



2026 | All Employees

Benefits Guide

Your Benefits, Your Choice





SUMMARY

BENEFITS GUIDE

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Contacts

Carex Consulting Group Benefits Contact

HR Department

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carexhumanresources@carexconsultinggroup.com

Coverage	Carrier	Phone Number	Website/Email
Medical Insurance	Quartz Benefits	800-362-3310	www.quartzbenefits.com
Dental Insurance	Ameritas	800-659-2223	www.ameritas.com
Vision Insurance	Delta Vision 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 Reimbursement Arrangement	EBC	608-831-8445	www.ebcflex.com
Health Savings Account	Monona Bank	608-223-3000	www.mononabank.com



Medicare Part D Notice:

If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to page **29-30** for details.

Eligibility

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:** These 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.

* **IMPORTANT:** 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

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Definition of “Eligible Dependents”

Medical, Dental, and Vision Coverage dependents include:

- **Your legally married spouse.** 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.
- **Your dependent children under age 26.** This includes natural, step, foster, adopted, or other children under your legal guardianship.
- For additional eligibility details, please refer to the policy contract or summary plan documents.



Employee Contributions

If you elect coverage, your premiums will be conveniently deducted from your paycheck. Please contact Human Resources regarding any questions or concerns.

For Medical:

- Employees in Wisconsin can choose between HMO or HSA plans.
- Employees outside of Wisconsin are only eligible for the PPO plan.

Medical	Prime Platinum \$500 HMO	Prime Bronze HSA (HDHP)	PPO - \$1,500
Employee Only	\$91.78	\$35.91	\$176.37
Employee + Spouse	\$578.19	\$263.97	\$740.74
Employee + Child(ren)	\$523.13	\$238.82	\$670.20
Family	\$881.05	\$402.22	\$1,128.74

Dental	
Employee Only	\$5.64
Family	\$54.67

Disability	To view your personalized rates, refer to your benefit highlight sheet for details.
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Vision	
Employee Only	\$1.45
Family	\$10.84

Medical

Quartz – Wisconsin Employees



Locate an in-network provider near you at [Quartz Benefits](#) or call 800-362-3310.

This coverage allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Medical – Wisconsin Employees	Prime Platinum \$500 HMO		Prime Bronze HSA (HDHP)
	In-Network		In-Network
Annual Deductible	Before HRA	With HRA	
Individual	\$4,500	\$500	\$6,000
Family	\$9,000	\$1,000	\$12,000
Coinsurance (You Pay)	20%		0%
Annual Out-of-Pocket Maximum	Before HRA	With HRA	
Individual	\$5,550	\$1,550	\$6,000
Family	\$11,100	\$3,100	\$12,000
Services	In-Network		In-Network
Preventive Care	Covered 100%		Covered 100%
Primary Care Office Visit	\$25		Deductible Applies
Specialist Office Visit	\$50		Deductible Applies
Urgent Care	\$50		Deductible Applies
Emergency Room	\$100		Deductible Applies
Hospitalization	20% AD		Deductible Applies
Prescription Drugs	In-Network		In-Network
Annual Out-of-Pocket Maximum			
Individual	\$2,350		Same as medical
Family	\$4,700		
Tier 1	\$10		Deductible Applies
Tier 2	\$35		Deductible Applies
Tier 3	\$60		Deductible Applies
Tier 4	\$200		Deductible Applies

Medical Premium Cost – See page 5 for employee cost	Prime Platinum \$500 HMO	Prime Bronze HSA (HDHP)
Employee Only	\$458.88	\$359.13
Employee + Spouse	\$963.65	\$754.18
Employee + Child(ren)	\$871.88	\$682.35
Family	\$1,468.41	\$1,149.21

AD = After Deductible

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Medical

Quartz – Employees Outside State of WI



Locate an in-network provider near you at [Quartz Benefits](#) or call 800-362-3310.

