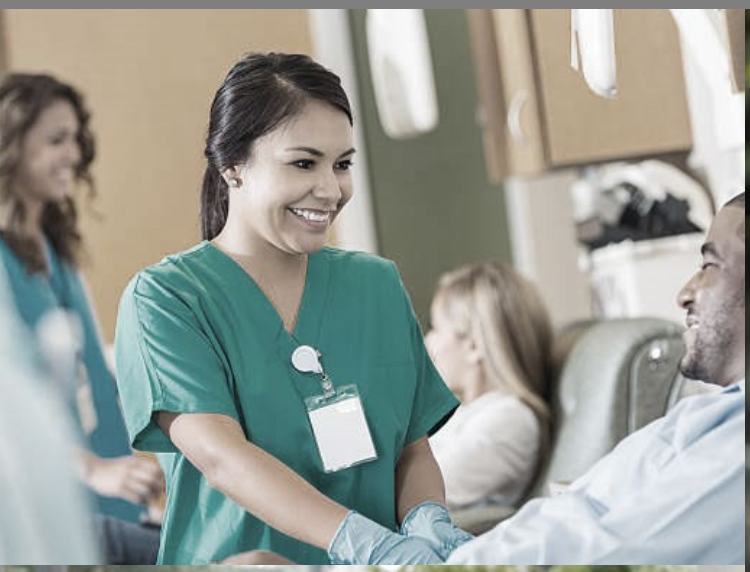
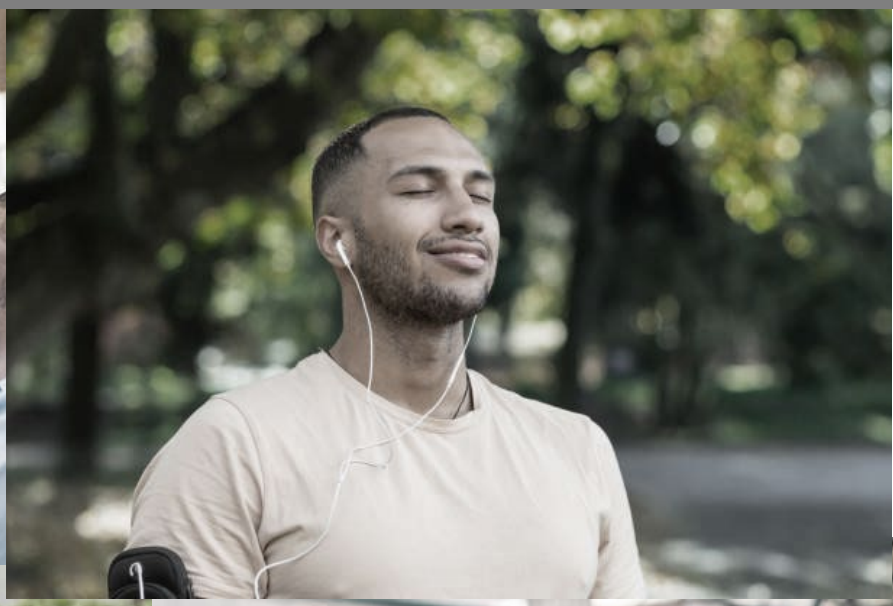
Community Care Partners





Benefits Guide

2025

Provided By:

HAUSER

Table of Contents

The information in this Enrollment Guide is presented for illustrative purposes and the text contained herein was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan, documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

Welcome

Community Care Partner's Purpose is *"We keep people out of the hospital."*

Community Care Partner's Promise is *"We deliver care that is personal. We treat patients how we would like to be treated."*

At CCP *we start with our team, we create a great environment where team members can realize their full potential and flourish.* Helping you and your families achieve and maintain good physical, emotional and financial health is the reason the company offers you this comprehensive benefits program. We are providing you with this overview to help you understand the benefits available to you and how to best use them. Please review it carefully and make sure to ask any important questions that are not addressed here. A list of plan contacts is provided at the back of this summary.

While we've made every effort to make sure this guide is comprehensive, it cannot provide a complete description of all benefit provisions. For more detailed information, please refer to the summary plan descriptions (SPDs) available on our benefits website, **ccptmbenefits.com**.

