2024

EMPLOYEE BENEFITS

Renuity, LLC

WELCOME TO YOUR BENEFITS ENROLLMENT!

renuity

statewide HOME IMPROVEMENT

FHIA REMODELING

HomeSmart

MaxHome

mad city HOME IMPROVEMENT

ClosetAmerica

Here's where to find...

Who is Eligible?

Benefits are available to all full-time employees working a minimum of 30 hours per week or an average of 130 hours per month and their eligible dependents. For those enrolling during Open Enrollment, your benefits will become effective on January 1, 2024. For new hires, your benefits will become effective on the 1st day of the month following 60 days of employment.

Eligible dependents include:

Your legal spouse or domestic partner

Your children from birth to age 26 or up to age 30 for medical only*

(Including your natural/legally adopted/stepchildren, and/or your unmarried dependent children of any age who are mentally or physically disabled and who are dependent on you for support)

Making Changes

You may only make changes to your elections during open enrollment each year or during the year if you experience a qualifying event. Qualifying events include, but are not limited to:

- Birth, legal adoption, or placement for adoption.
- Marital status.
- Dependent child reaches age 26*.
- Spouse gains or loses employment or eligibility with current employer.
- Death of a covered dependent.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or CHIP.
- Change in residence that changes eligibility for coverage.
- Court-ordered change.

Changes to your coverage due to a qualifying life event must be made within 31 days of that life event. Proof of the qualifying life event is required (marriage certificate, divorce decree, birth certificate, or loss of coverage letter).

Note: Any change you make to your coverage must be consistent with the change in status.

Tobacco-user Surcharge

The health and well-being of our employees is of great value to Renuity. We want to provide an incentive to those employees who do not use tobacco, as well as cessation opportunities for those wanting to quit. Through your organization, you have a new way to quit smoking! Participate in the Quit for Life Program, a digital quit-smoking program offered for FREE.

Starting January 1, 2024, employees who smoke or use tobacco or nicotine products including, but not limited to cigarettes, cigars, snuff, chewing tobacco, pipes, and electronic cigarettes, electronic vaping devices, etc. regardless of method or frequency of use will incur a monthly surcharge of $50 added to the medical monthly employee premium.

MEDICAL

UHC

myuhc.com

866.414.1959

Your medical options are provided by UHC. The HDHP and PPO Plans have in-network and out-of-network coverage. You will always have stronger benefits when visiting a provider participating in the **Choice Plus network** or visit **myuhc.com**.

Plan Provisions	UHC PPO Plus	UHC PPO	UHC HDHP
	In-Network	In-Network	In-Network
Calendar Year Deductible			
Individual/Family	$1,000/$2,000	$3,000/$6,000	$3,200/$6,400
Coinsurance			
Plan Pays/You Pay	80%/20%	70%/30%	80%/20%
Annual Out-of-Pocket Maximum			
Individual/Family	$6,000/$12,000	$7,150/$14,300	$4,500/$9,000
Office Visits			
Preventive Care	Covered 100%	Covered 100%	Covered 100%
Primary Care	$30 copay	$30 copay	20% after ded
Specialist	$60 copay	$60 copay	20% after ded
Hospital Services			
Emergency Room	$250	$350 + 30%	20% after ded
Urgent Care	$50 copay	$75 copay	20% after ded
Inpatient Care	20% after ded	30% after ded	20% after ded
Outpatient Services			
Diagnostic Services	20% after ded	30% after ded	20% after ded
Advanced Imaging	20% after ded	30% after ded	20% after ded
Surgery	20% after ded	30% after ded	20% after ded
Prescription Drugs			
Retail — 30 day supply			Medical deductible then,
Generic	$10 copay	$10 copay	$10 copay
Preferred Brand	$45 copay	$45 copay	$35 copay
Non-preferred Brand	$85 copay	$85 copay	$70 copay
Mail Order — 90 day supply	2.5x	2.5x	2.5x
Out-of-Network Benefits			
Calendar Year Deductible	$2,000/$4,000	$10,000/$20,000	$5,000/$10,000
Coinsurance	60%/40%	50%/50%	60%/40%
Annual Out-of-Pocket Maximum	$10,000/$20,000	$23,700/$47,400	$10,000/$20,000

Employees covered under the Renuity health plans and who are users of tobacco products will have a Tobacco User Surcharge of $50 per month added to their health insurance premiums. With the UnitedHealthcare Quit for Life smoking cessation program, you can get the help you need to quit tobacco at no additional cost to you. If you complete the Tobacco Cessation program, you may qualify to receive the Non-Tobacco User Rate.

HOW TO BE A SMART CONSUMER

Pharmacy

- Find an in-network pharmacy or use the drug cost estimator tool by visiting **myuhc.com**.
- Discount sites like GoodRx and WellRx can help you instantly save **(please note: prescriptions acquired under these plans do not go through your insurance and therefore do not count towards your deductible or out-of-pocket maximum)**.
- Ask if a generic/mail order is available.
- Generic contraceptives and diaphragms are covered and available at no cost.
- See if your drug has a Patient Assistance Program.

Verify the prescription drug tier using the plan's formulary list.

- Use the drug cost estimator tool by visiting **myuhc.com**.
- Ask if a generic drug or if mail order is available.
- See if your drug has a patient assistance program.
- Visit local retailers - Publix, Walgreens, and Walmart to see if your medication is included in their own discount programs and pay less.
- Prescription online sites like GoodRx and WellRx can help you save instantly. Visit **wellrx.com** and **goodrx.com** or download the mobile app to save on the go!

