RICHEY MAY

2024-2025 BENEFITS GUIDE

& ANNUAL COMPLIANCE NOTICES

TABLE OF CONTENTS

This guide highlights the main features of many of the benefit plans sponsored by Richey May & Co, LLP. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. Richey May reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

BENEFITS FOR YOU AND YOUR FAMILY

At Richey May, we know that our employees are our most important asset. We also realize the benefits we offer to you are an important part of your overall compensation package. With this in mind, we are continually working to ensure that you have benefit options available that are affordable, while also helping you and your family stay healthy, feel secure, and maintain a work/life balance. Listed below are the benefits available:

- Medical
- Dental
- Vision
- Health Savings Account
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account
- Short-Term Disability
- Long-Term Disability
- Life and AD&D
- Accident Insurance
- Critical Illness Insurance
- Hospital Indemnity Insurance
- Employee Assistance Program

For full details about our plans, please refer to the summary plan descriptions available on **A Day at Richey May.**

Who is Eligible?

Employees regularly scheduled to work at least 30 hours per week and their eligible dependents may participate in the Richey May benefits programs. Generally, dependents are defined as:

- Your legal spouse
- Dependent children up to age 26 – including natural born, stepchildren, adopted, and those for whom you are the legal guardian
- A child for whom you are required to provide coverage due to a QMCSO
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

New Hire Enrollment

For new hires, you are eligible for most of the benefits first of the month following your hire date. **You have 30 days to enroll** on the Paycom Self Service Portal.

How to Enroll

On your first day, you will receive a Benefits Enrollment Checklist via email. Your benefits enrollment will take place via the Paycom Self Service portal. To access the Paycom portal, please reference the **Benefits Enrollment Checklist** email or visit **A Day at Richey May**.

Changing Coverage During the Year

You can change your coverage during the year when you experience a qualified change in status, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage. **The change must be reported to the Human Resources Department within 30 days of the event**. The change must be consistent with the event. For example, if you get married and would like to add your spouse to the benefit plan(s), you have 30 days from the date of marriage to contact HR and add your spouse as a dependent.

USING ALEX TO MAKE BENEFIT DECISIONS

Richey May is happy to provide you access to ALEX, an easy-to-use online interactive decision-support tool, to help you with the benefit plan decision process. Before you make your enrollment decisions, be sure to spend a few minutes with ALEX to find the best benefit plan for you and your family.

ALEX will ask you a few questions about your health care needs (your answers remain anonymous, of course), crunch some numbers, and recommend a plan that is best for your personal needs. It is that easy!

Get to Know ALEX!

Q: Who is ALEX, and how can they help me?
A: ALEX is a benefits expert who can help you pick the right plans and explain any terms or concepts you do not understand.

Q: How do I access ALEX?
A: ALEX is available online, so you can use the tool with your spouse and family members from any computer at any time. Use the following link to launch the ALEX platform: https://start.myalex.com/richeymay

Q: How does ALEX help recommend benefits to me?
A: ALEX will ask you a few straightforward questions about your needs to form a custom recommendation that's right for you.

Q: I don't speak "insurance." Will this be difficult to follow?
A: For an expert on health insurance and employee benefits, ALEX is funny. The experience is designed to be light, jargon-free, and helpful.

Q: Can Richey May see my answers?
A: No! ALEX does not create, receive, maintain, transmit, collect, or store any identifiable end-user information. Whatever you share with ALEX remains completely private.

MEDICAL INSURANCE

Richey May offers medical coverage through the **Aetna Choice POS II** provider network. Our plan is administered by Meritain Health, a nationwide healthcare benefits administrator and independent subsidiary of Aetna. The chart on the following page provides a brief outline of the plan. Please refer to the summary plan description for complete plan details. To verify if a doctor or healthcare facility is in-network, visit: http://www.aetna.com/docfind/custom/mymeritain/.

Choosing a Health Plan

When it comes to medical coverage Richey May offers, you have three choices:

- A Preferred Provider Organization (PPO) Plan
- Two HSA-eligible High Deductible Health Plan (HDHP) Options

All plans provide access to providers through Aetna's national network, so you have network providers available even if you are traveling or have a dependent attending school elsewhere. Additionally, all three plans have both in-network and out-of-network coverage. While this does give you the freedom to see any provider you choose, services from in-network providers will cost less.

Preferred Provider Organization (PPO) Plan

The **PPO Plan** is on Aetna's broadest network, the **Aetna Choice POS II Network**. If you choose this plan, your monthly premiums will be higher, but you will pay less at the time of care as office visits are subject to copays. If you enroll in the PPO Plan, you are eligible to contribute to a tax-savings account called a **Health Care Flexible Spending Account (Health Care FSA).** With this account, you can pay for certain out-of-pocket health care expenses throughout the year. Please reference the Health Care FSA section for more information.

High Deductible Health Plan (HDHP) – HDHP #1 and HDHP #2

The **High Deductible Health Plans (HDHPs #1 and #2)** are also on the **Aetna Choice POS II Network**, which is the broadest network available to Richey May employees.

HDHP #1 has a $3,200 in-network individual deductible and $6,400 in-network family deductible. There are no office visit copays on this plan as services will be subject to deductible. On the HDHP Plan #1, once you meet your in-network deductible, you have also satisfied the in-network out-of-pocket maximum, and the plan will pick up any remaining eligible medical and prescription drug costs for you and your family for the remainder of the year.

HDHP #2 has a $4,000 in-network individual deductible and $8,000 in-network family deductible. Like HDHP #1, there are no office visit copays on this plan as services will be subject to deductible. However, once you meet your in-network deductible, you will pay 20% of the cost of services until you reach the in-network out-of-pocket maximum. The in-network out-of-pocket maximum $5,000 for an individual or $10,000 for family, which is inclusive of the in-network deductible. Once you have met this, the plan will pick up any remaining eligible medical and prescription drug costs for you and your family for the remainder of the year.

In addition, the HDHPs offer a tax-savings feature called the **Health Savings Account (HSA)**. This account is different than a Health Care FSA, but also allows you to pay for certain out-of-pocket medical expenses throughout the year. Please reference the HSA information page for more detail.

Meritain Participant Portal

MyMERITAIN, a participant website, gives you 24-hour access to a number of tools and resources to help you manage your health benefits, including: finding an in-network provider, checking eligibility and benefits, viewing the status of claims, and viewing explanation of benefits (EOBs) and benefit plan documents. To gain online access, go to www.meritain.com and click Register in the top righthand corner. Our company group number is **15156**.

