CAREX CONSULTING GROUP

2022

Employee Benefits Guide

Your Benefits, Your Choice

BENEFIT HIGHLIGHTS

- Eligibility & Enrollment
- Employee Contributions
- Medical Insurance
- Dental Insurance
- Vision Insurance
- Disability Insurance
- Flexible Spending Accounts
- Health Savings Account
- In-Network vs. Out-of-Network
- Benefit Terms
- Annual Required Notices

WELCOME TO YOUR EMPLOYEE BENEFITS!

We understand that your life extends beyond the workplace. That is why we offer a variety of benefit plans to help you and your family. Within this guide, you will find the highlights of the benefits offered by the company.

Current Employees

If you take no action during your open enrollment period, your current benefit elections will roll over—**with the exception of your Flexible Spending Account**. Once Open Enrollment ends, you will not have another opportunity to make changes until next year unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

New Employees

This is your chance to elect benefits and enroll yourself and your eligible dependents. **Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverages.** If you take no action now, you will have no benefits and you will not have another chance to elect them until next year's open enrollment—unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

CONTACTS

COVERAGE	CARRIER	PHONE NUMBER	WEBSITE/EMAIL
Medical Insurance	Quartz Benefits	800-362-3310	www.quartzbenefits.com
Dental Insurance	Delta Dental of WI	800-236-3712	www.deltadentalwi.com
Vision Insurance	Delta Dental of WI	800-236-3712	www.deltadentalwi.com
Voluntary LTD Insurance	Principal	800-986-3343	www.principal.com
Flexible Spending Account	TASC	800-422-4661	www.tasconline.com
Health Savings Account	Monona Bank	608-223-3000	www.mononabank.com

CAREX BENEFITS CONTACT		
Human Resources Department		keittiane@carexconsultinggroup.com carexhumanresources@carexconsultinggroup.com

DISCLAIMER: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

ELIGIBILITY & ENROLLMENT

Employee Eligibility

All full-time employees working 30 or more hours per week will be eligible for benefits. As a new employee, you have **14** days from your initial start date to enroll in benefits.

- Medical, Dental, Vision: Medical, Dental, and Vision coverages will take effect on the first of the month following date of hire.
- Other Coverages: All other coverages will take effect on the first of the month following date of hire.

**These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.*

Dependent Eligibility

- Medical, Dental, Vision: Employees enrolled in Medical, Dental, and Vision coverages also have the option to enroll their Dependent Spouse and Dependent Children on these plans. See below for a definition of an "eligible dependent" under these plans.

Definition of "Eligible Dependents"

The below definitions refer to Medical, Dental, and Vision Coverages.

- Your legal spouse who is a resident of the same country in which the Employee resides. Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, "spouse" shall not mean a common law spouse or domestic partner.
- The employee's dependent children until the end of the month, in which, they attain age 26, legally adopted children from the date the employee assumes legal responsibility, foster children that live with the employee and for whom the employee is the primary source of financial support, children for whom the employee assumes legal guardianship and stepchildren.
- Also included are the employee's children (or children of the employee's spouse) for whom the employee has legal responsibility resulting from a valid court decree.
- Children who are mentally or physically disabled and totally dependent on the employee for support, past the age of 26 or older. To be eligible for continued coverage past the age of 26, certification of the disability is required within 31 days of attainment of age 26. A certification form is available from the employer or from the claims administrator and may be required periodically. You must notify the claims administrator and/or the employer if the dependent's marital or tax exemption status changes and they are no longer eligible for continued coverage. {If Applicable}

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all your information is up to date, it's time to make your benefit elections. The decisions you make during open enrollment can have a significant impact on your life and finances, so it is important to weigh your options carefully.

When to Enroll

Open enrollment begins on February 8th and runs through February 18th. The benefits you choose during open enrollment will become effective on March 1st, 2022

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event.

Qualifying life events include:

- Marriage, divorce, legal separation or death of a spouse
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan.

MONTHLY EMPLOYEE CONTRIBUTIONS

If you have questions or concerns, please speak with Human Resources.

