24/7.

Employee Assistance Program (EAP)

Connects members to clinical, wellness, financial, legal or counseling resources anytime, day or night.

Advocate4Me

Whether via **myuhc.com** webchat or the mobile app, Advocate4Me® connects you with an expert over the phone — someone who can provide you with information and support to help you understand your benefits and claims, make more informed decisions about your health and access the care that fits your needs.

Rally

Rally® is a personalized digital experience designed to help you make small changes that may help improve your health. With missions built to help improve your diet, fitness and mood, you'll earn Rally Coins that you can use for a chance to win rewards.

*Data rates may apply.
**Certain prescriptions may not be available, and other restrictions may apply.

continued

United Healthcare

Real Appeal

Real Appeal® is a weight loss program designed to help you lose weight and keep it off. From personalized 1-on-1 coaching to a Success Kit with simple steps toward transformation to an app with tracking tools and more, Real Appeal gives you up to a full year of support — and it's included in your health plan at no additional cost to you.

Quit For Life

Quit For Life® is a clinically proven tobacco cessation program offered in collaboration with the American Cancer Society®. Digital and telephonic tools and resources — along with physical, psychological and behavioral strategies — help provide members with a personalized quit plan to overcome their tobacco addiction.

Learn more

Contact your UnitedHealthcare representative for additional information

United Healthcare

[1] Motion is available at no extra cost and rewards vary by plan.

Rally Health provides health and well-being information and support as part of your health plan. It does not provide medical advice or other health services, and is not a substitute for your doctor's care. If you have specific health care needs, consult an appropriate health care professional. Participation in the Health Survey is voluntary. Your responses will be kept confidential in accordance with the law and will only be used to provide health and wellness recommendations or conduct other plan activities.

Virtual Visits and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times or in all locations.

The material provided through the Employee Assistance Program (EAP) is for informational purposes only. EAP staff cannot diagnose problems or suggest treatment. EAP is not a substitute for your doctor's care. Employees are encouraged to discuss with their doctor how the information provided may be right for them. Your health information is kept confidential in accordance with the law. EAP is not an insurance program and may be discontinued at any time. Due to the potential for a conflict of interest, legal consultation will not be provided on issues that may involve legal action against UnitedHealthcare or its affiliates, or any entity through which the caller is receiving these services directly or indirectly (e.g., employer or health plan). This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

Real Appeal is a voluntary weight loss program that is offered to eligible participants as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receive items/tools.

The Advocate4Me service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room. The information provided through the program is for informational purposes only and provided as part of your health plan. Wellness nurses, coaches and other representatives cannot diagnose problems or recommend treatment and are not a substitute for your doctor's care. Your health information is kept confidential in accordance with the law. The program is not an insurance program and may be discontinued at any time. Additionally, if there is any difference between this information and your coverage documents (Summary Plan Description, Schedule of Benefits, and any attached Riders and/or Amendments), your coverage documents govern. Cost savings and health outcome results identified are not guaranteed.

The Quit For Life Program provides information regarding tobacco cessation methods and related well-being support. Any health information provided by you is kept confidential in accordance with the law. The Quit For Life Program does not provide clinical treatment or medical services and should not be considered a substitute for your doctor's care. Please discuss with your doctor how the information provided is right for you. Participation in this program is voluntary. If you have specific health care needs or questions, consult an appropriate health care professional. This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.

UnitedHealthcare Motion is a voluntary program. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. You should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for you. Receiving an activity tracker and/or certain credits and/or purchasing an activity tracker with earnings may have tax implications. You should consult an appropriate tax professional to determine if you have any tax obligations from receiving an activity tracker and/or certain credits under this program, as applicable. If any fraudulent activity is detected (e.g., misrepresented physical activity), you may be suspended and/or terminated from the program. If you are unable to meet a standard related to health factor to receive a reward under this program, you might qualify for an opportunity to receive the reward by different means. You may call us toll-free at 1-855-256-8669 or at the number on your health plan ID card, and we will work with you (and, if necessary, your doctor) to find another way for you to earn the same reward. Rewards may be limited due to incentive limits under applicable law. Subject to HSA eligibility, as applicable.

When life gets challenging, you've got caring, confidential help

Your Employee Assistance Program (EAP) provides support and resources to help you, and your family, with a range of issues, including:

- Managing stress, anxiety and depression
- Improving relationships at home or work
- Getting guidance on legal and financial concerns
- Coping with occupational stress and burnout support
- Addressing substance use issues

This service is provided to you at no additional cost.

