2027
Benefits Guide

Effective January 1, 2027









ECHO COMMUNITY + HEALTHCARE



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Important Notice

ECHO Community Healthcare has made every attempt to ensure the accuracy of the information described in this enrollment guide. This guide is not an official plan document and does not provide a complete description of your benefit plans. Any discrepancy between this guide and the insurance contracts, summary plan descriptions (SPDs) or any other legal documents that govern the plans of benefits described in this enrollment guide will be resolved according to those documents. ECHO Community Healthcare reserves the right to amend or discontinue the benefits described in this enrollment guide in the future, as well as change how eligible employees and ECHO Community Healthcare share plan costs at any time. This enrollment guide creates neither an employment agreement of any kind nor a guarantee of continued employment with ECHO Community Healthcare.

Welcome

OPEN ENROLLMENT is November 15 to December 15, 2026

At Echo Community Healthcare, we truly value the dedication that goes into your work every day. We're proud of our talented employees and understand that our success is because of you. That's why as a Echo Community Healthcare employee, you have access to a quality, comprehensive benefits package that offers flexibility and security for you and your family.

2027 Open Enrollment

Starting November 15, 2026, you will have the opportunity to make changes to your health care coverage that will become effective January 1, 2027. **All benefit elections must be made by December 15, 2026.**

You must participate in Open Enrollment if you wish to do any or all of the following:

- Make changes to your medical, dental, or vision coverage for the upcoming plan year
- Contribute to a Health Savings Account (HSA)
- Make changes to your income protection benefits

This is a passive enrollment. You will keep your current benefits if you decide to not complete open enrollment.

Review this guide to choose which benefits are right for you. If after reading this guide you need more information, please contact HR or EPIC.

Enrolling in Benefits

There are three opportunities to enroll in or make changes to your benefits:

1

AS A NEW HIRE

You can enroll in benefits effective after the first of the month following 30 days of employment. If you miss this initial enrollment window, your next opportunity to enroll will be the annual open enrollment period.

2

DURING OPEN ENROLLMENT

You can make changes to your benefits each year during the annual open enrollment period (normally held in November) for benefits effective January 1 through December 31 of the following year.

3

QUALIFYING LIFE EVENTS

Your 2027 elections will remain in effect throughout the plan year unless you experience a change in status that affects eligibility for benefits or another qualifying life event (in accordance with Internal Revenue Code rules). You must request an election change within 30 days and may need to provide supporting documentation (such as a marriage license or birth certificate).

Eligibility

Employees (working a minimum of 20 hours per week) and their eligible dependents can participate in ECHO Community Healthcare benefits. Eligible dependents include:

- Your legal spouse
- Child(ren) up to age 26
- Child(ren) of any age if you support the child and he or she is incapable of self-support due to mental or physical disability

Enrolling in Benefits

If you're eligible for ECHO Community Healthcare benefits, you can enroll by visiting Paylocity, www.paylocity.com. If after reading this guide you have enrollment questions, please contact HR or EPIC

Proof of Dependent Eligibility

You may be required to provide proof of eligibility for your dependents. Note that attempting to enroll an ineligible dependent could lead to discipline and possible termination of employment. If your dependent becomes ineligible for coverage during the year, you must contact HR within 30 days. Failure to provide notification may lead to discipline, termination of coverage and possible termination of employment.

Qualifying Life Events

Once you enroll in your benefit plan, your elections remain in effect for the remainder of the calendar year. The only exception is if you have a qualifying change in status. Any benefit changes resulting from a Qualifying Life Event must be requested by the employee within 30 days of the event. These qualifying events include:

- Marriage, divorce or legal separation
- Birth, adoption, placement for adoption or custody of a child
- The death of a dependent
- A change in your spouse's employment that affects your benefits eligibility (starting a new job, leaving a job, starting or returning from an unpaid leave of absence or changing from part-time to full-time status, etc.)
- A change in your dependent's eligibility for benefits
- A change in you or your dependent's residence that affects eligibility for coverage
- Receiving a court order, such as a Qualified Medical Child Support Order

Medical Plan Options

You have the choice of several quality and comprehensive medical plans through Unified Group Services. When choosing your plan, consider your budget, any planned procedures and other potential healthcare needs.

Each plan offers in and out-of-network coverage, but you will pay less for services when you use in-network providers. To find an in-network provider visit www.unifiedgrp.com.