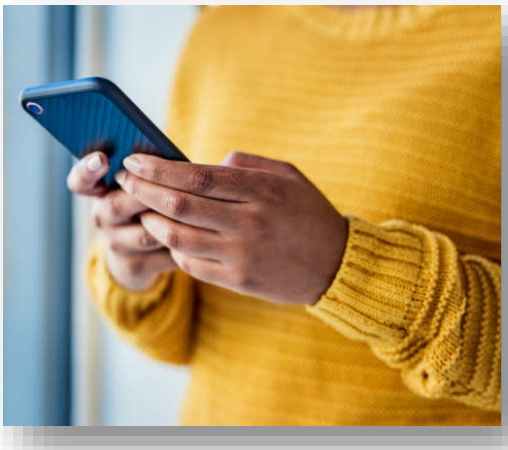
Your personal benefit elections will be housed in our HRIS system. This is the site you will use to make benefit elections during your new hire eligibility or Open Enrollment periods, as well as to review your current elections throughout the year.

When you are ready to make your elections, sign on to your HRIS portal and follow the instructions.

Once you confirm your elections, they will be locked and you will not be able to change them until the next open enrollment period, unless you have a qualified life-changing event.

Info on the Go!

Scan with your Smartphone to access your 2025 Benefits Guide and enrollment materials online ANYTIME.



Free Access to Care

CCP provides **team members** and **dependents** enrolled on our medical plan free access* to services at our facilities!

This includes any services performed at the place of service including labs and x-rays**.

**Does not pertain to Physical, Occupational, or other therapies offered by Community Care Partners.*
***Free Access to Care does not apply to lab work processed or completed by external vendors.*

Eligibility & Enrollment

Who Is Eligible?

If you are a full-time team member working 30 or more hours per week, you are eligible to enroll in benefits described in this guide. You are eligible for benefits on the **first of the month following 30 days of employment.**

You may enroll your eligible dependents in the same plans you choose for yourself, including medical, dental, vision and voluntary life and AD&D coverage. Eligible dependents may include the following:

- ✓ Your legal spouse
- ✓ Your Domestic Partner (same or opposite sex) or Common Law spouse
- ✓ Your children up to age 26
- ✓ Your unmarried dependent children over age 26 who are incapable of self-care because of a disability and who relyon you for support ***(please note: additional documentation will be require for overaged disabled dependents.)**
- ✓ Your grandchild provided that the grandchild meets the definition of Child. For example:
  - A lawfully adopted Child or Child placed with a covered team member in anticipation of adoption.
  - A Child for who the team member is required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO)
  - A Child for whom the team member has obtained legal guardianship

When you enroll dependents, please submit the following (if applicable):

- ✓ Affidavit of Domestic Partnership or Common Law Marriage
- ✓ Date of Birth
- ✓ Social Security Number

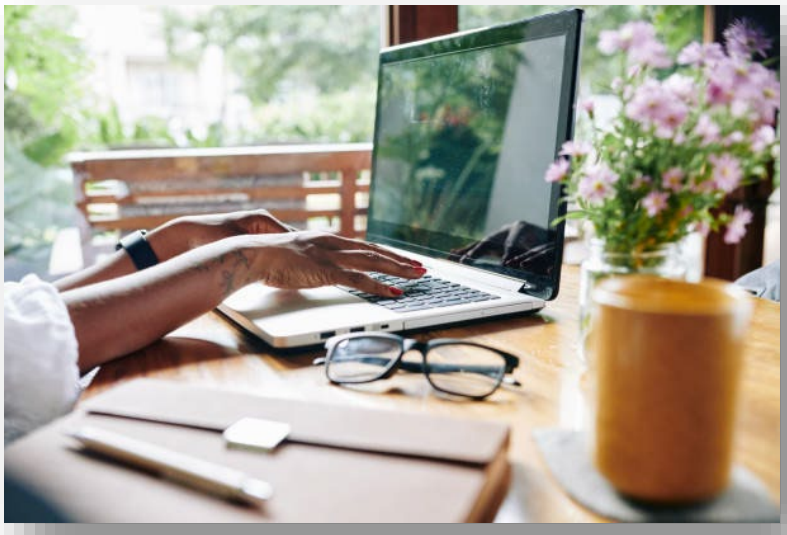
If you do not provide this documentation within 31 days of hire, your dependents will not be enrolled in benefits.

Enrolling for Coverage

Your enrollment period is an important time to review your benefits and choose the best options for you and your family. Review the 2025 Team Member Benefits Guide to understand the coverage available to you. **You must enroll in coverage within 31 days of your hire date or during the annual open enrollment period.**

Newly hired full-time team members enrolling for the first time will make their benefit elections on our HRIS platform. You can make your benefit elections during the enrollment window, and coverage begins on the first of the month following 30 days of employment. Team members who wish to enroll in the 401k plan must complete their enrollment through the John Hancock website.

