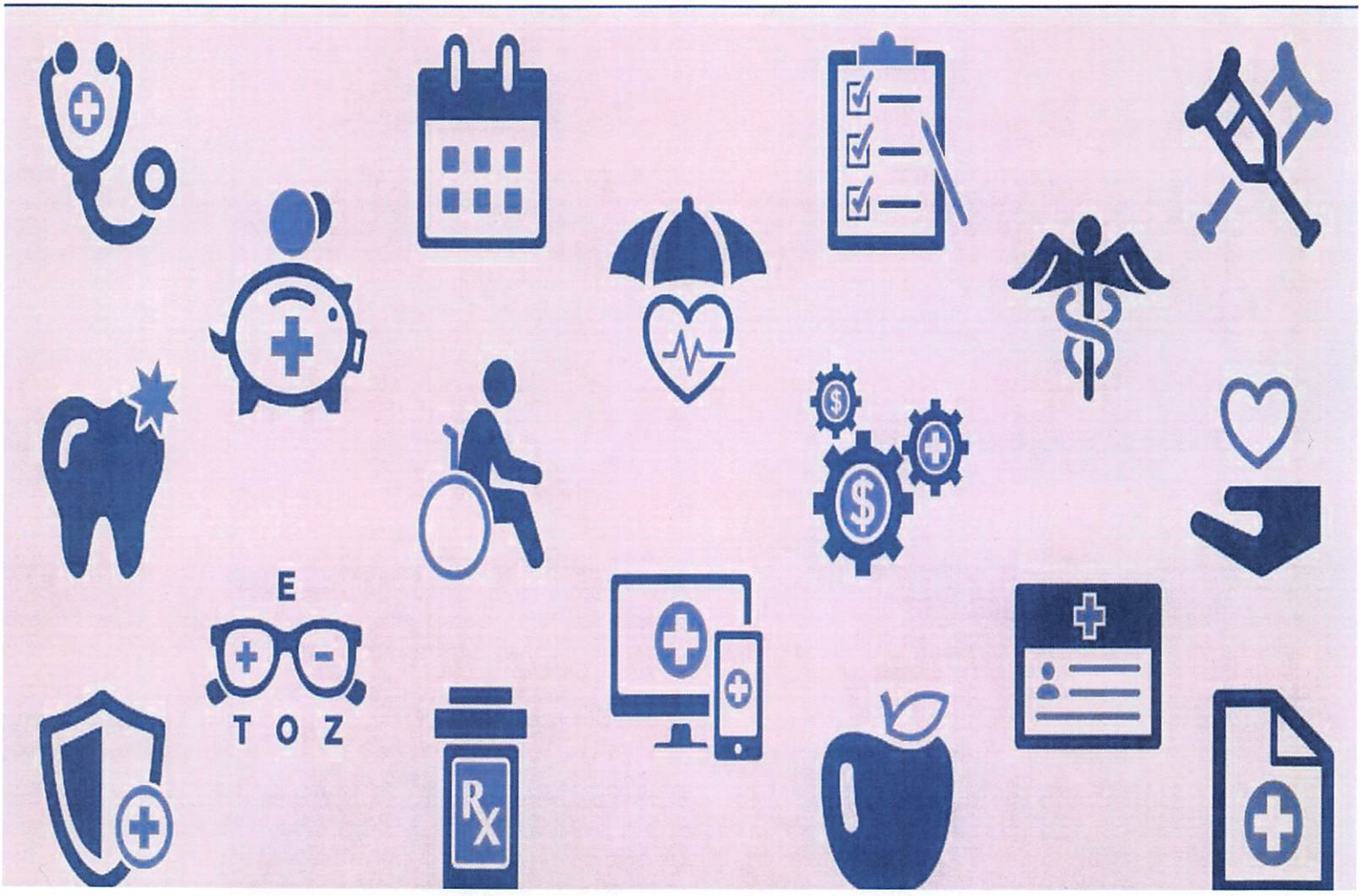
Guardian Angel Staffing Employee Benefits Guide

Coverage Period:
December 1, 2024 -November 30, 2025



Eligibility & How To Enroll

ELIGIBILITY

You are eligible for benefits if you work at least 30 hours per week. The waiting/eligibility period for enrollment is first of the month following 60 days from date of hire or change of status from part time to full time.

You may enroll your eligible dependents for coverage once you are eligible.
Your eligible dependents include:

- Your legal spouse
- Your children up to age 26

Once your benefit elections become effective, they remain in effect until the end of the plan year. You may only change coverage within 30 days of a qualified life event. Pre-tax benefits are in effect until the end of the year.

QUALIFIED LIFE EVENT

Generally, you may change your benefit elections only during the annual enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, commencement or termination of adoption proceedings, or change in spouse's benefits.

You must notify Human Resources within 30 days of the qualified life event. Depending on the type of event, you may be asked to provide proof of the event. If you do not contact Human Resources within 30 days of the qualified event, you will have to wait until the next annual enrollment period to make changes (unless you experience another qualified life event).

HOW TO ENROLL

If you would like to join the plan, add or delete dependents, you must complete the respective insurance carrier's application.

CONTACTS

Anthem Medical Benefits
Group Number: L04976
Customer Service: 1-855-330-1108
www.anthem.com

Delta Dental & Vision Benefits
Dental Client Number: G06100
Vision Client Number: G0610V
Customer Service: 1-800-955-2030
www.deltadentalky.com

Colonial Life Insurance: Group Accident, Short Term Disability& Critical Illness
Sandy Dougherty: 502-238-7255
www.coloniallife.com