Medical Plans Summary

Key Features	PPO Plan	HSA Plan 1	HSA Plan 2
	In-Network	In-Network	In-Network
Calendar Year Deductible Individual / Family Tier 1 Individual / Family Tier 2	$1,500 / $3,000 $2,500 / $5,000	$3,500 / $6,000 $4,000 / $8,000	$6,500 / $13,000 $7,300 / $14,600
Out-of-Pocket Maximum (includes deductible) Individual / Family Tier 1 Individual / Family Tier 2	$5,000 / $10,000 $7,000 / $14,000	$3,500 / $6,000 $5,000 / $10,000	$6,500 / $13,000 $8,300 / $16,600
Coinsurance (portion you pay)	0%	0%	0%
Preventive Care	Covered 100%	Covered 100%	Covered 100%
Physician Services Office Visit / Specialist Visit	$20 / $40 copay	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care Services	$50 copay	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room Services (waived if admitted)	$350 copay	Deductible & Coinsurance	Deductible & Coinsurance

Bi-weekly Employee Rates	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User
Employee Only	$158.46	$208.46	$136.84	$186.84	$110.92	$160.92
Employee + Spouse	$347.00	$397.00	$298.68	$348.68	$242.90	$292.90
Employee + Child(ren)	$293.27	$343.27	$252.39	$302.39	$205.29	$255.29
Employee + Family	$474.41	$524.41	$411.87	$461.87	$335.13	$285.13

Bi-weekly Employee Rates (20 – 29 Hours	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User
Employee Only	$206.00	$271.00	$177.89	$242.89	$144.20	$206.00
Employee + Spouse	$451.10	$516.10	$388.28	$453.28	$315.77	$451.10
Employee + Child(ren)	$381.25	$446.25	$328.11	$393.11	$266.88	$381.25
Employee + Family	$616.73	$681.73	$535.43	$600.43	$435.67	$616.73

Prescription Drug Benefits

Medical plan options include prescription drug coverage from TrueRx.

Key Features	PPO Plan	HSA Plan 1	HSA Plan 2
	In-Network	In-Network	In-Network
RETAIL PRESCRIPTIONS (30-DAY SUPPLY)			
Tier 1	$5 copay	Deductible & Coinsurance	Deductible & Coinsurance
Tier 2	$35 copay	Deductible & Coinsurance	Deductible & Coinsurance
Tier 3	$60 copay	Deductible & Coinsurance	Deductible & Coinsurance
Tier 4	Not Covered	Deductible & Coinsurance	Deductible & Coinsurance
MAIL-ORDER PRESCRIPTIONS (90-DAY SUPPLY)			
Tier 1	$12.50 copay	Deductible & Coinsurance	Deductible & Coinsurance
Tier 2	$87.50 copay	Deductible & Coinsurance	Deductible & Coinsurance
Tier 3	$150 copay	Deductible & Coinsurance	Deductible & Coinsurance
Tier 4	Not Covered	Deductible & Coinsurance	Deductible & Coinsurance

Ways to Save on Your Prescriptions

There are many ways to save on prescriptions! Keep these in mind the next time your provider prescribes a new medication.

Order by Mail

For maintenance medications, you can save time and money by using a mail-order service. Instead of a 30-day supply, you can have a 90-day supply shipped directly to you.

Compare Pharmacies

Less expensive prescriptions may be offered by some pharmacies, such as those at warehouse clubs or discount stores. Call ahead to determine which pharmacy has the most competitive price.

Check Over-The-Counter Options

Over-the-counter drugs can be an inexpensive alternative for some common ailments. Ask your pharmacist if they have any suggestions for options that serve the same purpose for less.

trueRx HEALTH STRATEGISTS

Changing the World of *Health Care*

You're more than a member number. You are *our patient*.

Your well-being is our priority, and we are here to support you every step of the way.

Live representatives answer your calls and chats

Our Patient Experience representatives are specially trained to address your pharmacy benefit questions.

Support for specialty medications

Dedicated care managers and clinical pharmacists are highly experienced in addressing the complexities and costs of specialty medications providing you with personalized care.

Manage your benefits anywhere with the True Rx+ mobile app

Access your insurance card and plan details, compare medication prices at local pharmacies, chat with a live True Rx Health Strategist, and more.

Next Steps

01 If you receive a new insurance card for the upcoming plan year, **be sure to bring it with you to the pharmacy.**

02 **Download True Rx+ in your app store** or use the member portal at "member.myplantruerx.com".