MEDICAL COVERAGE	**HMO 500**	**HSA**	**PPO**
Employee Only	$100.19	$29.92	$178.58
Employee + Spouse	$631.21	$219.93	$750.04
Employee + Child(ren)	$571.09	$198.98	$678.61
Family	$961.84	$335.13	$1,142.91

DENTAL COVERAGE	**Premium Rate**	**Employee Amount**	**Carex Covers**
Employee Only	$40.51	$8.10	$32.41
Family	$109.80	$65.88	$43.92

VISION COVERAGE	**Premium Rate**	**Employee Amount**	**Carex Covers**
Employee Only	$7.26	$1.45	$5.81
Family	$18.07	$10.84	$7.23

DISABILITY COVERAGE	**VOLUNTARY LONG-TERM**
Employee Only	Please see HR for Rates

MEDICAL INSURANCE

Quartz Benefits

We provide you the option to purchase affordable medical coverage.

MEDICAL COVERAGE HIGHLIGHTS	**Prime Platinum $500 HMO**	**Prime Bronze HSA (HDHP)**
	In-Network	In-Network
Annual Deductible		
Individual	$500	$6,000
Family	$1,000	$12,000
Coinsurance (percent paid after you reach your annual deductible)		
Plans Pays	80%	100%
You Pay	20%	0%
Annual Out-of-Pocket Maximum		
Individual	$1,000	$6,000
Family	$2,000	$12,000
Covered Services		
Preventive Care	100%	Deductible / Coinsurance
Primary Care Office Visit	$25 Copay	
Specialist Office Visit	$50 Copay	
Urgent Care	Deductible / Coinsurance	
Emergency Room	$100 Copay	
Hospitalization	Deductible / Coinsurance	

PRESCRIPTION DRUG COVERAGE HIGHLIGHTS	In-Network	In-Network
Rx Deductible	$2,350 Individual / $4,700 Family	Subject to medical Out-of-Pocket
Tier 1	$10	Deductible / Coinsurance
Tier 2	$40	
Tier 3	$80	
Tier 4	$200	

MEDICAL INSURANCE

Quartz Benefits

We provide you the option to purchase affordable medical coverage. The below plan allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider. **This plan is available only if you live outside the Wisconsin HMO network area.**

MEDICAL COVERAGE HIGHLIGHTS	**PPO - 1500**	
	In-Network	Out-of-Network
Annual Deductible		
Individual	$1,500	$3,000
Family	$3,000	$6,000
Coinsurance (percent paid after you reach your annual deductible)		
Plans Pays	80%	60%
You Pay	20%	40%
Annual Out-of-Pocket Maximum		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Covered Services		
Preventive Care	100%	Deductible / Coinsurance
Primary Care Office Visit	$30 Copay	
Specialist Office Visit	$30 Copay	
Urgent Care	Deductible / Coinsurance	
Emergency Room	$100 Copay	
Hospitalization	Deductible / Coinsurance	Deductible / Coinsurance

PRESCRIPTION DRUG COVERAGE HIGHLIGHTS	In-Network	Out-of-Network
	$2,350 / $4,700 Deductible	
Tier 1	$10	
Tier 2	$35	
Tier 3	$60	
Tier 4	$200	

DENTAL INSURANCE

Delta Dental

In addition to protecting your smile, dental insurance helps pay for dental care. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

DENTAL COVERAGE HIGHLIGHTS	PPO-Network	Premier or Out-of-Network
Annual Deductible	$50 Single / $150 Family	
Annual Benefit Maximum	$1,000	
Preventive Care	100%	
Basic Services	80%	
Major Services	50%	
Orthodontia Services	N/A	

VISION INSURANCE

Delta Dental

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

VISION COVERAGE HIGHLIGHTS	In-Network	Non-Network Reimbursement
Exam Once every 12 months	$10 Copay	$35
Lenses Once every 12 months	$10 - $75 Copay (Standard)	None
Frames Once every 24 months	$150 Allowance, then 20% off Balance	$75
Contact Lenses Once every 24 months; in lieu of lenses/frames glasses	$150 Allowance, then 15% off balance (Conventional)	$120

DELTA DENTAL

Choosing a Network Dentist

Discover the advantages of going to a dentist who belongs to a Delta Dental network.