Comparing Your 2024-2025 Medical Plan Options

The costs listed in the table below are the member cost, based on the type of services received.

	PPO Plan	HDHP #1	HDHP #2
	In-Network	*In-Network*	*In-Network*
Network	Aetna Choice POS II	Aetna Choice POS II	Aetna Choice POS II
HSA Eligible?	No	Yes	Yes
Annual Deductible (Individual/Family)	$500 / $1,000	$3,200 / $6,400	$4,000 / $8,000
Coinsurance (Plan pays)	90%	100%	80%
Annual OOP Max (Individual/Family)	$1,500 / $3,000	$3,200 / $6,400	$5,000 / $10,000
Physician Office Visit	$30 Copay	Deductible then 0%	Deductible then 20%
Specialist Office Visit	$50 Copay	Deductible then 0%	Deductible then 20%
Urgent Care Visit	$50 Copay	Deductible then 0%	Deductible then 20%
Emergency Room Visit	$250 Copay, Deductible then 10%	Deductible then 0%	Deductible then 20%
Teladoc Virtual Visit General Medicine or Behavioral Health	$30 Copay	Deductible then 0%	Deductible then 20%
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%
Major Diagnostics (i.e. MRI, CT)	Deductible then 10%	Deductible then 0%	Deductible then 20%
Hospital Services	Deductible then 10%	Deductible then 0%	Deductible then 20%
Prescription Drugs Retail Generic Retail Preferred Brand Retail Non-Preferred Brand Retail Specialty Drugs Mail Generic Mail Preferred Brand Mail Non-Preferred Brand Mail Specialty Drugs	 $15 copay $40 copay $80 copay 20% coinsurance $37.50 copay $100 copay $200 copay 20% coinsurance	Deductible then 0%	Deductible then 20%

Plan Costs

Monthly Cost	PPO Plan		HDHP #1		HDHP #2	
	Employee	Richey May	Employee	Richey May	Employee	Richey May
Employee Only	$141.25	$543.84	$58.15	$543.84	$0.00	$543.84
Employee + Spouse	$568.25	$801.93	$402.05	$801.93	$285.74	$801.93
Employee + Child(ren)	$340.37	$790.03	$203.25	$790.03	$107.30	$790.03
Family	$1,121.69	$830.82	$884.85	$830.82	$719.11	$830.82

Note that if you enroll in the **HDHP #1** or **HDHP #2** with Employee Only coverage, Richey May will currently contribute $1,000 annually to your HSA. If you enroll in a tier that covers dependents, Richey May will currently contribute $2,000 annually to your HSA. Please see the HSA information page for more detail.

DENTAL INSURANCE

Richey May offers dental coverage through **Guardian** using the **DentalGuard Preferred Network**. By using in-network providers, members will receive the greatest discounts for your dental services during the plan year, allowing your benefit maximum to go farther and cover more. With the Guardian network, you have access to a network of dentists who accept reduced fees for covered services, giving you the lowest out-of-pocket costs.

To search for in-network providers, visit GuardianAnytime.com and search in the **PPO: DentalGuard Preferred** network for dental providers.

	Guardian DentalGuard Preferred Network	Out-of-Network
Lifetime Deductible	$100 Individual $300 Family	$100 Individual $300 Family
Annual Maximum* per person	$2,000 plus Rollover*	$2,000 plus Rollover*
Preventive Care Routine exams, cleanings, x-rays, space maintainers Under age 16: fluoride treatments, sealants	100%, no deductible	$100, no deductible
Basic Services Fillings, Endodontics, Periodontics, oral surgery, general anesthetics	Deductible, then plan pays 80%	Deductible, then plan pays 80%
Major Services Crowns, inlays, onlays, dentures, bridges	Deductible, then plan pays 50%	Deductible, then plan pays 50%
Orthodontia	Not covered	Not covered

* For members who submit at least one paid claim and do not exceed the $500 rollover threshold, up to $250 can be rolled over into the annual maximum to use for future years.

Employee Costs

Monthly Cost	Dental Plan
Employee Only	$37.42
Employee + Spouse	$75.96
Employee + Child(ren)	$89.59
Family	$136.16

VISION INSURANCE

Richey May offers vision care coverage through **VSP**. If you elect vision coverage, be sure to register on vsp.com to view your benefit information and search for in-network providers. At your eye appointment, simply tell the provider you have VSP – **no ID card is necessary.**

	VSP Choice Network	Out-of-Network
Eye Exam		
Comprehensive Exam	$10 copay	Reimbursed up to $45
Retinal Imaging	Up to $39 copay	Not applicable
Lenses		Reimbursed between
Single Vision, Lined Bifocals, Lined Trifocals, Lenticular	$25 copay	$30-$100
Frame Allowance		
Provider Office & Retail *(including Walmart/Sam's Club)*	$150 allowance	Reimbursed up to $70
Costco	$80 allowance	Not available
Contact Lenses (in lieu of glasses)		
Elective	$150 allowance	Reimbursed up to $105
Medically Necessary	Covered in full	Reimbursed up to $210
Contact Fitting & Evaluation	Up to $60	Not applicable
Benefit Frequency		
Exam / Lenses / Contacts	Once per 12 months	
Frames	Once per 24 months	

Employee Costs

Monthly Cost	Vision Plan
Employee Only	$6.66
Employee + Spouse	$13.36
Employee + Child(ren)	$14.28
Family	$22.82

HEALTH SAVINGS ACCOUNT

When you are enrolled in one of the Qualified High Deductible Health Plans (QHDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to a Health Savings Account. Richey May allows you to open an HSA administered by **P&A Group. As a participant, you will pay P&A Group $2.50 from your HSA as a monthly administrative fee.**

What is a Health Savings Account (HSA)?

An HSA is a tax-sheltered bank account that you own and can use to pay for eligible health care expenses for you and/or your eligible dependents for current or future health (medical and prescription drug), dental and vision expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. **There is no "use it or lose it" rule;** your balance carries over year to year. You may even assign a beneficiary to your account in the event of death.

Plus, you get extra tax advantages with an HSA because:

- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply)
- When your account reaches a $1,000 balance, you also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time

Are you eligible to open a Health Savings Account (HSA)?