SCAN ME

Are you taking a high-cost maintenance medication?

Your employer is providing a new service to enrolled members in your current health plan. It's a prescription drug benefit and advocacy program provided through SHARx.

The SHARx program procures these targeted medications for members through alternate access points - many times at $0 cost to the member.

Watch this video to learn more about SHARx!

What is SHARx?

SHARx is an advocacy solution provided by your employer. This program was created to extend advocacy program benefits to employees like you. Our role is to help facilitate the on-boarding and advocacy process for each eligible member of your employer's health plan and provide access for all high-cost medications.

GETTING STARTED

1

If you have already received the welcome email from us, follow the custom link in the email to create your account

2

If you have already created your account but still need to finish onboarding with SHARx please go to *app.sharxplan.com*

3

If you need to speak with a member of our team to onboard with SHARx please call 314-451-3555 or email sharx@sharxplan.com to speak to our team of advocates

sharxplan.com | app.sharxplan.com | 314.451.3555

Where to Go for Care

With so many options for care, how do you know which is best for the flu, a broken bone or physical exam?

Depending upon where you receive medical attention, the cost can vary immensely. Here's a general guideline that can help you save on health care expenses and your time.

Location of Care	Cost	Common Conditions	Time Investment
Telemedicine 	$	• Cough/cold/sinus/flu • Earaches/stomach pain/diarrhea • Rashes/allergies/ • insect bites • Urinary tract infections • Pink eye	Appointments typically available within an hour No need to leave home
Primary Care Physician or Retail Clinic 	$$	• Checkups • Preventive services • Vaccinations and screenings • General health management • Sick visits for minor conditions	Usually need appointment Short wait times
Urgent Care 	$$$	• Severe Fever and flu symptoms • Sprains and strains • Stitches • Minor burns • Minor infections • Minor broken bones	No appointment needed Typically have extended hours
Emergency Room 	$$$$	• Chest pain • Heavy bleeding • Large open wounds • Spinal or head injuries • Major broken bones • Severe cuts/burns • Numbness or weakness • Sudden vision change	Open 24/7 No appointment needed Wait times can be up to several hours.

Health Savings Account (HSA)

If you're enrolling in a High Deductible Health Plan (HDHP) such as the HSA Plan 1 or HSA Plan 2, you are eligible to open a Health Savings Account (HSA) to pay for expenses on a pretax basis, such as eligible medical, dental and/or vision expenses.

Eligibility Requirements

- Must be enrolled in the HSA Plan 1 or HSA Plan 2
- Must not be enrolled in Medicare or TRICARE
- Must not be enrolled in Indian Health Services (IHS) or VA Benefits (other than preventive care or treatment for a service-related disability in the past 3 months)
- Must not be enrolled in other non-qualified medical coverage through another carrier or another family member
- You or your Spouse cannot be contributing to or participating in a general-purpose FSA through an employer

Advantages of an HSA

- Get free money from ECHO Community Healthcare: The company will contribute up to $750 your account. You can use these dollars to pay your out-of-pocket expenses. (Company contributions may be prorated based on your date of hire.)
- It's flexible: Use your HSA now or save it for later. You decide when to save and when to spend. You can even save for health care expenses after you retire.
- No use-it or lose-it: The money in your HSA belongs to you. It rolls over each year, and you can take it with you if you ever leave the company.
- Triple tax-advantaged: (Applies to federal and most state taxes.)[1]
  - Pay no taxes on money you contribute.
  - Pay no taxes on interest you earn.
  - Pay no taxes when you withdraw money.
- Invest your account: Once your account balance reaches a certain amount, you can choose to invest it in a variety of investments.

Each year, the IRS sets limits on how much you can contribute to an HSA. Maximum employee contributions for the 2026 calendar year are as follows:

- $4,500 for an individual
- $9,000 for an employee and dependents
- $1,000 catch up contribution for anyone over the age of 55

Important: HSAs involve very complex rules, including limitations on eligibility, contributions and expense reimbursement. Federal and state tax penalties may be assessed if these requirements are not met. You should talk to a tax advisor about your personal circumstances with respect to the HSA rules. Another helpful resource is IRS Publication 969 (https://www.irs.gov/publications/p969/ar02.html).

Four Great Things About the HSA

It's personal.

The account works like any other savings account, but it's specifically for health care expenses. You own all of the funds in the account, and the balance earns interest and rolls over from year to year.