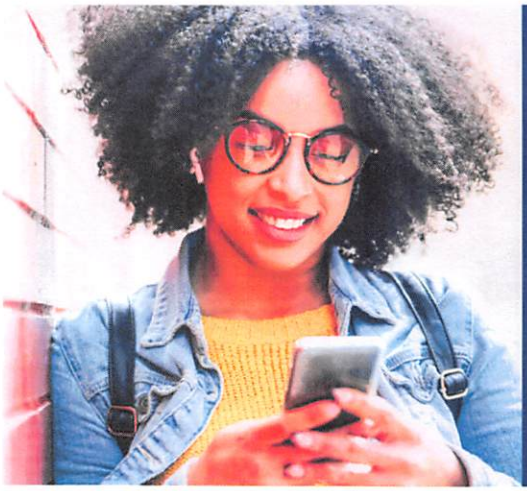
ANTHEM MEDICAL

	In Network	Out of Network
Deductible- Individual	$1500	$4500
Deductible- Family	$3000	$9000
Out of Pocket- Individual	$6500	$19500
Out of Pocket- Family	$13000	$39000
Office Visit	$20/$50	50%
Inpatient facility	Ded/20%	50%
Outpatient Facility	Ded/20%	50%
Urgent Care	$20	50%
ER	$300/20%	$300/20%
Lifetime Max	Unlimited	
Rx Retail: Level 1: $10/$35/$75/25% with $350 max Level 2: $20/$45/$85/25% with $450 max		
Rx Mail Order: $20 tier 1/ $88 tier 2/ $188 tier 3 Specialty Rx tier 3 or tier 4 25% with $350 max		

WEEKLY RATES

	Employee		Employee/Spouse		Employee/Child(ren)		Employee/Fam	
Demo	Male	Female	Male	Female	Male	Female	Male	Female
18-24	$16.36	$39.44	$93.97	$93.97	$75.48	$98.57	$174.13	$174.13
25-29	$17.25	$45.27	$102.77	$102.77	$76.38	$104.40	$182.93	$182.93
30-34	$19.99	$44.27	$110.90	$110.90	$79.11	$103.40	$191.06	$191.06
35-39	$25.10	$43.44	$127.12	$127.12	$84.23	$102.57	$207.28	$207.28
40-44	$31.39	$45.48	$150.14	$150.14	$95.28	$109.37	$236.07	$236.07
45-49	$41.12	$51.71	$188.79	$188.79	$105.01	$115.59	$274.72	$274.72
50-54	$54.62	$54.62	$236.70	$236.70	$118.51	$118.51	$322.63	$322.63
55-59	$55.62	$55.62	$241.04	$241.04	$119.51	$119.51	$326.97	$326.97
60-64	$55.62	$55.62	$241.04	$241.04	$119.51	$119.51	$326.97	$326.97
65+	$55.62	$55.62	$241.04	$241.04	$119.51	$119.51	$326.97	$326.97

This summary of benefits is a brief outline of coverage. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage. If there is a difference between this summary and the Certificate of Insurance or Evidence of Coverage, the Certificate of Insurance or Evidence of Coverage will prevail.



Anthem

The Sydney Health mobile app makes healthcare easier

Access personalized health and wellness information wherever you are

Use Sydney℠ Health to keep track of your health and benefits — all in one place. With a few taps, you can quickly access your plan details, Member Services, virtual care, and wellness resources. Sydney Health stays one step ahead — moving your health forward by building a world of wellness around you.

Find Care

Search for doctors, hospitals, and other healthcare professionals in your plan's network and compare costs. You can filter providers by what is most important to you, such as gender, languages spoken, or location. You'll be matched with the best results based on your personal needs.

My Health Dashboard

Use My Health Dashboard to find news on health topics that interest you, health and wellness tips, and personalized action plans that can help you reach your goals. It also offers a customized experience just for you, such as syncing your fitness tracker and scanning and tracking your meals.

Chat

If you have questions about your benefits or need information, Sydney Health can help you quickly find what you're looking for and connect you to an Anthem representative.

Virtual Care

Connect directly to care from the convenience of home. Assess your symptoms quickly using the Symptom Checker or talk to a doctor via chat or video session.

Community Resources

This resource center helps you connect with organizations offering no-cost and reduced-cost programs to help with challenges such as food, transportation, and child care.

My Health Records

See a full picture of your family's health in one secure place. Use a single profile to view, download, and share information such as health histories and electronic medical records directly from your smartphone or computer.

¿Prefieres obtener información en español?

Tienes opciones. Si tu teléfono móvil ya está configurado en español, la aplicación Sydney Health también estará en español. Si no es así, selecciona el **menú** dentro de la aplicación Sydney Health y elige **el idioma de la aplicación**. También puedes visitar anthem.com/es.

Download the Sydney Health app today

Use the app anytime to:

- Find care and compare costs.
- See what's covered and check claims.
- View and use digital ID cards.
- Check your plan progress.
- Fill prescriptions.

Scan the QR code to download the Sydney Health app.

You can also set up an account at anthem.com/register to access most of the same features from your computer.

In addition to using a telehealth service, you can receive in-person or virtual care from your own doctor or another healthcare provider in your plan's network. If you receive care from a doctor or healthcare provider not in your plan's network, your share of the costs may be higher. You may also receive a bill for any charges not covered by your health plan.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2024 The Virtual Primary Care experience is offered through an arrangement with Hydrogen Health.

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Anthem

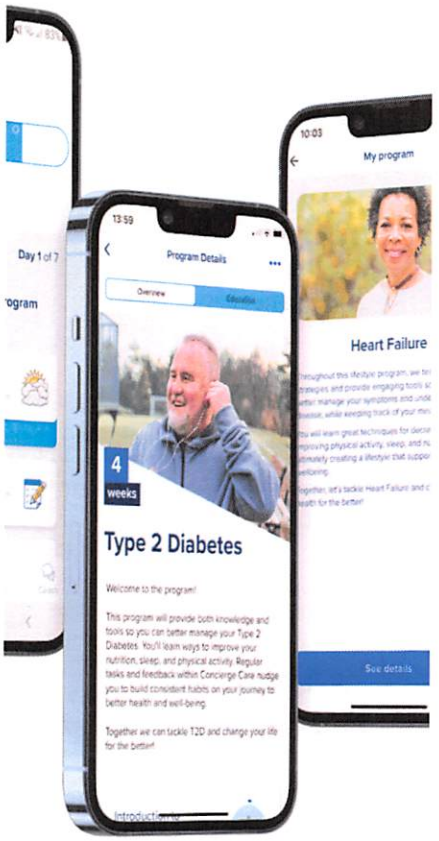
Personal support to manage your health condition at your fingertips

Concierge Care is a digital, app-based program that can pair you with a health advocate to provide personalized coaching on a variety of health conditions, and it is covered by your health plan. You'll receive on-demand access to professional support to help keep you healthy.