Pharmacy Mail-Order

Instead of picking up your medications every month, have them mailed to your home or a location of your choice. Use OptumRx® - UnitedHealthcare's home delivery provider to help manage the medications you take regularly. Home delivery is reliable, convenient, and cost effective. Choose home delivery by:

1. Going online visit myuhc.com to register and follow the simple step by-step instructions.
2. By phone Call the member phone number on the back of your plan ID card.
3. ePrescribe Your doctor can send an electronic prescription to OptumRx.

Cost Estimator

Different doctors and hospitals may charge different amounts for the same service. United Healthcare mobile app can help you compare costs based on your own benefits.

UnitedHealthcare Mobile Access

The United Healthcare app lets you easily access your healthcare information and gives you tools to help estimate costs, manage claims and find providers—anytime and anywhere. It's built to be your go-to healthcare resource when you're on the go. Search for the **myuhc.com** mobile app on your smart phone from your phone.

Available on the App Store

GET IT ON Google Play

Telemedicine

Get access to U.S. board-certified doctors 24/7/365 with United Healthcare Virtual Care Visits. It does not replace your primary care physician, but it is an affordable option for quality care. Doctors can diagnose and treat common medical issues such as cold, flu, fever, sinusitis, or a behavioral health professional can help work through challenges such as anxiety or grief. Doctors may write prescriptions, if appropriate. You must be enrolled in one of the health plans to access care. Sign up now! It's free to enroll and available through myUHC mobile app or **myuhc.com**.

Find a Provider

Find United Healthcare providers online in just a few quick steps.

1. Visit **uhc.com/providersearch**.
2. Select "Medical Directory"
3. Select "Employer and Individual" Plans
4. Select "Shopping Around"
5. Scroll down and select the "Choice Plus" network
6. Click "Change Location" and enter your zip code, if necessary, then click "People" to find a provider.

If you are already enrolled in a plan, you can login to your UHC account at **myuhc.com** or the mobile app and look for the "Find a Provider" button.

The path to quitting starts here

If you use tobacco and have thought about quitting, **Quit For Life® on Rally Coach™** may be able to help. Get tools and online resources designed to help you quit — and stay quit — at no additional cost.

Get coach support
Connect with a coach who will help create a personalized Quit Plan and guide you at every step

Access anytime, anywhere
Manage triggers with help from coach-led group sessions, trackers, text support, and more, all at your fingertips

View quit recommendations
Get real-life tips and plan your path to quit with recommended daily goals, articles and videos

Stay on track with **24/7** support

Quit For Life®

Get started

Go to Myuhc.com > Health & Wellness > My Health & Wellness > Programs > Quit Smoking

Complete this free program and provide proof of completion to remove the $50 surcharge. Please contact HR for further details.

United Healthcare

Get in on UHC Rewards

Good news—your health plan comes with a new way to earn up to $300. UnitedHealthcare Rewards is included in your health plan at no additional cost.

There's so much good to get

With UHC Rewards, a variety of actions—including many things you may already be doing—lead to rewards. The activities you go for are up to you—same goes for ways to spend your earnings. Here are some ways you can earn:

Reach daily goals

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

Complete one-time reward activities

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

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

Earn up to

$300

United Healthcare

Get support for your precious delivery

Whether you're thinking about having a baby or have one on the way, maternity support is here to provide information and support—throughout your pregnancy and after giving birth.

Online maternity content and courses

Good news: As part of maternity support, you have access to online resources to help you on your journey toward a healthier pregnancy — and beyond. Tap into our library of pregnancy information, including custom video courses you can stream anytime, 24/7. You'll be able to track what you've learned and keep tabs on what you'll find out about next.

Online maternity courses include:

- Preconception: Preparing for a Healthy Pregnancy
- Pregnancy Nutrition and Exercise
- Pregnancy in the First Trimester
- Pregnancy in the Second Trimester
- Pregnancy in the Third Trimester
- Postpartum: The Fourth Trimester after Pregnancy
- Exploring Breastfeeding

Whatever your journey, maternity support is here to help—and it's available to you at no additional cost as part of your plan benefits.

Explore maternity courses

Visit **myuhc.phs.com/pregnancy-resources**

United Healthcare

Health Advocate℠

Caring for you in all ways. Always.℠

At Health Advocate, we're here to help you and your family with any health or well-being issues. Our services are provided to you by your employer. Just call, tap, or click to reach us and receive confidential, personalized support from our caring team.

Health Advocate Frequently Asked Questions

Who is Health Advocate?

Health Advocate is the nation's leading healthcare advocacy and assistance company. We know all too well that the healthcare system is challenging to navigate. It makes people feel stressed, frustrated, and worried about costs—which often leads to them forgoing the care they need. That's why we're here: **We provide people with the personalized, expert care and support they need to take control of their health and well-being.**

Is Health Advocate the same as insurance?

No. Health Advocate is not an insurance company, and does not replace healthcare coverage, provide medical care or recommend treatment.

How does the Health Advocacy service work?

- Whenever you or an eligible family member has a healthcare-related issue or concern, you **simply call our toll-free number to connect with an experienced Health Advocate.**
- The Health Advocate will gather information about the issue and work to resolve it as quickly as possible.
- Before we can get to work, you may be asked to sign the Health Advocate Authorization Form. This form gives Health Advocate permission to gain access to medical information and interact with providers and insurance companies on your behalf.
- You will work with the same Health Advocate until all issues are completely resolved.

Who is eligible to use the service?

You, your spouse/partner, dependents, parents and parents-in-law can all access Health Advocate's services as often as you/they like.

Does it cost anything to use Health Advocate?

No. Health Advocate's services are provided to employees and their eligible family members at no cost.

