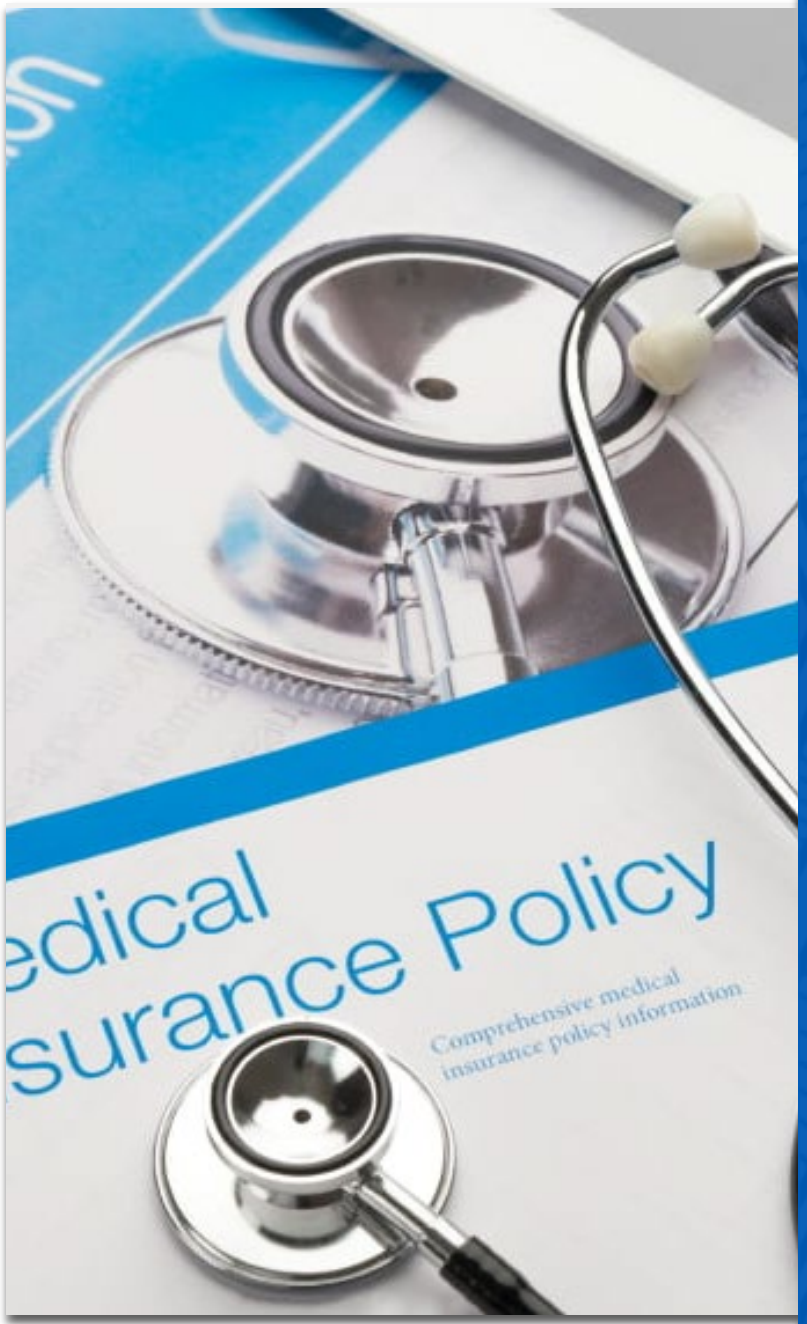

EMPLOYEE BENEFITS GUIDE

Benefits for January 1, 2024 – December 31, 2024

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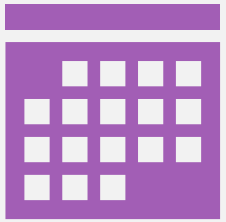


Time Off

PTO, Holidays, Floating Fridays, Day of Service, Leave

CIEE offers full-time team members at least 16 paid holidays each year:

- **New Year's Day**
- **MLK Jr. Day**
- **President's Day**
- **Memorial Day**
- **Juneteenth**
- **Independence Day**
- **Labor Day**
- **Indigenous People's Day**
- **Thanksgiving (Wed – Fri)**
- **December Holiday – typically five days**

Time Off

In addition to the holidays regular full-time employees are eligible for Floating Fridays as follows:

- 2 Winter Fridays taken between January 1st and May 31st
- 4 Summer Fridays taken between May 15th and September 15th

Regular full-time employees are eligible to accrue PTO to be used for vacation, illness, or other personal reasons. PTO is accrued bi-weekly based on the following schedule for regular full-time employees:

Annualized Vacation Time

- <2 years: 10 days per year
- 2-5 years: 15 days per year
- 5+ years: 20 days per year

Annualized Personal/Sick Time

- 7 days per year

***Any unused time off is not carried over into the next calendar year. Unused time will be forfeited unless prohibited by state law.**

Leave of Absence

CIEE provides various types of leaves which include:

- Parental Care Leave
- Family Medical Leave (FMLA)
- Personal Leave
- Military Leave
- Bereavement Leave

- Documentation and prior authorization are required
- Length of leave is based on meeting eligibility requirements and applicable state laws
- Contact HR Benefits for additional information: **HRBenefits@ciee.org**

Core Benefits

Medical, dental, vision, health savings account (HSA)

Eligibility

As a CIEE employee, you are eligible for benefits if you work at least 30 hours per week. Benefits are effective on the first day of the month following your date of hire. You may enroll your eligible dependents for coverage once you are eligible.