This coverage allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Medical – Out of State Employees	PPO - \$1,500			
	In-Network		Out-of-Network	
Annual Deductible	<i>Before HRA</i>	With HRA	<i>Before HRA</i>	With HRA
Individual	\$4,500	\$1,500	\$9,000	\$3,000
Family	\$9,000	\$3,000	\$18,000	\$6,000
Coinsurance (Plan Pays/You Pay)	20%		40%	
Annual Out-of-Pocket Maximum	<i>Before HRA</i>	With HRA	<i>Before HRA</i>	With HRA
Individual	\$5,550	\$2,550	\$11,100	\$5,100
Family	\$11,100	\$5,100	\$22,200	\$10,200
Services	In-Network		Out-of-Network	
Preventive Care	Covered 100%		Covered 100%	
Primary Care Office Visit	\$30		40% AD	
Specialist Office Visit	\$30		40% AD	
Urgent Care	\$60		40% AD	
Emergency Room	\$100		\$100	
Hospitalization	20% AD		40% AD	
Prescription Drugs	In-Network		Out-of-Network	
Annual Out-of-Pocket Maximum				
Individual	\$2,350		N/A	
Family	\$4,700			
Tier 1	\$10		N/A	
Tier 2	\$35		N/A	
Tier 3	\$60		N/A	
Tier 4	\$200		N/A	

Medical Monthly Cost	Premium Cost	Employee Cost
Employee Only	\$881.83	\$176.37
Employee + Spouse	\$1,851.85	\$740.74
Employee + Child(ren)	\$1,675.49	\$670.20
Family	\$2,821.85	\$1,128.74

AD = After Deductible

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.



Find a doctor or facility quick reference

Your Quartz provider network varies depending on your health network or coverage. Follow these steps to find an in-network provider or facility.



Step 1

Locate the Find a Doctor page

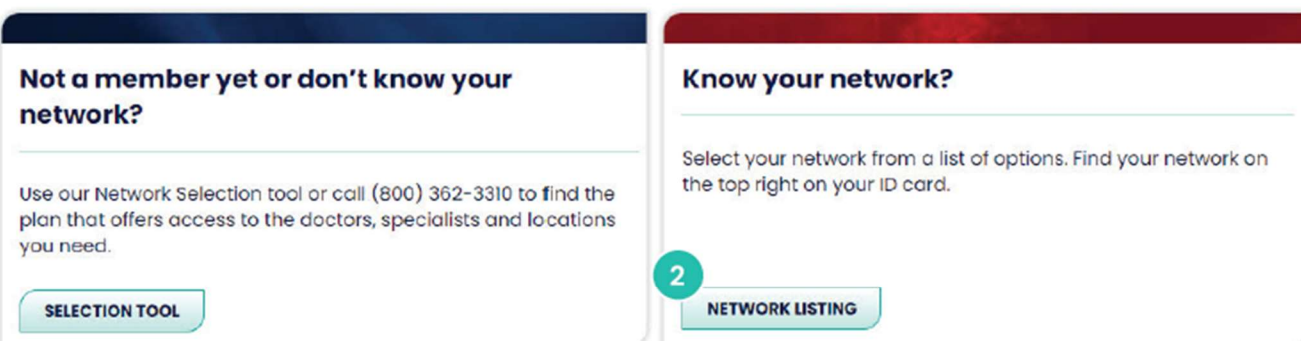
Go to QuartzBenefits.com. In the navy blue bar on the top of every page, you will find the text link to “Find a Doctor.” Click on it.



Step 2

Select your network

At the “Find a Doctor” page, scroll down and find the button labeled “Network Listing” under “Know your network?” Click on it.