HealthAdvocate℠

What kind of issues can Health Advocate help with?

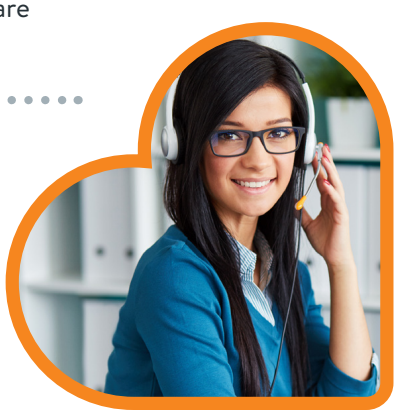
Our Health Advocates can help with a wide range of clinical and administrative issues.

Examples of clinical support

- Answer questions about medical diagnoses and review treatment options
- Research and identify the latest, most advanced approaches to care
- Coordinate clinical services related to all aspects of your care
- Locate "best-in-class" physicians and medical centers for second opinions
- Help prepare you for doctor visits

Examples of administrative support

- Answer benefit questions, including explaining employees' share of the costs
- Research and resolve insurance claims and medical billing issues
- Find the right in-network providers and make appointments
- Facilitate the transfer medical records
- Locate eldercare and other community services that may fall outside of traditional coverage
- Answer questions about Medicare



What are the qualifications of the Health Advocates?

Our Health Advocates are healthcare experts who know the ins and outs of the healthcare system. They are typically **registered nurses** supported by **medical directors** and **benefits and claims specialists**, and have extensive experience working in medical, healthcare and/or insurance settings.

Are all employee interactions kept confidential?

Yes. The privacy of our members is of utmost importance. Our entire staff complies with all government privacy standards, and all medical and personal information is kept strictly confidential.

Can you give some examples of how Health Advocate helps save money?

Interacting with the healthcare and insurance systems can be frustrating and take a lot of time. From **locating doctors** to **reviewing medical bills** to **negotiating provider discounts**, we take on those time-consuming issues so you can get the answers you need and stay productive. Our research often uncovers billing and other errors which can lead to significant savings.

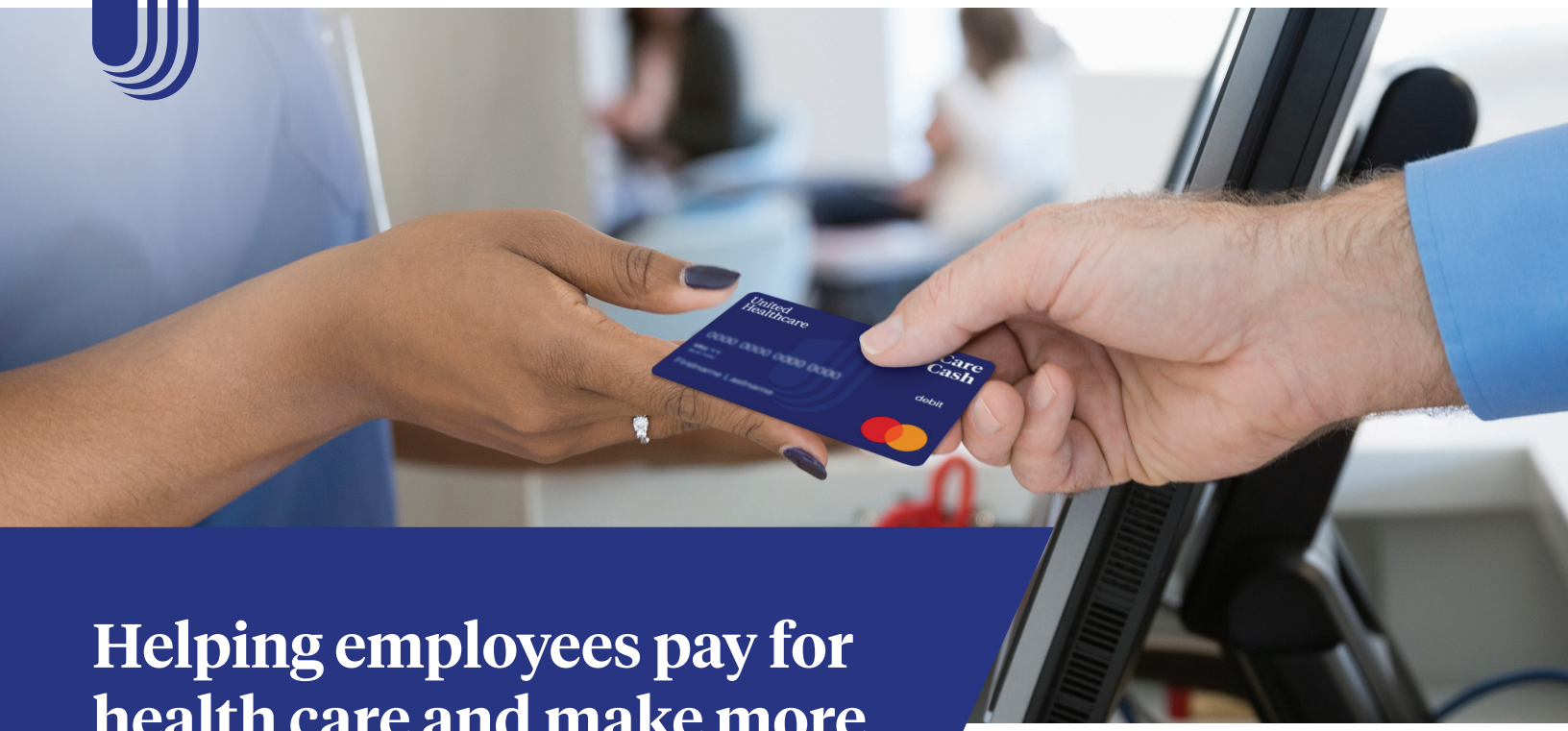
What are the hours of operation?