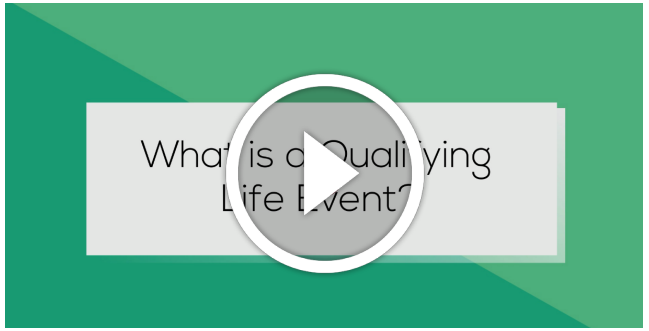
Your eligible dependents include:

- Your legal spouse
- Your domestic partner
- Your children up to the age of 26 (Children will be covered until the last day of the month in which they turn 26)

Once your benefit elections become effective, they remain in effect until December 31. You may only change your benefits within 30 days of a qualified life event. New hires and rehires have 30 days to enroll in benefits. **If you have a qualifying life event, contact ADP MyLife Advisors to make the applicable change to your benefits.**

This guide is a brief summary of benefits offered to your group and does not constitute a policy. CIEE reserves to itself, pursuant to its sole and exclusive discretion, the right to change, amend or terminate the benefits program at any time. The insurance companies' plan descriptions will contain the actual detailed provisions of your benefits. If there are any discrepancies between the information in the guide and the insurance companies' plan descriptions, the language in the insurance companies' plan descriptions will always prevail.

You can find detailed information on all of our programs by visiting the company HR website.



If you have a qualifying life event, contact ADP MyLife Advisors to make the applicable change to your benefits.

mylifeadvisor@adp.com
1-855-547-8508

Medical Plan Options

OPEN ACCESS PLUS PPO		
	In-Network	Out-of-Network
Deductible	$500 member / $1,500 family	$1,000 member / $3,000 family
Out-of-Pocket Max	$2,250 member / $4,500 family	$6,000 member / $11,000 family
Routine Physical	Covered at 100%	Covered at 100%
PCP Office Visit	$5 copay (tiered) / $25 copay (non-tiered)	Not covered (tiered) / 40% after deductible (non-tiered)
Specialist Visit	$20 copay (tiered) / $40 copay (non-tiered)	Not covered (tiered) / 40% after deductible (non-tiered)
Emergency Room Visit	$150 copay	$150 copay
Diagnostic Lab/X-Ray	20% after deductible	40% after deductible
Imaging	20% after deductible	40% after deductible
Inpatient Care	20% after deductible	40% after deductible
Outpatient Care	20% after deductible	40% after deductible
Prescriptions (30-day retail / 90-day mail-order)		
Generic	$10 / $20	Not covered
Preferred brand	$30 / $40	Not covered
Non-Preferred Brand	$50 / $150	Not covered
Specialty	$150 / $300	Not covered
Rx Out-of-Pocket Max	$3,000 member / $9,000 family	N/A

Cigna

*Services from out-of-network providers may be subject to balance billing (member would be responsible for any difference between the allowance and the provider's actual charge).

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Medical Plan Options

CONSUMER DRIVEN HEALTH PLAN (CDHP)		
	In-Network	Out-of-Network
Deductible	$1,600 member / $3,200 family	$3,000 member / $6,000 family
Out-of-Pocket Max	$6,150 member / $13,500 family	$12,300 member / $27,000 family
Routine Physical	Covered at 100%	Covered at 100%
PCP Office Visit	20% coinsurance	40% after deductible
Specialist Visit	20% coinsurance	40% after deductible
Emergency Room Visit	20% coinsurance	20% after deductible
Diagnostic Lab/X-Ray	20% coinsurance	40% after deductible
Imaging	20% coinsurance	40% after deductible
Inpatient Care	20% coinsurance	40% after deductible
Outpatient Care	20% coinsurance	40% after deductible
Prescriptions (30-day retail / 90-day mail-order)		
Generic	20% after deductible / 20% after deductible	40% after deductible / 40% after deductible
Preferred brand	20% after deductible / 20% after deductible	40% after deductible / 40% after deductible
Non-Preferred Brand	20% after deductible / 20% after deductible	40% after deductible / 40% after deductible
Specialty	20% after deductible / 20% after deductible	40% after deductible / 40% after deductible
Rx Out-of-Pocket Max	Combined with medical	Combined with medical

Cigna

*Services from out-of-network providers may be subject to balance billing (member would be responsible for any difference between the allowance and the provider's actual charge).

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Get the most out of your medical plan by using all of the free resources Cigna offers to members

- One-Guide Customer Service
  - Get one-on –one support you need to take control of your health – and your health spending. You can call one guide customer service for health coaching, specialized support, or cost saving guidance.
- Telehealth
  - See a doctor 24/7 with virtual care services. Employees will usually get an appointment in an hour or less, anytime, day or night.
- Secure (safe) Travel
  - Provides pre-trip planning, assistance while traveling, and unlimited medical evacuation and repatriation benefits when traveling 100 miles or more from home.
- Cigna Healthy Rewards
  - Use your Cigna ID Wallet when you pay and let the savings begin! Save on items like: Nutritional Meal Delivery Services, Vision Care, Lasik Surgery, Alternative Medicine and More!
- myCigna Mobile App
  - Track claims and benefits, check deductible balances, find a doctor, view your prescriptions, and complete reimbursement forms for Fitness and Weight Loss.
- My Secure Advantage
  - 30 Days pre-paid money-coaching for all types of financial planning and challenges; includes identity theft and fraud resolution services, and online tools for state specific wills and other important legal documents.