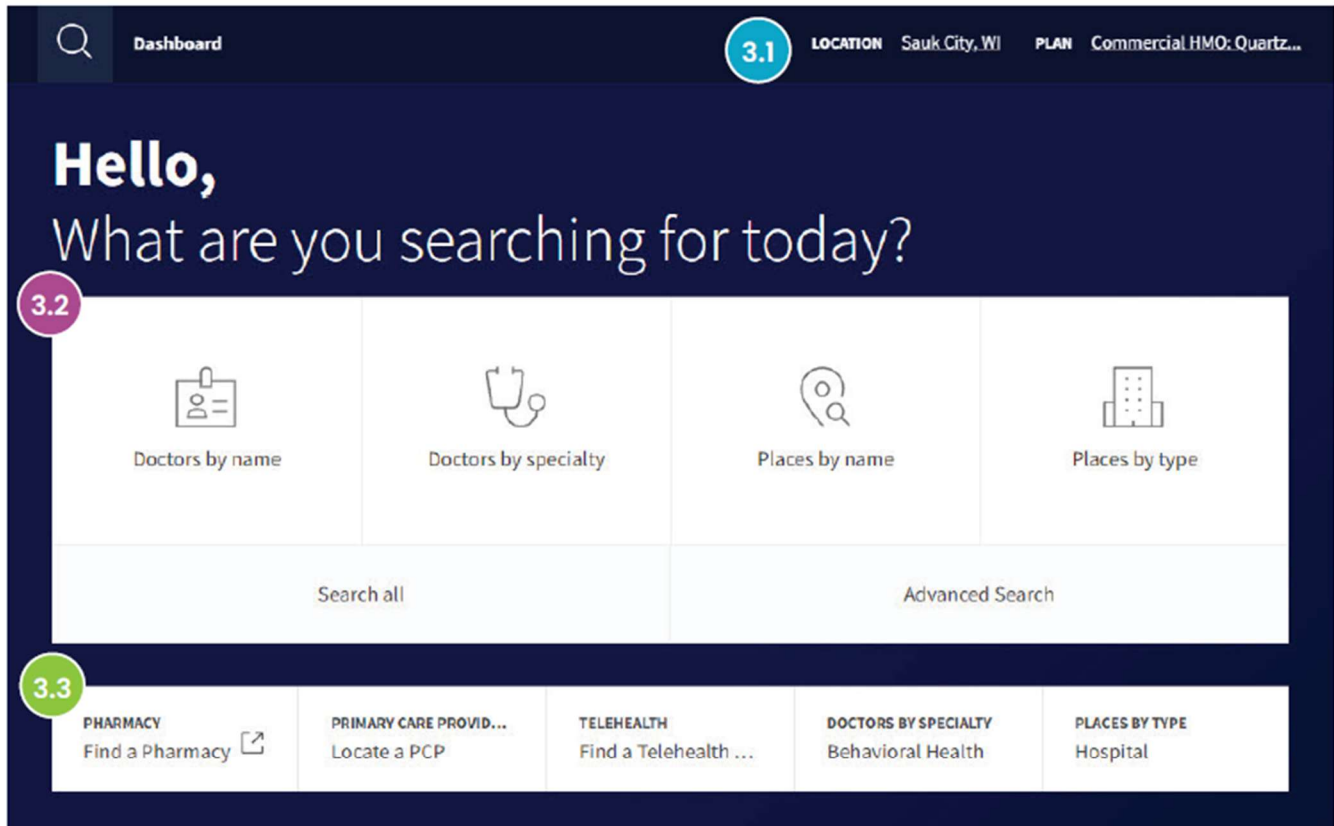


On the following “Network Listing” page, select your network by name. **You can find this information on your ID card.** Or, use our network selector tool and answer a few simple questions to guide you to the right network.

Step 3

Search for providers or facilities

Once you select your network on the “Network Listing” page, you will be directed to the provider search dashboard (shown below).



3.1

Check your location in the upper right corner. It defaults to where you are when you start your search. To look for providers elsewhere, change it to the desired location.

3.2

Use the quick links in the center of the page to search for “Doctors by name”, “Doctors by specialty”, “Places by name”, or “Places by type” (e.g., urgent care).

3.3

The smaller shortcut boxes at the bottom of the page will vary by network. These will take you to searches commonly requested.

Step 4

Filter your provider or facility search results

Once you input your search, the results will appear on the page. You are then able to use the filter functions to adjust your results to fit your needs. If you want to print or email your results, scroll to the end of your listing to "Print screen" or "Create PDF".



- **4.1**
Adjust the maximum mileage to narrow or expand your search radius.
- **4.2**
Change the search type from "Best Match" to "Distance (Closest)", "Name (A-Z)", or "Name (Z-A)".
- **4.3**
Click "Filters" for other ways to sort your results. These filters are dynamic and will change based on the type of search.

Step 5

Explore the full directory

If you want to review all in-network providers, scroll to the bottom of the search results screen and click "Quartz Printed Directories", then choose your network name to download a PDF of all providers. You can print or save the file. Please note that the full printed directory refreshes every night with the latest information.



Questions? Need help finding a provider?

Call Customer Success at **(800) 362-3310 (TTY: 711)**.
We're here to help.

Flexible Spending Account

TASC

Available to employees enrolled in the **Quartz HMO or PPO medical plan**.