Health Advocate can be accessed 24/7. Normal business hours are Monday - Friday, from 8 am to 10 pm, Eastern Time. Staff is available for assistance after hours and on weekends.

Do you have more questions? Contact us:

Call • Email • Message • Live Chat

HealthAdvocate℠



Helping employees pay for health care and make more informed care decisions

Studies show that 72% of consumers are concerned about health care and out-of-pocket expenses.[1] To help employees pay for certain health care costs and encourage them to use quality care, we offer Care Cash™. This preloaded debit card can be used for UnitedHealth Premium® primary care and specialist provider visits, as well as network primary care provider visits, Virtual Visits, urgent care visits and outpatient behavioral health visits.

Spending power

Care Cash is designed to give employees:

$200 for the year for individual coverage, or

$500 for family coverage

The card is reloadable, with any remaining balance rolling over each year.*

How it works:

1. Employees receive information about Care Cash and can request the card on **myuhc.com®**
2. Once received and activated, the Care Cash card can be used for certain eligible health care expenses
3. Employees have access to viewing other programs and benefits through **myuhc.com** or can call a toll-free number for guidance

United Healthcare

HEALTH SAVINGS ACCOUNT (HSA)

WEX *Available to participants enrolled in UHC HDHP.*

A Health Savings Account (HSA) is a tax-advantaged savings account that can be used for your qualified healthcare expenses. You own your HSA and can contribute to the account with pre-tax payroll deductions based on your needs.

Did you know an HSA provides triple tax benefits? The money you contribute is pre-tax, and the interest that accumulates in the account is tax-free. In addition, money withdrawn from an HSA isn't taxed, provided you use it for qualified healthcare expenses. Like a savings account, you will only be able to withdraw funds that are in the account.

As an added benefit, the company will contribute $250 to your HSA account.

You are eligible if:

- You are enrolled in the HDHP.
- You are not covered by a spouse's plan.
- You are not enrolled in Medicare, TRICARE or TRICARE for Life.
- You have not received VA benefits in the past 3 months

How do I access/make contributions to my HSA?

You can manage your HSA at **wexinc.com**. You'll set up your payroll contributions during your enrollment period and can make changes at any time throughout the year (although it may take between 1—2 payroll periods for any changes to be processed).

Other HSA Advantages

1. You can use the account to pay for qualified healthcare expenses.
2. Unspent dollars roll over each year and are yours to keep if you retire or leave the company.
3. You can invest your HSA funds, so your available healthcare dollars can grow over time.

How much can be deposited into an HSA in 2024?

<55*

Up to $4,150 for individual.
Up to $8,300 for family.

+55*

The maximum contribution increases by $1,000.

*Not enrolled in Medicare

FLEXIBLE SPENDING ACCOUNT (FSA)

WEX *Healthcare FSA not available to employees enrolled in UHC HDHP.*

What is a Flexible Spending Account?

A flexible spending account (FSA) is an account that can reimburse you for qualified healthcare or dependent care expenses. You can fund qualified expenses with pre-tax dollars deducted from your paychecks.

When electing an FSA, you will set an annual contribution amount. **You are able to rollover up to $640 of your remaining balance at the end of the plan year into the following year for the healthcare FSA account. The goal is to choose an amount that will cover medical or dependent care expenses, but that is not so high that the money will be forfeited at the end of the year.***

You can choose to participate in one or both accounts, and it's not necessary to "sign up" specific family members for these accounts.

Healthcare FSA

A healthcare FSA reimburses employees for eligible medical expenses, up to the amount contributed for the plan year. Eligible healthcare expenses include many of the out-of-pocket expenses you pay to maintain your health and well-being. Visit wexinc.com/insights/benefits-toolkit/eligible-expenses/ for a full list of eligible expenses.

You may contribute up to $3,200 annually (funds will be available as of the election effective date).

Dependent Care FSA

You may use pretax dollars from your Dependent Care FSA to pay expenses for the care of a dependent child, spouse or elderly parent inside your home (from a qualified provider), and expenses outside your home, such as baby-sitters, nursery schools, or day care centers.

You may contribute anywhere up to $5,000 annually (or $2,500 if you are married and file a separate tax return). You can only be reimbursed up to the amount that you have contributed.

*FSA's have a use-it-or-lose-it provision. Please plan carefully.

Flexible Spending Accounts Scenario Examples

Without Healthcare FSA	With Healthcare FSA
Gross Annual Pay: $60,000	Gross Annual Pay: $60,000
Tax Rate (18%): -$10,800	Annual FSA Contribution: -$2,600
Net Annual Pay: $49,200	Adjusted Gross Pay: $57,400
Healthcare Expenses: -$2,600	Tax Rate (18%): -$10,332
Final Take-Home Pay: $46,600	Final Take-Home Pay: $47,068

Take home this much more with a Healthcare FSA: **$468**

Without Dependent Care FSA	With Dependent Care FSA
Gross Annual Pay: $60,000	Gross Annual Pay: $60,000
Tax Rate (18%): -$10,800	Annual FSA Contribution: $5,000
Net Annual Pay: $49,200	Adjusted Gross Pay: $55,000
Dependent Care Expenses: -$5,000	Tax Rate (18%): -$9,900
Final Take-Home Pay: $44,200	Final Take-Home Pay: $45,100

Take home this much more with a Dependent Care FSA: **$900**

DENTAL

UHC

You have the choice of two dental plan options with UHC. The DPPO offers both a high and low plan that provides coverage for both in-network and out-of-network. Although you can choose any dental provider, when you use an in-network dentist, you will generally pay less. If you choose an out-of-network provider, you may be billed the difference between what UHC pays, and what your out-of-network provider charges for the services. To locate an in-network provider, please visit **myuhc.com** and select the **National Options PPO 20 for the DPPO Low** or **National Options PPO 30 for DPPO High.**

For services provided by a non-network dentist, UHC Dental will reimburse according to the Maximum Allowable Charge. The dentist may balance bill up to their usual fees.