With two dentist networks available, which one is right for you? The Delta Dental PPO network delivers the greatest savings, but fewer dentists belong. The Delta Dental Premier network is the largest dentist network, but the savings aren't as significant as with a Delta Dental PPO provider. This illustration shows how both networks save you money. Seeing either a Delta Dental PPO dentist or Delta Dental Premier dentist will ensure that treatments are guaranteed, claims are directly paid, and no balance-billing can occur.

Example Savings for a Common Procedure

	Estimated Charge	Maximum Allowed Fees	Percentage Paid by Delta Dental	Amount Delta Dental Pays	Amount Dentist can Balance Bill	Total Amount You Pay	Your Total Cost Savings
PPO Network	$1,200	$825	80%	$660	$0	$165	$375
Premier Network	$1,200	$985	80%	$788	$0	$197	$215
Out-of-Network	$1,200	$925	80%	$740	$275	$460	$0

Delta Dental PPO network

Delta Dental PPO network dentists have agreed to charge $825 for the $1,200 service, a savings of $375. Your Delta Dental plan covers 80 percent of the cost. Assuming you've already met your deductible for the year, Delta Dental will pay $660 and you'll pay $165.

Delta Dental Premier network

Delta Dental Premier network dentists have agreed to charge $985 – a savings of $215 compared to the fee the dentist charges non-network patients. Assuming you've met your deductible, Delta Dental will cover 80 percent of that $985, paying $788. You'll pay $197. That's an extra $32 tacked on to your share of the bill when compared to what you would have paid with a Delta Dental PPO dentist.

Out-of-network

Out-of-network dentists have not agreed to charge a lower fee and can bill the full $1,200. Delta Dental has set a limit on the accepted amount at $925, which means Delta Dental's share of the tab is $740. The dentist can bill you the difference between the maximum allowed fee and what they charge. This leaves you with a bill of $460, which includes the $275 the out-of-network dentist can "balance bill."

www.deltadentalwi.com

SS319-1606

DISABILITY INSURANCE

Principal

The company provides full-time employees with the option of voluntary long-term disability income benefits. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness.

In the event that you become disabled from a non-work-related injury or sickness, disability income benefits may provide a partial replacement of lost income.

VOLUNTARY LONG-TERM DISABILITY COVERAGE HIGHLIGHTS	
Monthly Benefit Amount	60% up to $6,000
Elimination Period	90 Days
Benefit Duration	To age 65
Pre-Existing Condition Limitations	12 months prior / 12 months insured

Please review the full summary plan documents for a list of your exclusions and limitations. *This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.*

Group disability insurance

Principal®

Help handling life's ups and downs

Life can be unpredictable. And it's not always easy. So it's a big deal to know there's help available when you need it. That's what the Employee Assistance Program (EAP), provided by Magellan Healthcare, is all about.

With an EAP, you and your immediate family have access to free, confidential resources to help handle life's everyday — and not so everyday — challenges.

Services for you and your family

Your EAP offers these services to help you and your family deal with the big and little things:

- LifeMart Discount Center, with savings on a variety of products and services
- Self-assessments for identifying issues with stress, depression or substance use
- Health and wellness articles, guides, webinars, podcasts and calculators
- Online assistance with eldercare, child care and other family life resources
- Help with teen and adolescent issues, including eating disorders and relationships
- Tips on parenting and grandparenting
- 24/7 phone consultation with licensed mental health professionals and referrals to supportive resources*
- Ongoing personal coaching sessions with scheduled telephonic appointments

Help when and where you need it — day or night

Life's challenges don't always happen during regular business hours. That's why you and your family have 24/7 access to your EAP.

800-450-1327
International: 800-662-4504
TTY: 800-456-4006

MagellanHealth.com/member

* You're responsible for any fees resulting from referrals outside the EAP, including those associated with medical benefits.

Help is just a click or phone call away

Online: MagellanHealth.com/member
Toll-free: 800-450-1327
TTY for hearing impaired: 800-456-4006
International access only: 800-662-4504

Magellan HEALTHCARE℠

Your Employee Assistance Program is provided by Magellan Healthcare.

Save money while improving your life

Everybody loves a discount! Use these to help improve your life — financially, mentally and physically. Offered by some of the most trusted companies in the U.S., these discounts and services are available through your group benefits from Principal®. These discounts are not insurance.

