

GUARDIAN ANGEL STAFFING

SUMMARY PLAN DESCRIPTION (SPD)

EMPLOYEE'S COPY

(Distribute a Copy to Employees with all SBC's attached)

SUMMARY PLAN DESCRIPTION (SPD) FOR GUARDIAN ANGEL STAFFING

Introduction

GUARDIAN ANGEL STAFFING (The "Employer") maintains the **GUARDIAN ANGEL STAFFING - SMACC TRADE ASSOCIATION HEALTH BENEFIT PLAN(S)** ("the Plan") for the exclusive benefit of its eligible employees and their eligible dependents. Benefits under the Plan are currently provided under a group health insurance contract ("the Group Health Insurance Contract") entered into between the Employer and **ANTHEM INSURANCE COMPANIES, INC.** ("ANTHEM").

Plan benefits, including information about eligibility, are summarized in the Certificate of Coverage, and Summary of Benefits Coverage issued by ANTHEM, copies of which are available from your Human Resources Department, free of charge. These documents together with this document constitute the Summary Plan Description required by the federal law known as the Employee Retirement Income and Security Act ("ERISA"). Capitalized terms not otherwise defined in this document are defined in the Certificate of Coverage.

Health Savings Account (HSA) contributions are permitted under this Plan and may be established as a benefit by the Employer under rules established by the Employer. To the extent that HSAs are identified as a Benefit Option in the Plan Information Summary, you may be permitted to make contributions to an HSA, as defined in Code Section 223, in accordance with the terms of the HSA.

Specific Plan Information

Plan Name: **SMACC TRADE ASSOCIATION HEALTH BENEFIT PLAN(S) for GUARDIAN ANGEL STAFFING, L04976.**

Type of Plan: A group health benefit plan.

Plan Year: December 1 to November 30

Plan Number: 501

Employer / Plan Sponsor: **GUARDIAN ANGEL STAFFING
MR SCOTT LANGNESS
HUMAN RESOURCES CONTACT
2821 S HURSTBOURNE PKWY STE 6 SUITE 6
LOUISVILLE, KY 40220
EMAIL: SCOTT@GUARDIANANGELSTAFFING.COM
PHONE: 502-495-1199
FAX: 502-495-0053**

and

The Chamber of St. Matthews
C/o Benefic Admin Solutions, LLC
136 Breckenridge Lane, Suite 101
Louisville, KY 40207
Phone: (502) 365-9440
Fax: (502) 638-2481
Email: contact@beneficeusa.com

Plan Funding and
Type of Administration:

The Plan is fully insured. Benefits are provided under the Group Health Insurance Contract between the Employer and ANTHEM, and various carriers as reflected in the SBCs attached to this document. Claims for benefits are sent to ANTHEM, which is responsible for paying claims. BENEFIC and the Employer share responsibility for administering the Plan.

Insurance premiums for employees and their eligible dependents are paid in part by the Plan Sponsor out of its general assets, and in part by employees' payroll deductions.

Plan Sponsor's Employer
Identification Number:

61-1359967

Plan Administrator:

**GUARDIAN ANGEL STAFFING
MR SCOTT LANGNESS
HUMAN RESOURCES CONTACT
2821 S HURSTBOURNE PKWY STE 6 SUITE 6
LOUISVILLE, KY 40220
EMAIL: SCOTT@GUARDIANANGELSTAFFING.COM**

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136 Breckenridge Lane, Suite 101
Louisville, KY 40207
Phone: (502) 365-9440
Fax: (502) 638-2481
Email: contact@beneficeusa.com

Named Fiduciary:

GUARDIAN ANGEL STAFFING
MR SCOTT LANGNESS
HUMAN RESOURCES CONTACT
2821 S HURSTBOURNE PKWY STE 6 SUITE 6
LOUISVILLE, KY 40220
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136 Breckenridge Lane, Suite 101
Louisville, KY 40207
Phone: (502) 365-9440
Fax: (502) 638-2481
Email: contact@beneficeusa.com

Agent for Service of
Legal Process:

GUARDIAN ANGEL STAFFING
MR SCOTT LANGNESS
HUMAN RESOURCES CONTACT
2821 S HURSTBOURNE PKWY STE 6 SUITE 6
LOUISVILLE, KY 40220
EMAIL: SCOTT@GUARDIANANGELSTAFFING.COM
PHONE: 502-495-1199
FAX: 502-495-0053

and

The Chamber of St. Matthews
C/o Benefic Admin Solutions, LLC
Eric L. Crump, Director
136 Breckenridge Lane, Suite 101
Louisville, KY 40207
Phone: (502) 365-9440
Fax: (502) 638-2481
Email: contact@beneficeusa.com

Service of process may also be made on the Plan Administrator.

125 Start Date:

December 1

Effective Date of this Plan:

December 1

Employer's Type of Business:

Important Disclaimer:

Plan benefits are provided under a Group Health Insurance Contract between the Employer and ANTHEM (and other providers who's SBCs are attached). If the terms of this summary document conflict with the

terms of the Group Health Insurance Contract, the terms of the Group Health Insurance Contract will control, unless superseded by applicable law.

Benefits Provided Under the Plan

The following Benefit Plans and Policies subject to the terms and conditions of the Plan are available for election by eligible Employees. The maximum a Participant can contribute via the SRA is the maximum aggregate cost of the Benefit Plans or Policies elected minus any Nonelective Contribution made by the Employer. It is intended that such Pre-tax Contribution amounts shall, for tax purposes, constitute an Employer contribution, but may constitute Employee contributions for state insurance law purposes. Copies of the Benefit Plans or Policies (or a list of eligible Policy numbers) shall be attached as an appendix to this Plan.

Health Savings Account (HSA) contributions are permitted under this Plan and may be established as a benefit by the Employer under rules established by the Employer. To the extent that HSAs are identified as a Benefit Option in the Plan Information Summary, you may be permitted to make contributions to an HSA, as defined in Code Section 223, in accordance with the terms of the HSA

Contribution Summary

- ☒ Medical Coverage
- ☒ Vision Care Coverage
- ☐ Disability Income - Short Term (A&S)
- ☐ Cancer Insurance
- ☒ Group Dental Coverage
- ☐ Group Term Life Insurance
- ☐ Disability Income - Long Term (LTO)
- ☐ Intensive Care Insurance
- ☐ Accident Insurance
- ☐ Hospital Indemnity Insurance (HIP)
- ☐ Specified Health Event
- ☐ Personal Sickness Indemnity (PSI)
- ☐ Medical Care Expense Reimbursement described in Appendix I to this SPD, not to exceed \$ _____ per Plan Year pursuant to the _____ Medical Care Expense Reimbursement Plan.