Plan Provisions	DPPO High		DPPO Low	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible				
Individual/Family	$50/$150	$50/$150	$50/$150	$100/$300
Annual Benefit Maximum				
Individual/Family	$1,500		$1,000	$500
Diagnostic and Preventive Care (Member Pays)				
Cleanings	100%	20%	100%	
Oral Exams				
Sealants				
X-Rays				
Basic Services (Member Pays)				
Simple Extractions	20% after deductible		30% after deductible	50% after deductible
Oral Surgery				
Restorations				
Fillings				
Major Services (Member Pays)				
Crowns	50% after deductible		50% after deductible	70% after deductible
Dentures and Bridges				
Inlays and Onlays				
Orthodontics (Member Pays)				
Children only (up to age 19)	50%		50%	
Lifetime Maximum	$1,500		$1,000	

Late Entrant Limitation Provision: Payment will be reduced by 50% for Basic and Major services for 12 months for eligible members that are allowed to enroll in this plan outside of the designated open enrollment period. This provision does not apply to new hires.

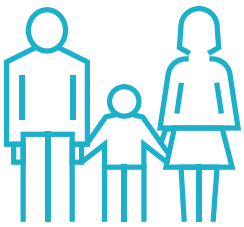
VISION

UHC

Our vision care benefits include coverage for eye exams, lenses and frames, contact lenses, and discounts for laser surgery. The vision plan is built around the UHC network providers, who have higher benefits at a lower cost to you. When you need services, consider using an in-network provider for the most bang for your buck! When you use an out-of-network provider, you will be reimbursed for services according to the grid below. To locate an in-network provider, visit **myuhcvision.com.**

	In-Network	Out-of-Network
Examination (Every 12 Months)	$20	Up to $45
Material	$20	N/A
Lenses (Every 12 Months)		
Single	Covered 100% after materials copay	Up to $40
Bifocal		Up to $65
Trifocal		Up to $75
Frames (Every 24 Months)		
New Frames	Up to $130; 20% discount on frame coverage	Up to $78
Contact Lenses* (Every 12 Months)		
Elective	Up to $130	Up to $105
Medically Necessary	Covered 100%	Up to $210

*In lieu of eyeglasses



LIFE AND DISABILITY INSURANCE

New York Life

newyorklife.com
800.225.5695

Life Insurance

We provide Basic Life and AD&D insurance at no cost to you!

Insurance Coverage	Benefit
Basic Life and AD&D	Flat $15,000

If you would like additional coverage, Voluntary Life and AD&D insurance is available to you, your spouse and your dependent children. You must enroll in coverage for yourself in order to cover your spouse or children. If you don't enroll in Voluntary Life when it's first available to you, or elect an amount over the Guaranteed Issue, you may be required to complete an Evidence of Insurability (EOI) form.

Insurance Coverage	Benefit	Guaranteed Issue
Voluntary Employee Life	Increments of $10,000 up to 5 x salary or $500,000	$230,000
Voluntary Spouse Life	Increments of $5,000 up to $250,000 or lesser of 50% employee amount	$50,000
Voluntary Child Life	Increments of $1,000 up to $10,000	Birth to 6 months: $500 6 months to 26 years: $10,000

Disability

The company offers you the option of enrolling in Voluntary Short-Term and/or Long-Term Disability. These plans give you income protection in the event you are ill or injured in a non-work related injury, and can't come to work. If you don't enroll in Disability coverage when it's first available to you, you may be required to complete an Evidence of Insurability (EOI) form.

Short-Term Disability Benefits		Long-Term Disability Benefits	
Elimination Period	14 days	Elimination Period	90 days
Weekly Benefit	60% of weekly earnings	Monthly Benefit	60% of monthly salary
Maximum Weekly Benefit	$1,000	Maximum Monthly Benefit	$5,000
Maximum Benefit Period	13 weeks	Maximum Benefit Period	Social Security Normal Retirement Age

Term Life and Accidental Death and Dismemberment Insurance.

Term Life insurance gives your family financial resources if you pass away while covered under the policy. Accidental Death and Dismemberment (AD&D) insurance offers additional financial protection if you suffer a serious or catastrophic covered injury. A payment will be sent to you or your beneficiaries to help pay for rehabilitation, home alterations, final expenses, the mortgage, daily living expenses, or your children's education.

How to file a Life and AD&D claim.

Claims should be reported as early as possible, within a month of the date of loss or injury. Claims can be filed in one of the following ways:

Submit your claim online:

Visit **nyl.com/life-and-add-claim** to begin a Life or AD&D claim:

- Read and agree to the state fraud warnings.
- Follow the steps to complete the claim form.

File your claim by fax, email, or mail:

Visit **nyl.com/customer-forms** to find blank/fillable claim forms:

- Select and complete the "Life and Accidental Death Proof of Loss Form".
- Print the completed form and submit by fax, email, or mail:
  - **Email** is the preferred method. Scanned document can be submitted to claims.pghlif2@newyorklife.com.
  - **Fax** documents to (877) 300-6770.
  - **Mail** documents to:
    New York Life Group Benefit Solutions
    Life & Accident Claim Services
    P.O. Box 22328
    Pittsburgh, PA 15222-0328

File your claim by phone:

Call tollfree **(800) 362-4462** between 7:00 a.m. – 7:00 p.m. CT.