You don't have to manage your care alone.

Choose the program that best fits your needs.

1. Scan the QR code and sign up with your details at no cost.
2. Receive a text message on your cell phone with a link to download the app on your device.
3. Create an account and start your personalized program.



Type 2 Diabetes

Navigating diabetes can be challenging, from nutrition, to insulin, to eye care. Your health advocate can provide personalized support to navigate every step of your journey.

Discharge Essentials

Personalized support to help prevent hospital readmission, and keep you healthy after getting discharged from the hospital.

Cancer Care Navigator

A cancer diagnosis can be overwhelming, but a care manager can support you every step of the way. Includes coordination of care with your oncologist and care team, emotional support, and medication management.

Heart Failure

Managing heart failure can be easier with a support system. Together with your health advocate, learn to better monitor your wellbeing and build new, heart-healthy habits.

Crohn's Disease

Personalized support to manage Crohn's disease, including assistance to find the best treatments.

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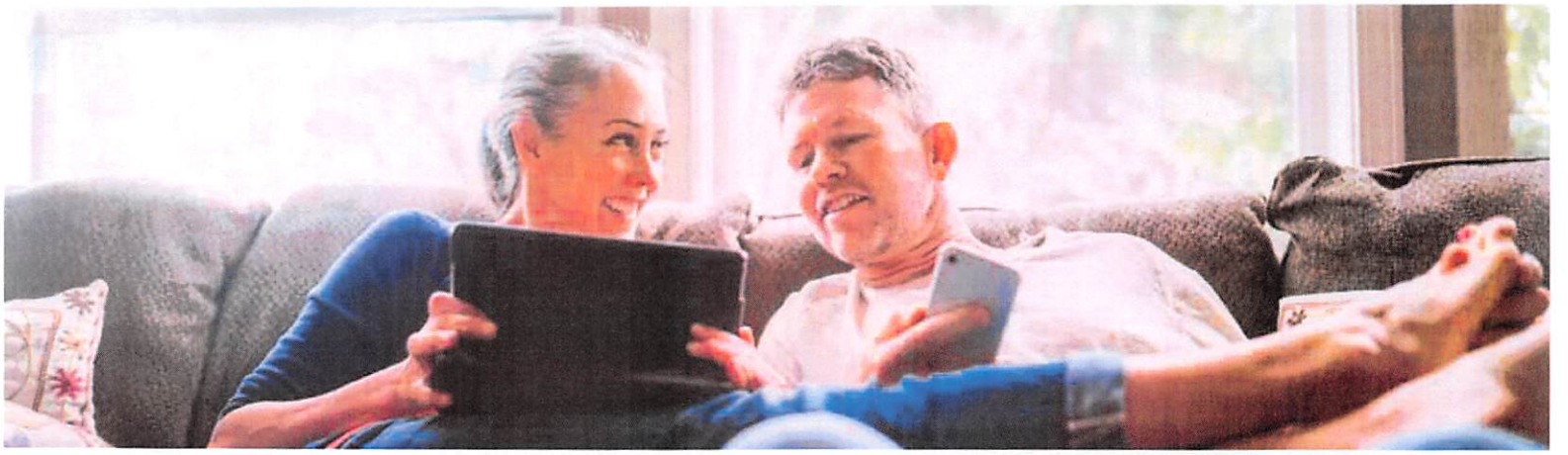

Save money and time with Rx Choice pharmacy network

Your Anthem health plan gives you choices about how and where to fill your prescriptions. With the Rx Choice pharmacy network, you can choose a pharmacy with lower prescription costs or a greater number of locations. You can also have prescriptions delivered right to your door. Choose CarelonRx Mail home delivery, if available, to save time and money when filling medicines you take daily. It even comes with automatic refills.

The Rx Choice network offers two levels of coverage:

Level 1

These are preferred pharmacies, where your copay or share of the prescription cost is lower. There are more than 20,000* Level 1 pharmacies nationwide, including these well-known chains:

- CVS
- Walmart
- Kroger
- Giant Eagle
- Albertsons/Safeway
- Hannaford/Ahold

Level 2

You'll pay more out of pocket when you fill your prescription at one of these 47,000* pharmacies, including these well-known chains:

- Walgreens
- Rite Aid
- Sam's Club
- Costco
- Meijer

Note: CarelonRx Mail home delivery is also available as a preferred pharmacy option.

How to find a pharmacy in the Rx Choice pharmacy network

- Log on to **anthem.com** or the Sydney℠ Health mobile app, and choose **Order and Manage Prescriptions**.
- On the *Pharmacy* page, choose **Find a Pharmacy**.
- Enter your ZIP code and how far you want to search to find pharmacies near you.

Choose CarelonRx Mail home delivery

You may be eligible to request a new home-delivery prescription on **anthem.com** or the Sydney Health mobile app.

We're here to help

If you have questions about the network or your pharmacy benefits, call the Pharmacy Member Services number on your plan ID card.

* IngenioRx data, 2022.

Services provided by CarelonRx, Inc.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2020-2022

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Focus on your well-being and earn rewards up to $200

The more activities you complete, the greater your reward

The Wellbeing Solutions program connects you with easy-to-use digital health and wellness tools that can help you stay your best. When you complete any of the activities listed below sponsored by your employer, you'll earn rewards to put toward electronic gift cards for select retailers. You choose the activities you'd like to complete to receive the maximum of $200.