Your personal benefit elections will be housed in the HRIS system.



Eligibility & Enrollment

Changing Your Coverage During the Year

Whether you are a newly hired team member or a current team member making modifications during the annual open enrollment, the elections you make at this time will remain in effect until our next open enrollment period, unless you have a qualifying life event (as defined by the IRS) that allows a mid-year plan change.

These changes include (but are not limited to):

- ✓ Birth or adoption of a baby or child
- ✓ Loss of other healthcare coverage
- ✓ Eligibility for new healthcare coverage
- ✓ Marriage
- ✓ Divorce
- ✓ Change in child's dependent status
- ✓ Change in residence due to an employment transfer for you or your spouse

If you experience a qualifying life event, or if you have questions, please contact Human Resources (HR). You have 31 days after a qualifying event to notify HR and request a change to your benefit elections.

Note: The benefit changes you make must be consistent with the life event.

When Dependent Children Age Out

Dependent children can remain on the medical, dental and/or vision coverage(s) until the end of the month in which they turn 26, at which time their coverage will cancelled. Coverage under Voluntary Life and AD&D ends at midnight on their 19th or if they're a full-time student on their 26th birthday.

Medical & Prescription Drug

Plan Year: January 1st through December 31st

Medical and prescription drug coverage provides you with benefits that help keep you healthy like preventive care screenings, access to urgent care and medications. It also provides important financial protection if you have a serious medical condition. **Community Care Partners** offers two medical plans administered by ***BPA*** under the **Cigna PPO Network**.

MEDICAL NETWORK: Cigna PPO Rx NETWORK: CVS caremark®

2025	HDHP – Base Plan		Premier – Buy Up Plan	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Annual Deductible [B]	$3,500 per member, up to $7,000 per family	$7,000 per member, up to $13,000 per family	$3,000 per member, up to $6,000 per family	$6,000 per member, up to $12,000 per family
Coinsurance	10%	40%	20%	50%
Annual Out-of-Pocket Max [B]	$6,250 per member, upto $12,500 per family	$12,500 per member, up to $25,000 per family	$6,250 per member, up to $12,500 per family	$12,500 per member, up to $25,000 per family
Lifetime Max	Unlimited	Unlimited	Unlimited	Unlimited
Office Visits Primary / Specialist	You pay 10% after deductible	You pay 40% after deductible	$25/$50 copay	Not Covered
Preventive Services	No charge	You pay 40% after deductible	No charge	You pay 50% after deductible
Inpatient Hospitalization	You pay 10% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 50% after deductible
Outpatient Surgery	You pay 10% after deductible	You pay 40% after deductible	You pay 20% after deductible	You pay 50% after deductible
Emergency Room	You pay 10% after deductible	You pay 40% after deductible	$300 copay	$300 copay
Urgent Care	You pay 10% after deductible	You pay 40% after deductible	$50 copay	You pay 50% after deductible
Prescription Drugs Retail *(31-day supply)* *Tier I* *Tier II* *Tier III*	$0- Preventive Generics After Deductible: $10 copay $30 copay $50 copay	Not Covered	$10 copay $30 copay $50 copay	Not Covered
Mail Order *(90-day supply)* *Tier I* *Tier II* *Tier III*	$0- Preventive Generics After Deductible: $20 copay $60 copay $100 copay	Not Covered	$20 copay $60 copay $100 copay	Not Covered

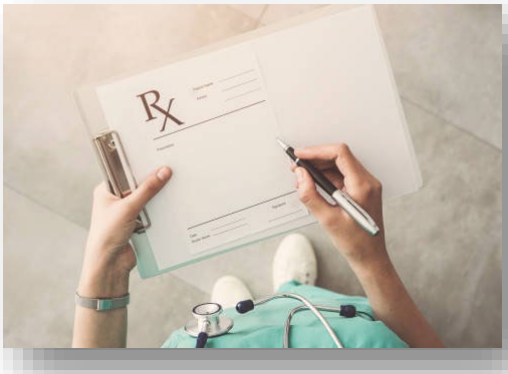
[B] The BPA plans have an **embedded** deductible and out-of-pocket (OOP), which means that a "per member" deductible and OOP are embedded within the "per family" thresholds. Each covered family member is subject only to their "per member" deductible or OOP.

Community Care Partners provides **team members** and **dependents** enrolled on our medical plan free access* to services at ***Community Care Partners***.