Although everyone is able to enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. **If you do not meet the following requirements, you cannot open an HSA.**

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP). Richey May's HDHP is an eligible plan.
- You must not be covered by another non-QHDHP health plan, such as a spouse's PPO plan
- You are not enrolled in Medicare
- You are not in the TRICARE or TRICARE for Life military benefits program
- You have not received Veterans Administration (VA) benefits within the past three months
- You are not claimed as a dependent on another person's tax return
- You are not enrolled in a health care flexible spending account (FSA). This includes your spouse's FSA.

HEALTH SAVINGS ACCOUNT (CONTINUED)

2024 HSA Contributions

The HSA is your bank account, and stays with you, even if you terminate coverage in the Richey May health plan. If you enroll in the High Deductible Health Plan and contribute to the Health Savings Account, Richey May will currently contribute up to $1,000 annually ($41.67 per paycheck) to your HSA for Employee Only coverage or $2,000 annually ($83.33 per paycheck) for those who enroll dependents on the medical plan. The table below shows the total amount you can contribute to your HSA each year. Please note that Richey May's contributions count toward the annual maximum.

HDHP Enrollment Tier	Richey May Annual Contribution	Maximum Employee Contribution	2024 IRS Mandated Combined Maximum
Employee Only	$1,000	$3,150	**$4,150**
Employee + Spouse	$2,000	$6,300	**$8,300**
Employee + Child(ren)	$2,000	$6,300	**$8,300**
Family	$2,000	$6,300	**$8,300**
Note: if you are age 55 or older, you may contribute an extra $1,000 catch-up contribution			

If you open an HSA mid-year, please note your HSA contribution will be prorated for the number of months you are enrolled in one of the Richey May HDHPs. For example, if you are new to the Richey May HDHP plan and open your HSA as of July 1, your contribution will be pro-rated to 6 months, or 50% of the IRS mandated maximum.

How to Enroll in the HSA

New hires can elect contributions to their HSA during new hire enrollment. You can open an HSA or change the amount of your contribution at any point throughout the year. Note, expenses incurred prior to your HSA being open are not permitted.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

You can set aside tax-free dollars each year to cover eligible health, dental and vision expenses with a Health Care Flexible Spending Account (FSA). Richey May administers the FSA through **P&A Group**.

What is a Health Care FSA?

This account is used to pay for expenses associated with health care expenses not covered or reimbursed through insurance or another source. Eligible expenses include office visit copayments, deductibles, coinsurance and some over-the-counter items and medications.

Please Note: To enroll in the Health Care FSA, you must be enrolled in Richey May's PPO Plan. Employees enrolling in either of the HDHP options are not eligible to enroll in the Health Care FSA.

2024 Health Care FSA Contributions

The maximum annual contribution is $3,200. The total amount of contributions you elect will be available on January 1, before all paycheck deductions are made. You may use the Health Care FSA for any expenses incurred between January 1, 2024 – March 15, 2025. Claims must be submitted to P&A Group by April 30, 2025. If you enroll in the Health Care FSA, be sure to plan carefully as the "use it or lose it" rule applies! Any unused funds remaining in your account will be forfeited after April 30, 2025.

How to Enroll in the Health Care FSA

The Health Care FSA plan operates on a calendar year basis, beginning January 1. New hires can elect the Health Care FSA during new hire enrollment. If you are not a new hire, you will need to wait until the fall to elect contributions to the Health Care FSA for the following calendar year. The only time you are permitted to change the amount of your Health Care FSA contribution is if you experience a qualified change in status (see page 4, "Changing Coverage During the Year").

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT (FSA)

You can set aside tax-free dollars each year to cover eligible daycare expenses with a Dependent Care Flexible Spending Account (FSA). Richey May administers the FSA through **P&A Group**.

What is a Dependent Care FSA?

This account is used to pay for expenses associated with the care of children under age 13 (or a disabled child older than age 13) who qualifies as your dependent for tax purposes; or, anyone you can claim as a dependent, such as an elderly parent or disabled spouse, in order for you & your spouse to work full-time.

The account can be used for daycare, preschool, before & after school care, summer day camp and elder care. Services may be provided inside or outside your home (care provider must claim income on federal tax return).

2024 Dependent Care FSA Contributions

The maximum annual contribution is $5,000 if married filing jointly or single and claiming the dependent on your tax return, $2,500 if married filing separately. The total amount of contributions you elect will not be available on January 1. Funds will be available as they are deducted from payroll. You may use the Dependent Care FSA for any expenses incurred between January 1, 2024 – March 15, 2025. Claims must be submitted to P&A Group by April 30, 2025. If you enroll in the Dependent Care FSA, be sure to plan carefully as the "use it or lose it" rule applies! Any unused funds remaining in your account will be forfeited after April 30, 2025.

How to Enroll in the Dependent Care FSA

The Dependent Care FSA plan operates on a calendar year basis, beginning January 1. New hires can elect the Dependent Care FSA during new hire enrollment. **If you are not a new hire, you can enroll or update the amount of your Dependent Care FSA contribution when you begin to have eligible dependent care expenses, or if your cost of care changes.**

LIFE AND DISABILITY

Richey May offers life and disability coverage to provide financial protection in the event you become disabled or die while working. This coverage is administered through **Sun Life**.

Basic Life & AD&D Insurance

The Basic Life and AD&D benefit is 3x your annual earnings to a maximum of $200,000, which is payable in the event of your death and/ or accident. The IRS requires any employer-provided life insurance in excess of $50,000 be imputed income. You will be taxed on amounts over $50,000 based on the Premium Table included in IRS Publication 15-B found at www.irs.gov/pub/irs-pdf/p15b.pdf.

You must designate a beneficiary for Basic Life Insurance benefits when you enroll. Your beneficiary is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You can change your beneficiaries at any time during the year.

If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.

Short-Term Disability

Short-Term Disability (STD) benefits are provided by Richey May to all eligible employees at no premium cost. Your STD benefits will replace 60% of your earnings, up to $2,000 per week. The benefit is paid tax-free as you are taxed each paycheck on the premium amount.

Your STD benefits begin on day 15 in the case of an accident or illness. The maximum benefit payment period is 11 weeks per STD claim.

Long-Term Disability

If you remain totally disabled and unable to work for more than 90 days, you may be eligible for Long-Term Disability (LTD) benefits. Richey May automatically provides you LTD benefits that replace up to 60% of your monthly earnings, up to a maximum of $10,000 per month. The benefit is paid tax-free as you are taxed each paycheck on the premium amount.