Activity Type	Activities	Amount
Preventive care	Have an annual preventive wellness exam or well woman exam with your doctor	$25
	Get an annual cholesterol test[1]	$20
	Have a colorectal cancer screening (ages 45 and older)	$25
	Have a routine mammogram (women ages 40 to 74)	$25
	Have an annual eye exam[2]	$25
	Get an annual dental exam*	$25
	Get an annual flu shot	$20

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Activity Type	Activities	Amount
Condition management programs	ConditionCare: Work one on one with your health coach and earn rewards for participating in and completing the program[3]	Up to $50 ($20/$30)
	Building Healthy Families: Support is available through the Sydney℠ Health app wherever you are in your family planning process, such as trying to conceive or raising your toddler[4]	Up to $40 ($10/$10/$10/$10)
	Well-being Coach – Weight Management: Receive one-on-one coaching by phone as you complete your goal to earn a reward[5]	$25
	Well-being Coach – Tobacco Cessation: Receive one-on-one coaching by phone as you complete your goal to earn a reward[6]	$25
Digital & wellness activities	Log in to your Anthem account	$5
	Connect a fitness or lifestyle device	$5
	Complete a health assessment and receive tailored health recommendations	$20
	Complete action plans around eating healthy, weight management, and physical activity	Up to $25 ($5 per action plan)
	Track your steps	Up to $60 ($2 per 50,000 steps tracked)
	Complete Well-being Coach digital daily check-ins[7]	Up to $20 ($4 per milestone)
	Update your contact information	$10

Well-being Coach can help you meet your goals

The Well-being Coach digital coaching app offers you 24/7 personalized support. Well-being Coach can help you maintain a healthy weight, quit tobacco, and improve your nutrition, exercise habits, mindfulness, and sleep. If you need extra support with weight management or quitting tobacco, talk to a certified health coach.

Earn rewards

Here's how and when you'll earn rewards for completing the activities already mentioned.

Preventive care: Simply visit your doctor for any of the screenings or appointments listed in the chart. Your rewards are added to your account after your claim is processed, which may take up to 60 days.

Condition management: Rewards are added to your account as you meet certain benchmarks or complete a program. Programs include: ConditionCare (for asthma, diabetes, and heart or lung conditions), Building Healthy Families, and Well-being Coach for weight management and tobacco cessation.

Digital and wellness activities: Log in to the Sydney Health app or **anthem.com** to complete available activities, such as taking a health assessment, participating in the Well-being Coach digital program, and tracking your steps. Rewards are added to your account as activities are completed.

Use your rewards toward electronic gift cards for select retailers.

1. To view your rewards, open the Sydney Health app or go to **anthem.com**. Next, go to *My Health Dashboard*.
2. Select **My Rewards**.
3. Select **Redeem Rewards** to see how much you've earned. Use your rewards toward electronic gift cards from popular retailers, including Amazon, Uber, Gap Options (all brands), Apple, Target, The Home Depot, and TJ Maxx. The minimum gift card amount is set by each individual retailer.

Download the Sydney Health mobile app by scanning this QR code with your phone's camera.

Do you have questions?

Log in at **anthem.com** or open the Sydney Health app. Then go to *My Health Dashboard* and select **My Rewards** to learn more. You can also call Member Services at the number on your ID card.

Anthem

Live your life with less back and joint pain

Get advanced, personalized therapy at no extra cost

If you're living with back or joint pain, finding relief without surgery or injections can be hard. That's why we created the **Back and Joint Pain Guide program**. It may give you the extra support you need to feel better without leaving home. It's a six-week online program — available at no extra cost through Livara — using simple exercises that take about 15 minutes a day.

This personalized program focuses on helping you:

- Strengthen your muscles
- Improve your posture and movement
- Relieve back and joint pain

How the program works

Talk to a personal health coach who will create an exercise plan for your exact needs and goals.

Access custom, at-home exercise videos you can follow anytime.

Receive support from a team of medical experts, including doctors and physical therapists, as they track your progress.

Get access to nutrition, mindfulness, and sleep counseling.

Livara has helped more than 100,000 people find pain relief*

- Participants find their pain is **reduced** by an average of **51.4%**.
- **More than 70%** of them have stopped taking narcotics for pain relief.
- Nearly **10 in 10 patients** would recommend Livara.

*Livara Health (Accessed July 2023): livarahealth.com.

Enroll today to find long-term relief without surgery or injections. To sign up, visit **backandjointguide.anthem.com** or call **866-455-8417** from 8:30 a.m. to 5 p.m. ET, Monday through Friday.

Scan this QR code with your phone's camera to learn more.

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A program focused on helping you improve your health

Introducing digital diabetes prevention coaching

Roughly 88 million Americans are living with prediabetes but 84% aren't even aware they have it.[1] Prediabetes often doesn't cause symptoms, but it does increase the risk of developing type 2 diabetes, heart disease, and stroke. That's why Anthem partnered with Lark to offer a diabetes prevention program that can help determine if you're at risk for prediabetes and if needed, take steps to address it.

This program can help you:

- Lose weight
- Eat healthier
- Increase activity
- Sleep better
- Manage stress

Better health is within reach

Participation in this program is at no extra cost as part of your health plan. Track progress, check in with a personalized coach, and learn more about prediabetes right in Lark's free mobile app. This program is flexible, convenient, and follows guidelines from the Centers for Disease Control and Prevention (CDC) to help make small changes that can improve health and decrease risk over time.

Anthem

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Weight loss with Lark

Losing weight can make a difference in lowering risk for type 2 diabetes. Lark members lose an average of 4.2% of their body weight in 12 months on the diabetes prevention program.[2] Participants in the program receive a wireless scale at no extra cost to help track weight loss progress. The scale also syncs with the Lark app so participants can share updates with their coach.

24/7 coaching support

Losing weight and making lifestyle changes can feel intimidating even if it can lead to better health. Coaches can help you stay motivated. If you enroll in the program, you can send a message to a coach anytime from anywhere and receive an immediate response as well as extra support. During the course of the program, coaches will:

- Provide educational information on prediabetes and preventing type 2 diabetes.
- Be available 24/7 through the Lark mobile app to provide personalized coaching.
- Customize a program based on your food preferences and lifestyle.
- Provide information about how stress affects your health and how to cope with it.

You are in control of your health. Prevent diabetes and start improving your overall health and well-being today.

Learn if you are at risk for prediabetes

Scan the QR code to download the Sydney℠ Health mobile app and login using your existing health plan credentials. Once you login, you will find the Lark DPP screen under Programs in My Health Dashboard to take the one-minute survey.

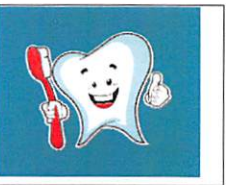
1 Centers for Disease Control and Prevention website: *Prediabetes - Your Chance to Prevent Type 2 Diabetes* (accessed October 2021): cdc.gov.