**Does not pertain to Physical, Occupational, or other therapies offered by Community Care Partners.*

Medical & Prescription Drug

Medical Key Reminders



- ✓ To limit your Out-of-Pocket expenses, please seek services from a *Cigna* provider. To find a provider, visit https://hcpdirectory.cigna.com/web/public/consumer/directory/search.
- ✓ If services are provided by a non-*Cigna* provider, the member is responsible for any amounts exceeding the "allowable charges," in which case balance billing could occur.
- ✓ Dependent Child Age Limits: Covered to age 26.

Prescription Drug Coverage

We know prescription drug coverage is important to you and your family, so when you elect medical coverage, you are automatically covered under the prescription drug plan. You may fill your prescriptions at participating retail pharmacies. Under both medical plan option, the mail order option allows you to buy qualified prescriptions in larger 90-day quantities at a reduced cost (with the exception of specialty medications). Mail order saves you time in trips to the pharmacy because prescriptions are delivered right to your door.

There are several categories of drugs under the plans. The differences between these categories are described below:

- ✓ **Tier 1 –Generic:** Frequently prescribed generic drugs. *($10 Copay)*
- ✓ **Tier 2 – Preferred Brand:** Lowest cost brand name drugs. *($30 Copay)*
- ✓ **Tier 3 – Non-Preferred Brand:** Brand names drugs with higher costs than preferred brand name drugs. *($50 Copay)*
- ✓ **Specialty**: Typically for chronic high-cost conditions. *($10, $30 or $50 copay depending upon applicable tier*). Specialty drugs are limited to a 31-day supply and must be obtained through CVS/Caremark's Specialty Pharmacy (http://www.cvscaremarkspecialtyrx.com).

Choose Generics - The member pays the applicable copay (if applicable) only if the physician requires brand. Ifthe member requests brand when a generic is available, the member pays the applicable copay plus the difference between. Be sure to discuss this with your physician when he or she writes your prescription.

If you are enrolled in the HDHP, there are many Preventive Generic drugs available at NO COST. To review the list of applicable drugs you can visit: https://www.ccptmbenefits.com/benefits-guide-handouts

Find individualized information on your benefit coverage, determine tier status, check the status of claims and search for network pharmacies by logging on to www.caremark.com or by calling *CVS Caremark*.

Helpful Terms

Deductible – The amount you must pay out-of-pocket for expenses before the insurance company will cover any benefit costs for the year (except for preventive care and other services where the deductible is waived).
Coinsurance – The cost share between you and the insurance company. Coinsurance is always a percentage totaling 100%. For example, if the plan pays 80%, you are responsible for paying the remaining 20% of the cost.
Copay – The fee you pay to a provider at the time of service.
Out-of-Pocket Maximum – The most you would pay out-of- pocket for covered services in a year. Once you reach your out- of-pocket maximum, the plan covers 100% of eligible expenses.
Balance Billing – Non-network providers are allowed to charge you more than the plan's allowable charge. This is called Balance Billing.

Health Savings Account (HSA)

Plan Year: January 1st through December 31st

Health Savings Account (HSA)

Do you want to save money on taxes? A Health Savings Account is a tax-advantaged, portable (you own it!) savings account. You **must** be enrolled in the HSA-Base Plan to establish and/or contribute to a Health Savings Account.

You and your employer can contribute pre-tax money to your account to save for out-of-pocket healthcare expenses. And, any money you don't spend grows year after year and can be used in the future, even after you retire. ***Navia Benefits Solutions*** administers this program.

THE COMPANY'S CONTRIBUTION TO YOUR ACCOUNT

BPA HSA – Base Plan	
Team Member Only	$450 annually
Team Member + Spouse	$450 annually
Team Member + Family/Child(ren)	$900 annually

The company's contribution to your HSA will be made in **monthly installments.** Mid-year enrollees will receive a pro-rated contribution from the company based on the month in which your coverage change is processed.

MAKING YOUR OWN HSA CONTRIBUTIONS

The IRS has set limits on the total amount that can be contributed to your Health Savings Account each calendar year. Contributions by you and your employer count toward this limit. **In 2025, the IRS limit for HSA contributions is $4,300 for an individual and $8,550 for a family.** If you're over 55, the IRS allows you to contribute an additional $1,000—this is called a "catch-up contribution."