$0

Call today for access to EAP resources at no additional cost

EAP provides coverage for 3 free counseling sessions per incident, per year.

Services are completely confidential and will not be shared with your employer.

Get started – call EAP 24/7 at **1-888-887-4114**

United Healthcare

Get in on UHC Rewards

UnitedHealthcare Rewards is a digital experience where you can earn up to $300 for reaching program goals and completing one-time reward activities. And get this: It's included in your health plan at no additional cost. The activities you go for are up to you—same goes for ways to spend your earnings.

There's so much good to get

With UHC Rewards, a variety of actions—including many things you may already be doing—lead to rewards. Here are some ways you can earn:

Reach daily goals

- Track 5,000 steps or 15 active minutes each day, or double it for an even bigger reward
- Track 14 nights of sleep

Complete one-time reward activities

- Go paperless
- Get a biometric screening
- Take a health survey
- Connect a tracker

Personalize your experience by selecting activities that are right for you—and look for new ways of earning rewards to be added throughout the year.

Earn up to

$300

United Healthcare

There are 2 ways to get started

On the UnitedHealthcare® app

- Scan this code to download the app
- Sign in or register
- Select the **Me** tab and choose **Rewards**
- Activate Rewards and start earning
- Though not required, connect a tracker and get access to even more reward activities

On myuhc.com®

- Sign in or register
- Select **Rewards**
- Activate Rewards
- Choose reward activities that inspire you—and start earning

Your health

Get in on an experience that's designed to help inspire healthier habits

Your goals

Personalize how you earn by choosing the activities that are right for you

Your rewards

Earn up to $300 and use it however you want

Questions?

Call customer service at **1-866-230-2505**

United Healthcare

Dental Benefits at a glance

KAD dental and vision insurance is available nationwide through Principal Dental and Vision Service Plan. Dental and vision must be elected together, but may be elected independently of medical coverage.

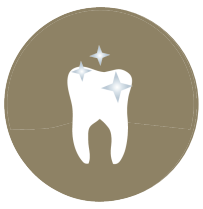
Benefit levels shown below are in-network. The provider network is Principal. Services received from non-network providers will be paid at reasonable and customary rates, and the participant will be responsible for any remaining balance.

Principal I www.principal.com/dentist I (800) 843-1371

Calendar-year deductible per person	Calendar-year maximum per person	Orthodontia lifetime maximum	Preventive and diagnostic services	Basic services	Major services	Orthodontic services
$50 $150 max per family	**$1,500** per year	**$1,500** to age 19 only	plan pays **100%** no deductible	plan pays **80%** after deductible	plan pays **50%** after deductible	plan pays **50%** no deductible

• Preventive and diagnostic services include routine exams, cleanings (2 per year), topical application of fluoride, and x-rays.
• Basic (restorative) services include sealants, space maintainers, fillings, endodontics, and periodontics.
• Major services include crowns, bridges, dentures, inlays, onlays, repairs to bridges & dentures, general anesthesia, and oral surgery.
• Orthodontic services include braces, retainers, and other appliances that correct misalignments for dependent children to age 19 only.
• There is no coverage for placement/replacement of dental implants, implant-supported crowns, implant-supporting structures, abutments, or prosthesis.
• ID cards are issued when enrollment is processed.

Additional limits and exclusions apply; see the Certificate of Coverage for complete coverage details.



Clear Aligner Therapy

You may be eligible for clear aligner therapy such as Invisalign® or Clear Correct™! Contact your dentist to learn more!

Vision benefits at a glance

KAD vision insurance is available nationwide through Vision Service Plan Choice (VSP) network. Dental and vision must be elected together, but may be elected independently of medical coverage. Benefits are available to eligible employees nationwide.

Benefit amounts shown below are for in-network services. The provider network is VSP Choice, The plan generally pays 100% of eligible expenses after the copay when network providers are used.