Laser Vision Correction	Imagine your life free from glasses and contacts. You, your spouse and dependent children save $800 off LASIK through the National Lasik Network, administered by LCA-Vision, Inc. principallasik.com | 888-647-3937
Hearing Aid Program	Protect your hearing health to improve your quality of life. You, your spouse, children, parents and grandparents can get exclusive discounts on hearing aids, with a 60-day trial to ensure your full satisfaction. You can also receive a free hearing consultation at any of their 3,000+ locations nationwide. principal.com/hearingbenefits/ahb | 877-890-4684

Available with your disability insurance

401K

In Carex's 401k plan, new employees are automatically enrolled at a 4% contribution level. This is a voluntary plan in which every employee can participate or opt out of. All contributions are by the employee and immediately vest at 100% A list of funds can be found at https://www.guideline.com/funds.

CAREX PERKS

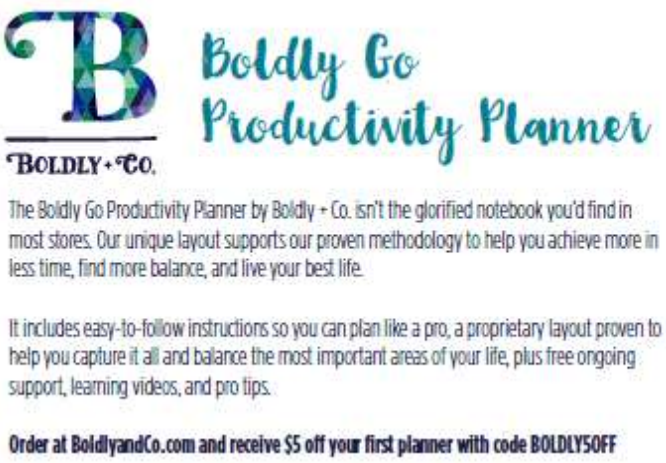
Whether you are new to the Madison area or have lived in the area for years, finding dependable businesses to work with is priceless. Carex has firsthand experience with the establishments included in this document and we personally recommend them. Additionally, several of these businesses are pleased to offer discounts to friends of Carex.

Animal Care

Company Name	*Discount Available*	*Company Website*	*Company Phone*
Precision Vet	***Low cost spay/neuter***	https://precisionveterinary.com/	***(608) 405-3148***
Dog Haus University	***Dog grooming/daycare/boarding***	http://doghausuniversity.com/	***(608) 515-8255***
Happy Dogz	***Dog grooming/daycare/boarding***	http://happyz.com/	***Middleton: (608) 831-1283 Fitchburg: (608) 278-8563***
Bivvy	***Pet Insurance***	https://bivvy.com/	***(608) 434-3744***

Health and Wellness

- **Boldly + Co.**
  A company dedicated to helping women maximize their time through a proven methodology



Food

• **EatStreet** • One of the largest independent online and mobile food ordering and delivery services in the U.S., based in Madison, WI	• ***EatStreet is a Madison born-and-raised food delivery service. They are the smartest shortcut from hungry to happy, delivering the tastiest eats from over 230 Madison restaurants right to your office. For your first delivery order, EatStreet is offering $10 off an order of $20 or more with the code: CAREX10. This code is only valid on first-time orders and EatStreet Delivery restaurants. You can tell which restaurants apply by picking out the listings with the little green car image next to the restaurant name. Simply enter your address on*** eatstreet.com ***or in the app, peruse the restaurant listings until you find your perfect craving quencher, and enter the code at checkout to apply your discount.*** ***If you have trouble applying your discount code or need assistance on your order, feel free to reach out to*** EatStreet Customer Support***.***

Fitness and Nutrition

- Peter Kraus

• **The Barre Code Madison** • The Barre Code goes beyond the barre to offer cardio, strength, and restorative workouts with an emphasis on positivity & empowerment.	• ***The Barre Code is a comprehensive full-body fitness program designed for individuals to find their 'strong.' Built on the principles of cardio, strength, and restoration, The Barre Code goes beyond the barre, with classes ranging from cardio kickboxing, HIIT, Bootcamp, to full mind & body restoration. In addition, our program and community work for EVERY body. Whether you're a fitness professional or brand-new to exercise, our empowering and motivational community will make you feel strong, centered, and inspired. Come join the Carex team at a Barre Code Madison (we're there every Friday at noon) and get your first class free. Use code FREECLASS when signing up online:*** https://www.thebarrecode.com/studio/madison/