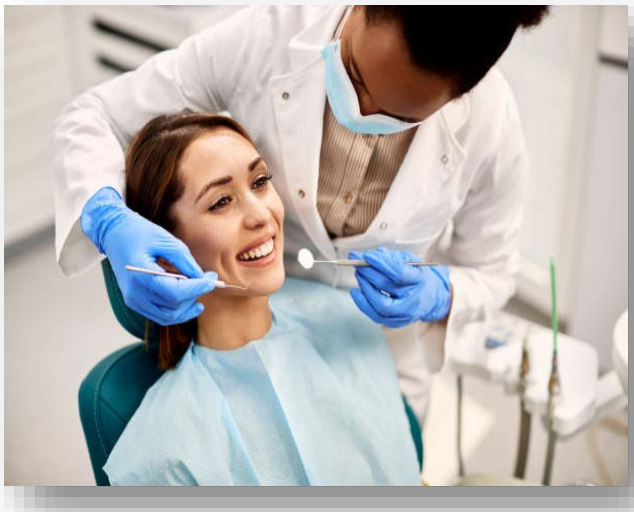
Your contribution limits are calculated based on the coverage under the company's HDHP for the full calendar year, exclusive of any "catch-up contribution."Please contact HR to confirm your contribution limit if you have a mid-year enrollment change.

Dental Benefits

Plan Year: January 1st through December 31st

Regular visits to your dentists can help more than protect your smile: they can help protect your health. Recent studies have linked gum disease to damage elsewhere in the body and dentists are able to screen for oral symptoms of many other diseases including cancer, diabetes and heart disease.

The company offers you a dental plan through ***MetLife***.



	MetLife Dental	
	In-Network [A]	**Out-Of-Network [B]**
Calendar Year Deductible [C]	$50 per member, up to $150 per family	$50 per member, up to $150 per family
Calendar Year Maximum	$1,500 per member	$1,500 per member
Diagnostic & Preventive (Periodic Oral Evaluation, Fillings, Radiographs, Labs andOther Diagnostic Tests, Cleaning, Fluoride, Sealants, Space Maintainers)	No charge	No charge
Basic Services (Restorations, Simple Extractions)	You pay 20% after deductible	You pay 20% after deductible
Major Services (Crowns, Bridges, Dentures, Implants, In/Onlays, Veneers)	You pay 50% after deductible	You pay 50% after deductible
Orthodontic Services	You pay 50%	You pay 50%
Lifetime Maximum	$1,000 per member	$1,000 per member
Orthodontia Covers	Dependent Children up to age 19	Dependent Children up to age 19

[A] *Services provided by a MetLife Dental PPO network dentist will be covered according to MetLife's Contracted Fee Schedule.*

[B] *Services provided by an out-of-network dentist will be covered by MetLife according to Reasonable and Customary Allowances at the 90th percentile. Out-of-network dentists may balance bill you up to their usual fees.*

[C] *Applies to Basic and Major Services only*

Voluntary Vision Benefits

Plan Year: January 1st through December 31st

Routine vision exams are important, not only for correcting vision, but because they can detect other serious health conditions.

The company offers you a plan through VSP. Our policy covers routine eye exams and other procedures and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses. The following chart outlines the Vision benefits we offer. The network for this plan is the VSP network.

	VSP Vision	
	In-Network	**Out-Of-Network**
Examination	$10 copay	Reimbursed up to $45
Frequency	12 months	12 months
Materials	$10 copay	$10 copay
Eyeglass Lenses		
Single Vision Lens	$10 copay	Reimbursed up to $30
Bifocal Lens	$10 copay	Reimbursed up to $50
Trifocal Lens	$10 copay	Reimbursed up to $65
Frequency	12 months	12 months
Frames	$150 allowance + 20% discount on costs in excess	Reimbursed up to $70
Frequency	12 months	12 months
Contacts (Elective)	$150 allowance + 15% discount on costs in excess	$105 allowance
Fitting	Covered in full	Applied to contact lens allowance
Frequency (in lieu of glasses)	12 months	12 months

Cost of Coverage

Community Care Partners pays a portion of your health care premiums; however, we do require team members contribute toward their health care costs as well. Team members pay a dollar amount based on the level of coverage they select. The following Team Member Payroll Deductions will be effective for this plan year and will be reflected on your first paycheck after your effective date.

MEDICAL Plan Payroll Deductions

PLAN	Team Member		Team Member + Spouse		Team Member + Children		Team Member + Family	
	Semi- Monthly	Monthly	Semi- Monthly	Monthly	Semi- Monthly	Monthly	Semi- Monthly	Monthly
Base HDHP/HSA	**$50.00**	*$100.00*	**$192.50**	*$385.00*	**$156.00**	*$312.00*	**$330.00**	*$660.00*
Premier Buy-Up	**$146.53**	*$293.05*	**$372.26**	*$744.52*	**$318.80**	*$637.59*	**$594.03**	*$1,188.07*

Free Access to Care

Community Care Partners provides **team members and dependents** enrolled on our medical plan free access* to services at Community Care Partners facilities! This includes services performed at the place of service, such as labs and x-rays, **but excludes** Physical Therapy services and any diagnostics performed outside of the clinic.