FSAs can save you money on eligible expenses because you don't have to pay taxes on the amount contributed to the account. However, using an FSA does require careful planning to reap the financial benefits.

Health FSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Copays
- Coinsurance
- Other health-related expenses

2026 annual contribution limit	\$3,300
Rollover	\$660

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.

Limited-Purpose FSA

If you contribute to an HSA, you are only eligible to use a Health FSA for dental and vision expenses only.

2026 annual contribution limit	\$3,300
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Dependent Care FSA

Set aside tax-free money to care for children under age 13 or an elderly, dependent parent who is unable to care for themselves. Cover care expenses while you work, such as:

- Preschool
- Before and after school programs
- Summer day camp
- Elder care

2026 annual contribution limit	Married (Filing separately)	\$2,500
	Single/Married (Filing jointly)	\$5,000



Is a Health FSA Right for You?

www.cbmicrosite.com/video/healthfsa



Visit www.irs.gov and search for IRS Publications 502 (Medical and Dental) and 503 (Dependent Care) to learn more about eligible expenses.

Quartz / Monona Bank

If you are enrolled in an HSA-qualified plan, you may be eligible to open a tax-free health savings account. The money in your HSA is carried over from year to year so you can budget for current and future expenses. Plus, you own the account so it's yours to keep even if you change jobs or retire.



www.cbmicrosite.com/video/hsa



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 \$1,600 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.

HSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

Deductibles	Other health-related expenses
Coinsurance	

2026 annual contribution limit	Individual	\$4,400
	Family	\$8,750
	Catch-up contribution (Age 55 or older)	\$1,000
Rollover		Full Amount

All HSA contributions require an open and active account. Contributions cannot be made and are forfeited if no active account exists and cannot be paid later or in a different form.

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.

Year 1		➔	Year 2	
HSA Balance	\$1,000		HSA Balance	\$1,850
Total Expenses:			Total Expenses:	
Prescription drugs: \$150			Office visit: \$100	
			Prescription drugs: \$200	
			Preventive care services: \$0 (covered by insurance)	
	- \$150			- \$300
HSA Rollover to Year 2	\$850		HSA Rollover to Year 3	\$1,550

Since Justin did not spend all his HSA dollars in year 1, the remaining funds roll over.

Once again Justin did not spend all his HSA dollars, so they roll over to the next year.

Health Reimbursement Arrangement (HRA)

EBC

Employees enrolled in the Quartz HMO & PPO medical plan are auto enrolled.

HRAs provide a tax-free, employer-funded amount of money for health care expenses. This arrangement is a great way to pay for out-of-pocket qualified medical expenses while working to meet your plan deductible.

What Are the Benefits of an HRA?

You may enjoy several benefits from having an HRA:

- **It's employer funded.** Your employer contributes tax-free money to the account.
- **It's a tax-saver.** Contributions made by your employer can be excluded from your gross income, meaning you don't pay taxes on that money.
- **It saves you money.** Reimbursement from your HRA will make it much easier to meet your deductible while taking advantage of a health plan with lower premiums.
- **You don't need to set up or fund anything.** The HRA is automatic.
- **You still get the same provider networks and coverage.** The only change is how the deductible is funded.

How Does the HRA Work?

HMO PLAN

Employee Only: You pay 100% of the first \$500 of the deductible. The next \$4,000 is automatically paid 100% by the HRA

Employee + Spouse/Child or Family Coverage: You pay 100% of the first \$1,000 of the deductible. The next \$8,000 is automatically paid 100% by the HRA

PPO PLAN

Employee Only: You pay 100% of the first \$1,500 of the deductible. The next \$3,000 is automatically paid 100% by the HRA

Employee + Spouse/Child or Family Coverage: You pay 100% of the first \$3,000 of the deductible. The next \$6,000 is automatically paid 100% by the HRA

How Do I Get an Explanation of Benefits (EOB)?

- 1) You will be mailed an EOB each time a claim is filed in which you paid a portion of the overall deductible.
- 2) You can also call Quartz directly to request they mail the most recent copy of your EOB.

Check with the plan administrator or Human Resources to learn more.



Is an HRA Right for You?

www.cbmicrosite.com/video/hra

Visit www.irs.gov and search for IRS Publication 502 to learn more about eligible expenses.