Name and Address of Medical Care Expense Reimbursement Plan COBRA Administrator (if applicable):

- ☐ Dependent Care Expense Reimbursement described in Appendix I to this SPD, not to exceed \$5,000 per Plan Year or \$2,500 for married filing separate returns pursuant to the SHIELDS SERVICE Dependent Care Expense Reimbursement Plan.
- ☐ Health Savings Account (as defined in Code Section 223) established with the following Custodian/Trustee:

- ☐ opt-out Option: See Employer enrollment material.

The Funding Agent

The Employer selects the following Funding Agent for the Plan (check one):

- ☒ The Employer, which will comply with the requirements of Article VII of the Plan.
The BENEFIC Section 125 Plan Trust created concurrently with the execution of the Plan, which shall receive contributions under the Plan in accordance with Article VII of the Plan.

Administrative Expenses

Administrative Expenses incurred in operating the Plan shall be paid by (check one):

- ☒ The Employer, except as otherwise noted in the Plan.
- ☐ The Participants, except as otherwise noted in the Plan.

ID Cards

You will be issued an ID card after you enroll with ANTHEM. Please carry your Card with you and present it each time you receive care.

If you lose your ID card, you can request a new one by calling ANTHEM Member Services at: Phone: 1-800-870-2159; Fax: 800-844-6367; Anthem Blue Cross and Blue Shield, P.O. Box 659802, San Antonio, TX 78265-9102, or visit:
https://www.anthem.com/wps/portal/ahpemployernational?content_path=national/noapplication/f5/s5/t1/pw_ad083532.htm&state=na&label=How%20to%20Contact%20Member%20Services

Eligibility

You are eligible to participate in the Plan if you have been employed with the company more than 60 days.

An eligible Employee may become a Participant in the Plan:

- ☐ Immediately, upon the first day of employment (but not prior to the Effective Date of the Plan).
- ☐ On the day following commencement of employment.
- ☐ On the first day of the month following 180 days of employment.
- ☒ Other: **After 60 days of employment with Company.**
Provided the Employee completes a Salary Redirection Agreement ("SRA"). However, eligibility for coverage under any given Benefit Plan or Policy shall be determined by the terms of that Benefit Plan of Policy, and reductions of the Employee's Compensation to pay Pre-tax or After-tax Contribution(s) shall commence when the Employee becomes covered under the applicable Benefit Plan or Policy.

An eligible Employee may become a Participant in the Dependent Care and/or Medical Expense Reimbursement Plan(s) (if elected below):

- ☒ On the same day such Employee is eligible for the Pre-Tax Contribution benefits under the Plan.
- ☐ On the day following commencement of employment.
- ☐ On the first day of the month following days of employment.
- ☐ Other: OTHER, provided the Employee completes an SRA selecting such benefits.

To determine whether your spouse and dependent children are eligible to participate in the Plan, please read the eligibility information contained in the Certificate of Coverage issued by ANTHEM.

The Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are your natural children. Also eligible is any child covered under a Qualified Medical Child Support Order (QMCSO) as defined by applicable law and determined by your Employer under its QMCSO procedures, a copy of which is available from your Human Resources Department, free of charge.

If eligible, you must complete an application form to enroll in the Plan and ANTHEM (available from your Human Resources Department) or otherwise comply with your Employer's enrollment procedures.

Coverage will terminate if you no longer meet the eligibility requirements. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, etc. (See the Certificate of Coverage for more information.) Coverage for your spouse and dependents stops when your coverage stops. Their coverage will also stop for other reasons specified in the Certificate of Coverage.

Special Situations, Extension of Coverage

Family and Medical Leave Act (FMLA)

If the Family Medical Leave Act (FMLA) applies to your Employer and you qualify for an approved family or medical leave of absence (as defined in the FMLA), eligibility may continue for the duration of the leave if required contributions are paid toward the cost of the coverage. Your Employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your Employer will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, your Employer has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence, coverage for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible under the plan. Any waiting period for pre-existing conditions or other waiting periods will not apply. However, all accumulated annual and lifetime maximums will apply.

If you do not return to work at the end of an FMLA leave, you may be entitled to elect COBRA Continuation Coverage, even if you were not covered under the Plan during the leave. Coverage continued under this provision is in addition to coverage described below under the section entitled "Continuation Coverage (COBRA)."

The Plan intends to comply with all existing FMLA regulations. If for some reason the information presented differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

Military Leave Coverage

The Uniformed Services Employment and Reemployment Rights Act (USERRA) establishes requirements that employers must meet for certain employees who are involved in the uniformed services.

As used in this provision, "Uniformed Services" means:

- The Armed Forces;
- The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (pursuant to orders issued under federal law);
- The commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active-duty training;
- Inactive duty training;
- Full-time National Guard duty.
- A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;
- A period for which you are absent from your job for the purpose of performing certain funereal honors duty; and
- Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

If you were covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

- 1) You fail to make a premium payment within the required time;
- 2) You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or
- 3) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled "COBRA Continuation Coverage."

If your coverage under the Plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under this Plan is reinstated, all of the Plan's provisions and limitations will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. (For complete information regarding your rights under USERRA, contact your Employer.)

The Plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the plan in accordance with such actual regulations.

COBRA Continuation Coverage

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." The following are qualifying events:

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and/or your eligible dependents;
- A reduction in your hours. Coverage may continue for you and/or your eligible dependents;
- Your death. Coverage may continue for your eligible dependents;
- Your divorce or legal separation. Coverage may continue for your eligible dependents;
- Your becoming entitled to Medicare. Coverage may continue for your eligible dependents; and
- Your covered dependent child's ceasing to be a dependent child under the Plan. Coverage may continue for that dependent.

Note: To choose this continuation coverage, an individual must be covered under the Plan on the day before the qualifying event. In addition, your newborn child or child placed for adoption with you during a period of continuation coverage will remain eligible for continuation coverage for the remaining period of coverage even if you and/or your spouse terminate continuation coverage following the child's birth or placement for adoption.

Notification Requirements

Under the law, you or the applicable dependent has the responsibility to inform the Plan Administrator, in writing, within 60 days of a divorce or legal separation or of a child losing dependent status under the Plan. Failure to provide this written notification within 60 days will result in the loss of continuation coverage rights.