Information you'll need:

- All beneficiary designations on file
- Assignments, court orders, or any other documents that may affect payment
- Copy of the death certificate
- Information you saved when you enrolled
- Police or medical examiner report, if available/applicable

Questions?

Call **(800) 238-2125** or **(866) 562-8421** (Español) to speak with a customer service representative.

Short-term and/or Long-term Disability Insurance.

For many people, every paycheck counts. What would happen to your bills, your savings, and your lifestyle if you couldn't work? With disability insurance, you'll receive a portion of your paycheck if you become disabled and can't work for a period of time due to a covered illness or injury. It provides you and your family additional financial security to help pay for daily living expenses, the mortgage, or unplanned medical costs. It's like having insurance for some of your paycheck.

How to file STD and/or LTD claim.

For an STD claim, contact your employer on, or before your first day out of work to report your absence. If you know you'll be out for more than seven days in a row, make sure you call **(888) 842-4462** between 7:00 a.m. – 7:00 p.m. CT and initiate your claim before your seventh day out of work. If your plan allows for coverage before seven days, report your claim as soon as possible.

For an LTD claim, contact New York Life Group Benefit Solutions at least 30 days before the start of your LTD. If you have STD insurance, the claim will automatically be started for you.

Submit your claim online:

Visit **myNYLGBS.com** to create a new leave request online:

- From the Home screen, select Submit an Absence Request
- Complete the information and submit (print your confirmation page).
- Need help registering? Contact us: **(800) 644-5567**.
  - You can also file your claim at: **nyl.com/disability-claim**.

File your claim by phone:

Call tollfree **(888) 842-4462** between 7:00 a.m. – 7:00 p.m. CT.

Information you'll need:

- Personal information, such as your name, address, phone number, birth date, Social Security number, and email address
- Employment information, such as employer's name, email address, date of hire, and job title
- The reason for your claim – illness, injury, or pregnancy
- Workers' compensation claims you've filed or plan to file
- Details about doctor, hospital, or clinic visits, including dates and contact information
- Bank information if you'd like your benefit payments deposited directly into your checking or savings account

Questions?

Call **(888) 842-4462** or **(866) 562-8421** (Español) to speak with a customer service representative.

Solutions for all your financial and legal challenges.

Financial, Legal & Estate Support.

We know financial and legal challenges can be very stressful for you and your family. That's why New York Life Group Benefit Solutions provides our Financial, Legal & Estate Support program[1] to help you navigate these issues, at no additional cost. Leaving you with fewer worries.

Our suite of value-add resources includes:

› FinancialConnect®

Sometimes you may not know where to start when facing a stressful financial challenge or when you need financial planning expertise. With FinancialConnect® you and your family members have unlimited access to a team of qualified experts including Certified Public Accountants (CPAs), CERTIFIED FINANCIAL PLANNERS™ (CFP®) and other financial professionals to help guide you. If additional help is needed, you can request referrals to financial professionals in your local community.

In addition, on **guidanceresources.com**, you will have access to financial information on a wide range of topics including debt management, family budgeting, estate planning and tax planning as well as interactive tools and financial calculators.

› LegalConnect®

If you are facing a difficult legal challenge and don't know where to start, LegalConnect® can help. This program gives you access to unlimited phone consultations with a staff of attorneys who can provide guidance on issues such as divorce, adoption, estate planning, real estate, and identity theft. If needed, you can be referred to a local attorney for a free 30-minute consultation and a 25 percent reduction in fees thereafter. Lastly, information on low cost and no legal options are available along with referrals to consumer advocacy groups and governmental organizations if needed.

› EstateGuidance®

This user-friendly online tool allows you and your family members to write a last will and testament, a living will and documents outlining your wishes for final arrangements quickly, easily and cost effectively. EstateGuidance® walks you through the entire process, guiding your choices with a series of questions and breaking down each step into easy-to-understand terms. Access is available anytime, anywhere via tablet, desktop, or mobile app.

Contact Info:

Financial, Legal & Estate Support 24/7

Phone: (800) 344-9752

Website: **guidanceresources.com**
Web ID: NYLGBS

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

SUPPLEMENTAL HEALTH BENEFITS

888.299.2070
myuhc.com
supphealthclaims@uhc.com

UHC

Our medical plans provide great coverage for you and your family's healthcare needs. Still, everyone's needs are slightly different. That's where supplemental health options come in! These benefits are designed to protect your family's finances in case of an unforeseen injury or illness. These benefits are offered to you through UHC. Please visit **myuhc.com** for additional details.

Accident Insurance

Accident plans pay cash benefits directly to you to help pick up some of the costs remaining after your health insurance plan kicks in following a covered accident.

Coverage includes initial and emergency care, hospitalization, fractures and dislocations, follow-up care, accidental death and dismemberment benefit and a $50 wellness benefit for completing a health screening test.

Plan Benefits

- Ground Ambulance $400
- Emergency room $200
- Hospital Admission $1,500
- ICU Admission $3,000
- Coma $20,000
- Various Fractures $600 - $9,000
- Lacerations and burn $150/$600
- Concussions $375

Critical Illness Insurance

Critical illness insurance helps protect your income and personal assets when out-of-pocket expenses increase as a result of a specified illness. This plan covers conditions like: heart attack, stroke, end stage renal failure, invasive cancer, and more.