Vision Service Plan I vsp.com I 800.877.7195

In-network

WellVision® exam every 12 months	Glasses frames every 24 months	Single vision lenses every 12 months	Lined bifocal lenses every 12 months	Lined trifocal lenses every 12 months	Lenticular lenses every 12 months	Contact lens every 12 months (in lieu of glasses)
You pay **$10** copay	Plan pays up to **$130** for frames	You pay **$25** copay	You pay **$25** copay	You pay **$25** copay	You pay **$25** copay	Plan pays up to **$130** after $60 copay

Out-of-network

WellVision® exam every 12 months	Glasses frames every 24 months	Single vision lenses every 12 months	Lined bifocal lenses every 12 months	Lined trifocal lenses every 12 months	Lenticular lenses every 12 months	Contact lens every 12 months (in lieu of glasses)
Plan pays up to **$45** copay	Plan pays up to **$70** for frames	Plan pays up to **$30**	Plan pays up to **$50**	Plan pays up to **$65**	Plan pays up to **$100**	Plan pays up to **$105**

- You may receive a benefit for either glasses (lenses only) or contact lenses per 12-month period, but not both.
- Benefits for frames are once every 24 months.
- Visually necessary contact lenses are covered 100% after a $25 copay upon review and authorization by VSP.
- Progressive, polycarbonate, tinted and photochromic lenses, as well as anti-reflective or scratch-resistant coatings aand other lens enhancements, will generally receive a 20-25% discount off provider price after base lens copay.
- No ID card is required. Simply tell your network provider you are a VSP member.

Additional limits and exclusions apply; see the Certificate of Coverage for complete coverage details.

Additional discounts and special offers for contract lens exams, LASIK, eyeglass frames, sunglass frames, and TruHearing™ digital hearing aids are available to VSP members. Visit vsp.com/offers for more information.

One of the things I value most about KAD is the people, from my co-workers to those leading the company. Our team and leaders are incredibly compassionate & understanding people who look out for one another's best interest. This makes working for KAD so different (in the best way) from any other company I've worked with in the past. Welcome to KAD, you're part of the family now!

-Aspen G.

Understanding Your Medical Coverage

Annual out-of-pocket maximum (OOPM)

This is the most a participant must pay out of their own pocket during the calendar year before the plan begins to pay 100% of eligible expenses. Medical calendar-year deductibles, copays, and coinsurance (including prescriptions, unless otherwise noted) generally apply toward satisfying the annual out-of-pocket maxiumum. KAD coverage options with embedded deductibles will have embedded OOPMs; HDHP coverage options with aggregate deductibles will have aggregate OOPMs.

Calendar-year Deductible

This is the amount owed for certain covered health care services before the plan begins to pay benefits. Not all covered services require this deductible to be met (e.g., office visit copays under non-HDHP coverage options). All KAD coverage options cover in-network physician office visits for preventative care services (as defined in the applicable Certificate of Coverage) at 100% with no copay or coinsurance, regardless of whether any deductible has been met.

Except as otherwise noted for certain HDHP-type coverage options, The KAD Group® coverage options generally have "embedded" calendar-year deductibles and OOPMs. For family coverage under the embedded design, each covered family member needs to satisfy only an individual calendar-year deductible (not the entire family deductible) before the individual member can recieve covered medical services or prescription drugs at copay or coinsurance levels. Individual family members are responsible for their own out-of-pocket covered medical expenses up to the individual-level OOPM. Combined individual out-of-pocket covered medical expenses for a family will never exceed the family level OOPM.

Coinsurance

This is the Plan or participant's share of the cost of a covered service, calculated as a percent of the allowed amount for the service. Coinsurance (where applicable) applies after the participant satisfies any applicable calendar-year deductible. Also, coinsurance generally will not apply where a copay applies. Unless otherwise indicated, percentages reflected in the medical coverage options charts reflect the coinsurance amount to be paid by the participant.

Copays

A fixed amount you pay for a covered service from an in-network provider. Generally whenever a medical copay applies, coinsurance will not apply, and you are not required to first satisfy any applicable medical calendar-year deductible.

High deductible health plan (HDHP) options

HDHP coverage options generally do not cover any medical expenses other than preventative care until the applicable calendar-year deductible is met. All medical and pharmacy expenses apply to the applicable calendar-year deductible and OOPM. These expenses are the participant's responsibility until the deductible is met. All insperity HDHP coverage options are HSA-qualified.

In-network

Providers and facilities that contract with your health insurance carrier are considered in-network; you will pay in-network copays, deductibles and coinsurance rates for eligible expenses from network providers.

Out-of-network

Providers and facilities that do not contract with your health insurance carrier are considered out-of-network.

If your elected coverage option pays benefits for services received from out-of-network providers, your financial responsibility will likely be much greater. It is important to understand how your specific insurance carrier reimburses for out-of-network services, and it is your responsibility to pay any cost difference between what the out-of-network provider charges and what the plan covers (i.e., what the insurance carrier pays).