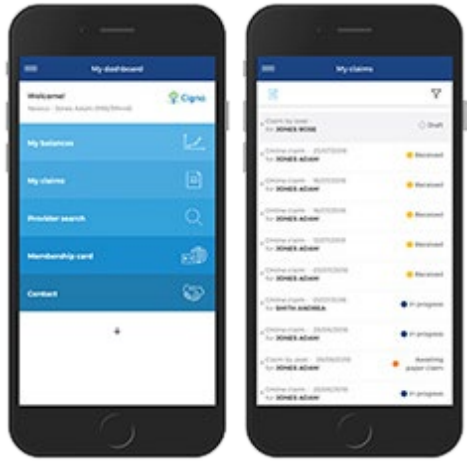
Cigna Extras

Cigna Member App

- track claims & benefits
- check deductible balances
- find a doctor
- track your medications
- view your member ID card
- contact member services

visit the Cigna website to learn more

scan to download



member login | support | learn more

Cigna

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Medical Plan Education

Know Where to Go

Learn how you can save money for the same care by choosing the right facility

Click here to learn where to go

Staying In Network

You will almost always save money by getting your care in-network

Click here to learn more

Learn the Lingo

Insurance terminology can be confusing, so you may want to brush up on definitions

Click here to browse some common healthcare definitions

Health Savings Account (HSA)

Max Annual Contribution

Individuals: $4,150 Families: $8,300

Employees age 55+ may contribution an additional $1,000 annually

Eligible Expenses

Medical, dental, and vision expenses. View the full list here.

How to Use Funds

Use your debit card at the point of sale or submit receipts for reimbursement through the member portal

Account Owner

You own this account. The funds remain there until you use or invest them, and the account is portable should you leave CIEE

HSA Eligibility

- You must be enrolled in the CDHP medical plan
- You cannot be enrolled in another medical plan
- You cannot be enrolled in Medicare or Medicaid
- You cannot be claimed as a dependent on another person's tax return
- You cannot be enrolled in a general-purpose healthcare FSA plan (including through a spouse)

hsabank

How the HSA Works

1 Money Goes In

CIEE gives all HSA enrollees an annual contribution towards their HSA plans: $500 to individuals, $1,000 to family. CIEE contributions are made bi-annually and prorated for employees hired during the year. You may contribute additional funds through pre-tax payroll deductions, up to the established IRS maximums.

2 Money Comes Out

You pay the full cost of non-preventive care, including Rx, until you meet your deductible. When you have an eligible expense, you can decide whether to use your HSA funds or pay out of pocket. Either way, these expenses count towards your deductible and out-of-pocket maximum.

3 Have Money Left? It Rolls Over!

Any money left in your account is yours to pay for healthcare in the future or to invest. If you leave CIEE, you'll take your HSA with you – you own this account.

Tax Advantages of an HSA:

1. 100% deductible contributions up to a legally mandated maximum amount
2. Money withdrawn for medical spending never falls under taxable income
3. Tax-deferred interest savings
4. Tax-free interest earnings, if money is spent on healthcare costs

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Vision Plan

AMERITAS VISION PLAN		
	In-Network	Out-of-Network Reimbursement
Eye Exam	Covered in full	Up to $45
Frames	$250 allowance	Up to $70
Lenses		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Progressive	Covered in full	Up to $50
Lenticular	Covered in full	Up to $100
Lens Enhancements		
Std. Polycarbonate	$40	Not Covered
Tint (solid & gradient)	$15	Not Covered
Scratch Resistant Coating	$15	Not Covered
Anti-Reflective Coating	Standard: $45; Premium - Tier 1: $57; Tier 2: $68; Tier 3: 80% of cost	Not Covered
Ultraviolent Coating	$15	Not Covered
Lasik or PRK	Average discount of 15% off retail price or 5% off promotional price at US Laser Network participating providers.	Not Covered
Contact Lenses		
Standard fit & follow up	Up to $60	N/A
Conventional/Disposable	$200 allowance	Up to $145
Medically Necessary	Covered in full	Up to $210

Ameritas

*Services from out-of-network providers may be subject to balance billing (member would be responsible for any difference between the allowance and the provider's actual charge).

**All benefits available once every 12 months

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Vision Plan Education

Choose your network

When electing vision coverage, you will need to select from one of the two available plan networks. To search for a participating eye doctor within each network:

- VSP – Visit www.vsp.com, click on “Find A Doctor” and search within the “VSP Choice” network using your ZIP code.

member login | phone support | learn more

- EyeMed – Visit www.eyemed.com, click on “Find An Eye Doctor” and search within the “Insight” network using your ZIP code.

member login | phone support | learn more

VSP On the Go App

- track claims & benefits
- check deductible balances
- find a doctor
- view your member ID card
- contact member services

EyeMed Mobile App

- track claims & benefits
- check deductible balances
- find a doctor
- view your member ID card
- contact member services

Ameritas

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Dental Plan

	DELTA DENTAL PLAN	
	In-Network	Out-of-Network*
Deductible	$50 member / $150 family	$50 member / $150 family
Calendar Year Max	$1,500 / year	$1,500 / year
Preventive Care	100% covered; deductible does not apply	100% covered; deductible does not apply
Basic Care	80% covered after deductible	80% covered after deductible
Major Care	50% covered after deductible	50% covered after deductible
Orthodontia (All ages)	50% covered up to the separate lifetime max of $1,500	50% covered up to the separate lifetime max of $1,500

*Services from out-of-network providers may be subject to balance billing (member would be responsible for any difference between the allowance and the provider's actual charge).