ACCIDENT INSURANCE

Accident Insurance pays you benefits for specific injuries and events resulting from a covered accident. Coverage is provided by **Sun Life**, and the amount paid depends on the type of injury and care received. Accident insurance can help with: medical expenses, home healthcare costs, lost income due to missed time at work and everyday expenses.

If you enroll in accident insurance, you also have access to a wellness benefit which provides a $100 benefit to you and your enrolled dependents if a preventive care screening is completed.

Employee Costs

Monthly Cost	Accident Insurance
Employee Only	$15.29
Employee + Spouse	$22.00
Employee + Child(ren)	$29.40
Family	$36.11

CRITICAL ILLNESS INSURANCE

Critical Illness Insurance through **Sun Life** pays a lump sum benefit (up to the elected amount) if you or a covered family member is diagnosed with a covered critical illness. This can include conditions such as cancer, heart attack, stroke, major organ transplant, end-stage renal failure and brain tumor. The benefit can be used any way you choose, and you don't have to be disabled or terminally ill to receive the benefits.

Employee Costs

Monthly Cost (Based on Employee Age)						
Coverage amounts for Employee & Spouse	Under age 30	30-39	40-49	50-59	60-69	70 and over
$10,000	$5.00	$6.80	$11.80	$21.80	$31.20	$54.60
$20,000	$10.00	$13.60	$23.60	$43.60	$62.40	$109.20
$30,000	$15.00	$20.40	$35.40	$65.40	$93.60	$163.80
$40,000	$20.00	$27.20	$47.20	$87.20	$124.80	$218.40

You can elect child(ren) coverage in increments of $5,000, up to a maximum of $20,000. The monthly rate per $5,000 of child coverage is $0.50.

HOSPITAL INDEMNITY INSURANCE

Hospital Indemnity Insurance through **Sun Life** is designed to help provide financial protection for a covered individual by paying a benefit due to a hospitalization. Employees can use the benefit for out-of-pocket expenses such as copays, deductibles and everyday living expenses. Benefits are paid directly to the employee based on your coverage, regardless of the actual cost of treatment.

Employee Costs

Monthly Cost	Hospital Indemnity Insurance
Employee Only	$21.84
Employee + Spouse	$45.26
Employee + Child(ren)	$35.65
Family	$59.07

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Through our lines of coverage with Sun Life, Richey May employees and their families have access to a confidential, free Employee Assistance Program through **ComPsych**. **This program is available to all employees and members of their household, regardless of their enrollment in any benefit.** ComPsych provides a variety of services and resources, including three face-to-face counseling sessions per employee/member of household per issue per year, as well as unlimited telephonic counseling.

In addition to the EAP consultative services, ComPsych also offers work/life and legal/financial assistance resources such as:

- Child and elder care referral
- Employee discounts
- Legal and financial consultations
- ID theft
- Will preparation
- Tax consultation
- Assistance for New Parents
- Online Self-service legal documents

To contact ComPsych, call 1-877-595-5281 or visit the ComPsych Member Portal at GuidanceResources.com and enter the Web ID code **EAPBusiness**.

RICHEY MAY

Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts

Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.

Financial Resources

Our financial experts can assist with a wide range of issues.

- Retirement, taxes, mortgages, budgeting and more

For additional guidance, we can refer you to a local financial professional and arrange to reimburse you for the cost of an initial one-hour in-person consult.

Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions

Help for New Parents

ParentGuidance℠ supports you through the process of becoming a biological or adoptive parent, including:

- Preparing for the baby emotionally and financially
- Finding child care
- Planning for back-to-work and other issues

Free Online Will Preparation

EstateGuidance® lets you quickly and easily create a will online.

- Specify your wishes for your property
- Provide funeral and burial instructions
- Choose a guardian for your children

Contact EAPBusiness Class℠ Anytime

No-cost, confidential solutions to life's challenges.

Your ComPsych® GuidanceResources® program EAPBusiness Class offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 877.595.5281
TDD: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant℠, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: EAPBusiness

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

24/7 Support, Resources & Information

Contact EAPBusiness Class Anytime

Call: 877.595.5281
TDD: 800.697.0353
Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: EAPBusiness

RICHEY MAY

IMPORTANT CONTACTS

Resource	Phone Number	Website/Email
Medical & Prescription Drug Meritain	1-800-925-2272	Account.Meritain.com Group # 15156
Teladoc Virtual Health (General Medicine & Behavioral Health)	1-800-835-2362	www.Teladoc.com
Dental Guardian	1-800-627-4200	GuardianAnytime.com
Vision VSP	1-800-877-7195	VSP.com
Flexible Spending Accounts and Health Savings Account P&A Group	716-852-2611	PAdmin.com
Life Insurance and Long-Term Disability Sun Life	1-800-547-6875	SunLife.com/Account
Short-Term Disability Insurance Sun Life	1-877-932-7287	SunLife.com/Account
Accident, Critical Illness, and Hospital Indemnity Insurance Sun Life	1-877-820-5306	Submit a Claim: SunLife.com/Account SLFWorksiteClaims@DisabilityRMS.com
Employee Assistance Program ComPsych	1-877-595-5281	GuidanceResources.com Web ID: EAPBusiness
Richey May Benefit Partners Holmes Murphy		RicheyMay@holmesmurphy.com

RICHEY MAY

NOTES

ANNUAL COMPLIANCE NOTICES

The below notices will be outlined in the following pages:

Summaries of Benefits and Coverage

The government-required Summaries of Benefits and Coverage (SBCs), which summarize important information about your Meritain health plan options, are available on Richey May's Intranet site, A Day at Richey May, under Documents > Employee HR Documents > Health Dental Vision. A paper copy is also available upon request.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since January 31, 2024, 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

State	Website/E-mail	Phone
Alabama (Medicaid)	http://www.myalhipp.com/	1-855-692-5447
Alaska (Medicaid)	*Premium Payment Program:* http://myakhipp.com/ *Medicaid Eligibility:* https://health.alaska.gov/dpa/Pages/default.aspx *E-mail:* CustomerService@MyAKHIPP.com	*1-866-251-4861*
Arkansas (Medicaid)	http://myarhipp.com/	1-855-692-7447
California (Medicaid)	http://dhcs.ca.gov/hipp hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado (Medicaid and CHIP)	*Medicaid:* https://www.healthfirstcolorado.com/ *CHIP:* https://hcpf.colorado.gov/child-health-plan-plus *HIBI:* https://www.mycohibi.com/	1-800-221-3943 1-800-359-1991 1-855-692-6442 State relay 711