Use it now or later.

You can spend the money in your HSA to pay for health care expenses now or save them to use after you retire.

It offers triple tax savings.

Your contributions are taken from your paycheck pretax, which lowers your taxable income. The account grows tax-free, and withdrawals are tax-free, as long as you use them for eligible health care expenses.

Control is at your fingertips.

You can manage your account online and change your contributions at any time.

[1] Certain states do not treat HSA contributions as tax-free (e.g., California and New Jersey). Consult your tax advisor to understand how HSA participation may impact you and your family members from a tax perspective.

UMB Healthcare Services

EMPLOYER NAME
ECHO Community Health Care

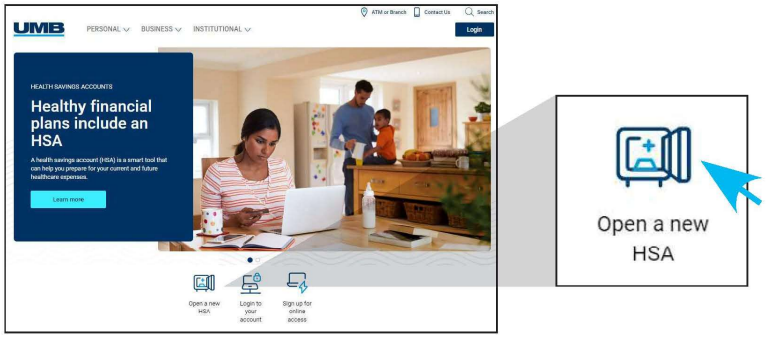
ENROLLMENT VERIFICATION NUMBER
THA0001 — 161056

UMB HSA Online Enrollment Guide

Before you start, make sure you have the following required information available:

- Your physical address (you must have a physical address to open the account, but you may also enter a P.O. Box in "mailing address"), phone number, email address
- Your Date of Birth and Social Security number
- DOB & SSN for your spouse and/or dependents (age 18 or older) if requesting additional debit cards
- Employer verification code and program start date, provided by your employer

Note: You will not choose your beneficiary during enrollment. You will do this the first time you log on to your HSA.



Follow the six-step online enrollment process:

STEP 1: Enrollment Verification Number

Use the unique link provided by your employer, which will take you to Step 2.
OR
Scan the QR Code or go to **UMB.com/HSA** and click "**Open a new HSA**" and enter the Enrollment Verification # provided above.

STEP 2: Eligibility Requirements

Before proceeding, you will be prompted to confirm your eligibility to enroll in an HSA. This confirmation is performed by asking a series of questions. If you answer correctly based on the IRS requirements for eligibility, you will be able to proceed to Step 3.

STEP 3: Account Owner Personal Information

This step contains "sub-screens" that will capture all your personal information, verify your email address (UMB will send a code to your email), and allow you to input additional cardholders, if desired (spouse and/or dependents). **Note**: you must input a physical address to open your HSA or you will get an error message.

STEP 4: Review and Consent to Disclosures

In this step you will be required to open the disclosure documents and consent before you can continue. The documents will open in PDF format.

STEP 5: Verify and Submit Enrollment Information

You will be given a final opportunity to review all the information you typed in before your enrollment is transmitted to UMB for CIP review (Customer Identification Program, as required by Section 326 of the USA PATRIOT ACT, and UMB's CIP policy).

STEP 6: Confirmation

Based on the results during the session, you will get one of the following screens:

Complete Enrollment
The account is created (IF YOU GET THIS SCREEN, NO ADDITIONAL DOCUMENTATION IS REQUIRED).

Incomplete Enrollment
A message will appear indicating that UMB needs additional documentation from you (a copy of your social security card and driver's license) before we can open your account. The message provides three options (request a secure email link, fax or U.S. mail) for sending documentation copies to UMB.
Note: Your account will not be opened during this session. Your account will remain in pending status and unable to accept contributions until UMB receives the requested documentation and opens your account manually.

Once you have completed enrollment, within 7-10 business days you will receive two envelopes in the mail:

1. Your welcome letter with your account number, log on instructions, and additional information about your UMB HSA
2. HSA debit card including additional cards you ordered during your online enrollment session.

Once you receive your welcome letter, you may set up your online access, log in to your account and choose your beneficiary(s).

For questions or more information call 1.866.520.4HSA (4472).