DELTA DENTAL®

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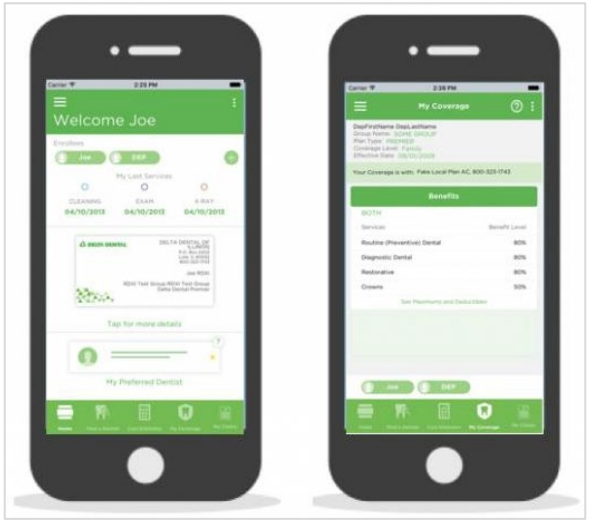
Dental Plan Education

- Your Dental Benefits
  - Your plan allows you **four dental cleanings a year**, and one routine x-ray every 12 months
  - When you remain enrolled in the Delta Dental plan and continue to receive preventive care, **you can roll over up to $250 to the next Calendar Year Maximum***, increasing your benefit for the next year

*See the HR website for full details around the rollover

- Delta Dental Mobile App
  - track claims & benefits
  - check deductible balances
  - find a doctor
  - view your member ID card
  - contact member services
  - download the mobile app



- Why It Pays to Stay In-Network
  - When you see a Delta Dental network dentist, benefits are covered at the in-network level – you will enjoy the greatest savings. Click here to find an in-network dental provider.

member login | phone support | learn more

DELTA DENTAL®

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Voluntary Benefits

Life insurance, flexible spending accounts (FSA), accident insurance, critical illness insurance, 403(b) retirement plan

Basic Life, Voluntary Life & Disability

	LIFE AND AD&D*	VOLUNTARY LIFE AND AD&D			SHORT & LONG-TERM DISABILITY	
	100% Employer Paid	Employee Coverage	Spouse Coverage	Dependent Coverage	Short-Term Disability	Long-Term Disability
Life and AD&D Coverage	Class 1: 3x Basic Annual Earnings Class 2: 2x Basic Annual Earnings	Elect up to a maximum of $500,000 in increments of $10,000	Elect up to a maximum of $250,000 in increments of $10,000	Birth but less than 6 months of age: Elect $1,000 6 months – 26 years old: Elect $2,500, $5,000, $7,500 or $10,000	100% of your weekly pre-disability earnings	Class 1: 60% of your monthly pre-disability earnings up to $20,000/month Class 2: 60% of your monthly pre-disability earnings up to $10,000/month
Additional Information	Class 1 Maximum: $975,000 Class 2 Maximum: $400,000	Guaranteed Issue: $100,000	Guaranteed Issue: $20,000	Guaranteed Issue: Up to $10,000	Approved benefits begin on your first day of disability	Elimination Period: 90 days
Benefit Length	Benefit reduces to 67% at age 70-74, and to 34% at age 75+	Benefit Reduction Schedule: Age 75-79: 60% Age 80-84: 35% Age 85-89: 27.5% Age 90-94: 20% Age 95-99: 7.5% Age 100+: 5%			Benefit pays up to a maximum of 11 weeks	Benefit pays up to Social Security Normal Retirement Age
Cost Responsibility	CIEE pays 100% of the cost of this benefit	If you choose to enroll in this benefit, you are 100% responsible for the cost of this benefit			CIEE pays 100% of the cost of this benefit	

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*AD&D stands for Accidental Death and Dismemberment

**Guaranteed issue is the benefit amount you can receive without having to provide medical information

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Healthcare Flexible Spending Account (FSA)

How It Works

- Contribute up to $3,200 pre-tax annually
- Use funds to pay for eligible medical, dental, and vision expenses. You can view eligible expenses here
- Use your debit card at the point of sale or submit receipts for reimbursement through the member portal
- You may rollover up to $640 in unused funds from the 2024 plan year into 2025; funds remaining above the $640 rollover maximum will be forfeited

Enrolling in the Healthcare FSA

- Per IRS regulations, participants are required to designate a new contribution amount each year
- When you enroll, you will elect the amount you would like to contribute for the entire plan year
- On the first day of the plan, your entire annual election is available to use

Watch: Everything You Need to Know About FSAs

Dependent Care FSA

How It Works

- Contribute up to $5,000 annually; or if married and filing separately, you may contribute up to $2,500 each
- Use funds to pay for eligible childcare and eldercare expenses. You can view eligible expenses here
- You may submit receipts for reimbursement through the Wex, Inc. member portal or mobile app
- There is no rollover allowed; unused funds are forfeited