State	Website/E-mail	Phone
Florida (Medicaid)	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
Georgia (Medicaid)	*HIPP:* https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp *CHIPRA:* https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana (Medicaid)	*Healthy Indiana Plan for low-income adults 19-64:* http://www.in.gov/fssa/hip/ *All other Medicaid:* https://www.in.gov/medicaid	1-877-438-4479 1-800-457-4584
Iowa (Medicaid and CHIP)	*Medicaid:* https://dhs.iowa.gov/ime/members *CHIP:* http://dhs.iowa.gov/Hawki *HIPP:* https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	1-800-338-8366 1-800-257-8563 1-888-346-9562
Kansas (Medicaid)	https://www.kancare.ks.gov/	1-800-967-4660 HIPP: 1-800-967-4660
Kentucky (Medicaid and CHIP)	*Medicaid:* https://chfs.ky.gov/agencies/dms *KI-HIPP:* https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.apsx *KI-HIPP E-mail:* KIHIPP.PROGRAM@ky.gov *KCHIP:* https://kynect.ly.gov	 1-855-459-6328 1-877-524-4718
Louisiana (Medicaid)	www.medicaid.la.gov www.ldh.la.gov/lahipp	1-888-342-6207 1-855-618-5488
Maine (Medicaid)	https://www.maine.gov/dhhs/ofi/applications-forms https://www.mymaineconnection.gov/benefits/s/?language=e n_US	*Enroll:* 1-800-442-6003 *Private HIP:* 1-800-977-6740 TTY: Maine relay 711
Massachusetts (Medicaid and CHIP)	https://www.mass.gov/masshealth/pa Email: masspremassistance@accenture.com	1-800-862-4840 TTY: 711
Minnesota (Medicaid)	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri (Medicaid)	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana (Medicaid)	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HHSHIPPProgram@mt.gov	1-800-694-3084
Nebraska (Medicaid)	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 *Lincoln:* 402-473-7000 *Omaha:* 402-595-1178
Nevada (Medicaid)	http://dhcfp.nv.gov/	1-800-992-0900
New Hampshire (Medicaid)	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program	603-271-5218 or 1-800-852-3345, ext. 5218
New Jersey (Medicaid and CHIP)	*Medicaid:* http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ *CHIP:* http://www.njfamilycare.org/index.html	*Medicaid:* 609-631-2392 *CHIP:* 1-800-701-0710
New York (Medicaid)	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina (Medicaid)	https://medicaid.ncdhhs.gov/	919-855-4100
North Dakota (Medicaid)	https://www.hhs.nd.gov/healthcare	1-844-854-4825
Oklahoma (Medicaid and CHIP)	http://www.insureoklahoma.org	1-888-365-3742
Oregon (Medicaid)	http://healthcare.oregon.gov/Pages/index.aspx	1-800-699-9075
Pennsylvania (Medicaid and CHIP)	*Medicaid:* https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx *CHIP:* https://www.dhs.pa.gov/chip/pages/chip.aspx	*Medicaid:* 1-800-692-7462 *CHIP:* 1-800-986-KIDS (5437)
Rhode Island (Medicaid and CHIP)	http://www.eohhs.ri.gov/	1-855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina (Medicaid)	https://www.scdhhs.gov	1-888-549-0820
South Dakota (Medicaid)	http://dss.sd.gov	1-888-828-0059
Texas (Medicaid)	https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	1-800-440-0493
Utah (Medicaid and CHIP)	*Medicaid:* https://medicaid.utah.gov/ *CHIP:* http://health.utah.gov/chip	1-877-543-7669
Vermont (Medicaid)	https://dvha.vermont.gov/members/medicaid/hipp-program	1-800-250-8427
Virginia (Medicaid and CHIP)	https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs	1-800-432-5924
Washington (Medicaid)	https://www.hca.wa.gov/	1-800-562-3022
West Virginia (Medicaid)	https://dhhr.wv.gov/bms/ http://mywvhipp.com/	*Medicaid:* 304-558-1700 *CHIP:* 1-855-699-8447
Wisconsin (Medicaid and CHIP)	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming (Medicaid)	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-800-251-1269

Health Insurance Marketplace Coverage Options and Your Health Coverage

Part A: General Information

Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Kathy Sealman at (303) 721-6131.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health

insurance coverage and contact information for a Health Insurance Marketplace in your area.

Part B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Richey May & Co, LLP		4. Employer Identification Number (EIN) 71-0911208
5. Employer address 9780 S Meridian Blvd. Suite 500		6. Employer phone number (303) 721-6131
7. City Englewood	8. State CO	9. ZIP code 80112
10. Who can we contact about employee health coverage at this job? Kathy Sealman		
11. Phone number (if different from above) (303) 721-6131	12. E-mail address kathy@richeymay.com	

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

As your employer, we offer a health plan to eligible employees.

- Eligible employees are:
  - Partners
  - Full-Time employees
  - Part-Time employees who are regularly scheduled at least 30+ hours per week

With respect to dependents, we do offer coverage.

- Eligible dependents are:
  - Legal spouse or partner in a civil union
  - Dependent children under age 26 – including natural born, step-children, adopted and those for whom you are the legal guardian

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

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

If you decide to shop for coverage in the Marketplace, www.healthcare.gov will guide you through the process.

Richey May Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the Richey May Health Plan (The Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on January 1, 2024.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Richey May requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Richey May for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

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

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Kathy Sealman | (303) 721-6131 | kathy@richeymay.com
Richey May & Co. | 9780 S Meridian Blvd, Suite 500 Englewood, CO 80112

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit **www.hhs.gov/ocr** for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Important Notice from Richey May About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Richey May 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. Richey May has determined that the prescription drug coverage offered by the Group Health Plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are 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 Richey May coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Richey May coverage, be aware that you and your dependents may not 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 Richey May 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 Richey May 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 "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: 7/1/2024

Richey May & Co. | 9780 S Meridian Blvd, Suite 500 Englewood, CO 80112
Kathy Sealman | (303) 721-6131 | kathy@richeymay.com

COBRA Rights Notice

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

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

What is COBRA Continuation Coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;

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

When Is COBRA Coverage Available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: the plan administrator using the procedures specified below. If these procedures are not followed or if the notice is not provided <u>in writing</u> to the Plan Administrator or its designee during the 60-day notice period, any spouse or eligible child who loses coverage will not be offered the option to elect continuation coverage.