Dental

Ameritas

Dental	PPO-Network	Premier or Out-of-Network
Annual Deductible	\$50 per individual \$150 per family	\$75 per individual \$225 per family
Annual Benefit Maximum	\$1,000	\$750
Lifetime Orthodontia Maximum	\$1,000	U&C
Plan Pays		
Preventive Care	100% Covered	80% Covered
Basic	80%	50%
Major	50%	40%
Orthodontia	65%	U&C

Dental Monthly Cost	Premium Rate	Employee Cost
Employee Only	\$28.20	\$5.64
Family	\$91.12	\$54.67

Locate an in-network provider near you at www.ameritas.com or call 800-659-2223.

Please review the full plan documents for details **including out-of-network coverage**. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

*U&C = Usual & Customary

Vision

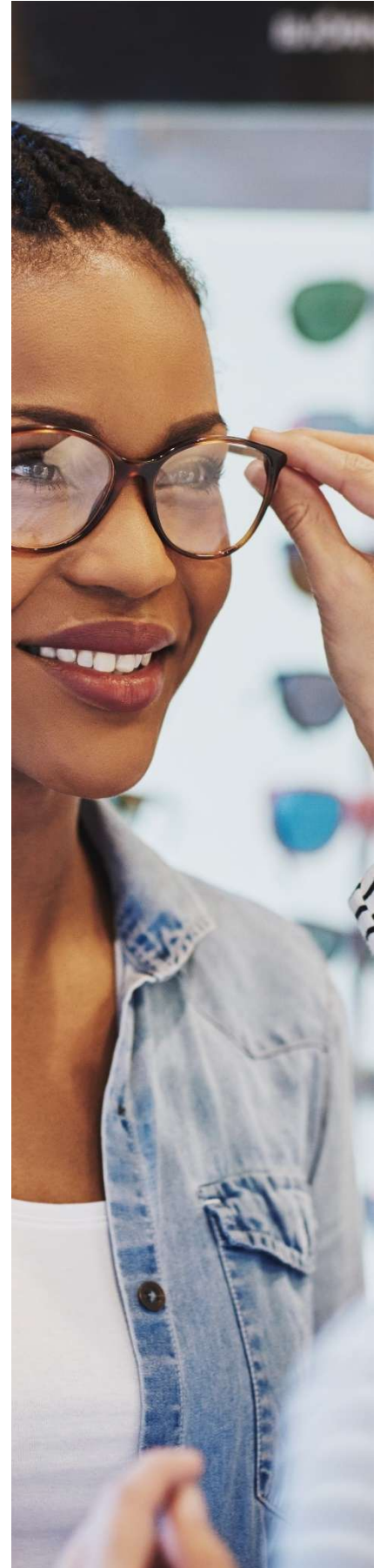
Delta Vision

Vision	In-Network	Non-Network Reimbursement
Exam	\$10 copay	\$35 copay
Lenses	\$10-\$75 copay	N/A
Frames	\$150 allowance then 20% off	\$75 allowance
Contact Lenses	\$150 allowance then 15% off	\$120 allowance
Frequencies		
Exams	1 per 12 months	
Lenses or Contacts	1 per 12 months	
Frames	1 per 24 months	

Vision Monthly Cost	Premium Rate	Employee Cost
Employee Only	\$7.26	\$1.45
Family	\$18.07	\$10.84

Locate an in-network provider near you at [DeltaVision®](#) | [Delta Dental](#) or call 800-877-7195.

Please review the full plan documents for details **including out-of-network coverage**. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.



401(k) RETIREMENT PLAN

Carex Consulting Group offers eligible employees the opportunity to save for retirement through our 401(k) plan, administered by Vestwell.

GETTING STARTED

After your **first paycheck**, Vestwell will send an enrollment invitation to your email address. **Action is required** when you receive this invitation.

You can also register directly using the link below:

Vestwell Registration: <https://connect-b.vestwell.com/register?>

You have two options:

1. ENROLL & CUSTOMIZE YOUR CONTRIBUTIONS Create your Vestwell account and select: • The percentage of your pay you would like to contribute • Your contribution type, such as Traditional (pre-tax) and/or Roth • Your investment selections	2. OPT OUT If you do not want to participate in the Carex 401(k) plan, you must follow the instructions provided by Vestwell to opt out of automatic enrollment.
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IMPORTANT: AUTOMATIC ENROLLMENT

If you take **no action** after receiving your Vestwell enrollment invitation, you will be **automatically enrolled** in the Carex 401(k) plan at the plan's default contribution rate.