Enrolling in the Dependent Care FSA

- Per IRS regulations, participants are required to designate a new contribution amount each year
- When you enroll, you will elect the amount you would like to contribute for the entire plan year
- Dependent Care FSA funds become available as they are distributed to your account from your paycheck

Watch: Everything You Need to Know About FSAs

Voluntary Accident Insurance

Benefit Examples	Benefit Pays
Ambulance	$100 ground; $500 air
Chiropractic Services	$25 per session; 6 sessions
Coma	$5,000
Concussion	$100
Diagnostic Exams	$100 per CT/MRI scan
Initial Hospital Admission	$500
ICU Hospital Admission	$1,000
Hospital Confinement	$200 per day; 365-day max
ICU Confinement	$400 per day; 30-day max
Lacerations	Up to $400
Physical Therapy	$25 per session; 6 session max
Physician Visit	$50 initial; $50 follow-up
Rehab Facility Confinement	$50 per day; 30-day max
X-rays	$25
Wellness	$50 health screening

Please click here to view the coverage certificate for a complete list of covered services and benefit details.

What is it?

Accident insurance provides payment for treatments and services resulting from an accidental injury, such as treatment for fractures, dislocations, lacerations, as well as emergency room, ambulance, and hospitalizations related to the accident.

How Much Does it Cost?

Level of Coverage	Bi-Weekly Cost	Monthly Cost
Employee Only	$4.74	$10.27
Employee + Sp	$7.38	$15.99
Employee + Ch	$8.17	$17.70
Family	$11.07	$23.99

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Voluntary Critical Illness Insurance

Diagnosis (Adult)	Benefit Pays
Alzheimer's Disease	100%
Heart Attack	100%
Coma	100%
Major Organ Failure	100%
Multiple Sclerosis	100%
Carcinoma in Situ	25%
Diagnosis (Child)	**Benefit Pays**
Cerebral Palsy	100%
Cystic Fibrosis	100%
Downs' Syndrome	100%
Muscular Dystrophy	100%
Spina Bifida	100%
Type 1 Diabetes	100%

Please click here to view the coverage certificate for a complete list of covered services and benefit details.

Monthly Employee & Spouse cost per $1,000 of coverage					
Age	Rate	Age	Rate	Age	Rate
0-29	$0.46	45-49	$1.97	65-69	$8.60
30-34	$0.73	50-54	$2.78	70-74	$14.12
35-39	$0.92	55-59	$3.87	75-79	$23.80
40-44	$1.30	60-64	$5.76	80-84	$32.94
Child: $1.34 per $1,000, regardless of age					

What is it?

Critical Illness insurance provides benefits to help pay for expenses arising from critical illnesses that are not normally covered by health insurance. Typical expenses due to critical illness include loss of work, transportation, lodging, etc.

How Much Coverage You May Purchase:

Employee	Elect between $5,000 and $30,000 in $1,000 increments. Guaranteed issue is $30,000
Spouse	Elect between $5,000 and $30,000 in $1,000 increments. Guaranteed issue is $30,000
Child(ren)	25% of employee amount up to $7,500

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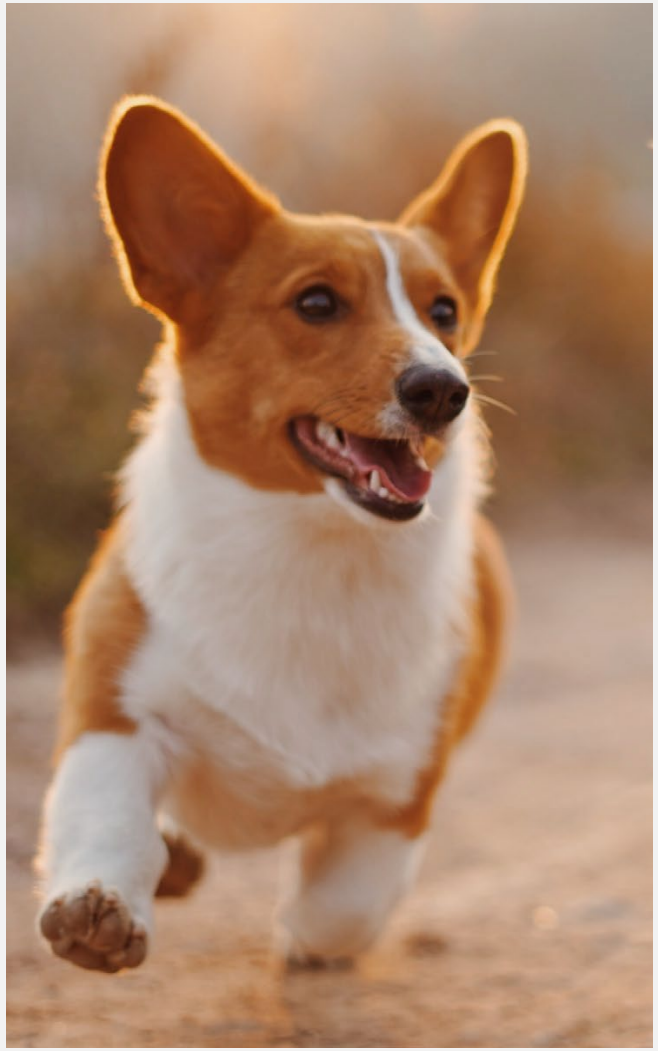

Pet Insurance

Caring for your pets can be expensive. CIEE employees are eligible for a 10% discount on pet insurance for one pet through ASPCA. If more than one pet is added to the policy, all additional pets will be covered with a 20% discounted cost to the employee. Monthly rates will vary depending on the breed and age of the pet being covered.