2 Lark internal data

Diabetes Prevention Program is provided by Lark, an independent company.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan.

Dental Insurance
Delta Dental Insurance



	Employee	Employee + Spouse	Employee + Child(ren)	Family
Dental Weekly Rates	$5.61	$11.04	$13.58	$19.93

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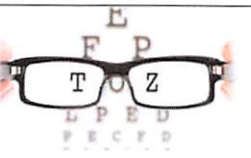
Vision Insurance
Delta Vision Insurance



	Employee	Employee + Spouse	Employee + Child(ren)	Family
Vision Weekly Rates	$1.45	$2.90	$3.11	$4.97

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DELTA DENTAL

Standard Plan SBV

This dental program allows members to utilize any licensed provider. Members who choose a Delta Dental PPO network provider have the lowest out of pocket expenses and cannot be balance billed. Members who choose a Delta Dental Premier network provider cannot be balance billed.

	Delta Dental PPO Network	Delta Dental Premier or Out of Network Benefits
Diagnostic & Preventive Services		
Oral examination (2 per benefit period) Palliative emergency treatment Periapical, bitewing, panoramic or complete series x-ray Topical fluoride application (through age 18) Routine cleanings Sealants (through age 15) Space maintainers (through age 13) Oral cancer detection test	100% coverage No deductible	80% coverage No deductible
Minor Services		
Routine fillings (includes posterior composite fillings) Simple extractions Simple denture repair Oral Surgery	80% coverage	60% coverage
Major Services *		
Inlays or crowns Prosthetic services (bridges, dentures and partials) Implants Root canal therapy Periodontic services	50% coverage	40% coverage
Deductible		
Per benefit period (does not apply to D&P)	$50 individual $150 family	$50 individual $150 family
Annual Maximum		
Per covered person, per benefit year	$1,000	$1,000
Age Limitations		
Dependent Age	26	26

**12-month waiting period for Major Services. Replacement of missing teeth prior to the effective date are not covered.*

Please note: Dentists who have signed participating agreements with Delta Dental of Kentucky agree to accept the Allowable Amount as payment in full for Covered Services as these terms are defined in the Certificate of Coverage. Each Covered Person is responsible for the amount of Coinsurance, Deductible and non-covered charges. Dentists who have signed a participating agreement may bill you directly for any amount of their charge in excess of the Allowable Amount. In cases where the dentist's charges exceed the Allowable Amount, your coinsurance will be larger. Certain procedures require preauthorization and/or are subject to limitations.

Dental benefits offered by Delta Dental of Kentucky, Inc.

DELTA DENTAL

VSP Vision care for life

DeltaVision® by Delta Dental of Kentucky
administered by VSP®

DeltaVision 130

Benefit	Description	Copay
WellVision Exam		
Exams 1 exam every 12 months	Comprehensive eye exam to ensure overall visual wellness	$10
Prescription Glasses		$25
Frames 1 pair every 24 months	$130 allowance for wide selection of frames 20% savings on amount over allowance $70 Costco, Walmart/Sam's Club frame allowance	Included in Prescription Glasses Copay
Lenses 1 pair every 12 months	Single vision, lined bifocal and lined trifocal lenses Polycarbonate lenses for children	Included in Prescription Glasses Copay
Covered Lens Enhancements	Standard Progressive Lenses	$0
Optional Lens Enhancements	Standard Anti-Reflective Coating Premium Progressive Lenses Custom Progressive Lenses Average savings of 20-25% on other lens enhancements	$41 $95 - $105 $150 - $175
Contact Lenses - instead of glasses		
Contacts every 12 months	$130 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation)	up to $60
Extra Savings		
Featured Frames	$150 allowance on featured frame brands. Check vsp.com for current offers.	
Glasses and Sunglasses	20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam	
Retinal Screening	No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
Laser Vision Correction	Average 15%-20% discount	
Additional Programs		
Included	Primary Eyecare, Eye Health Management (including Diabetic Exam Reminder Letters)	
Your coverage with Out-of-Network Providers		
Exam - up to $45 Frame - up to $70 Single Vision Lenses - up to $30	Lined Bifocal Lenses - up to $50 Lined Trifocal Lenses - up to $65 Lenticular Lenses - up to $100	Progressive Lenses - up to $50 Contacts - up to $105 Necessary Contact Lenses - up to $210

Member Services*

Delta Dental of Kentucky
Customer Service
800-955-2030

*Please contact DDKY for eligibility before contacting VSP Member Services

VSP Vision
Member Services
800-877-7195
Hearing impaired customers may call 800-428-4833

VSP Choice Network
100,000 Access Points • In-network with Costco, Walmart/Sam's Club

Rev. 097/2020

Deductions per year: 52

Group Accident for KY

Applicable to policy forms GACC1.0-P & GACC1.0-C

- Off-Job Accident Coverage, Health Screening Benefit ($50 Benefit)

Preferred

ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
17-99	$3.09	$5.04	$5.46	$7.41

Group Disability for KY *A Risk Class*

Applicable to policy forms GDIS-P & GDIS-C

- Off-Job Accident and Off-Job Sickness

6 Month Benefit Period

ELIMINATION PERIOD	ISSUE AGE	$1,300*	$1,500*	$1,700*	$1,900*	$2,100*
14 days Accident/14 days Sickness	17-49	$7.68	$8.86	$10.04	$11.22	$12.41
	50-64	$9.72	$11.22	$12.71	$14.21	$15.70
	65-74	$12.96	$14.95	$16.95	$18.94	$20.94

12 Month Benefit Period

ELIMINATION PERIOD	ISSUE AGE	$1,300*	$1,500*	$1,700*	$1,900*	$2,100*
14 days Accident/14 days Sickness	17-49	$10.26	$11.84	$13.42	$15.00	$16.57
	50-64	$13.62	$15.72	$17.81	$19.91	$22.00
	65-74	$21.84	$25.20	$28.56	$31.92	$35.28