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Dental Benefits

The HRI-Dental Health Options dental plan is designed to keep you smiling year after year. Good dental health can have an impact on you as a whole and can be the first sign of a more serious health issue. Take advantage of our comprehensive plan option and keep up with your preventive dental care.

Plan Features	
DMO	• Provides benefits only if you see an in-network dentist • Requires you to choose a primary care dentist to coordinate all your care • Provides benefits based on a copay schedule
Finding a dentist	• Visit www.insuringsmiles.com • Call 1-800-727-1444

Dental Plans Summary

Key Features	Dental Plan DHO 6
	In-Network
Calendar Year Deductible (Individual / Family)	No deductible
Preventive Services (no deductible)	100% coverage
Basic Services	50% coverage
Major Services	50% coverage
Orthodontics	Only for children up to age 26
Orthodontics Lifetime Maximum	$1,000
Annual Calendar Year Maximum	$1,000

Bi-weekly Employee Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Dental Plan	$5.51	$15.24	$16.74	$25.08

Vision Benefits

You and your dependents have access to vision coverage through VSP. The plan pays benefits for both in-network and out-of-network services. When you visit an in-network provider VSP pays for eligible expenses at a higher level. If you receive care outside the network, you will need to pay the full cost upfront and file a claim to be reimbursed for a portion of the costs.

Vision Plans Summary

Key Features	In-Network	Frequency
Exam	$10 copay	Once Every 12 months
Lenses Single, lined bifocal, lined trifocal	Included in $25 Prescription Glasses copay	Once Every 12 months
Frames	$130 allowance $150 allowance for featured frame brands 20% savings on the amount over allowance	Once Every 24 months
Contact Lenses (instead of glasses)	Fitting & Evaluation: Up to $60 copay Elective: Up to $130 allowance for contacts; copay does not apply	Once Every 12 months
Laser Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	N/A

Bi-weekly Employee Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Vision Plan	$1.87	$3.14	$3.21	$5.17



Life Insurance

Basic Life and AD&D

ECHO Community Healthcare provides you with Basic Life and AD&D insurance of $40,000*. You are automatically enrolled and there is no cost to you. If your death is the result of an accident, you will receive an additional Accidental Death & Dismemberment (AD&D) benefit. If you lose a limb or your eyesight as the result of an accident, the AD&D plan will pay a percentage of your AD&D benefit amount.

Supplemental Life and AD&D

You have the option to supplement your company-paid coverage by purchasing additional Life and AD&D insurance for yourself, your spouse and your children. You are required to purchase coverage for yourself in order to enroll your family members. You pay the full cost of this coverage on an after-tax basis. The cost varies depending on your age and the amount of coverage you choose. This chart shows the coverage amounts you can choose.

Voluntary Life	Employee	Spouse	Children
Benefit Amount	$10,000 increments to a max of $500,000 or 5x salary	$5,000 increments up to 100% of employee benefit, up to $250,000	$5,000 increments up to $20,000
Guaranteed Issue Amount	$500,000 or the lesser of 5 times your annual earnings	$250,000	100% employee amount up to $20,000

Please note: Evidence of insurability may be required if you enroll after your initial eligibility period or if you elect amounts over the policy's Guarantee Issue amount.

EMPLOYEE PREMIUM TABLE (26 PAYROLL DEDUCTIONS PER YEAR)

Age	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
0 - 29	$0.30	$0.61	$0.91	$1.22	$1.52	$1.83	$2.13	$2.44	$2.74	$3.05
30 - 34	$0.35	$0.70	$1.05	$1.40	$1.75	$2.10	$2.46	$2.81	$3.16	$3.51
35 - 39	$0.49	$0.98	$1.47	$1.96	$2.45	$2.94	$3.42	$3.91	$4.40	$4.89
40 - 44	$0.77	$1.53	$2.30	$3.06	$3.83	$4.60	$5.36	$6.13	$6.90	$7.66
45 - 49	$1.09	$2.18	$3.27	$4.36	$5.45	$6.54	$7.62	$8.71	$9.80	$10.89
50 - 54	$1.92	$3.84	$5.76	$7.68	$9.60	$11.52	$13.44	$15.36	$17.28	$19.20
55 - 59	$2.94	$5.87	$8.81	$11.74	$14.68	$17.61	$20.55	$23.48	$26.42	$29.35
60 - 64	$3.03	$6.06	$9.08	$12.11	$15.14	$18.17	$21.19	$24.22	$27.25	$30.28
65 - 69	$5.52	$11.04	$16.56	$22.08	$27.60	$33.12	$38.64	$44.16	$49.68	$55.20
70 - 74	$11.66	$23.32	$34.98	$46.63	$58.29	$69.95	$81.61	$93.27	$104.93	$116.58
75 - 79	$34.78	$69.56	$104.34	$139.13	$173.91	$208.69	$243.47	$278.25	$313.03	$347.82
80+	$75.03	$150.06	$225.08	$300.11	$375.14	$450.17	$525.19	$600.22	$675.25	$750.28