Your Employer has the responsibility to notify the Plan Administrator of your death, termination of employment, reduction in hours, or entitlement to Medicare within 30 days of the qualifying event.

Subject to the Plan Administrator being informed in a timely manner of the qualifying events described in the above paragraphs, the Plan will promptly notify you and other qualifying individual(s) of their continuation coverage rights. You and any applicable dependents must elect continuation coverage within 60 days after Plan coverage would otherwise end, or, if later, within 60 days of the notice of continuation coverage rights. Failure to elect continuation coverage within this 60-day period will result in loss of continuation coverage rights.

Trade Act of 2002

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, they you will be provided with an additional 60-day enrollment period, with continuation coverage beginning on the date of such TAA approval.

Notice of Unavailability of Continuation Coverage

If the Plan Administrator receives a notice of a qualifying event from you or your dependent and determines that the individual (you or your dependent) is not entitled to continuation coverage, the Plan Administrator will provide to the individual an explanation as to why the individual is not entitled to continuation coverage. This notice will be provided within the same time frame that the Plan Administrator would have provided the notice of right to elect continuation coverage.

Maximum Period of Continuation Coverage

The maximum period of continuation coverage is 36 months from the date of the qualifying event unless the qualifying event is your termination of employment or reduction in hours. In that case, the maximum period of continuation coverage is generally 18 months from the date of the qualifying event.

However, if a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of continuation coverage, continuation coverage for the qualifying individual and any non-disabled eligible dependents who are also entitled to continuation coverage may be extended to 29 months provided the qualifying individual or dependent, if applicable, notifies the Plan Administrator in writing within the 18-month continuation coverage period and within 60 days after receiving notification of determination of disability.

If a second qualifying event occurs (for example, your death or divorce) during the 18- or 29-month coverage period resulting from your termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first qualifying event but will be extended to the full 36 months if required by the subsequent qualifying event.

A special rule applies if the qualifying individual is your spouse or dependent child whose qualifying event was the termination or reduction in hours of your employment and you became entitled to Medicare within 18 months before such qualifying event. In that case, the qualifying individual's maximum period of continuation coverage is the longer of 36 months from the date of your Medicare entitlement or their otherwise applicable maximum period of coverage.

Cost of Continuation Coverage

The cost of continuation coverage is determined by the Employer and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102 percent of the Plan's cost of providing coverage. The cost of coverage during a period of extended continuation coverage due to a disability cannot exceed 150 percent of the Plan's cost of coverage.

Premium payments for continuation coverage for you or your eligible dependent's "initial premium month(s)" are due by the 45th day after electing continuation coverage. The "initial premium month(s)" are any month that ends on or before the 45th day after you or the qualifying individual elect's continuation coverage. All other premiums are due on the first of the month for which coverage is sought, subject to a 30-day grace period. Premium rates are established by your Employer and may change when necessary due to Plan modifications. The cost of continuation coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make the first payment within 45 days or any subsequent payment within 30 days of the established due date will result in the permanent cancellation of continuation coverage.

When Continuation Coverage Ends

Continuation of coverage ends on the earliest of:

1. The date the maximum continuation coverage period expires;
2. The date your Employer no longer offers a group health plan to any of its employees;
3. The first day for which timely payment is not made to the Plan;

4. The date the qualifying individual becomes covered by another group health plan. However, if the new plan contains an exclusion or limitation for a pre-existing condition of the qualifying individual, continuation coverage will end as of the date the exclusion or limitation no longer applies;
5. The date the qualifying individual becomes entitled to coverage under Medicare; and
6. The first day of the month that begins more than 30 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer disabled.

Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that all health insurance carriers that offer coverage in the individual market accept any eligible individuals who apply for coverage without imposing a pre-existing condition exclusion. In order to be eligible to apply for such coverage from a carrier after ceasing participation in the Plan, you or your eligible dependents must elect continuation coverage under the Plan, continue through the maximum continuation coverage period (18, 29, or 36 months, as applicable), and then apply for coverage with the individual insurance carrier before a 63-day lapse in coverage. For more information about your right to such individual insurance coverage, contact an independent insurance agent or your state insurance commissioner.

Notice of Termination Before Maximum Period of COBRA Coverage Expires

If continuation coverage for a qualifying individual terminates before the expiration of the maximum period of continuation coverage, the Plan Administrator will provide notice to the individual of the reason that the continuation coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the Plan Administrator's determination regarding termination of the continuation coverage.

The Plan intends to comply with all applicable law regarding continuation (COBRA) coverage. If for some reason the information presented in this Plan differs from actual COBRA requirements, the Plan reserves the right to administer COBRA in accordance with such actual COBRA requirements.

Summary of Plan Benefits

The Plan provides eligible employees and their eligible dependents with health insurance. These benefits are provided under the Group Health Insurance Contract with ANTHEM. A summary of the benefits provided under the Plan is in the Certificate of Coverage issued by ANTHEM.

The Plan, through the Group Health Insurance Contract, provides benefits in accordance with the applicable requirements of federal laws, such as Employee Retirement Income Security Act (ERISA), Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability Accountability Act (HIPAA), Newborns' and Mothers' Health Protection Act (NMHPA), Mental Health Parity Act (MHPA), and the Women's Health and Cancer Rights Act (WHCRA).

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discriminating among them.

The Plan is fully insured. Benefits are provided under the Group Health Insurance Contract entered into between the Employer and ANTHEM. Claims for benefits are sent to ANTHEM, and ANTHEM, not the Employer, is responsible for paying them. ANTHEM is also responsible for determining eligibility for and the amount of any benefits payable under the Plan and prescribing claims procedures and forms to be followed to receive Plan benefits. ANTHEM also has the discretionary authority to require participants to furnish it with such information as it determines is necessary for the proper administration of claims for Plan benefits.

Claims and Appeals.

ANTHEM is responsible for evaluating all benefit claims under the Plan. ANTHEM will decide your claim in accordance with its reasonable claim's procedures, as required by ERISA. If your claim is denied, you may appeal to ANTHEM for a review of the denied claim and ANTHEM will decide your appeal in accordance with its reasonable procedures, as required by ERISA. See the Certificate of Coverage for complete details regarding ANTHEM's claims and appeals procedures.

Amendment or Termination of the Plan

As Plan Sponsor, the Employer has the right to amend or terminate the Plan at any time. You have no vested or permanent rights or benefits under the Plan. Plan benefits will typically change from year-to-year and you should examine the SPD provided to you each year to determine the benefits of the Plan.