Group Disability for KY *A Risk Class*

Applicable to policy forms GDIS-P & GDIS-C

- Off-Job Accident and Off-Job Sickness

6 Month Benefit Period

ELIMINATION PERIOD	ISSUE AGE	$2,200*	$2,400*	$2,600*	$2,800*	$3,000*
14 days Accident/14 days Sickness	17-49	$13.00	$14.18	$15.36	$16.54	$17.72
	50-64	$16.45	$17.94	$19.44	$20.94	$22.43
	65-74	$21.93	$23.93	$25.92	$27.91	$29.91

12 Month Benefit Period

ELIMINATION PERIOD	ISSUE AGE	$2,200*	$2,400*	$2,600*	$2,800*	$3,000*
14 days Accident/14 days Sickness	17-49	$17.36	$18.94	$20.52	$22.10	$23.68
	50-64	$23.05	$25.14	$27.24	$29.34	$31.43
	65-74	$36.96	$40.32	$43.68	$47.04	$50.40

Important Notice

Insurance coverage has exclusions and limitations that may affect benefits payable. For a complete description of benefits, limitations and exclusions, please refer to an outline of coverage, sample policy/certificate, proposal description or see your Colonial Life benefits counselor. Coverage type, benefits and rates vary by state. Coverage may not be available in all states. Rates provided are illustrative and your actual premium may be different depending on your particular situation and plan choices.

Colonial Life products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand.

Sandy Dougherty | sandy.dougherty@coloniallifesales.com | (502) 238-7255

Sandy Dougherty 502-238-7255 sandy.dougherty@coloniallifesales.com

Group Critical Care for KY

Applicable to policy forms GCC1.0-P & GCC1.0-C

- Full CI Benefit, with Subsequent Diagnosis, Diagnosis of Cancer Benefit

Non-Tobacco Rates

	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
$5,000	16-29	$0.39	$0.58	$0.45	$0.64
	30-39	$0.77	$1.16	$0.83	$1.21
	40-49	$1.61	$2.41	$1.67=	$2.48
	50-59	$2.95	$4.50	$3.01	$4.55
	60-74	$4.74	$7.20	$4.81	$7.30
$10,000	16-29	$0.78	$1.17	$0.90	$1.29
	30-39	$1.54	$2.33	$1.66	$2.42
	40-49	$3.23	$4.82	$3.34	$4.96
	50-59	$5.90	$9.00	$6.02	$9.11
	60-74	$9.48	$14.40	$9.62	$14.60
$15,000	16-29	$1.71	$1.75	$1.35	$1.93
	30-39	$2.31	$3.49	$2.49	$3.63
	40-49	$4.84	$7.23	$5.01	$7.44
	50-59	$8.85	$13.50	$9.03	$13.66
	60-74	$14.22	$21.60	$14.43	$21.90

Tobacco Rates

	ISSUE AGE	NAMED INSURED	EMPLOYEE & SPOUSE	ONE-PARENT FAMILY	TWO-PARENT FAMILY
$5,000	16-29	$0.63	$0.95	$0.70	$1.00
	30-39	$1.21	$1.81	$1.26	$1.86
	40-49	$2.53	$3.81	$2.60	$3.87
	50-59	$4.61	$7.15	$4.73	$7.20
	60-74	$7.65	$11.70	$7.74	$11.80
$10,000	16-29	$1.26	$1.91	$1.40	$2.00
	30-39	$2.42	$3.62	$2.53	$3.73
	40-49	$5.07	$7.63	$5.21	$7.75
	50-59	$9.34	$14.30	$9.46	$14.44
	60-74	$15.30	$23.40	$15.48	$23.60
$15,000	16-29	$1.89	$2.86	$2.10	$3.00
	30-39	$3.63	$5.43	$3.79	$5.59
	40-49	$7.60	$11.44	$7.81	$11.62
	50-59	$14.01	$21.45	$14.19	$21.60
	60-74	$23.01	$35.10	$23.22	$35.40

Important Notice

Insurance coverage has exclusions and limitations that may affect benefits payable. For a complete description of benefits, limitations and exclusions, please refer to an outline of coverage, sample policy/certificate, proposal description or see your Colonial Life benefits counselor. Coverage type, benefits and rates vary by state. Coverage may not be available in all states. Rates provided are illustrative and your actual premium may be different depending on your particular situation and plan choices.

Colonial Life products are underwritten by Colonial Life & Accident Insurance Company, for which Colonial Life is the marketing brand.

Sandy Dougherty | sandy.dougherty@coloniallifesales.com | (502) 238-7255

Colonial Life

Group Critical Illness Insurance
Plan 2 Full

For more information, talk with your benefits counselor.

ColonialLife.com

If you're diagnosed with a covered critical illness or cancer, group critical illness insurance* from Colonial Life can help with your expenses, so you can concentrate on what's most important – your treatment, care and recovery.

*The policy name is Critical Illness and Cancer Group Specified Disease Insurance.

Face amount: $_____

Critical illness benefit

For the diagnosis of this covered critical illness condition:[1]	This percentage of the face amount is payable:
Heart attack (myocardial infarction)	100%
Stroke	100%
End-stage renal (kidney) failure	100%
Major organ failure	100%
Coma	100%
Permanent paralysis due to a covered accident	100%
Blindness	100%
Occupational infectious HIV or occupational infectious hepatitis B, C or D	100%
Coronary artery bypass graft surgery/disease[2]	25%

Subsequent diagnosis of a different critical illness[3]

If you receive a benefit for a critical illness, and later you are diagnosed with a different critical illness, the original percentage of the face amount is payable for that particular critical illness.

Subsequent diagnosis of the same critical illness[3]

If you receive a benefit for a critical illness, and later you are diagnosed with the same critical illness, 25% of the original face amount is payable. Critical illness conditions that do not qualify are: coronary artery bypass graft surgery/coronary artery disease[2] and occupational infectious HIV or occupational infectious hepatitis B, C or D.

Diagnosis of cancer benefit

Covered cancer benefits	
For this condition:[1]	**The amount payable is:**
Diagnosis of cancer (internal or invasive)	100% of the face amount
Diagnosis of carcinoma in situ	25% of the face amount
Skin cancer	$500

Cancer vaccine benefit: $50

This benefit is payable if you or your covered family members incur a charge for any FDA-approved cancer vaccine while your certificate is inforce.