SPOUSE PREMIUM TABLE (26 PAYROLL DEDUCTIONS PER YEAR)

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 29	$0.15	$0.30	$0.46	$0.61	$0.76	$0.91	$1.07	$1.22	$1.37	$1.52
30 - 34	$0.18	$0.35	$0.53	$0.70	$0.88	$1.05	$1.23	$1.40	$1.58	$1.75
35 - 39	$0.24	$0.49	$0.73	$0.98	$1.22	$1.47	$1.71	$1.96	$2.20	$2.45
40 - 44	$0.38	$0.77	$1.15	$1.53	$1.92	$2.30	$2.68	$3.06	$3.45	$3.83
45 - 49	$0.54	$1.09	$1.63	$2.18	$2.72	$3.27	$3.81	$4.36	$4.90	$5.45
50 - 54	$0.96	$1.92	$2.88	$3.84	$4.80	$5.76	$6.72	$7.68	$8.64	$9.60
55 - 59	$1.47	$2.94	$4.40	$5.87	$7.34	$8.81	$10.27	$11.74	$13.21	$14.68
60 - 64	$1.51	$3.03	$4.54	$6.06	$7.57	$9.08	$10.60	$12.11	$13.62	$15.14
65 - 69	$2.76	$5.52	$8.28	$11.04	$13.80	$16.56	$19.32	$22.08	$24.84	$27.60

ALL CHILDREN PREMIUM TABLE (26 PAYROLL DEDUCTIONS PER YEAR)*

$5,000	$10,000	$15,000	$20,000
$0.29	$0.58	$0.87	$1.16

Income Protection Benefits

Disability

ECHO Community Healthcare offers Short-Term Disability (STD) and Long-Term Disability (LTD) insurance through Mutual of Omaha.

Plan	Short-Term Disability Buy Up	Long-Term Disability
When Benefits Begin	1st day after illness or 8th day after accident	180 days after illness or accident
When Benefits End	Up to 26 weeks, including the waiting period (7 days)	Benefits continue until you are no longer disabled or until you reach Social Security Normal Retirement Age, whichever comes first.
Benefits Paid	You receive 60% of your pay, up to a maximum benefit of $1,000 per week. Elect 40%, 50% , or 60%.	You receive 60% of your pay, up to a maximum benefit of $5,000 per month.
Who Pays	Employee; Rate per $10 of Weekly Benefit $0.36	Company
Pre-existing Conditions	3/12: Any condition treated in the past 3 months, will not be covered under STD for the next 12 months	None



Voluntary Benefits

Voluntary benefits provide cash reimbursement during your time of need. Unlike traditional insurance, which covers medical costs, these benefits provide you with a cash benefit should you become ill with a critical illness, experience an accident, are hospitalized. These benefits can help pay for out-of-pocket expenses not covered by other plans. You can enroll yourself and your eligible family members. Coverage for the voluntary plans is 100% employee-paid.

Critical Illness

Critical Illness Insurance pays a benefit if you are diagnosed with a serious illness covered by the plan. The benefit is paid to you and can be used to pay medical costs or living expenses such as childcare or mortgage payments. Covered illnesses may include:

Benefit Category	Condition	% of CI Principal Sum
Heart / Circulatory / Motor Function	Heart Attack, Heart Transplant, Stroke, ALS (Lou Gehrig's), Advanced Alzheimer's, Advanced Parkinson's	100%
Organ	Major Organ Transplant/Placement on UNOS List, End-Stage Renal Failure	25%
Childhood / Developmental *benefits only available to children	Cerebral Palsy, Structural Congenital Defects, Genetic Disorders, Congenital Metabolic Disorders, Typer 1 Diabetes	100%
Cancer	Cancer (Invasive)	100%
	Bone Marrow Transplant	50%
	Carcinoma in Situ, Benign Brain Tumor	25%