DENTAL Plan Payroll Deductions

Team Member		Team Member + Spouse		Team Member + Children		Team Member + Family	
Semi- Monthly	Monthly	Semi- Monthly	Monthly	Semi- Monthly	Monthly	Semi- Monthly	Monthly
$10.21	*$20.41*	**$30.49**	*$60.98*	**$35.08**	*$70.16*	**$57.52**	*$115.04*

VISION Plan Payroll Deductions

Team Member		Team Member + Spouse		Team Member + Children		Team Member + Family	
Semi- Monthly	Monthly	Semi- Monthly	Monthly	Semi- Monthly	Monthly	Semi- Monthly	Monthly
$3.83	*$7.65*	**$7.66**	*$15.31*	**$8.08**	*$16.15*	**$12.09**	*$24.18*

VOLUNTARY LIFE/AD&D FOR YOU AND/OR FOR YOUR DEPENDENTS

Your cost will be reflected in our HRIS platform when you enroll

VOLUNTARY SHORT-TERM DISABILITY

Your cost will be reflected in our HRIS platform when you enroll

Flexible Spending Accounts

Plan Year: January 1st through December 31st

A Flexible Spending Account lets you set aside money—before it's taxed—through payroll deductions. The money can be used for eligible healthcare and dependent day care expenses you and your family expect to have over the next year. The main benefit of using an FSA is that you reduce your taxable income, which means you have more money to spend. **This benefit must be re-elected each year to participate in and receive the tax benefits of an FSA**. ***Navia Benefits Solutions*** administers this program.

IMPORTANT CONSIDERATIONS

- 2025 plan year expenses must be incurred between 01/01/25 and 12/31/25 and submitted for reimbursement no later than 03/31/26.
- Elections cannot be changed during the plan year unless you have a qualified life change event.
- If you elect the Healthcare FSA, you can keep (roll-over) up to $660 of unused money for use in the next plan year by re-enrolling in the following plan year. Unused amounts above $660 will be lost, so it is very important that you plan carefully before making your election.
- FSA funds can be used for you, your spouse, and your tax dependents only.
- You can obtain reimbursement for eligible expenses incurred by your spouse or tax dependent children, even if they are not covered on the company health plan.
- You cannot obtain reimbursement for eligible expenses for a domestic partner or their children unless they qualify as your tax dependents (Important: questions about the tax status of your dependents should be addressed with your tax advisor).
- Keep your receipts. In most cases, you'll need to provide proof that your expenses were considered eligible for IRS purposes.

HEALTHCARE FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket healthcare expenses with pre-tax dollars from your **General Healthcare FSA**. Eligible expenses include medical, dental, and vision costs including plan deductibles, copays, coinsurance amounts, and other non-covered healthcare costs for you and your tax dependents. You may access your entire annual election from the first day of the plan year and you can set aside up to **$3,300** this year.

If you are enrolled in the HSA-Base Plan, you can participate in our **Limited Purpose Healthcare FSA** which covers out-of-pocket for only **vision** and **dental** expenses.

DEPENDENT CARE FSA ACCOUNT

This plan allows you to pay for eligible out-of-pocket dependent care expenses with pre-tax dollars. Eligible expenses may include daycare centers, in-home childcare, and before or after school care for your dependent children under age 13. Other individuals may qualify if they are considered your tax dependent and are incapable of self- care. **It is important to note that you can access money only after it is placed into your dependent care FSA account.**

All caregivers must have a tax ID or Social Security Number. This information must be included on your federal tax return. If you use the dependent care reimbursement account, the IRS will not allow you to claim a dependent care credit for reimbursed expenses. Consult your tax advisor to determine whether you should enroll in this plan. You can set aside up to **$5,000** per household for eligible dependent care expenses for the year

Life and AD&D Insurance

Plan Year: January 1st through December 31st

If you have loved ones who depend on your income for support, having life and accidental death insurance can help protect your family's financial security.

BASIC LIFE

Basic Life Insurance pays your beneficiary a lump sum if you die. **The cost of coverage is paid in full by Community Care Partners**. Coverage is provided by ***MetLife***.

Basic Life Amount	**1X your Basic Annual Earnings** ($50,000 minimum coverage) up to amaximum of $150,000

ACCIDENTAL DEATH & DISMEMBERMENT(AD&D)

AD&D provides another layer of benefits to either you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing,or if you die in an accident. **The cost of coverage is paid in full by Community Care Partners.** Coverage is provided by ***MetLife***.