Customizable options available:

- Annual limit from $3-10k
- Annual deductible from $100-$500
- Reimbursement percentages from 70-90%

Employees can enroll or change their plan at any time by visiting: www.aspcapetinsurance.com/ciee

Company Priority Code: EB22CIEE

ASPCA Pet Health Insurance

Identity Theft Protection

The Benefit

- CIEE provides you the support of a comprehensive Identity Theft Protection program through Norton LifeLock.
- This benefit provides 24/7 telephone support and step-by-step guidance by anti-fraud experts, help canceling stolen cards and reissuing new cards, and help notifying financial institutions and government agencies, and more.

Employees have the option of enrolling in two separate plans: Benefit Essential & Benefit Premier. You can view the differences between the Essential and the Premier plan here.

Benefit Essential	Bi-Weekly Cost	Monthly Cost
Employee Only	$3.69	$7.99
Family	$7.38	$15.98
Benefit Premier	**Bi-Weekly Cost**	**Monthly Cost**
Employee Only	$5.30	$11.49
Family	$10.14	$21.98

NortonLifeLock

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Saving for Retirement

Employees can contribute up to $23,000 pre-tax annually to their 403(b)-retirement plan. You may contribute an additional $7,500 if you are age 50+ in an annual "catch-up contribution".

Company Contribution

After 2 years of service employees are eligible for a discretionary company contribution of 2.5%. Following 3 years of service the employer contribution increases to 5%. **If you previously worked for an educational institution, we would count your service toward our eligibility for the CIEE contribution upon confirmation from your employer.**

Eligibility

CIEE employees are eligible to contribute into the 403(b) plan immediately upon hire. All contributions are immediately 100% vested.

403(b) Retirement Plan

How much do you need to save for retirement?

That depends on your expenses. **Use this calculator** to determine how much you should be saving now to be comfortable in your retirement. You can access all of **Voya's financial calculators here**.

VOYA FINANCIAL

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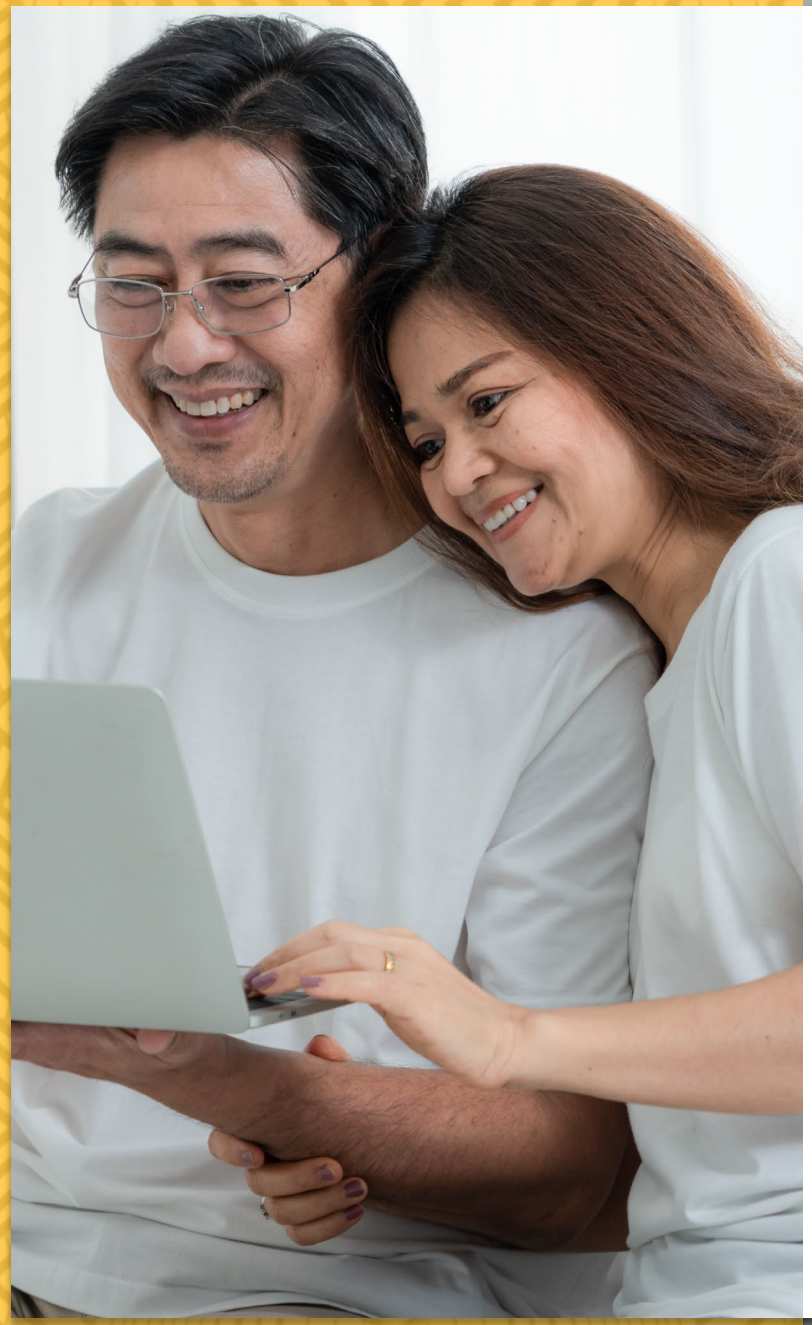
Enrolling in the 403(b) Retirement Plan