Plan Benefits

Employees can choose coverage in amounts of $10,000, $20,000, or $30,000. Spouse and children coverage is available up to 50% of employee amount.

Hospital Indemnity Insurance

An unexpected or even planned stay in the hospital can be expensive as you meet your deductible and out-of-pocket obligations under the medical plan. The Hospital Indemnity plan is designed to provide financial protection by paying you a direct benefit to meet out-of-pocket expenses and extra bills that can occur.

Plan Benefits

- Hospital Admission: $1,000 per day (2 days per calendar year)
- Hospital Confinement: $100 per day (30 days per calendar year)
- ICU Confinement: $200 per day (30 days per calendar year)
- **Guaranteed issue with no pre-existing condition limitations**

ADDITIONAL BENEFITS

Benefit	Description	Contact information	Who pays?
Employee Assistance Program	We are pleased to offer an Employee Assistance Program to assist you and your family through difficult times. ▪ Unlimited access to Master's-level counselors by phone 24/7. ▪ Up to three face-to-face visits with a counselor at no cost. ▪ Unlimited access to helpful tools and resources online. ▪ Referrals available.	New York Life 800.344.9752	Employer Paid
Guidance Resources	We provide quick access to valuable information and tools for managing life's challenges through **guidanceresources.com**. Topics covered include health and wellness, legal regulations, family and relationships, work and education, money and investments, as well as home and auto. Our resources encompass articles, podcasts, videos, slideshows, on-demand trainings, and "Ask the Expert" for personalized responses to your questions.	New York Life 800.344.9752 **guidanceresources.com** Web ID: NYLGBS	Employer Paid
Well-Being Coaching	To support you in attaining your objectives, we provide access to a certified coach who will collaborate with you individually. This personalized assistance addresses concerns related to health and well-being, including issues like: ▪ Burnout ▪ Time management ▪ Stress management You are entitled to five sessions annually, all of which are conducted via telephone for your convenience.	New York Life 800.344.9752	Employer Paid
Family Source	Managing the everyday concerns of home, work and family can be difficult. To help resolve those concerns, you have access to family care service specialists that provide customized research, educational materials and pre-screened referrals for childcare, adoption, elder care, education, and pet care.	New York Life 800.344.9752	Employer Paid

Additional protection when you travel.

Emergencies can happen while traveling, but help is only a phone call away.

New York Life Group Benefit Solutions (NYL GBS) Secure Travel offers pre-trip planning, assistance while traveling and emergency medical transportation benefits for covered persons traveling 100 miles or more from home (see your plan for details). Service is a phone call away, 24/7/365.

Pre-trip planning	Traveling assistance	Emergency assistance*
• Immunization requirements • Visa and passport requirements • Embassy/consular referrals • Foreign exchange rates • Travel advisories and weather conditions • Cultural information	• 24-hour multilingual assistance and referral to interpretation and translation services • Referrals to physicians, dentists, medical facilities and legal assistance providers • Arrangements for payment of medical expenses up to $10,000 if required prior to treatment** • Assistance with lost or stolen items, including luggage and prescription replacement services** • Emergency cash advances, up to $1,500** • Advancement of bail**	• Emergency evacuation and repatriation, when medically necessary; arrange and cover the cost of transportation to the nearest adequate medical facility*** • Travel arrangements for the return of a travel companion or children under age 18 who are left unattended due to the covered person's medical emergency • Cover round-trip transportation as well as accommodations, up to $150 per day for up to seven days, for a family member or friend to visit a covered person who is hospitalized more than 100 miles away from home for more than seven days • Arrange and cover the costs associated with returning a deceased covered person's remains to his or her place of residence for burial • Emergency message relay, toll-free • Assistance with making emergency travel arrangements**

NYL GBS Secure Travel

From the United States and Canada, call **(888) 226-4567**

From other locations, call collect **(202) 331-7635**

Fax: **(202) 331-1528**

Email: ops@us.generaliglobalassistance.com

Emergency services must be coordinated through Generali Global Assistance. Services coordinated outside of this program may not be eligible for payment.

Policyholder name: Renuity, LLC

Policy # OK 0970832 Group#57

To learn more, call (888) 226-4567

* Emergency Assistance services may be insured under a group or blanket insurance policy issued by Life Insurance Company of North America. All other NYL GBS Secure Travel services are NOT insurance and do not provide reimbursement of expenses or financial losses. Expenses for medical care are not covered.

** Covered person is responsible for any advances, payments, travel-related replacement costs and must provide confirmation of reimbursement. Credit card(s) used to guarantee reimbursement must have sufficient available limit to cover the amount of the advance.

*** Initial transport by ambulance following a covered medical emergency is excluded.

NYL GBS Secure Travel is provided under a contract with Generali Global Assistance (GGA). Neither GGA nor New York Life Group Benefit Solutions guarantees the quality of any medical services provider or medical facility. The final selection of a local medical provider or facility is the covered person's right and responsibility. The medical professionals or attorneys suggested or designated by GGA are solely responsible for their services. They are not employees or agents of GGA or New York Life Group Benefit Solutions. Emergency evacuation and repatriation benefits are insured by Life Insurance Company of North America and New York Life Group Insurance Company of NY, subsidiaries of New York Life Insurance Company. Policy Forms: GA-00-1000 et al.; BA-01-1000 et al. All other services are provided by GGA and are subject to the terms of the service agreement with GGA. Presented here are highlights of the NYL GBS Secure Travel program. See the plan documents for details.

Generali Global Assistance is not affiliated with New York Life Insurance Company.

New York Life Group Benefit Solutions products and services are provided by Life Insurance Company of North America and New York Life Group Insurance Company of NY, subsidiaries of New York Life Insurance Company.