No Contract of Employment

The Plan is not intended to, and does not, either directly or indirectly constitute any form of employment contract or other employment arrangement between you and Employer.

Other Materials

The Certificate of Coverage (including the Member Payment Summary, and the Provider & Facility Directory) issued by BENEFIC are part of the Summary Plan Description. Please refer to these materials for other important provisions regarding your participation in the Plan.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

As a participant in the Plan (which is a type of employee welfare plan called a "group health plan") you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all group health plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, free of charge, from a group health plan or a health insurance issuer when you lose coverage under a group health plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**NOTICES REQUIRED UNDER THE
EMPLOYEE RETIREMENT INCOME SECURITY ACT
(ERISA), AND OTHER STATUTES**

HIPAA Special Enrollment Rights Notice

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides employees additional opportunities to enroll in a group health plan if they experience a loss of other coverage or certain life events.
- If you are declining coverage at this time for either yourself or your eligible dependents, you may be able to enroll yourself and/or your eligible dependents in coverage at a later date if there is a loss of other coverage. You must enroll and provide the required supporting documentation within 31 days of the date your other coverage ends.
- In addition, you may be able to enroll yourself and your eligible dependents if you have a qualifying life event (e.g., change in your marital status, birth or adoption of a child, death of dependent or change in employment status.) You must enroll and provide the applicable required supporting documentation within 31 days of the qualifying life event.
- For additional information regarding your rights under HIPAA, please visit the US Department of Labor website at the link below.
- http://www.dol.gov/ebsa/faqs/faq_consumer_hipaa.html

Newborn's and Mothers' Health Protection Act Notice

MATERNITY BENEFITS: Under Federal and state law you have certain rights and protections regarding your maternity benefits under the Plan. Under federal law known as the "Newborns' and Mothers' Health Protection Act of 1996" (Newborns' Act) group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Under Virginia State law, if your Plan provides benefits for obstetrical services your benefits will include coverage for postpartum services. Coverage will include benefits for inpatient care and a home visit or visits, which shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Coverage for obstetrical services as an inpatient in a general Hospital or obstetrical services by a Physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and Copayments that are no less favorable than for physical illness generally.

Women's Health and Cancer Rights 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 deductibles and coinsurance found in the attached SBC apply. If you would like more information on WHCRA benefits, call your plan administrator.

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

If you or your children are eligible for Medicaid or CHIP and you are 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 are not eligible for Medicaid or CHIP, you will not 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 are not 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, 2017. Contact your State for more information on eligibility.

INDIANA – Medicaid Website: <http://www.in.gov/fssa>; Phone: 1-800-889-9949

KENTUCKY – Medicaid Website: <http://chfs.ky.gov/dms/default.htm>; Phone: 1-800-635-2570

To see if any other states have added a premium assistance program since July 31, 2017, or for more information on special enrollment rights, contact either:

To see if any other states have added a premium assistance program since July 31, 2017, or for more information on special enrollment rights, contact either:

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

Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Important Notice from Your Employer 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 your employer 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Your Employer has determined that the prescription drug coverage offered by your health benefit plan is, on average for all plan participants, may NOT be expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage may be considered Non-Creditable Coverage. This is important because, most likely, you may get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from your Employer's health benefit plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from your employer. However, because your coverage might be non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 January 7th.

If you are losing creditable prescription drug coverage under the Plan, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under the Plan, may not be creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but did not join, if you go 63 continuous days or longer without prescription drug coverage that is creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 Employer's coverage might or might not be affected. See the Summary of Benefits Coverage attached at the end of this document to determine this or consult with your insurance agent or Human Resources department to determine the status of your coverage.

Guidance is also available at <http://www.cms.hhs.gov/CreditableCoverage/>, which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Employer coverage, be aware that you and your dependents might or might not be able to get this coverage back.

For More Information about This Notice or Your Current Prescription Drug Coverage...

Contact your Human Resources department with your employer for more information. NOTE: You will 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 your Employer 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 will 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).



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 December 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 does not meet certain standards. The savings on your premium that you are 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.¹⁶

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your company's insurance agent.

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.

EMPLOYER NAME: GUARDIAN ANGEL STAFFING	EMPLOYER FEIN: 61-1359967
EMPLOYER ADDRESS: 2821 S HURSTBOURNE PKWY STE 6 SUITE 6	EMPLOYER PHONE: 502-495-1199
CITY: LOUISVILLE	STATE: KY
ZIP: 40220	CONTACT ABOUT HEALTH COVERAGE: MR SCOTT LANGNESS HUMAN RESOURCES CONTACT
CONTACT PHONE: 502-495-1199	EMAIL: SCOTT@GUARDIANANGELSTAFFING.COM

¹⁶ 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.

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

- ☒ As your employer, we offer a health plan to some employees. Eligible employees are eligible after 60 days of employment.
- ☒ With respect to dependents we do offer coverage. Eligible dependents are: Defined in SBC (attached).
- ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here is the employer information you will enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

28. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

- ☒ **Yes (Continue)**
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____(mm/dd/yyyy) (Continue)
- ☐ **No (STOP and return this form to employee)**

14. Does the employer offer a health plan that meets the minimum value standard*?

- ☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* *offered only to the employee* (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and did not receive any other discounts based on wellness programs.

- a. How much would the employee have to pay in premiums for this plan? \$ _____
- b. How Often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you do not know, STOP and return form to employee.

16. What change will the employer make for the new plan year? _____

- ☐ Employer will not offer health coverage.
- ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
- a. How much would the employee have to pay in premiums for this plan? \$ _____
- b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

* 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

BENEFIC PRIVACY POLICIES

This Privacy Notice is given to you on behalf of one or more of BENEFIC ADMINISTRATIVE SOLUTIONS, LLC.

We are required by law to give you this notice. Please read it carefully. It describes in broad terms how we learn about you and members of your household who may be covered under your insurance with us (collectively "you") and how we treat the information we get about you. At BENEFIC, we respect your right to privacy. We treat all your personal information confidentially – before, during and even after your business relationship with us.

Why We Need Information: We need to know about you so that we can provide the insurance and other products and services you have asked for. When you first apply, we need information to determine if you qualify for coverage and at what rate. If you are insured with us, we may need information to conduct periodic reviews to make sure that you are still eligible for coverage, and that the rate charged is correct. We may also need it to administer your business with us, evaluate claims, process transactions, and run our business. What we need to know includes names of all members of your household, address, age, and other basic information. But we may need more information, such as employment, business conducted with us, with other BENEFIC companies (our "affiliates") or with other companies and information from consumer reports.