- If you're enrolling in the 403(b)-retirement plan for the first time, follow these instructions:
  - Enrolling online:
    - Go to enroll.voya.com
    - Enter the plan number: **664TV8**
    - Enter the verification number: **664TV899**
    - Click '**Let's Go**' and follow the prompts
  - Enrolling over the phone
    - Call 888-311-9487 weekdays 8am – 9pm ET

Download the enrollment flyer



Accessing your Retirement Account

A Personal Identification Number (PIN) is required to access your account by phone or to register for online account access. After your account is set up, Voya will mail a unique PIN directly to you.

- Login to your member account online
- Access your account over the phone: 1-800-584-6001
- Access your account from the mobile app

Learn more about accessing your account by following the steps in this flyer.

Perks

Employee assistance program (EAP), public service student loan forgiveness (PSLF), fitness reimbursement, education program discounts, ADP/LifeMart discount programs

Contact ACI Specialty Benefits

24 hours a day

7 days a week

Call 1-800-932-0034

Visit https://acispecialtybenefits.com/program/eap

Employee Assistance Program

ACI Specialty Benefits

CIEE offers a free and confidential Employee Assistance Program (EAP) through ACI Specialty that can assist you and your family members to address any concern(s) that is a barrier to your health & well-being. All employees are automatically enrolled in this program at no cost to you.

The EAP provides short-term counseling, information, resources, and referrals related to:

- Depression, anxiety & other mental health concerns
- Stress management
- Childcare and elder care
- Legal and financial issues
- Nutrition consultation
- And many other work-life issues

ACI SPECIALTY BENEFITS

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Public Service Student Loan Forgiveness (PSLF)

CIEE employees are eligible to participate in the federal government's Public Service Loan Forgiveness (PSLF) program.

What is the PSLF?

This is a program that was signed into law in 2007 that allows for student loan forgiveness for those employed in public service or non-profit organizations upon meeting certain criteria.

Eligiblity

Any full-time CIEE employee is eligible to apply and receive credit for service with us.

How to Apply

To apply for this benefit, access the PSLF Help Tool. Once you've completed your application, simply email it to us at hrbenefits@ciee.org, we'll complete the employer portion and you're on your way!

Learn How it Works

You can find complete information on the program by accessing the Federal Student Aid site here.

CIEE Program Discounts

Gym Reimbursement Program

- At CIEE, full-time staff are eligible for reimbursement of up to $25/month on an individual fitness membership.
- The first $20 is the employee's responsibility.
- To access this Gym Reimbursement Program complete a reimbursement request form and submit to HRBenefits@ciee.org
- The reimbursement applies to any health club, fitness program (such as yoga, Zumba, etc.), where you pay a monthly or annual fee. At-home fitness programs where you pay a monthly or annual fee also qualify.

CIEE Program Discounts

- Employees and immediate family members are eligible for a 50% discount off the list price of our Study Abroad Programs after 1 year of employment.
- CIEE staff are also eligible to take the 150-hour CIEE TEFL course for only $275 (regular price is $1,100)

ADP/LifeMart Discount Program

- Offers discounts on restaurants, groceries, hotels, movies and more
- Sign up by going into ADP and clicking on:
  - Myself > Benefits > Employee Discounts > LifeMart

Costs & Contacts

	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Medical – Cigna OAP	$84.69	$211.73	$211.73	$296.43
Medical – Cigna CDHP	$61.57	$184.71	$184.71	$258.59
Dental	$6.16	$12.32	$12.32	$20.95
Vision	$1.06	$1.53	$1.53	$2.76
Basic Life & Disability	CIEE pays 100% of the cost of this benefit			
Voluntary Life	100% employee funded. Monthly premium rates will vary based on age & elected amount			
Flexible Spending Account (FSA)	100% employee funded			

Benefit Costs

Contacts

Medical

Cigna

1-800-244-6224

Pharmacy

CVS Caremark

1-800-552-8159

Telehealth

MD Live

1-888-726-3171

Dental

Delta Dental

1-800-537-1715

Vision

Ameritas (VSP or EyeMed Network)

1-800-659-2223

Health & Dependent FSA

WEX Benefits

1-866-451-3399

Health Savings Account

HSA Bank

1-800-244-6224

403(b) Retirement

Voya

1-800-584-6001

Employee Assistance Program (EAP)

ACI Specialty Benefits

1-800-932-0034

Life, Voluntary Life, Disability, Accident and Critical Illness

Reliance Matrix

1-800-435-7775

MyLife Advisors

mylifeadvisor@adp.com

1-855-547-8508

Health Plan Notices

HEALTH PLAN NOTICES

Affordable Care Act Consumer Protections - (a.) Coverage for Children Up to Age of 26. The Affordable Care Act of 2010 requires that the Plan must make dependent coverage available to adult children until they turn 26 regardless if they are married, a dependent, or a student.