Miscellaneous

- Realtor: Andrea Bolen at Relish Realty

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• **Camera Kisses Photography** • Professional head shot, portrait, and event photography in the Madison area since 2009	Debbie Borth of Camera Kisses has been a professional portrait and event photographer in the Madison area since 2009. As she says, "I love what I do and take pride in my ability to capture everyone at their best!" Camera Kisses strives to provide excellent photos and service at a variety of options to fit into anyone's budget. She offers various headshot sessions...from no frills, ultra-simple sessions to complete studio setup with dozens of backgrounds to choose from. Mention Carex when booking to receive $20 off an individual headshot plus a free Photoshop touch-up; groups of 5 or more receive $50 off their group headshot session.

FLEXIBLE SPENDING ACCOUNTS (FSA)

TASC

*Available to employees enrolled on **Quartz HMO or PPO***
Paying for health care can be stressful. That's why the company offers an employer-sponsored FSA.

What Are the Benefits of an FSA?

There are a variety of different benefits of using an FSA, including the following:

- **It saves you money**. Allows you to put aside money tax-free that can be used for qualified medical expenses.
- **It's a tax-saver**. Since your taxable income is decreased by your contributions, you'll pay less in taxes.
- **It is flexible**. You can use your FSA funds at any time, even if it's the beginning of the year.

You cannot stockpile money in your FSA. **If you do not use it, you lose it.** You should only contribute the amount of money you expect to pay out of pocket that year. **The maximum amount you may contribute each year to an FSA in 2022 is $2,800 per year. Note: Even if you signed up last year, you must re-enroll each year.**

What Is a Dependent Care FSA?

Dependent Care FSAs allow you to contribute pre-tax dollars to qualified dependent care. **The maximum amount you may contribute each year is $5,000 (or $2,500 if married and filing separately).**

FSA Case Study

Because FSAs provide you with an important tax advantage that can help you pay for health care expenses on a pre-tax basis. Due to the personal tax savings you incur, your spendable income will increase. The example that follows illustrates how an FSA can save money.

Bob and Jane's combined gross income is $30,000. They are married and file their income taxes jointly. Since Bob and Jane expect to spend $3,000 in medical expenses in the next plan year, they decide to direct a total of $2,750 (the maximum allowed amount per individual, for that taxable year) into their FSAs.

	Without FSA	With FSA
Gross income	$30,000	$30,000
FSA contributions	$0	**-$2,800**
Gross income	$30,000	$27,200
Estimated taxes		
Federal	-$2,550*	-$1,776*
State	-$900**	-$750**
FICA	-$2,295	-$1,913
After-tax earnings	$24,255	$22,811
Eligible out-of-pocket medical expenses	-$3,000	-$300
Remaining spendable income	$21,255	$22,511
Spendable income increase	--	$1,256

**Assumes standard deductions and four exemptions. **Varies, assumes 3 percent. This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.*

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA.
Check with the plan administrator or Human Resources to learn more.

HEALTH SAVINGS ACCOUNT (HSA)

Quartz

*Available to employees enrolled on **Quartz HSA plan***

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany a Health Savings Account Qualified Plan, such as a High Deductible Health Plan (HDHP). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in).

What Are the Benefits of an HSA?

There are many benefits of using an HSA, including the following:

- **It saves you money**. HDHPs have lower monthly premiums, meaning less money is being taken out of your paycheck.
- **It is portable**. The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.
- **It is a tax-saver**. HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you'll pay less in taxes.

HSA Contribution Limits

The maximum amount that you can contribute to an HSA is $3,600 (individual) or $7,200 (family) in 2021 and $3,650 (individual) and $7,300 (family) in 2022. If you are age 55 or older, you may make an additional "catch-up" contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don't exceed the annual maximum.