Basic AD&D Amount	**1X your Basic Annual Earnings** up to a maximum of $150,000

Beneficiary Reminder: It is required that you name a beneficiary for your life insurance benefit. It's important to know many states require that a spouse be named as the beneficiary unless they sign awaiver.

VOLUNTARY LIFE & AD&D

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Voluntary Accidental Death and Dismemberment (AD&D) protects your family's financial security in case you suffer from loss of limb, speech, sight or hearing or if you die in anaccident. Coverage is provided by ***MetLife***. ***Please note that the Life and AD&D policies offer through MetLife are Term Life policies.***

Team member Voluntary Life and AD&D Amount	**Increments of $10,000 up to $500,000, not to exceed 5X your Basic Annual Earnings** **New Entrants Guarantee Issue: $200,000**
Spouse Voluntary Life and AD&D Amount	**Increments of $5,000 up to $100,000**; not to exceed 50% of the team member benefit **New Entrants Guarantee Issue: $30,000**
Child(ren) (No differentiating cost for multiple children) Voluntary Life and AD&D Amount	**15 days to 6 months: $1,000** **6 months to 26 years*: Options of $1,000, $2,000, $4,000, $5,000, or $10,000** **New Entrants Guarantee Issue: $10,000**

**26 years old if a full-time student*

Taxes: Due to IRS regulations, a life insurance benefit of $50,000 or more is considered a taxable benefit. You will see the value of the benefit included in your taxable income on your paycheck and W-2.

- **New entrant:** If you elect coverage when you are initially eligible, evidence of insurability is required only for any amount over $200,000.
- **New entrant**: If you elect coverage for your spouse when you are initially eligible, evidence of insurability is required only for any amount over $30,000.
- **Late entrant:** Employees who previously declined coverage during their initial enrollment (as new entrant) can elect coverage for themselves and their spouse but must complete the required evidence of insurability form.

Evidence of Insurability (EOI): Depending on the amount of voluntary coverage you select, or you did not elect when first eligible,you will need to submit an EOI form, which involves providing the insurance company with additional information about your health. Once your EOI is reviewed, they will notify you in writing, approving or denying your request for coverage.

Disability Income Benefits

Plan Year: January 1st through December 31st

If you become disabled and cannot work, your financial security may be at risk. Protecting your income stream can provide you and your family with peace of mind.

VOLUNTARY SHORT-TERM DISABILITY INSURANCE

If you purchase Short-Term Disability coverage it pays you a benefit if you temporarily can't work because of an injury, illness, or maternity leave. **Benefits may be reduced by income from other income sources, such as paid time off and state-mandated disability insurance plans (California, New York, Washington, Oregon, New Jersey, and Colorado).** Your doctorand the insurance company will work together to determine how long benefits are payable, based on your condition. Coverage is provided by ***MetLife***.

Weekly Benefit Amount	Plan pays 60% of your weekly salary
Maximum Weekly Benefit	$1,500 per week
Benefits Begin After:	
Accident	7 days of disability
Sickness	7 days of disability
Maximum Payment Period*	12 weeks
Pre-Existing Condition**	3 months lookback. 12 months exclusion

** Maximum payment period is based on the first day you are disabled, not when benefits begin.*

***A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.*

LONG-TERM DISABILITY INSURANCE

Long-Term Disability coverage pays you a certain percentage of your income if you can't work because an injury or illness prevents you from performing any of your job functions over a long time. **The cost of the coverage is paid in full by Community Care Partners.**

It's important to know that benefits are reduced by income from other benefits you might receive while disabled like workers' compensation and Social Security.

If you qualify, long-term disability benefits begin after short-term disability benefits end. Coverage is provided by ***MetLife***.

Monthly Benefit Amount	Plan pays 50%
Maximum Monthly Benefit	$5,000 per month
Benefits Begin After:	
Accident	90 days of disability
Sickness	90 days of disability
Maximum Payment Period*	5-year duration

**The age at which the disability begins may affect the duration of thebenefits*

Team Member Assistance Program

MetLife

Professional support and guidance for everyday life

Life doesn't always go as planned. And while you can't always avoid the twists and turns, you can get help to keep moving forward.

We can help you and your family, those living at home, get professional support and guidance to make life a little easier. Our Employee Assistance Program (EAP) is available to you in addition to the benefits provided with your MetLife insurance coverage. This program provides you with easy-to-use services to help with the everyday challenges of life — at no additional cost to you.