Coverage Guidelines	Employee	Spouse	Children *Benefit for each children*
Benefit Amount	$5,000 increments to a max of $50,000	$5,000 increments up to 100% of employee benefit, up to $50,000	50% of employee benefit, up to $10,000
Guaranteed Issue Amount	$15,000	$15,000	$5,000

Critical Illness Premium Rates

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

To select your benefit amount and calculate your premium, do the following:

1) Locate the benefit amount you want from the top row of the employee premium table. Your benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.
2) Find your age bracket in the far left column.
3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
4) Enter the benefit and premium amounts into their respective areas in the Voluntary Critical Illness section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want to select. For example, if you want $20,000 in coverage, you obtain your premium amount by multiplying the rate for $10,000 times 2.

VOLUNTARY CRITICAL ILLNESS EMPLOYEE OR SPOUSE PREMIUM RATES (26 PAYROLL DEDUCTIONS PER YEAR)

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
0 - 29	$0.51	$1.02	$1.52	$2.03	$2.54	$3.05	$3.55	$4.06	$4.57	$5.08
30 - 39	$1.29	$2.58	$3.88	$5.17	$6.46	$7.75	$9.05	$10.34	$11.63	$12.92
40 - 49	$2.70	$5.40	$8.10	$10.80	$13.50	$16.20	$18.90	$21.60	$24.30	$27.00
50 - 59	$5.28	$10.57	$15.85	$21.14	$26.42	$31.71	$36.99	$42.28	$47.56	$52.85
60 - 69	$9.53	$19.06	$28.59	$38.12	$47.65	$57.18	$66.72	$76.25	$85.78	$95.31
70+	$19.13	$38.26	$57.39	$76.52	$95.65	$114.78	$133.92	$153.05	$172.18	$191.31

Child dependent coverage is offered at no additional cost.

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse coverage. **Your spouse's rate is based on your age,** so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of $5,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

Voluntary Benefits

Accident Insurance

Accident Insurance helps cover the cost of emergency medical care, physical therapy and other unexpected expenses that result from an accidental injury.

Benefit Category	Option 1	Option 2	Option 3
	Amounts	Amounts	Amounts
Initial Care & Emergency – Most treatment / service required within 72 hours of accident; Once per accident per insured person			
Emergency Room	$100	$150	$150
Urgent Care Center	$75	$100	$100
Initial Physician Office Visit	$50	$75	$75
Ambulance	Up to $500	Up to $1,000	Up to $1,000
Specified Injuries			
Fractures (Surgical / Non-surgical)	Up to $5,000 / Up to $2,500	Up to $6,000 / Up to $3,000	Up to $8,000 / Up to $4,000
Dislocations (Surgical / Non-surgical)	Up to $6,000 / Up to $3,000	Up to $9,000 / Up to $4,500	Up to $10,000 / Up to $5,000
Lacerations	Up to $600	Up to $800	Up to $1,000
Burns	Up to $10,000	Up to $15,000	Up to $20,000
Dental	Up to $200	Up to $300	Up to $400
Hospital, Surgical & Diagnostic			
Admission	$1,000	$1,500	$2,000
Daily Confinement (Up to 365 days per accident)	$200 per day	$300 per day	$400 per day
ICU Confinement (Up to 15 days per accident)	$400 per day	$600 per day	$800 per day
Rehab. Facility Confinement (Up to 30 days per accident)	$100 per day	$150 per day	$200 per day
Surgical	Up to $1,500	Up to $2,000	Up to $2,500
Diagnostic	Up to $200	Up to $300	Up to $400

Bi-weekly Employee Rates	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Option 1	$4.91	$8.05	$10.09	$13.36
Option 2	$6.87	$11.36	$14.30	$18.96
Option 3	$9.10	$15.10	$18.96	$25.16