New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010

811361 | 0521 SMRU 1903054 Exp. Date 06.09.2023 Renuity, LLC

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Glossary of Terms

COPAYMENT: A copayment (copay) is the fixed dollar amount you pay for certain in-network services on a PPO-type plan. In some cases, you may be responsible for coinsurance after a copay is made.

COINSURANCE: Your share of the costs of a healthcare service, usually figured as a percentage of the amount charged for services. You start paying coinsurance after you've met the deductible. Your plan pays a certain percentage of the total bill, and you pay the remaining percentage.

DEDUCTIBLE: A deductible is the amount of money you must meet before your plan begins paying for services covered by coinsurance. Some services, such as office visits that require copays do not apply to the deductible. For example, if your plan's deductible is $1,000, you'll pay 100 percent of eligible healthcare expenses until you have met the $1,000 deductible. After that, you share the cost with your plan by paying coinsurance.

FORMULARY: A list of prescription drugs covered by the plan. Also called a drug list.

IN-NETWORK: A group of doctors, clinics, hospitals and other healthcare providers that have an agreement with your medical plan provider. You pay a negotiated rate for services when you use in-network providers.

OUT-OF-NETWORK: Care received from a doctor, hospital or other provider that is not part of the plan agreement. You'll pay more when you use out-of-network providers since they don't have a negotiated rate with your plan provider. You may also be billed the difference between what the out-of-network provider charges for services and what the plan provider pays for those services.

OUT-OF-POCKET MAXIMUM: This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles and coinsurance, your health plan pays 100 percent of the costs of covered benefits. However, you must pay for certain out-of-network charges above reasonable and customary amounts.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): This is a type of medical plan that requires the member to reach a deductible prior to having services covered by coinsurance. All expenses paid by the member count toward the deductible and out-of-pocket maximum.

CONTACTS

Medical Plan • UHC

866.414.1959

myuhc.com

Dental Plan • UHC

866.414.1959

myuhc.com

Vision Plan • UHC

800.638.3120

myuhcvision.com

HSA and FSA Accounts • WEX

866.451.3399

wexinc.com

Supplemental Health Benefits • UHC

800.754.3207

myuhc.com

supphealthclaims@uhc.com

Health Advocacy • Health Advocate

866.799.2728

HealthAdvocate.com/members

answers@HealthAdvocate.com

Life and Disability • New York Life

800.225.5695

newyorklife.com

Annual notices are available here:
https://online.flippingbook.com/view/830140658

RENUITY, LLC

HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From RENUITY, LLC About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE
IMPORTANT NOTICE FROM RENUITY, LLC 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 RENUITY, LLC and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. RENUITY, LLC has determined that the prescription drug coverage offered by the RENUITY, LLC Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
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. See the RENUITY, LLC Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the RENUITY, LLC Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the RENUITY, LLC Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your RENUITY, LLC prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call Email: Humanresources@renuityhome.com.
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 RENUITY, LLC changes. You also may request a copy.

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 whether or not you are required to pay a higher premium (a penalty).

Date:	January 1, 2024
Name of Entity/Sender:	Human Resources
Address:	1 Alhambra Plaza, Suite 600 Coral Gables, FL 33134
Email:	Humanresources@renuityhome.com

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

RENUITY, LLC
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

RENUITY, LLC HEALTH AND WELFARE PLAN*

* This notice pertains only to healthcare coverage provided under the plan.

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by RENUITY, LLC that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this

Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.

- **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as RENUITY, LLC) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.
  - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
  - **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
  - **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
  - **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
  - **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
  - **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Human Resources
Humanresources@renuityhome.com

Effective Date

The effective date of this notice is: January 1, 2024.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

RENUITY, LLC EMPLOYEE HEALTH CARE PLAN

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

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *31 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 *31 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Human Resources
Humanresources@renuityhome.com

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

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 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. 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. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

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. If you believe you are eligible for this extension, contact the Plan Administrator.

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

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

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

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:
Human Resources
1 Alhambra Plaza, Suite 600
Coral Gables, FL 33134
Humanresources@renuityhome.com

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

RENUITY, LLC Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan issuer at 866-414-1959.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from RENUITY, LLC Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the RENUITY, LLC Employee Health Care Plan at:

Human Resources
Humanresources@renuityhome.com

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

RENUITY, LLC Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The RENUITY, LLC Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

UHC PPO Plus	In-Network	Out-of-Network
Individual Deductible	$1,000	$2,000
Family Deductible	$2,000	$4,000
Coinsurance	80%	60%
UHC PPO	In-Network	Out-of-Network
Individual Deductible	$3,000	$10,000
Family Deductible	$6,000	$20,000
Coinsurance	70%	50%

UHC HDHP	In-Network	Out-of-Network
Individual Deductible	$3,200	$5,000
Family Deductible	$6,400	$10,000
Coinsurance	80%	60%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Human Resources
Humanresources@renuityhome.com

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Human Resources, Humanresources@renuityhome.com.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) NOTICE

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) NOTICE

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	FLORIDA – Medicaid
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	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)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – 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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – 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)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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)

ILLINOIS DOL EMPLOYER EHB LIST MODEL NOTICE

Employer Name:	Renuity, LLC
Employer State of Situs:	Florida
Name of Issuer:	United Healthcare
Plan Marketing Name:	PPO Plus, UHC PPO, UHC HDHP
Plan Year:	1/1/2024

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2024 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Depends if mandated coverage or purchased as a buy up.
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Not Covered
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Depends if mandated coverage or

				purchased as a buy up.
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Depends if mandated coverage or purchased as a buy up.
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	No
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.


2802
renuity