FOR PURPOSES OF ALL BENEFIC PRIVACY POLICIES AND DOCUMENTS IT IS UNDERSTOOD THAT BENEFIC'S ROLE IS LIMITED TO THAT OF PLAN ADMINISTRATOR AND NEITHER SMACC NOR BENEFIC, NOR ANY OF THEIR AGENTS OR AFFILIATES PROVIDE INSURANCE COVERAGE. ALL INSURANCE COVERAGE IS PROVIDED BY FULLY FUNDED AND LICENSED INSURERS AND THE INSURANCE CARRIER PROVIDING COVERAGE UNDER YOUR PLAN IS RESPONSIBLE FOR ALL CLAIMS PROCESSING, NOTIFICATION, AND OTHER INSURANCE COVERAGE RELATED MATTERS.

How We Get Information: What we know about you we get mostly from you. Your application and claims are important sources of information for us. But we may also have to find out more about you to make sure that what we know is correct and complete. Those sources may include adult relatives, our affiliates, unaffiliated insurers, consumer reporting agencies, and others. For example, we may ask another insurer for information about the insurance you have with them and the claims you have filed.

We may also ask a consumer reporting agency for a "consumer report" about you. Any consumer reporting agency that gathers information about you may share this information with others who are authorized to use consumer reports by the Federal Fair Credit Reporting Act or by state credit reporting acts. Consumer reports may tell us certain things about you including but not limited to:

Your driving record (e.g., Motor Vehicle Reports or MVR's), financial information (e.g., Credit Reports), your record of claims, or the condition and maintenance of your property.

Please see the Consumer Reports section below.

How We Protect What We Know: We treat what we know about you confidentially. Our employees are told to take care in handling your information. They may get information about you only when there is a good reason to do so. We take steps to make our computer data bases secure and to safeguard the information we have about you.

How We Use and Disclose What We Know about You: We may use what we know about you to help us serve you better and to ensure you are treated fairly. We are allowed by law to use it, and disclose it to our affiliates and others, for many purposes. For instance, we may use your information, and disclose it to others, in order to:

- Help us evaluate your request for a product or service from us or an affiliate.
- Help us process claims and other transactions.
- Confirm or correct what we know about you.
- Help us prevent fraud and other crimes.
- Help us run our business.
- To comply with applicable laws
- Process information for us
- Perform research for us.
- Audit our business.

We generally will not give information about you to third parties without your consent, unless otherwise permitted by law. When we do disclose information, we generally will disclose only what we consider reasonably necessary and no more. If necessary, to conduct our business, we may give information to:

- Our agents.
- Our affiliates, or
- Others who perform business services for us.

When we disclose information to others to perform business services for us, they must agree to protect this information. And they may use the information only for the purposes of performing those business services. Other reasons we may disclose what we know about you include:

- Doing what a court or government agency requires us to do; for example, complying with a search warrant or subpoena.
- Telling another company about you, if we may be selling any part of our business or merging with another company; or giving your information to someone pursuant to your written authorization.

We may use what we know about you in order to offer you our other products and services. We may also provide information to others outside of the BENEFIC companies, such as marketing companies, to help us offer our own products and services to you. If you do not qualify for coverage from the BENEFIC affiliate to which you applied, and you directed us to do so on your application, we may share information with an affiliated BENEFIC company that offers a similar policy for which you qualify. In addition, we can tell you about our affiliates and the products that they offer. To the extent permitted by law, we may also disclose information to your own Independent Insurance Agent or Broker.

Unless you tell us not to (see "Opt Out" Election below), we may disclose information to our affiliates so that they can offer their products and services directly to you - without your specific authorization or direction. Our affiliates include life, securities firms, broker-dealers, a bank, a legal plans company and financial advisors. In the future, we may have affiliates in other businesses. In addition, if we have joint marketing agreements with unaffiliated companies, we may give them information about you so that we can offer products jointly or so they can offer products and services endorsed or sponsored by us to you. But we will not share information for joint marketing if you tell us not to or if the law that applies to you does not allow it.

Even if you do not "opt out," we will not share your information with unaffiliated companies who may want to market their products directly to you, unless it is in connection with a joint marketing arrangement (as described above). For example, we will not sell or otherwise disclose your information to a catalog company.

"Opt Out" Election: You can tell us not to share your information to let our affiliates market their products directly to you or not to disclose your information to a third party in connection with a joint marketing arrangement. To make this election, please complete an "Opt Out" form and mail it to the address indicated on the form. If you are renewing your policy and have not received a form with this notice please see "You Can Get Other Information from Us" below. If you bought your BENEFIC insurance through an Independent Agent or certain of our BENEFIC Group Insurance Programs, you do not need to Opt Out. Our contract with your representative prohibits us from sharing your information for marketing purposes.

Email Opt-In

By providing a valid email address during your application process, you consent to receive details regarding your online quote and other marketing messages from us. BENEFIC protects your personal information, including your email address, to maintain its confidentiality. We will not sell, distribute, or share your personal information with a third party, other than in accordance with our privacy policy.

Consumer Reports: Consumer reporting agencies are independent and impartial. They provide information to others in the form of consumer reports. They do not make decisions related to the insurance you applied for or have with us.

If we deny or change your coverage based on information in a consumer report, we will tell you and provide the name and address of the consumer reporting agency to you. You may obtain a copy of your consumer report by contacting the consumer reporting agency directly. If you contact the consumer reporting agency within sixty (60) days of the denial, change or premium increase, the report will be furnished free of charge.

In a few cases, if you have authorized us to do so in connection with your application, we may ask a consumer reporting agency to provide us with an "investigative" consumer report - which means they will ask others about you. This type of report is described in more detail on the application or related materials given to you with the application. In this case, we will ask the agency to contact you as well. The information collected may be kept by the agency and later given to others, as permitted by law.

You Can See and Correct Your Information: Generally, we will let you review what we know about you if you ask us in writing. (Because of its legal sensitivity, we will not show you anything that we learned in connection with a claim or lawsuit.) If you tell us that what we know about you is incorrect, we will review it. If we agree with you, we will correct our records. If we do not agree with you, you may tell us in writing, and we will include your statement when we give your information to anyone outside BENEFIC. It will also be sent to anyone that you designate who may have received such information in the past two years, or as otherwise required by law.