HSA Case Study

Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. His plan's annual deductible is $1,500 for individual coverage. Here is a look at the first two years of Justin's HSA plan, assuming the use of in-network providers. This example only includes HSA contribution amounts and does not reflect any investment earnings.

Year 1	
HSA Balance	$1,000
Total Expenses: Prescription drugs: $150	(-$150)
HSA Rollover to Year 2	$850
Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

→

Year 2	
HSA Balance	$1,850
Total Expenses: Office visits: $100 Prescription drugs: $200 Preventive care services: $0 (covered by insurance)	(-$300)
HSA Rollover to Year 3	$1,550
Once again, since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.	

Your eligibility for an HSA may be misrepresented if you and/or your spouse currently utilize an FSA.
Check with the plan administrator or Human Resources to learn more.

IN-NETWORK VS OUT-OF-NETWORK

Applies to employees enrolled in the PPO plan as the PPO and HSA plans do not offer any out-of-network benefits at all.

The Basics

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

In-network Provider—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.

Out-of-network Provider—A provider who is not contracted with your health insurance company.

Getting the Most Out of Your Care

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network.

If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your health insurance company, you will be billed differently depending on the type of provider you use for your care.

In-network Bill

Provider	Network	Bill	Insurance Company Payment, Explanation of Benefits	Patient
The patient receives treatment. The doctor then sends the bill to the insurance company.	Appropriate discount for using an in-network provider is applied.	The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.	Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.	Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

Out-of-network Bill

Provider	Bill	Insurance Company Payment, Explanation of Benefits	Patient
The patient receives treatment. The doctor then sends the bill to the insurance company.	The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.	Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.	Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.

Preventive Care

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, counseling and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

BENEFIT TERMS

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

ANNUAL REQUIRED NOTICES

Carex Consulting Group Inc,
Health Law Notices

Michelle's Law Notice
If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage.

Benefits During Family Medical Leave
Assuming the Plan Administrator meets certain criteria during the preceding calendar year, the Plan will comply with the Family and Medical Leave Act (FMLA) of 1993 as amended, which provides benefit continuation rights during an approved medical leave of absence. If the Plan Administrator is subject to the law, an employee and any dependents covered under a health benefit plan may be eligible to continue the coverage under that plan for a certain period of time.

Any employer contributions made under the terms of the Plan shall continue to be made on behalf such employee electing to maintain coverage while on FMLA leave. An employee on FMLA leave must make any applicable contributions to maintain coverage. To the extent required under the FMLA and in accordance with procedures established by the Plan Administrator such employee contributions may be payable:

- prior to the employee taking the leave; or
- during the leave; or
- repaid to the employer through payroll deductions upon return to work following the leave.

Contact the Plan Administrator for additional information on the FMLA leave policy or to request leave. Certain rights under specific state family leave laws may also apply.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
Under USERRA, an employer is required to offer COBRA-like continuation of coverage to covered employees in the uniformed services if their absence from work during military duty would result in a loss of coverage as a result of such active duty. The maximum length of USERRA continuation of coverage is the lesser of 24 months beginning on the date of the employee's departure, or the period beginning on the date of the employee's departure and ending on the date on which the employee failed to return from active duty or apply for reemployment within the time allowed by USERRA. If an employee elects to continue coverage pursuant to USERRA, such employee, and any covered dependents, will be required to pay up to 102% of the full premium for coverage elected. For military leaves of 30 days or less, the employee is not required to contribute more than the amount he or she would have paid as an active employee. Continued coverage under this provision pursuant to USERRA will reduce any coverage continuation provided under COBRA Continuation.

Premium Assistance Under Medicaid and The Children's Health Insurance Program (CHIP) – Applies to Group Health Plans Only
If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States, may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2021. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711
CHP+ Website:
https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991 / State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

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

GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext. 2131

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

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

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

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
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: 1-800-977-6740
TTY: Maine Relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll-Free: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and 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
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

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

OREGON – Medicaid
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/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

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

UTAH – Medicaid and 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

VIRGINIA – Medicaid and CHIP
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 VIRGINIA – Medicaid
Website: http://mywvhipp.com/
Toll-Free: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since July 31, 2021, 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

Important Disclosures

Women's Health and Cancer Rights Act of 1998
The Federal Women's Health and Cancer Rights Act of 1998 requires coverage of treatment related to mastectomy. If the participant is eligible for mastectomy benefits under health coverage and elects breast reconstruction in connection with such mastectomy, she is also covered for the following:

a. Reconstruction of the breast on which mastectomy has been performed;
b. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
c. Prostheses;
d. Treatment of physical complications of all states of mastectomy, including lymphedema.