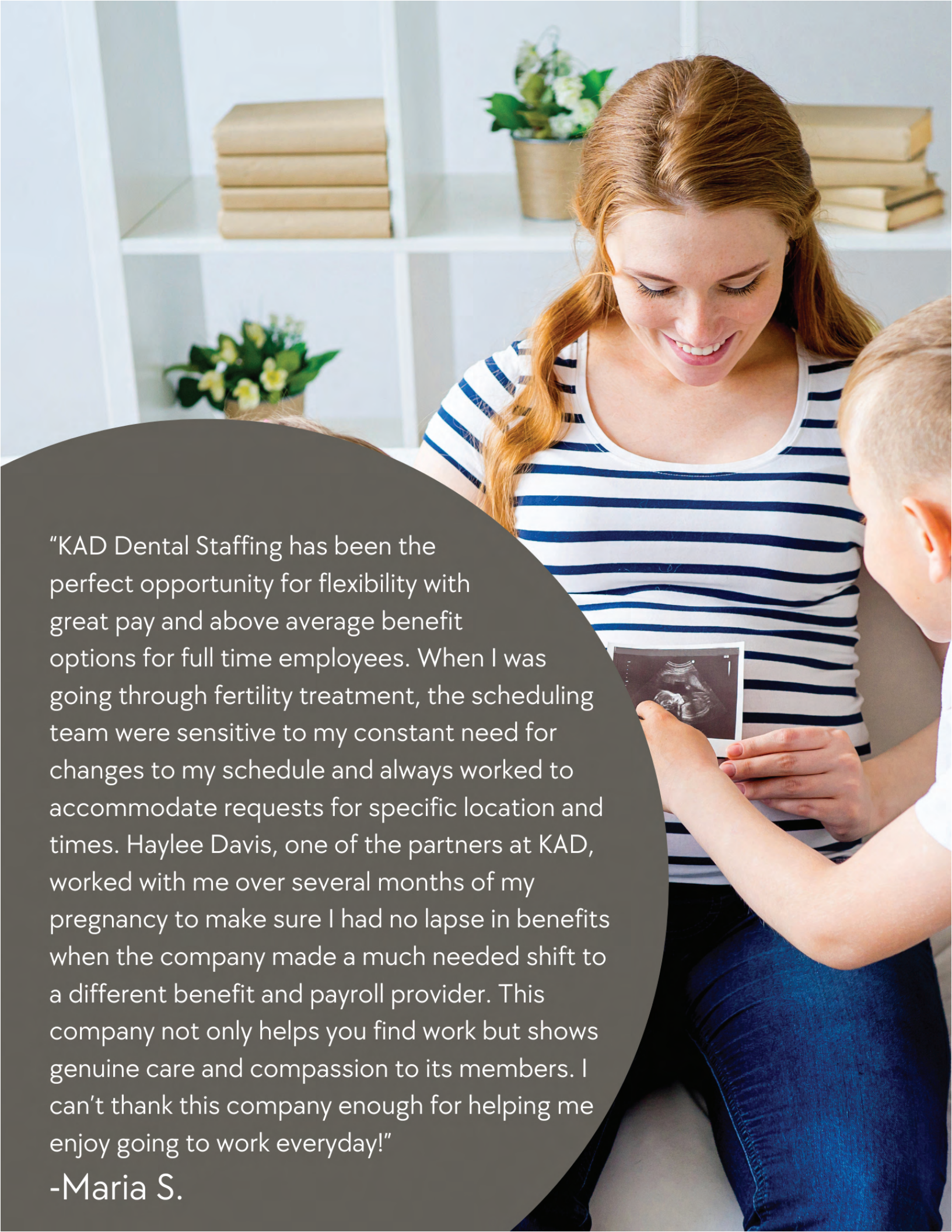
Limitations and exclusions

Certain health services have notification requirements and limitations that may vary based upon coverage option, insurance provider or state mandate. It is your responsibility as a participant to confirm that the services you plan to receive are covered health services, and to determine what percentification and/or notification requirement or limitations may apply

For each coverage option available to you, specific limitations and exclusions may apply, as outlined in the Certificate of Coverage (COC) for that option. These are available upon request by calling KAD. Should there be any discrepancy or conflict between the information presented here and the actual Plan documents and insurance contracts, the Plan documents and insurance contracts will govern.