You Can Get Other Information from Us: In addition to any other privacy notice we may give you; we must give you a summary of our privacy policy once each year. You may have other rights under the law. If you want to know more about our privacy policy, please contact us through our Ask a Privacy Policy Question form or call us at the number indicated in your Customer and Service Claim Directory which you received at the time you purchased or renewed your policy with us.

BENEFIC HIPAA Notice of Privacy Practices for Protected Health Information

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.

Dear BENEFIC Customer:

This is your Health Information Privacy Notice from BENEFIC or a member of the BENEFIC ADMINISTRATIVE SOLUTIONS, LLC, family of companies, (collectively, "BENEFIC"). Please read it carefully. You have received this notice because of your Health coverage with us that is administered by either St. Mathews Area Chamber of Commerce, or Your Employer (your "Coverage"). BENEFIC strongly believes in protecting the confidentiality and security of information we collect about you. This notice refers to BENEFIC by using the terms "us," "we," or "our." FOR PURPOSES OF ALL BENEFIC PRIVACY POLICIES AND DOCUMENTS IT IS UNDERSTOOD THAT BENEFIC'S ROLE IS LIMITED TO THAT OF PLAN ADMINISTRATOR AND NEITHER SMACC NOR BENEFIC, NOR ANY OF THEIR AGENTS OR AFFILIATES PROVIDE INSURANCE COVERAGE. ALL INSURANCE COVERAGE IS PROVIDED BY FULLY FUNDED AND LICENSED INSURERS AND THE INSURANCE CARRIER PROVIDING COVERAGE UNDER YOUR PLAN IS RESPONSIBLE FOR ALL CLAIMS PROCESSING, NOTIFICATION, AND OTHER INSURANCE COVERAGE RELATED MATTERS.

This notice describes how we protect the personal health information we have about you which relates to your BENEFIC Coverage ("Protected Health Information" or "PHI"), and how we may use and disclose this information. PHI includes individually identifiable information which relates to your past, present or future health, treatment, or payment for health care services.

This notice also describes your rights with respect to the PHI and how you can exercise those rights. We are required to provide this notice to you by the Health Insurance Portability and Accountability Act ("HIPAA"). For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please see the privacy notices contained at our website, www.BENEFICUSA.com. You may submit questions to us there or you may write to us directly at: contact@beneficusa.com - Benefic Administrative Solutions, LLC, 136 Breckenridge Lane, Suite 101, Louisville, KY 40207, Phone: (502) 365-9440, Fax: (502) 638-2481.

NOTICE SUMMARY

The following is a brief summary of the topics covered in this HIPAA notice. Please refer to the full notice below for details.

As allowed by law, we may use and disclose PHI to:

- make, receive, or collect payments;
- conduct health care operations;
- administer benefits by sharing PHI with affiliates and Business Associates;
- assist plan sponsors in administering their plans; and
- inform persons who may be involved in or paying for another's health care.

In addition, we may use or disclose PHI:

- Where required by law or for public health activities;
- To avert a serious threat to health or safety;
- For health-related benefits or services;
- For law enforcement or specific government functions;
- When requested as part of a regulatory or legal proceeding; and
- To provide information about deceased persons to coroners, medical examiners, or funeral directors.

You have the right to:

- receive a copy of this notice;
- inspect and copy your PHI, or receive a copy of your PHI;
- amend your PHI if you believe the information is incorrect;
- obtain a list of disclosures we made about you (except for treatment, payment, or health care operations);
- ask us to restrict the information we share for treatment, payment, or health care operations;
- request that we communicate with you in a confidential manner; and
- complain to us or the U.S. Department of Health and Human Services if you believe your privacy rights have been violated.

We are required by law to:

- maintain the privacy of PHI;
- provide this notice of our legal duties and privacy practices with respect to PHI;
- notify affected individuals following a breach of unsecured PHI; and
- follow the terms of this notice.

NOTICE DETAILS

We protect your PHI from inappropriate use or disclosure. Our employees, and those of companies that help us service your BENEFIC Coverage, are required to comply with our requirements that protect the confidentiality of PHI. They may look at your PHI only when there is an appropriate reason to do so, such as to administer our products or services.

We will not use or disclose PHI that is genetic information for underwriting purposes. For example, we will not use information from a genetic test (such as DNA or RNA analysis) of an individual or an individual's family members to determine eligibility, premiums, or contribution amounts under your Coverage.

We will not sell or disclose your PHI to any other company for their use in marketing their products to you. However, as described below, we will use and disclose PHI about you for business purposes relating to your Coverage. The main reasons we may use and disclose your PHI are to evaluate and process any requests for coverage and claims for benefits you may make or in connection with other health-related benefits or services that may be of interest to you. The following describe these and other uses and disclosures.

- **For Payment:** We may use and disclose PHI to pay benefits under your Coverage. For example, we may review PHI contained in claims to reimburse providers for services rendered. We may also disclose PHI to other insurance carriers to coordinate benefits with respect to a particular claim. Additionally, we may disclose PHI to a health plan or an administrator of an employee welfare benefit plan for various payment related functions, such as eligibility determination, audit, and review, or to assist you with your inquiries or disputes.
- **For Health Care Operations:** We may also use and disclose PHI for our insurance operations. These purposes include evaluating a request for our products or services, administering those products or services, and processing transactions requested by you.
- **To Affiliates and Business Associates:** We may disclose PHI to Affiliates and to business associates outside of the BENEFIC family of companies if they need to receive PHI to provide a service to us and will agree to abide by specific HIPAA rules relating to the protection of PHI. Examples of business associates are billing companies, data processing companies, companies that provide general administrative services, health information organizations, e-prescribing gateways, or personal health record vendors that provide services to covered entities. PHI may be disclosed to reinsurers for underwriting, audit or claim review reasons. PHI may also be disclosed as part of a potential merger or acquisition involving our business in order that the parties to the transaction may make an informed business decision.
- **To Plan Sponsors:** We may disclose summary health information such as claims history or claims expenses to a plan sponsor to enable it to obtain premium bids from health plans, or to modify, amend or terminate a group health plan. We may also disclose PHI to a plan sponsor to help administer its plan if the plan sponsor agrees to restrict its use and disclosure of PHI in accordance with federal law.
- **To Individuals Involved in Your Care:** We may disclose your PHI to a family member or other individual who is involved in your health care or payment of your health care. For example, we may disclose PHI to a covered family member whom you have authorized to contact us regarding payment of a claim.
- **Where Required by Law or for Public Health Activities:** We disclose PHI when required by federal, state, or local law. Examples of such mandatory disclosures include notifying state or local health authorities regarding particular communicable diseases or providing PHI to a governmental agency or regulator with health care oversight responsibilities.
- **To Avert a Serious Threat to Health or Safety:** We may disclose PHI to avert a serious threat to someone's health or safety. We may also disclose PHI to federal, state, or local agencies engaged in disaster relief, as well as to private disaster relief or disaster assistance agencies to allow such entities to carry out their responsibilities in specific disaster situations.
- **For Health-Related Benefits or Services:** We may use your PHI to provide you with information about benefits available to you under your current coverage or policy and, in limited situations, about health-related products or services that may be of interest to you.