(b.) Prohibition of Lifetime Dollar Value of Benefits: the Affordable Care Act of 2010 prohibits the Plan from imposing a lifetime limit on the dollar value of benefits.

(c.) Your Health Insurance Cannot be Rescinded - The Affordable Care Act of 2010 prohibits the Plan, or any insurer, from rescinding your health insurance coverage except as permitted under the Act.

(d.) Prohibition of Pre-Existing Conditions - No insurance plan can reject you, charge you more, or refuse to pay for essential health benefits for any condition you had before your coverage started.

(e.) Prohibition of Restrictions on Annual Limits on Essential Benefits - The Affordable Care Act of 2010 prohibits the Plan, or any insurer, effective January 1, 2014 from placing annual limits on the value of essential health benefits.

(f) Notice of Marketplace/Exchange - You have the option to purchase health insurance at the Health Insurance Marketplace. The Marketplace offers "one-stop shopping" to find and compare private health insurance options as well as a premium tax credit or a cost sharing reduction for certain qualified individuals. If you purchase a health plan through the Marketplace, you will lose any employer contribution toward the cost of your health coverage. Employer contributions to employer-provided coverage may be excludable for federal income tax purposes. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.Healthcare.gov for more information and contact information for a Health Insurance Marketplace in your area.

The Genetic Information Nondiscrimination Act (GINA) - GINA prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any benefits under the Plan. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history.

Wellness - Your health plan is committed to helping you achieve your best health. If your Plan includes a Wellness program that provides rewards or surcharges based on your ability to complete an activity or satisfy an initial health standard, and if you think you might be unable to meet a standard for a reward under the wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Plan Administrator and 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.

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

HEALTH PLAN NOTICES

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). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Plan Administrator.

Grandfathered Status - The Plan believes that none of the group health plans available under the Plan are "grandfathered health plans" as described under the Patient Protection and Affordable Care Act (the "Affordable Care Act").

Special Rule for Maternity and Infant Coverage - 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 attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

Special Rule for Women's Health Coverage (WHCRA) - 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 co-insurance applicable to other medical and surgical benefits provided under the ABC Company Health Plan. If you would like more information on WHCRA benefits, please call your Plan Administrator

Notice Regarding Lifetime and Annual Dollar Limits - In accordance with applicable law, any lifetime dollar limits and annual dollar limits set forth in the Plan shall not apply to "essential health benefits," as such term is defined under Section 1302(b) of the Affordable Care Act. The law defines "essential health benefits" to include, at minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory services. A determination as to whether a benefit constitutes an "essential health benefit" will be based on a good faith interpretation by the Plan Administrator of the guidance available as of the date on which the determination is made.

Patient Protection Disclosure - You have the right to designate any participating primary care provider who is available to accept you or your family members (for children, you may designate a pediatrician as the primary care provider). For information on how to select a primary care provider and for a list of participating primary care providers, contact the Plan Administrator. You do not need prior authorization from the Plan or from any other person, including your primary care provider, in order to obtain access to obstetrical or gynecological care from a health care professional; however, you may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the health plan.

Michelle's Law - Michelle's Law provides continued health and dental insurance benefits under the Plan for dependent children who are covered under the Plan as a student but lose their student status in a post-secondary school or college because they take a medically necessary leave of absence from school. If your child is no longer a student because he or she is out of school because of a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence.

HEALTH PLAN NOTICES

You are 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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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.

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 may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other 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 care out-of-network. You can choose a provider or facility in your plan's network.

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

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

Your health plan generally must:

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

If you believe you've been wrongly billed, you may contact the Centers for Medicare & Medicaid Services https://www.cms.gov/nosurprises

Visit https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets for more information about your rights under federal law.

HEALTH PLAN NOTICES

11. Important Notice 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. 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. Your employer has determined that the prescription drug coverage offered by the employer sponsored medical plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

Your current coverage pays for other health expenses, in addition to prescription drugs. If you are actively employed and decide to join a Medicare drug plan, your current medical coverage will not be affected; you can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you are actively employed and you decide to join a Medicare drug plan and drop your current medical coverage, be aware that you and your dependents may be able to get this coverage back at the next open enrollment period or upon a qualifying status change if you remain otherwise eligible to enroll in the Plan.

If you are no longer actively employed and you decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will not be able to get this coverage back.

HEALTH PLAN NOTICES

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 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 plan administrator for further information.

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).

HEALTH PLAN NOTICES

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

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

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

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

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

HEALTH PLAN NOTICES

Alabama
Website: http://myalhipp.com/
Phone: 1-855-692-5447

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

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

California
Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

Colorado
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+:
https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buyprogram
HIBI Customer Service: 1-855-692-6442

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

Georgia
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

Massachusetts
Website: https://www.mass.gov/info-details/masshealthpremium-assistance-pa
Phone: 1-800-862-4840

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

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

Montana
Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

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

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

HEALTH PLAN NOTICES

New Hampshire
Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

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

New York
Website:
https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

North Carolina
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

North Dakota
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

Oklahoma
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

Oregon
Website:
http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

Pennsylvania
Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

Rhode Island
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

South Carolina
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

South Dakota
Website: http://dss.sd.gov
Phone: 1-888-828-0059

Texas
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

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

Vermont
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

Virginia
Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-800-432-5924

Washington
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

West Virginia
Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

Wisconsin
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

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

HEALTH PLAN NOTICES

To see if any other states have added a premium assistance program, 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 four 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, 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.