Questions about your KAD Benefits?

Important Benefit Contacts	Contact	Website	Phone
Medical and Prescription Drug	United Healthcare	www.myuhc.com	(866) 801-4409
Dental	Principal	www.principal.com/dentist	(800) 843-1371
Vision	Principal	wwwvsp.com	(800) 877-7195
Life/AD&D Voluntary Life/AD&D	Principal	www.principal.com	(800) 245-1522
Short-Term Disability Long-Term Disability	Principal	www.principal.com	(800) 245-1522
Group Agent	Garrett Moore	gmoore@LSBinc.com	214.619.0936
Account Executive	Kimberly Brown	kbrown@LSBinc.com	(214) 619-0934



"KAD Dental Staffing has been the perfect opportunity for flexibility with great pay and above average benefit options for full time employees. When I was going through fertility treatment, the scheduling team were sensitive to my constant need for changes to my schedule and always worked to accommodate requests for specific location and times. Haylee Davis, one of the partners at KAD, worked with me over several months of my pregnancy to make sure I had no lapse in benefits when the company made a much needed shift to a different benefit and payroll provider. This company not only helps you find work but shows genuine care and compassion to its members. I can't thank this company enough for helping me enjoy going to work everyday!"

-Maria S.

IMPORTANT NOTICES & REMINDERS

The following notices contain important information about your employee benefits plan(s). Please read through all notices and contact Human Resources for more information.

SPECIAL ENROLLMENT NOTICE

This notice is being provided to make certain that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive health insurance coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

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

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

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

YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. If you elect one of our traditional health insurance plans that has office visit and prescription copays, the prescription drug coverage is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage and is therefore considered Creditable Coverage. Because you existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan. However, for anyone that elects a Health Savings Account plan, the prescription drug coverage is not considered Creditable Coverage. Because of this, if you do not enroll in Medicare Part D, when first eligible, you will pay a penalty when you try to enroll in Part D at a later date.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

Alabama - Medicaid	California - Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 I Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
Alaska - Medicaid	**Colorado - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
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	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-healthplan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurancebuy-program HIBI Customer Service: 1-855-692-6442

Arkansas - Medicaid

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

Florida - Medicaid

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

Georgia - Medicaid

GA HIPP Website: https://medicaid.georgia.gov/
healthinsurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-
partyliability/childrens-health-insurance-
programreauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

Massachusetts - Medicaid & Chip

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102

Indiana - Medicaid

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

Minnnesota - Medicaid

Website:
https://mn.gov/dhs/people-we-serve/
children-andfamilies/health-care/health-care-
programs/programs-andservices/other-insurance.jsp
Phone: 1-800-657-3739
IOWA

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website:
https://dhs.iowa.gov/ime/members/
medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

MISSOURI - Medicaid

Website:
http://www.dss.mo.gov/mhd/participants/pages/
hipp.htm
Phone: 573-751-2005

Kansas- Medicaid

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

Montana - Medicaid

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

Kentucky - Medicaid

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

Louisiana - Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Maine– Medicaid

Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: -800-977-6740.
TTY: Maine relay 711

New Jersey- Medicaid & Chip

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

New York- Medicaid

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

Nebraska- Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

Nevada- Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

New Hampshire- Medicaid

Website: https://www.dhhs.nh.gov/programsservices/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

South Dakota - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

Texas - Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

North Carolina- Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

North Dakota - Medicaid

Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

Oklahoma - Medicaid & Chip

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

Oregon - Medicaid & Chip

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

Pennsylvania- Medicaid

Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx
Phone: 1-800-692-7462

Rhode Island- Medicaid & Chip

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

South Carolina- Medicaid & Chip

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

Utah - Medicaid & Chip

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

Vermont- Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

Virgina- Medicaid

Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

Washington- Medicaid

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

West Virgina- Medicaid & Chip

Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

Wisconsin- Medicaid & Chip

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

Wyoming- Medicaid & Chip

Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-andeligibility/
Phone: 1-800-251-1269

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

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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 1/31/2023)

Important COBRA Information

The following notices contain important information about your employee benefits plan(s). Please read through all notices and contact Human Resources for more information.

** CONTINUATION COVERAGE RIGHTS UNDER COBRA **

Introduction
You're getting this notice because you recently gained coverage under a group health plan. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:
- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA 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:

• 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. You must provide this notice to the Human Resource Department.

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.

If you have question
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 Administratio (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.

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