<u>Notice Procedure:</u>

Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department, or firm listed below, at the following address:

P&A Group
6400 Main Street, Suite 210
Williamsville, NY 14221

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- The **name of the plan or plans** under which you lost or are losing coverage,
- The **name and address of the employee** covered under the plan,
- The **name(s) and address(es) of the qualified beneficiary(ies),** and
- The **qualifying event** and the **date** it happened.

If the qualifying event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

The plan requires you to follow the procedures specified in the box above, under the heading entitled *"Notice Procedures."* In addition, your notice must include:

- The name of the disabled qualified beneficiary,
- The date that the qualified beneficiary became disabled, and
- The date that the Social Security Administration made its determination.

Your notice must also include a copy of the Social Security Administration's determination. ***If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required period, then there will be no disability extension of COBRA continuation coverage.***

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, **Children's Health Insurance Program (CHIP),** or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After my Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the

Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit **https://www.medicare.gov/medicare-and-you**.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep Your Plan Informed of Address Changes

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

Plan Contact Information

Dated 7/1/2024 | Richey May & Co. | 9780 S Meridian Blvd, Suite 500 Englewood, CO 80112
Kathy Sealman | (303) 721-6131 | kathy@richeymay.com

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

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 consultations with the attending physician and the patient, for:

- All states 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, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, please refer to your Summary Plan Description or contact your medical plan administrator.

Notice of Special Enrollment Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans to provide a special enrollment opportunity to an employee (or COBRA enrollee) upon the occurrence of specific events. This Chart summarizes the qualifying events and the corresponding special enrollment rights. This notice is being provided to ensure that you understand your right to apply for the Richey May Group Health Care Plan. You should read this notice even if you plan to waive coverage at this time.

EVENT	SPECIAL ENROLLMENT RIGHT
Acquisition of New Dependent(s) due to Marriage	• Employee may enroll the employee (if not previously enrolled). • Employee may also enroll newly-eligible spouse and/or newly-eligible stepchild(ren).
Acquisition of New Child due to birth or adoption (including placement for adoption)	• Employee may enroll the employee (if not previously enrolled). • Employee may also enroll spouse and/or newly-eligible child(ren).
Gain Eligibility for Premium Assistance Subsidy under Medicaid or CHIP	• Employee may enroll the employee and the spouse or child(ren) who have become eligible for the premium assistance.

Loss of Other Health Coverage if due to:
• Loss of eligibility.
  ○ Death of spouse; divorce, legal separation
  ○ Child loses status (e.g. reaches age limit)
  ○ Employment change (e.g. termination, reduction in hours, unpaid FMLA)
• Expiration of COBRA maximum period
• Moving out of HMO plan's service area
• Other employer terminates its plan (or discontinues employer contributions)
	• Employee may enroll the employee (if not previously enrolled).
	• Employee may also enroll spouse and/or children who have lost other health coverage.
	Note: Person losing the Other Health Coverage must have had the other coverage since the date of this employer plan's most recent enrollment opportunity.

Loss of Medicaid or CHIP coverage	Employee may enroll the employee and the spouse or child(ren) who have lost Medicaid/CHIP entitlement.

Notes:

1. HIPAA Special Enrollees must be given 31 days (from the date of the event) to enroll.
2. For events related to Medicaid/CHIP, the special enrollment period is 60 days.
3. Special enrollment, if elected, must take effect no later than the first day of the month following the enrollment request. If the event is the birth or adoption of a child, the special enrollment must take effect retroactively on the date of birth or adoption (or placement for adoption).

For more information or assistance, please contact Kathy Sealman in Human Resources
(303) 721-6131 | kathy@richeymay.com

Your Rights & Protections Against Surprise Medical Bills

When you obtain emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

EMERGENCY SERVICES

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

See a summary of related state balance billing laws at: https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections.

CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER

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

If you obtain other services at these in-network facilities, out-of-network providers **cannot** balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. Also, you are not required to obtain care out-of-network. You can choose a provider or facility in your plan's network.

In certain states, you may also have related state protections:

Visit The Commonwealth Fund website for updated state balance-billing protections at https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections.

Applicable state balance billing laws or requirements for noted states are as follows:

ARIZONA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
    - To HMO and PPO enrollees
    - For (1) emergency services provided by out-of-network professionals at in-network facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
    - Provided by all or most classes of health care professionals
- State provides a dispute resolution process for claims over $1000, which must be initiated by the enrollee
- Protections do not apply to:
    - ground ambulance services
    - services at out-of-network facilities
    - enrollees who consent to non-emergency out-of-network services
    - enrollees of self-funded plans

CALIFORNIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
    - To HMO and PPO enrollees
    - For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
    - Provided by all or most classes of health care professionals
- State provides a payment standard
- Protections do not apply to:
    - ground ambulance services
    - enrollees who consent to non-emergency out-of-network services
    - enrollees in self-funded plans

COLORADO PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply
    - To HMO and PPO enrollees
    - For (1) emergency services provided by out-of-network professionals, facilities, and ground ambulance service providers and (2) non-emergency services provided by out-of-network professionals at in-network facilities

- Provided by all or most classes of health care providers
- State provides a payment standard
- Protections do not apply:
  - to enrollees who consent to out-of-network non-emergency services
  - to enrollees of self-funded plans

CONNECTICUT PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
  - To HMO and PPO enrollees
  - For (1) emergency services and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by all or most classes of health care professionals
- State provides a payment standard
- Protections do not apply to:
  - ground ambulance services
  - out-of-network facility charges for emergency services
  - enrollees who consent to non-emergency out-of-network services
  - enrollees of self-funded plans

DELAWARE PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for emergency services provided
  - by out-of-network professionals
  - at out-of-network facilities
  - by certain out-of-network ground ambulance service providers
- State prohibits providers from balance billing enrollees for non-emergency services provided at in-network facilities unless they obtain consent from the enrollee
- Above protections apply to:
  - HMO and PPO enrollees
  - For services provided by all or most classes of health care professionals
- State provides a payment standard for emergency services
- State provides the option of arbitration
- Protections do not apply to:
  - enrollees who consent to non-emergency out-of-network services
  - enrollees in self-funded plans