However, we will not send marketing communications to you in exchange for financial remuneration from a third party without your authorization.

- **For Law Enforcement or Specific Government Functions:** We may disclose PHI in response to a request by a law enforcement official made through a court order, subpoena, warrant, summons, or similar process. We may disclose PHI about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **When Requested as Part of a Regulatory or Legal Proceeding:** If you or your estate are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process, but only if efforts have been made to tell you about the request or to obtain an order protecting the PHI requested. We may disclose PHI to any governmental agency or regulator with whom you have filed a complaint or as part of a regulatory agency examination.
- **PHI about Deceased Individuals:** We may release PHI to a coroner or medical examiner to assist in identifying a deceased individual or to determine the cause of death. In addition, we may disclose a deceased's person's PHI to a family member or individual involved in the care or payment for care of the deceased person unless doing so is inconsistent with any prior expressed preference of the deceased person which is known to us.
- **Other Uses of PHI:** Other uses and disclosures of PHI not covered by this notice and permitted by the laws that apply to us will be made only with your written authorization or that of your legal representative. If we are authorized to use or disclose PHI about you, you or your legally authorized representative may revoke that authorization in writing at any time, except to the extent that we have acted relying on the authorization or if the authorization was obtained as a condition of obtaining your Coverage. You should understand that we will not be able to take back any disclosures we have already made with authorization.

Your Rights Regarding Protected Health Information That We Maintain About You

The following are your various rights as a consumer under HIPAA concerning your PHI. Should you have questions about or wish to exercise a specific right, please contact us in writing at the applicable Contact Address listed on the last page.

- **Right to Inspect and Copy Your PHI:** In most cases, you have the right to inspect and obtain a copy of the PHI that we maintain about you. If we maintain the requested PHI electronically, you may ask us to provide you with the PHI in electronic format, if readily producible; or, if not, in a readable electronic form and format agreed to by you and us. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing, electronic media, or other supplies associated with your request. You may also direct us to send the PHI you have requested to another person designated by you, so long as your request is in writing and clearly identifies the designated individual. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes or PHI collected by us in connection with, or in reasonable anticipation of, any claim or legal proceeding. In very limited circumstances, we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.
- **Right to Amend Your PHI:** If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must specify the reason for your request. We may deny your request if it is not in writing or does not include a reason that supports the request.

In addition, we may deny your request if you ask us to amend PHI that:

- is accurate and complete;
- was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment;
- is not part of the PHI kept by or for us; or
- is not part of the PHI which you would be permitted to inspect and copy.

- **Right to a List of Disclosures:** You have the right to request a list of the disclosures we have made of your PHI. This list will not include disclosures made for treatment, payment, health care operations, purposes of national security, to law enforcement, to corrections personnel, pursuant to your authorization, or directly to you. To request this list, you must submit your request in writing. Your request must state the time period for which you want to receive a list of disclosures. You may only request an accounting of disclosures for a period of time less than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be free. We may charge you for responding to any additional requests. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before you incur any cost.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on PHI we use or disclose about you for treatment, payment, or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, we are not required to agree to it. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing and specify how or where you wish to be contacted. We will accommodate all reasonable requests.
- **Contact Addresses:** If you have any questions about a specific individual right or you want to exercise one of your individual rights, please submit your request in writing to the address below which applies to your Coverage:

BENEFIC ADMINISTRATIVE SOLUTIONS, LLC
 Attention: HIPAA Privacy Officer
 136 Breckenridge Lane
 Suite 101
 Louisville, KY 40207

- **Right to File a Complaint:** If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, please contact BENEFIC ADMINISTRATIVE SOLUTIONS, LLC – U.S. HIPAA Privacy Office, 136 Breckenridge Lane, Suite 101, Louisville, KY 40207. All complaints must be submitted in writing.

You will not be penalized for filing a complaint. If you have questions as to how to file a complaint, please contact us at telephone number: (502) 365-9440, or by fax at: (502) 638-2481, or by email at contact@beneficusa.com.

ADDITIONAL INFORMATION

Changes to This Notice: We reserve the right to change the terms of this notice at any time. We reserve the right to make the revised or changed notice effective for PHI we already have about you, as well as any PHI we receive in the future. The effective date of this notice and any revised or changed notice may be found on the last page, on the bottom right-hand corner of the notice.

You will receive a copy of any revised notice from BENEFIC by mail or by e-mail, if e-mail delivery is offered by BENEFIC and you agree to such delivery. Further Information: You may have additional rights under other applicable laws. For additional information regarding our HIPAA Medical Information Privacy Policy or our general privacy policies, please e-mail us at contact@beneficusa.com or call us at telephone number: (502) 365-9440, or by fax at: (502) 638-2481, or write us at: BENEFIC ADMINISTRATIVE SOLUTIONS, LLC, Attention: HIPAA Privacy Officer, 136 Breckenridge Lane, Suite 101, Louisville, KY 40207, Louisville, KY 40202

If you have questions relating to Coverage administered by one of the non- BENEFIC entities above, please contact the administrator directly at the listed address.

OPTING OUT OF INFORMATION SHARING FORM
(Optional for Employee)

Federal law gives you the right to limit how we share your personal information for marketing purposes among BENEFIC's family of companies. "Personal information" includes information about your income, account history, or credit worthiness. By opting out, you are instructing BENEFIC not to share your personal information with their affiliates — or unaffiliated business partners as part of a joint marketing arrangement — for marketing purposes. If your BENEFIC policy or account is jointly owned with one or more other people, you can opt out for one or all of them. Even if you opt out, however, any BENEFIC company fortunate enough to have you as a customer may continue to send you information about products or services offered by any of our affiliated or unaffiliated companies. Your agent may also continue to tell you about other products or services that may help you achieve your financial goals. We will honor your opt out choice until you instruct us to change it. So, if you already opted out, you do not need to act again. To submit an "opt out" request for yourself, please complete this information:

Name: _____ Date of Birth: _____
Company: GUARDIAN ANGEL STAFFING
Last four digits of social security number: _____ Account or Policy Number(s): L04976
Current Address: _____

Select your preferences:

_____ I do not want my BENEFIC policy/account provider to share information about me with other BENEFIC affiliates to market their own products to me.