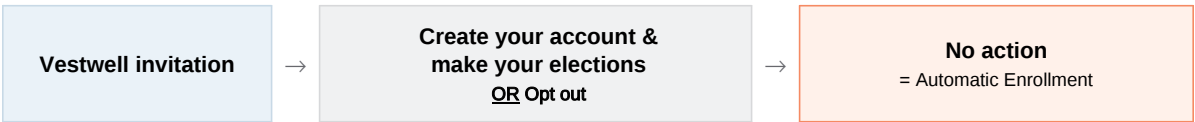
Once automatically enrolled, 401(k) contributions will be deducted directly from your paycheck according to the terms of the plan.

Simply ignoring the Vestwell invitation does not opt you out of the plan. If you do not wish to have 401(k) contributions deducted from your paycheck, you must actively opt out through Vestwell.

You can access your Vestwell account to review or manage your contribution elections in accordance with the terms of the plan.

WATCH FOR AN EMAIL FROM VESTWELL

After your first paycheck:



Questions? Contact Carex or Vestwell for assistance with your 401(k) enrollment.

Disability

Principal

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

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.

Long-Term Disability

Benefit Amount	Replaces 60% of earnings, up to a \$6,000 benefit per month
Benefit Begins	After a period of 90 days
Benefit Duration	Up to Social Security normal retirement age (SSNRA)
Pre-Existing Condition Limitations	12-month look back period 12-month exclusion period

Disability Cost

To view your personalized rates, refer to your benefit highlight sheet for details.



Pre-Existing Condition Limitations:

If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:

New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

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

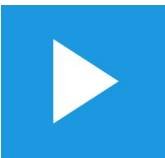
Healthcare Tips

Get the Most Out of Your Care

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.

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.



Where Should I Go for Care?

www.cbmicrosite.com/video/nowheretogo



Billing & Claim Differences

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

Provider The patient receives treatment. The doctor then sends the bill to the insurance company.	>	In-Network Discount Appropriate discount for using an in-network provider is applied.	>	Bill The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.
Patient Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.	<	Insurance Company Payments, Explanation of Benefits (EOB) 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.		



Take advantage of 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, 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.



Know Where to Go for Care



Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs \$1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room (\$\$\$\$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Uncontrollable bleeding
- Shortness of breath
- Poisoning

Urgent Care (\$\$\$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

Doctor's Office (\$\$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

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

Carex Consulting Group: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. 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 a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

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 January 31, 2026. V 0.7.0. 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:

<https://dhss.alaska.gov/dpa/Pages/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

Fax: 916-440-5676

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://hcpf.colorado.gov/child-health-plan-plus>

CHP+ Customer Service:

1-800-359-1991/State Relay 771

Health Insurance Buy-In Program (HIBI) Website: <https://www.mycohibi.com/>

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: <https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>

Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162, Press 1

GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>

Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program

All other Medicaid

Website: <https://www.in.gov/medicaid/>

<http://www.in.gov/fssa/dfr/>

Family and Social Services Administration

Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: [Iowa Medicaid | Health & Human Services](#)

Medicaid Phone: 1-800-338-8366

Hawki Website: [Hawki - Healthy and Well Kids in Iowa | Health & Human Services](#)

Hawki Phone: 1-800-257-8563

HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](#)

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <https://www.kancare.ks.gov/>

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

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: KIHIPPPROGRAM@ky.gov

KCHIP Website: <https://kynect.ky.gov>

Phone: 1-877-524-4718

Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

LOUISIANA – Medicaid

Website: <https://www.ldh.la.gov/healthy-louisiana>

Medicaid Customer Service Line: 1-888-342-6207

Louisiana Medicaid email: healthy@la.gov

Louisiana Health Insurance Premium Program (LaHIPP) Website: <https://www.ldh.la.gov/lahipp>

LaHIPP phone: 1-877-697-6703

LaHIPP email: La.HIPP@la.gov

LaHIPP fax: 1-888-716-9787

LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003

TTY: Maine Relay 711

Private Health Insurance Premium Webpage: <https://www.maine.gov/dhhs/ofi/applications-forms>

Phone: 1-800-977-6740

TTY: Maine Relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840

TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website:

<https://mn.gov/dhs/health-care-coverage/>

Phone: 1-800-657-3672

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

Email: HSHIPPProgram@mt.gov

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/programs-services/medicaid/health-insurance-premium-program>

Phone: 603-271-5218

Toll free number for the HIPP program:

1-800-852-3345, ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website: <http://www.njfamilycare.org/index.html>

CHIP Phone: 1-800-701-0710 (TTY: 711)

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: <https://www.hhs.nd.gov/healthcare>

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>

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>

Phone: 1-800-692-7462

CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html)

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: <http://www.eohhs.ri.gov/>

Phone: 1-855-697-4347 or

401-462-0311 (Direct Rlte 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: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>

Email: upp@utah.gov

Phone: 1-888-222-2542

Adult Expansion Website: <https://medicaid.utah.gov/expansion/>

Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>

CHIP Website: <https://chip.utah.gov/>

VERMONT – Medicaid

Website: <https://dvha.vermont.gov/members/medicaid/hipp-program>

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>

<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>

Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: <https://www.hca.wa.gov/>

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: <https://dhhr.wv.gov/bms/>

<http://mywvhipp.com/>

Medicaid Phone: 304-558-1700

CHIP Toll-free phone:

1-855-MyWVHIPP (1-855-699-8447)

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 January 31, 2026, 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 ❖

Notice Regarding Wellness Program

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us, Human Resources, and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. ❖

Patient Protection Notice

If the Carex Consulting Group generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

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.
- Treatment of physical complications of the mastectomy, including lymphedema.

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

Newborns' and Mothers' Health Protection Act

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 9.96% of household income for the plan year beginning in 2026, 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](https://www.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 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 no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

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

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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Carex Consulting Group (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

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

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

We are required by law to:

- a. maintain the privacy of your PHI;
- b. provide you with certain rights with respect to your PHI;
- c. provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and
- d. follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

HOW THE PLAN MAY USE AND DISCLOSE YOUR PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient:

1. For Treatment: When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by health care providers. For example, we might disclose information about you with physicians who are treating you.

2. For Payment: We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

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

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

5. To Business Associates: We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI by entering into a Business Associate Agreement with us.

6. Substance Use Disorder (SUD) Treatment Information: Some of your health information may be part of a SUD patient record and subject to additional protections under federal law (42 CFR Part 2) governing confidentiality of SUD patient records.

If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a “Part 2 Program”) through a general consent you provide to the Part 2 Program to use and disclose the SUD patient record for purposes of treatment, payment or health care operations, we may use and disclose your SUD patient record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your SUD patient record through specific consent you provide to us or another third party, we will use and disclose your SUD patient record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your SUD patient record, or testimony that describes the information contained in your SUD patient record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

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

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

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

10. Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by

someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

11. Law Enforcement Purposes: We may disclose your PHI if asked to do so by a law-enforcement official:

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

12. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, we may release PHI to identify a deceased person or to determine a cause of death or other duties as authorized by law.

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

14. Military and National Security: If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

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

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

17. Government Required Disclosures: We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

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

HOW THE PLAN MAY USE AND DISCLOSE YOUR PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. Not every use or disclosure in a category will be listed. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient:

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Inspect and Copy: You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if possible. If we cannot agree on an electronic form and format, or you request a paper copy, we will provide you with a paper copy. We may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

To inspect and copy your PHI, you must submit your request in writing. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request.

Right to Amend: If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.

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

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. There may be a charge for the cost of providing lists beyond the last 12-month period.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing. Your request must specify how or where you wish to be contacted, but you do not have to provide a reason for your request. We will accommodate all reasonable requests.

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

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

Contact Information and Complaints: If you have any questions about this Notice or about our privacy practices, and for any correspondence or requests related to the contents of this Notice, please contact Carex Consulting Group, 551 W Main St STE 100, Madison, WI 53703 , (608) 286-3539.

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

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

Important Notice from Carex Consulting Group about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Carex Consulting Group 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 has determined that the prescription drug coverage offered by the Carex Consulting Group 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 coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Carex Consulting Group 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 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 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: February 12, 2026

Name of Entity/Sender: Carex Consulting Group

Contact--Position/Office: Human Resources

Address: 551 W Main St STE 100, Madison, WI 53703

Phone Number: (608) 286-3539 ❖