Colonial Life

ColonialLife.com

1 Please refer to the certificate for complete definitions of covered conditions.

2 Benefit for coronary artery disease applicable in lieu of benefit for coronary artery bypass graft surgery when health savings account (HSA) compliant plan is selected.

3 Dates of diagnoses of a covered critical illness must be separated by at least 180 days.

THIS POLICY PROVIDES LIMITED BENEFITS.

Insureds in MA must be covered by comprehensive health insurance before applying for this coverage.

EXCLUSIONS AND LIMITATIONS FOR CRITICAL ILLNESS

We will not pay the Critical Illness Benefit or Benefit Payable Upon Subsequent Diagnosis of a Critical Illness that occurs as a result of a covered person's: alcoholism or drug addiction; felonies or illegal occupations; intoxicants and narcotics; psychiatric or psychological conditions; suicide or injuries which any covered person intentionally does to himself; war or armed conflict; or pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is diagnosed with a critical illness.

EXCLUSIONS AND LIMITATIONS FOR CANCER

We will not pay the Diagnosis of Cancer Benefit, Diagnosis of Carcinoma in Situ Benefit, the Cancer Treatment and Care Benefit or the Skin Cancer Benefit for a covered person's cancer (internal or invasive), carcinoma in situ or skin cancer that: is diagnosed or treated outside the territorial limits of the United States, its possessions, or the countries of Canada and Mexico; is a pre-existing condition, unless the covered person has satisfied the pre-existing condition limitation period shown on the Certificate Schedule on the date the covered person is initially diagnosed as having cancer (internal or invasive), carcinoma in situ or skin cancer. No pre-existing condition limitation will be applied for dependent children who are born or adopted while you are covered under the policy, and who are continuously covered from the date of birth or adoption.

This is not an insurance contract and only the actual certificate provisions will control. Applicable to certificate form GCC1.0-C (including state abbreviations where used, for example: GCC1.0-C-TX). The certificate or its provisions may vary or be unavailable in some states. Please see your Colonial Life benefits counselor for details.

Underwritten by Colonial Life & Accident Insurance Company, Columbia, SC

HEALTH PLAN COMPLIANCE NOTICES

Guardian Angel Staffing

10/15/2024

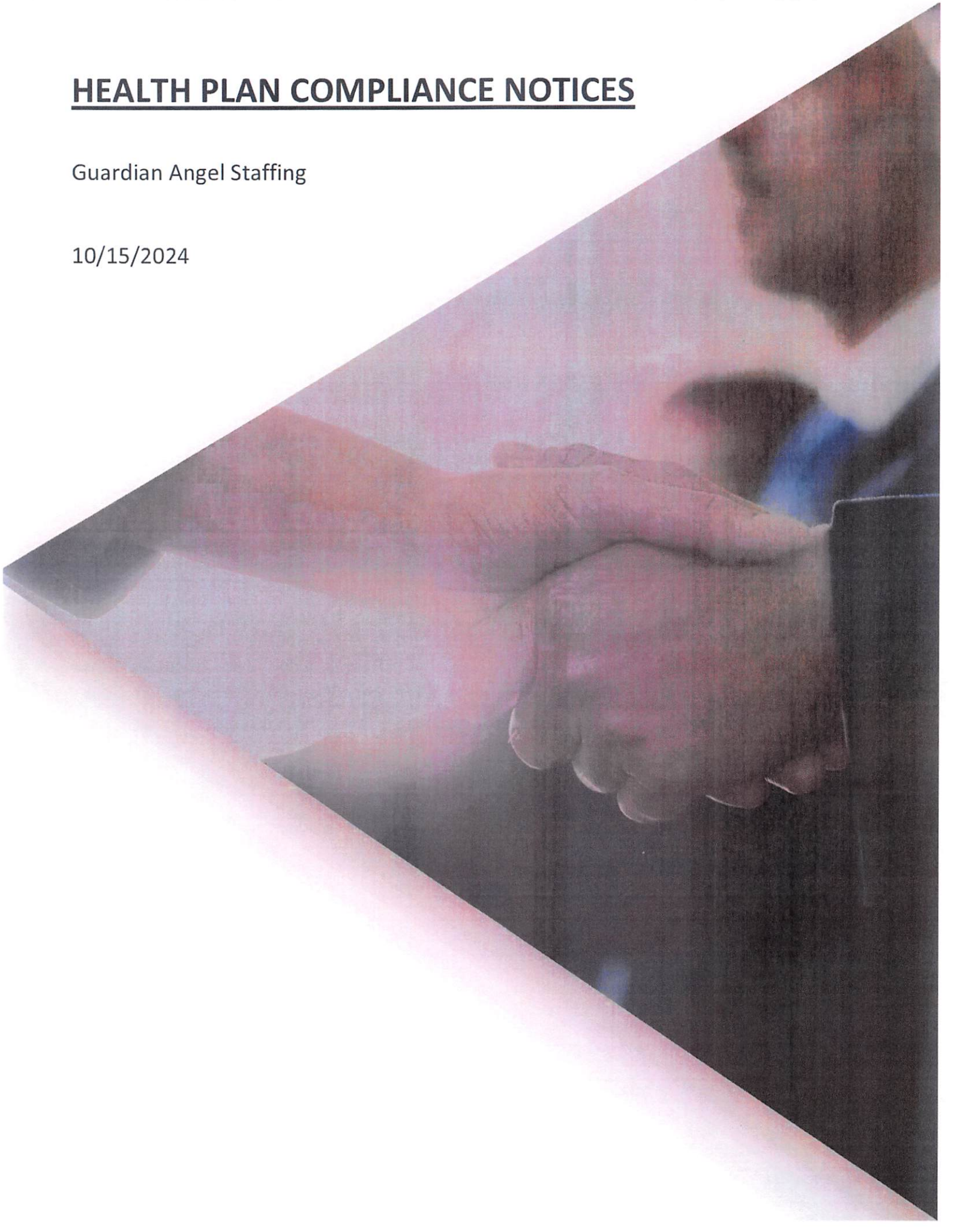

TABLE OF CONTENTS

ADA Notice Regarding Wellness Program

However, employees who choose to participate in the wellness program will receive an incentive of gift cards for obtain preventative healthcare.

. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Scott Langness at 2821 S Hurstbourne Pkwy, Suite 6, Louisville, Kentucky 40220, 5024951199 x , scott@guardianangelstaffing.com.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Guardian Angel Staffing may use aggregate information it collects to design a program based on identified health risks in the workplace, 2024 - 2025 Plan Year will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) The only individual(s) who will receive your personally identifiable health information is your provider in order to provide you with services under the wellness program in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact:

Scott Langness

2821 S Hurstbourne Pkwy

Louisville, Kentucky 40220

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

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

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

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

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

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, 2024. 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, 2024, or for more information on special enrollment rights, contact either:

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

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

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)

General Notice of COBRA Rights

(For use by single-employer group health plans)

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

- You become divorced or legally separated from your spouse.

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

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Guardian Angel Staffing, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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 to:

Scott Langness
2821 S Hurstbourne Pkwy
Louisville, Kentucky 40220

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying

event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of 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, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

2024 - 2025 Plan Year
Scott Langness
2821 S Hurstbourne Pkwy
Louisville, Kentucky 40220

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Health Insurance Exchange Notice

For Employers Who Offer a Health Plan to Some or All Employees

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

Scott Langness
2821 S Hurstbourne Pkwy
Louisville, Kentucky 40220

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Guardian Angel Staffing	4. Employer Identification Number (EIN) 611359667	
5. Employer address 2821 S Hurstbourne Pkwy	6. Employer phone number 5024951199	
7. City Louisville	8. State Kentucky	9. ZIP code 40220
10. Who can we contact about employee health coverage at this job? Scott Langness		
11. Phone number 5024951199	12. Email address scott@guardianangelstaffing.com	

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

- As your employer, we offer a health plan to:

☑ All employees

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are: spouse and children

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

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

Medicare Part D Creditable Coverage Notice

Important Notice from Guardian Angel Staffing 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 Guardian Angel Staffing and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Guardian Angel Staffing has determined that the prescription drug coverage offered by the 2024 -2025 Plan Year is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Guardian Angel Staffing coverage will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription drug coverage. If they select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage

If you do decide to join a Medicare drug plan and drop your current Guardian Angel Staffing coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Guardian Angel Staffing and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information call Scott Langness at 5024951199. 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 Guardian Angel Staffing changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 10/15/2024

Name of Entity/Sender: Guardian Angel Staffing

Contact--Position/Office: Scott Langness, President

Address: 2821 S Hurstbourne Pkwy Louisville, Kentucky 40220

Phone Number: 5024951199

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the 2024 - 2025 Plan Year with respect to mental health or substance use disorder benefits, please contact your plan administrator at 5024951199.

Newborns' and Mothers' Health Protection Act Notice

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

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in- network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

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

A new federal law, the No Surprises Act, protects you from: Surprise bills for covered emergency out-of-network services, including air ambulance services (but not ground ambulance services), and For more information go to: www.cms.gov/nosurprises

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

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

A new federal law, the No Surprises Act, protects you from: A facility (such as a hospital or freestanding emergency room (ER)) or a provider (such as a doctor) may not bill you more than your in-network coinsurance, copays, or deductibles for emergency services, even if the facility or provider is out-of-network For more information go to: www.cms.gov/nosurprises

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Help Desk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

Notice of Privacy Practices

Guardian Angel Staffing
2821 S Hurstbourne Pkwy
Louisville, Kentucky 40220

Privacy Official:
Scott Langness
2821 S Hurstbourne Pkwy
Louisville, Kentucky 40220

Effective Date: 12/01/2024

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:
  Scott Langness
  2821 S Hurstbourne Pkwy
  Louisville, Kentucky 40220
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and share your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Information

Notice of Special Enrollment Rights

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 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). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact:

Scott Langness

2821 S Hurstbourne Pkwy

Louisville, Kentucky 40220

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
    - Initial employment;
    - Reemployment;
    - Retention in employment;
    - Promotion; or
    - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm.*

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm.* Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Wellness Program Disclosure

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Please contact:

Scott Langness

2821 S Hurstbourne Pkwy

Louisville, Kentucky 40220

We will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $1500 deductible (in-network) and 80% coinsurance (in-network) and $4500 deductible (out-of-network) and 50% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at 5024951199.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 5024951199 for more information.

Receipt of Employee Benefits Guide & Federal Required Notices

I acknowledge that I have received a copy of the Benefits Guide, Federal & ACA Required Notices. I agree to read it thoroughly, including statements describing benefits and legal notices.

Notices: Exchange Notice Medicaid (CHIP), Women's Preventive Care, Newborns and Mothers Health Protection Act of 1996, COBRA, Qualified Medical Support Order and HIPPA.

I understand that this guide is designed to introduce employees to employee benefits and educate on mandated benefits options and provide general guidelines on benefit offerings, and other information related to employment.

I understand that this guide and any other provisions obtained in it do not constitute a guarantee of benefits, express or implied. Benefits eligibility is based on implied waiting period and contract provisions.

In addition, I understand that this guide states benefits in effect on the date of publication. I understand that nothing contained in the guide may be construed as promising future benefits or a binding contract with for benefits or for any other purpose. Benefit policies are applied at the discretion of your employer and the approval of insurance providers. Your employer reserves the right to change, withdraw, apply or amend any benefits and will provide ample notice to employees.

I understand that as an eligible employee, it's my responsibility to notify Human Resources in a timely manner if I'm newly eligible for benefits (new hire), experience a life change (within 30 days of event) or any other circumstance in which my benefits may be impacted. I understand that failure to provide required information/documentation may forfeit my enrollment period and future changes occur at open enrollment only.

By signing below:

- I understand that I have 14 days from the date signed below to enroll in Guardian Angel's offered insurance plan(s). Failure to complete and return my application(s) within the 14 day open enrollment period will constitute as my waiver of these offered insurance(s).

- I acknowledge that I have a copy of the Benefits Guide, Federal & ACA Required Notices, and I understand that it is my responsibility to read and comply with the policies contained within it and any revisions made to it.

- Furthermore, I acknowledge that this guide is neither a contract of benefits nor a legal document.

_____ _____

Signature Date

_____

Please print your full name