Key Contacts

For Questions About	Carrier	Plan/Group ID	Phone Number	Website/Email
Medical & Prescription Drug	Unified Group Services	4880	1-800-291-5837	www.unifiedgrp.com
Dental	Health Resources, Inc.	805914741520	1-800-727-1444	www.insuringsmiles.com
Vision	VSP	30081406	1-800-877-7195	www.vsp.com
Life and AD&D Insurance	Mutual of Omaha	G000C8Q3	1-800-369-3809	www.mutualofomaha.com
Short-Term Disability (STD)	Mutual of Omaha	G000C8Q3	1-800-369-3809	www.mutualofomaha.com
Long-Term Disability (LTD)	Mutual of Omaha	G000C8Q3	1-800-369-3809	www.mutualofomaha.com
Critical Illness	Mutual of Omaha	G000C8Q3	1-800-369-3809	www.mutualofomaha.com
Accident	Mutual of Omaha	G000C8Q3	1-800-369-3809	www.mutualofomaha.com
For Additional Assistance	Name	Phone Number	Email	
EPIC Insurance	Charles Brown Client Executive	317-574-7861	charles.brown@epicbrokers.com	
	Alison Lewis Client Manager	812-421-2562	alison.lewis@epicbrokers.com	



Compliance Notices

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

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

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductible and coinsurance you will be subject to depends on your medical plan. If you would like more information on WHCRA benefits, call your plan Administrator.

HIPAA Notice of Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, if you or your dependents lose eligibility for that other coverage (or if the employer stops contributions towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
To request special enrollment or obtain more information, contact your director of Human Resources with appropriate or required documentation of the change in which you are submitting. Please know that you may be asked to complete the carrier specific change form, for the change you are currently requesting.

Newborns' And Mothers' Health Protection Act Notice
Group Health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).Administrator.

Michelle Law Notice
The health plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from school. Coverage may continue for up to a year, unless your child's eligibility would end earlier for another reason. Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.
If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, contact your Human Resource Department as soon as the need for the leave is recognized. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

HIPAA Notice of Privacy Practices

Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

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

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

I. Contact Information

If you have any questions about this Notice or about our privacy practices, and for any correspondence or requests related to the contents of this Notice, please contact HR.

II. Effective Date

This Notice is effective January 1, 2027

III. Our Responsibilities

We are required by law to:

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

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

IV. How We May Use and Disclose Your PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient.

For Treatment. When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by health care providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about you with physicians who are treating you.

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

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

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

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

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

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

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

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

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

V. Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

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

Military. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

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

Public Health Risks. We may disclose your PHI for public health activities. These activities generally include the following:

a) to prevent or control disease, injury, or disability;
b) to report births and deaths;
c) to report child abuse or neglect;
d) to report reactions to medications or problems with products;
e) to notify people of recalls of products they may be using;
f) to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
g) to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

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

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

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

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

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your PHI to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your PHI to researchers when:

a) The individual identifiers have been removed; or
b) When an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

VI. Required Disclosures

The following is a description of disclosures of your PHI we are required to make.

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

Disclosures to You. When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

VII. Other Disclosures

Personal Representatives. We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney).

Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

a) You have been, or may be, subject to domestic violence, abuse, or neglect by such person; or
b) Treating such person as your personal representative could endanger you; and
c) In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

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

VIII. Your Rights

You have the following rights with respect to your PHI:

Right to Inspect and Copy. You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your PHI, you must submit your request in writing. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

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

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a) is not part of the medical information kept by or for the Plan;
b) was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
c) is not part of the information that you would be permitted to inspect and copy; or
d) is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your PHI that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

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

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

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

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

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

IX. Complaints

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

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

Compliance Notices

Model General Notice of COBRA Continuation Coverage Rights (For use by single-employer group health plans)
**** Continuation Coverage Rights Under COBRA****

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs.

Compliance Notices

Model General Notice of COBRA Continuation Coverage Rights (For use by single-employer group health plans)
**** Continuation Coverage Rights Under COBRA****

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.
There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

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

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of CO BRA continuation coverage, for a maximum of 3 6 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 Prom-am (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 period1 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.

Compliance Notices

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

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

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

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

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

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

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

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

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

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

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

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurancepremium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website:
https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act- 2009-chipra
Phone: 678-564-1162, Press 2

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

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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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

Compliance Notices

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

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

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

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

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

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

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

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

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

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

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

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

OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website:
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website:
Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

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

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

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

TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

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

Compliance Notices

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

VERMONT– Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

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

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

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

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

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement
According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person

shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.
The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent.

Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Compliance Notices

MEDICARE PART D CREDITABLE COVERAGE NOTICE 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 ECHO Community Healthcare 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. ECHO Community Healthcare has determined that the prescription drug coverage offered by ECHO Community Healthcare Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current ECHO Community Healthcare coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current ECHO Community Healthcare coverage, be aware that you and your dependents will or will 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 [Insert Name of Entity] 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 [or call HR. 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 ECHO Community Healthcare changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

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