FLORIDA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
  - To HMO and PPO enrollees

- For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
- Provided by all or most classes of health care professionals

- For PPOs, state payment standard applies to (1) emergency services and (2) non-emergency services provided by out-of-network professionals at in-network facilities
- For HMOs, state payment standard only applies to emergency services but the state also has a claim dispute resolution program in place
- Protections do not apply to:
  - ground ambulance services for PPO enrollees
  - PPO enrollees who consent to non-emergency out-of-network services
  - enrollees of self-funded plans

GEORGIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
  - To HMO and PPO enrollees
  - For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by all or most classes of health care professionals
- State provides a payment standard for professionals but not facilities
- State provides a dispute resolution process
- Protections do not apply to:
  - ground ambulance services
  - enrollees who consent to non-emergency out-of-network services
  - enrollees in self-funded plans

ILLINOIS PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
  - To HMO and PPO enrollees
  - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by certain specific classes of health care professionals
- State provides a dispute resolution process
- Protections do not apply to:
  - ground ambulance services
  - services received at out-of-network facilities
  - enrollees who consent to non-emergency out-of-network services
  - enrollees of self-funded plans

INDIANA PROTECTIONS AVAILABLE

- For HMOs, with respect to emergency services provided by out-of-network professionals and facilities, state (1) requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing; and (2) prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- For HMOs and PPOs, with respect to non-emergency services provided by out-of-network professionals at in-network facilities, state prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing. This prohibition applies to all providers in the state, and therefore might also protect enrollees of self-funded plans.
- Above protections apply to services provided by all or most classes of health care professionals.
- Protections do not apply to:
    - ground ambulance services
    - enrollees who consent to non-emergency out-of-network services

IOWA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
    - To HMO and PPO enrollees
    - For emergency services provided by out-of-network professionals and facilities
    - Provided by all or most classes of health care professionals
- Protections do not apply to:
    - enrollees of self-funded plans
    - non-emergency services

MAINE PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
    - To HMO and PPO enrollees
    - To enrollees of self-funded plans that have opted into the protections
    - For (1) emergency services by out-of-network professionals, facilities and ambulance providers; and (2) non-emergency services provided by out-of-network professionals at in-network facilities
    - Provided by all or most classes of out-of-network health care professionals
- State provides a payment standard
- Protections do not apply to enrollees who consent to out-of-network non-emergency services

MASSACHUSETTS PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
    - To HMO and PPO enrollees
    - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
    - Provided by all or most classes of out-of-network health care professionals
- Protections do not apply to:
    - ground ambulance services
    - services at out-of-network facilities

- enrollees who consent to out-of-network services
- enrollees of self-funded plans

MARYLAND PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
  - To (1) emergency services provided by out-of-network professionals, facilities, and ambulance providers; and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by all types of out-of-network health care professionals for HMO enrollees
  - Provided by on-call or hospital-based physicians who agree to accept assignment of benefits for PPO enrollees
- State provides a payment standard
- Protections do not apply to enrollees in self-funded plans

MICHIGAN PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
  - To HMO and PPO enrollees
  - For (1) emergency services by out-of-network professionals and facilities; and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by all or most classes of out-of-network health care professionals
- State provides a payment standard
- State provides a dispute resolution process
- Protections do not apply to:
  - ground ambulance services
  - enrollees who consent to non-emergency out-of-network services
  - enrollees in self-funded plans

MINNESOTA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
  - To HMO and PPO enrollees
  - For non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by all or most classes of out-of-network health care professionals
- State provides a dispute resolution process
- Protections do not apply to:
  - emergency services
  - enrollees of self-funded plans

MISSISSIPPI PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
    - To HMO and PPO enrollees
    - For (1) emergency services by out-of-network professionals and facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
    - Provided by all or most classes of health care professionals
- Protections do not apply to:
    - ground ambulance services
    - enrollees of self-funded plans

MISSOURI PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protection applies to:
    - To HMO, PPO, and EPO enrollees
    - For emergency services provided by out-of-network professionals at in-network facilities
    - Provided by all or most classes of health care professionals
- State provides dispute resolution process
- Protections do not apply to:
    - ground ambulance services
    - services provided at out-of-network facilities
    - non-emergency services
    - enrollees of self-funded plans

NEBRASKA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network professionals and facilities from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
    - To HMO and PPO enrollees
    - For emergency services
    - Provided by all or most classes of health care professionals
- Protections do not apply to:
    - ground ambulance services
    - non-emergency services
    - enrollees of self-funded plans
- State provides a payment standard

NEVADA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply

- To HMO and PPO enrollees
- To enrollees of self-funded plans that have opted into the protections
- For emergency services by out-of-network professionals and facilities
- Provided by all or most classes of health care providers

- State provides a dispute resolution process
- Protections do not apply to:
  - ground ambulance services
  - non-emergency services

NEW HAMPSHIRE PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protection applies:
  - To any network-based major medical health insurance product, including HMO, PPO, EPO and POS products
  - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by certain specific classes of health care professionals
- State provides a dispute resolution process
- Protections do not apply to:
  - ground ambulance services
  - services at out-of-network facilities
  - enrollees of self-funded plans

NEW JERSEY PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
  - To HMO, PPO, EPO and POS enrollees
  - To enrollees of self-funded plans that have opted into the protections
  - For (1) emergency services provided by out-of-network professionals and facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by all or most classes of health care professionals
- State provides a dispute resolution process
- Protections do not apply to:
  - ground ambulance services
  - enrollees who consent to non-emergency out-of-network services

NEW MEXICO PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
  - To HMO and PPO enrollees

- For (1) emergency services by out-of-network professionals and facilities and (2) non-emergency services provided by out-of-network professionals at in-network facilities
- Provided by all or most classes of health care professionals

- State provides a payment standard
- Protections do not apply to:
  - ground ambulance services
  - enrollees who consent to out-of-network non-emergency services
  - enrollees of self-funded plans

NEW YORK PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
  - To HMO, PPO and EPO enrollees.
  - For (1) emergency services provided by out-of-network facilities, professionals, and ground ambulance providers; and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by all or most classes of health care professionals
- State provides a dispute resolution process
- Protections do not apply to
  - enrollees who consent to non-emergency out-of-network services†
  - enrollees of self-funded plans