Coverage for reconstructive breast surgery may not be denied or reduced on the ground that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan. Coverage for breast reconstruction and related services will be subject to applicable deductibles, co-payments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan.

Maternity Coverage Length of Hospital Stay
Group health plans and health insurance issuers offering group health insurance coverage 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 normal 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 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Medical Child Support Orders
A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.61% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

Note: If a health plan is purchased through the Marketplace instead of accepting health coverage offered by an employer, then the Employee may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as the employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Any Employee payments for coverage through the Marketplace are made on an after-tax basis.

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

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

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

Special Enrollment Periods

Special Enrollment Rights – If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan on the first day of the month after the Plan receives the enrollment form.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP) - If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply. The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP.

HIPAA Notice of Privacy Practices Effective Date: March 1, 2013

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

HIPAA Notice of Privacy Practices

The Carex Consulting Group Inc, Group Medical Plan (the "Plan"), which includes medical, dental and flexible spending account coverages offered under the Carex Consulting Group Inc, Plans, are required by law (under the Administrative Simplification provision of the Health

Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures Carex Consulting Group Inc, has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor: As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law: When required to do so by any federal, state or local law.

4. Health Oversight Activities: To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety: As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes: To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation: If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions: For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation: As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach
Carex Consulting Group Inc, is required maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made

only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Carex Consulting Group Inc, , [COMPANY ADDRESS], 608-233-1452.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Carex Consulting Group Inc, , [COMPANY ADDRESS], 608-233-1452. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at Carex Consulting Group Inc, , [COMPANY ADDRESS], 608-233-1452. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Carex Consulting Group Inc, , [COMPANY ADDRESS], 608-233-1452. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Carex Consulting Group Inc, , [COMPANY ADDRESS], 608-233-1452. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Carex Consulting Group Inc, , [COMPANY ADDRESS], 608-233-1452 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at Carex Consulting Group Inc, , [COMPANY ADDRESS], 608-233-1452. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated.

Important Notice from Carex Consulting Group Inc, About Your Prescription Drug Coverage and Medicare (Creditable Coverage) Applies to HMO / PPO

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Carex Consulting Group Inc, 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. Carex Consulting Group Inc, has determined that the prescription drug coverage offered by the Carex Consulting Group Inc, Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Carex Consulting Group Inc, coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Carex Consulting Group Inc, coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Carex Consulting Group Inc, and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Carex Consulting Group Inc, changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date: 10/01/2021
Name of Entity/Sender: Carex Consulting Group Inc,
Contact--Position/Office: Human Resources
Address: [6720 FRANK LLOYD WRIGHT AVE, STE 265, MIDDLETON, WI 53562
Phone Number: 608-233-1452

APPLIES TO HIGH DEDUCTIBLE HEALTH PLAN ONLY

Important Notice from Carex Consulting Group Inc, About Your Prescription Drug Coverage and Medicare (Non-Creditable Coverage) Applies to HSA

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Carex Consulting Group Inc, 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Carex Consulting Group Inc, High Deductible Health Plan has determined that the prescription drug coverage offered by Carex Consulting Group Inc, is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Carex Consulting Group Inc, high deductible health plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Carex Consulting Group Inc, . However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you decide to drop your current coverage with Carex Consulting Group Inc, , since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Carex Consulting Group Inc, high deductible health plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under the Carex Consulting

Group Inc, high deductible health plan, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Carex Consulting Group Inc, coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Carex Consulting Group Inc, coverage, be aware that you and your dependents will be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Carex Consulting Group Inc, changes. You also may request a copy of this notice at any time.

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

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

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

Date: 10/01/2021
Name of Entity/Sender: Carex Consulting Group Inc,
Contact--Position/Office: Human Resources
Address: [COMPANY ADDRESS]
Phone Number: 608-233-1452