_____ I do not want BENEFIC to share information about me with companies with whom it has joint marketing arrangements for those companies to market their own products to me.

If your policy or account is jointly owned, and you want to opt out for one or all of the joint owners, please provide the following information for the Joint Owner(s).

Name: _____ Date of Birth: _____
Last four digits of social security number: _____ Account or Policy Number(s): _____
Current Address: _____

Name: _____ Date of Birth: _____
Last four digits of social security number: _____ Account or Policy Number(s): _____
Current Address: _____

Mail completed form to: BENEFIC Customer Privacy Department by fax to (502) 540-9957 or by mail to BENEFIC ADMINISTRATIVE SOLUTIONS, 136 Breckenridge Lane, Suite 101, Louisville, KY 40207.

**ATTACHMENT I – SUMMARY ANNUAL REPORT FOR FORM
5500 FILED BEFORE 7/15/26 ON BEHALF OF THE HEALTH
INSURANCE PROGRAM**

**DISTRIBUTED TO EMPLOYEES WITH
SUMMARY PLAN DESCRIPTIONS**

SUMMARY ANNUAL REPORT SMACC TRADE ASSOCIATION BENEFIT PLAN(S)

This is a summary of the annual report of the SMACC TRADE ASSOCIATION BENEFIT PLAN(S); FEIN: 61-1036073; Health Insurance Benefit Plan for the 2025 calendar year. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

ALL BENEFITS PROVIDED UNDER THIS PLAN ARE FULLY INSURED BY INDEPENDENT INSURANCE CARRIERS

THE PLAN SPONSOR IS NOT RESPONSIBLE FOR PAYING ANY CLAIMS INCURRED UNDER THE TERMS OF ITS FULLY INSURED HEALTH BENEFIT PLANS

ALL EXPENSES AND PREMIUMS PAID THROUGH THESE SPONSORED PLANS ARE BILLED DIRECTLY TO PARTICIPATING EMPLOYERS AND NO EMPLOYEE/EMPLOYER FUNDS ARE COLLECTED AND/OR RETAINED BY THE PLAN SPONSOR

Insurance Information

The plan has (a) contract(s) with ANTHEM HEALTH PLANS OF KENTUCKY to pay certain HEALTH INSURANCE CLAIMS incurred under the terms of the plan. The total premiums paid for the plan year ending 12/01/2025 were \$39,073,416.00.

Because it is a so called "experience-rated" contract, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 12/31/2025, the premiums paid under such "experience-rated" contract(s) were \$39,073,416.00 and the total of all benefit claims paid under the(se) experience-rated contract(s) during the plan year was not provided by the carrier on the Schedule A provided to the Plan Sponsor.

NO FUNDS ARE RETAINED IN TRUST BY THE PLAN SPONSOR.

Basic financial statement

The value of plan assets, after subtracting liabilities of the plan, was \$0.00 as of 12/31/2025, compared to \$0.00 as of 12/31/2024. During the plan year the plan experienced no increase or decrease in its net assets of \$0.00. This amount includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of \$0.00 including employer contributions of \$0.00, employee contributions of \$0.00, realized no gains or losses from the sale of assets (none held), and earnings from investments of \$0.00 (none held). Plan expenses were \$39,073,416.00. These expenses included \$39,073,416.00 (premiums reported by carrier billed directly to participating employers) in benefits paid to participants and beneficiaries, minus \$369,098.00 in administrative expenses, and \$1,904,301.00 in other expenses. All Expenses of the program were covered and included into premiums paid directly to Anthem in the course of the year, and no additional assets aside from said premiums have been collected and/or distributed.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. insurance information including sales commissions paid by insurance carriers; and
2. information regarding any common or collective trusts, pooled separate accounts, master trusts.

To obtain a copy of the full annual report, or any part thereof, write or call the office of BENEFIC ADMINISTRATIVE SOLUTIONS LLC, who is the plan administrator, 136 BRECKENRIDGE LANE 101 LOUISVILLE KY 4020, 502-540-9958. The charge to cover copying costs will be \$6.25 for the full annual report, or \$.25 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (136 BRECKENRIDGE LANE LOUISVILLE KY 40207), (at any other location where the report is available for examination), and at the U.S. Department of Labor in Washington, D.C. or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N-1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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 less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)

ATTACHMENT II - SUMMARY OF BENEFITS AND COVERAGE

*(Prepared by your insurance company; contact your employer or your insurance agent to get
the current SBC for your specific plan.)*

A late enrollment penalty on individuals who do not maintain creditable coverage for 63 days or longer following their initial enrollment period for the Medicare prescription drug benefit may apply. This information is essential to an individual's decision to enroll in a Medicare Part D prescription drug plan. You can view a sample letter at cms.hhs.gov/creditablecoverage.

Creditable prescription plans ensure that when a Medicare-eligible individual pays for prescription medication, the costs are the same or less than what Medicare covers.

A noncreditable prescription plan means that drugs cost more, on average, than what Medicare's plan covers.

You should notify Medicare-eligible members about their coverage:

- Before their initial enrollment period for Part D.
- Before the annual coordinated election period each year, which begins October 15.
- Before the effective enrollment date in the plan.
- Every time a change impacts a plan's creditable status.
- Upon request from the beneficiary.

You must send a *Notice of Non-Creditable Coverage* every year to let Medicare-eligible individuals know if their current prescription drug benefit is noncreditable coverage. You need to do this yearly for all Medicare-eligible active employees and their dependents, Medicare-eligible COBRA individuals and their dependents, Medicare-eligible disabled individuals covered under the prescription drug plan, and any retirees and their dependents.

This information must also be recorded with the Centers for Medicare & Medicaid Services (CMS). Go to cms.hhs.gov/creditablecoverage and complete the [Disclosure to CMS Form](#) unless your organization is exempt, as outlined in the disclosure to CMS guidance. For details about creditable coverage and forms you need, visit cms.hhs.gov/creditablecoverage.

The prescription drug benefit included in all of the 2027 Kentucky Large Group (51 – 99) are considered “creditable.”

If you have questions about creditable and noncreditable coverage, please contact your Anthem representative.