NORTH CAROLINA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protections apply:
  - To HMO and PPO enrollees
  - For emergency services by out-of-network professionals
  - Provided by all or most classes of health care professionals
- Protections do not apply to:
  - ground ambulance services
  - emergency services by out-of-network facilities
  - non-emergency services
  - enrollees of self-funded plans

OHIO PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
  - To HMO and PPO enrollees
  - For (1) emergency services provided by out-of-network professionals, facilities, and ground ambulance service providers and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by those classes of health care professionals as defined by regulation
- State provides a payment standard
- State provides a dispute resolution process
- Protections do not apply to:

- enrollees of self-funded plans
- enrollees who consent to out-of-network non-emergency services

OREGON PROTECTIONS AVAILABLE

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protection applies:
  - To HMO and PPO enrollees
  - For (1) emergency services provided by out-of-network professionals at in-network facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by all or most classes of health care professionals
- State provides a payment standard
- Protections do not apply to:
  - ground ambulance services
  - services at out-of-network facilities
  - enrollees who consent to non-emergency out-of-network services
  - enrollees of self-funded plans

PENNSYLVANIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
  - To HMO and PPO enrollees
  - For emergency services
  - Provided by all or most classes of health care professionals
- Protections do not apply to:
  - ground ambulance services
  - out-of-network facility emergency service charges, for PPO enrollees only
  - non-emergency services
  - enrollees of self-funded plans

RHODE ISLAND PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
  - To HMO enrollees
  - For (1) emergency services, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
  - Provided by all or most classes of health care professionals
- Protections do not apply to:
  - PPO enrollees
  - ground ambulance services
  - enrollees of self-funded plans

TEXAS PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing

- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
    - To HMO, PPO, and EPO enrollees
    - For (1) emergency services by out-of-network professionals and facilities, and (2) non-emergency services provided by out-of-network professionals at in-network facilities
    - Provided by all or most classes of health care professionals
- State provides dispute resolution process
- Protections do not apply to:
    - ground ambulance services
    - enrollees who consent to out-of-network non-emergency services
    - enrollees of self-funded plans

VERMONT PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
    - To HMO and PPO enrollees
    - For emergency services including ground ambulance services
    - Provided by all or most classes of health care professionals
- Protections do not apply to:
    - out-of-network facility charges for emergency services
    - non-emergency services
    - enrollees of self-funded plans

VIRIGINA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
    - To HMO and PPO enrollees
    - To enrollees of self-funded plans that have opted into the protections
    - For (1) emergency services by out-of-network professionals and facilities, and (2) non-emergency surgical or ancillary services provided by all or most classes of out-of-network professionals at in-network facilities
- State provides a dispute resolution process
- Protections do not apply to ground ambulance services

WASHINGTON STATE PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
    - To HMO and PPO enrollees
    - To enrollees of self-funded plans that have opted into the protections

- For (1) emergency services provided by all or most classes of health care professionals and out-of-network facilities and (2) non-emergency surgical or ancillary services provided by all or most classes of out-of-network professionals at in-network facilities
- State provides a dispute resolution process
- Protections do not apply to ground ambulance services

WEST VIRGINIA PROTECTIONS AVAILABLE

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- Above protection applies:
  - To HMO enrollees
  - For emergency services including ground ambulance services
  - Provided by all or most classes of health care professionals
- Protections do not apply to:
  - out-of-network facility charges for emergency services
  - non-emergency services
  - enrollees of self-funded plans

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

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

If you believe you've been wrongly billed:

Visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

Visit https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections for more information about your rights under your state laws.

COLORADO
Family and Medical Leave Insurance Program (FAMLI)
Department of Labor and Employment

Sun Life

Colorado Paid Family & Medical Leave (PFML) Plan Notice

We have partnered with Sun Life Assurance Company of Canada ("Sun Life") to provide paid family and medical leave administration and benefits starting on January 1, 2024. Plan benefits are available to most Colorado employees who have a qualifying condition and who earned $2,500 over the previous year for work performed in Colorado.

Employee contribution to premium

- Contributions will be collected via payroll from all Colorado employees. The contribution amount will never exceed the state's prescribed maximum.

Benefits

- Qualifying conditions for paid family and medical leave
  - Caring for a new child during the first year after the birth, adoption, or foster care placement
  - Caring for a family member with a serious health condition
  - Caring for your own serious health condition
  - Making arrangements for a family member's military deployment
  - Obtaining safe house, care, and/or legal assistance in response to domestic violence, stalking, sexual assault, or sexual abuse
- Employees are entitled to up to 12 weeks of paid family and medical leave per year. Employees with serious health conditions caused by pregnancy complications or childbirth complications are entitled to up to 4 more weeks of paid family and medical leave per benefit year for a total of 16 weeks. Leave can be taken continuously, intermittently, or on a reduced schedule.
- If FAMLI leave is used for a reason that also qualifies as leave under the federal FMLA, then the leave will also count as FMLA leave used.
- Employees may choose to use sick leave or other paid time off before using FAMLI benefits, but they are not required to do so.
- Employers and employees may mutually agree to supplement FAMLI benefits with sick leave or other paid time off in order to provide full wage replacement.

Benefit calculation

- Benefits will be paid at a rate of up to 90% of the employee's average weekly wage, based on a sliding scale. The calculation and maximum benefit will be as announced by the Division of Family and Medical Leave Insurance (FAMLI).

Filing claims

- **Submit online:** Sign into your Sun Life account at www.sunlife.com/account and click "Submit a claim".
- **Submit by mail:** Access a claim form by going on www.sunlife.com/findaform and selecting "Short Term Disability" under the Employee Benefits Forms section, or by contacting us at 800-247-6875, Mon- Fri, 8:00 a.m. to 8:00 p.m. ET.
- Requests for a review of an initial claim determination should be made to Sun Life. If further reconsideration is required employees can appeal to the FAMLI Division at famli.colorado.gov.

Job protection and continued benefits

- Employers must maintain health care benefits for employees while they are on leave under this program, and both the employer and the employee remain responsible for paying for those benefits in the same amounts as before the leave began.
- An employee who has worked for the employer for at least 180 days is entitled to return to the same position, or an equivalent position, upon their return from FAMLI leave.

Retaliation, Discrimination and Interference Prohibited

- Employers may not interfere with employees' rights under FAMLI and may not discriminate or retaliate against them for exercising those rights.
- Employees who suffer retaliation, discrimination, or interference may file suit in court, or may file a complaint with the FAMLI Division.