Help is always at your fingertips.

Our mobile app makes it easy for you to access and personalize educational content important to you.

Search "LifeWorks" on iTunes App Store or Google Play. Log in with the username: **metlifeeap** and password: **eap**

Expert advice for work, life, and your well-being

The program's experienced counselors provided through LifeWorks — one of the nation's premier providers of Employee Assistance Program services — can talk to you about anything going on in your life, including:

- **Family:** Going through a divorce, caring for an elderly family member, returning to work after having a baby
- **Work:** Job relocation, building relationships with co-workers and managers, navigating through reorganization
- **Money:** Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues
- **Legal Services:** Issues relating to civil, personal and family law, financial matters, real estate and estate planning
- **Identity Theft Recovery:** ID theft prevention tips and help from a financial counselor if you are victimized
- **Health:** Coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking
- **Everyday Life:** Moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, training a new pet

Convenient and confidential help when you want it, how you want it

Your program includes up to **5** in person, phone or video consultations with licensed counselors for you and your eligible household members, per issue, per calendar year. You can call **1-888-319-7819** to speak with a counselor or schedule an appointment, 24/7/365.

When you call, just select "Employee Assistance Program" when prompted. You'll immediately be connected to a counselor.

If you're simply looking for information, the program offers easy to use educational tools and resources, online and through a mobile app. There is a chat feature so you can talk with a consultant to guide you to the information you are looking for or help you schedule an appointment with a counselor.

Log on to metlifeeap.lifeworks.com, username: metlifeeap and password: eap

Legal Assistance

Cover the costs on a wide range of common legal issues with a Legal Plan.

Access experienced attorneys to help with estate planning, home sales, tax audits andmore.

Legal experts on your side, whenever you need them

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you trust. For a monthly fee, you can have a team of top attorneys ready to help you take care of life's planned and unplanned legal events.

MetLife Legal Plans gives you access to the expert guidance and tools you need to handle the broad range of personal legal needs you might face throughout your life. This could be when you're buying or selling a home, starting a family, dealing with identity theft or caring for aging parents.

Reduce the out-of-pocket cost of legal services with MetLife Legal Plans.

How it works

Our service is tailored to your needs. With network attorneys available in person, by phone or by email and online tools to do-it-yourself — we make it easy to get legal help. And, you will always have a choice in which attorney to use. You can choose one from our network of prequalified attorneys or use an attorney outside of our network and be reimbursed some of the cost.

Best of all, you have unlimited access to our attorneys for all legal matters covered under the plan. For a monthly premium conveniently paid through payroll deduction, an expert is on your side as long as you need them.

When you need help with a personal legal matter, MetLife Legal Plans is there for you to help make it a little easier.

MONTHLY RATE
$19.75

How to use the plan

1. Find an attorney

Create an account at legalplans.com to see your coverages, select an attorney and get a case number for your legal matter. Or, give us a call at 800.821.6400 for assistance.

2. Make an appointment

Call the attorney you select, provide your case number, and schedule a time to talk or meet.

3. That's it!

There are no copays, deductibles or claim forms when you use a network attorney for a covered matter.

Identity & Fraud Protection

MetLife · AURA

MetLife and Aura Identity & Fraud Protection helps protect you from fraud and online threats with all features in one place and a consistent experience across web and an easy-to-use app.

Identity Theft Protection - Monitors personal info, accounts, and online reputation and sends alerts if we detect threats. Automatically requests removal of information found online to help keep it out of the hands of thieves and spammers.

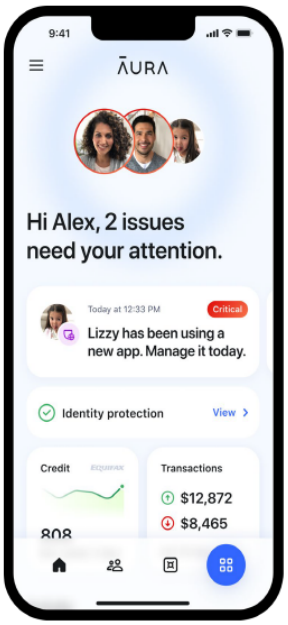
Financial Fraud Protection - Monitors credit, financial accounts, and property titles and sends alerts if suspicious changes are detected.

Privacy & Device Protection - Shop, bank, and connect online more securely and privately with intelligent safety tools that help protect passwords, devices, and WiFi connections from hackers.

Family Safety - Gives you the tools to protect loved ones — no matter who they are, how old they are, or where they live — from online predators and thieves.

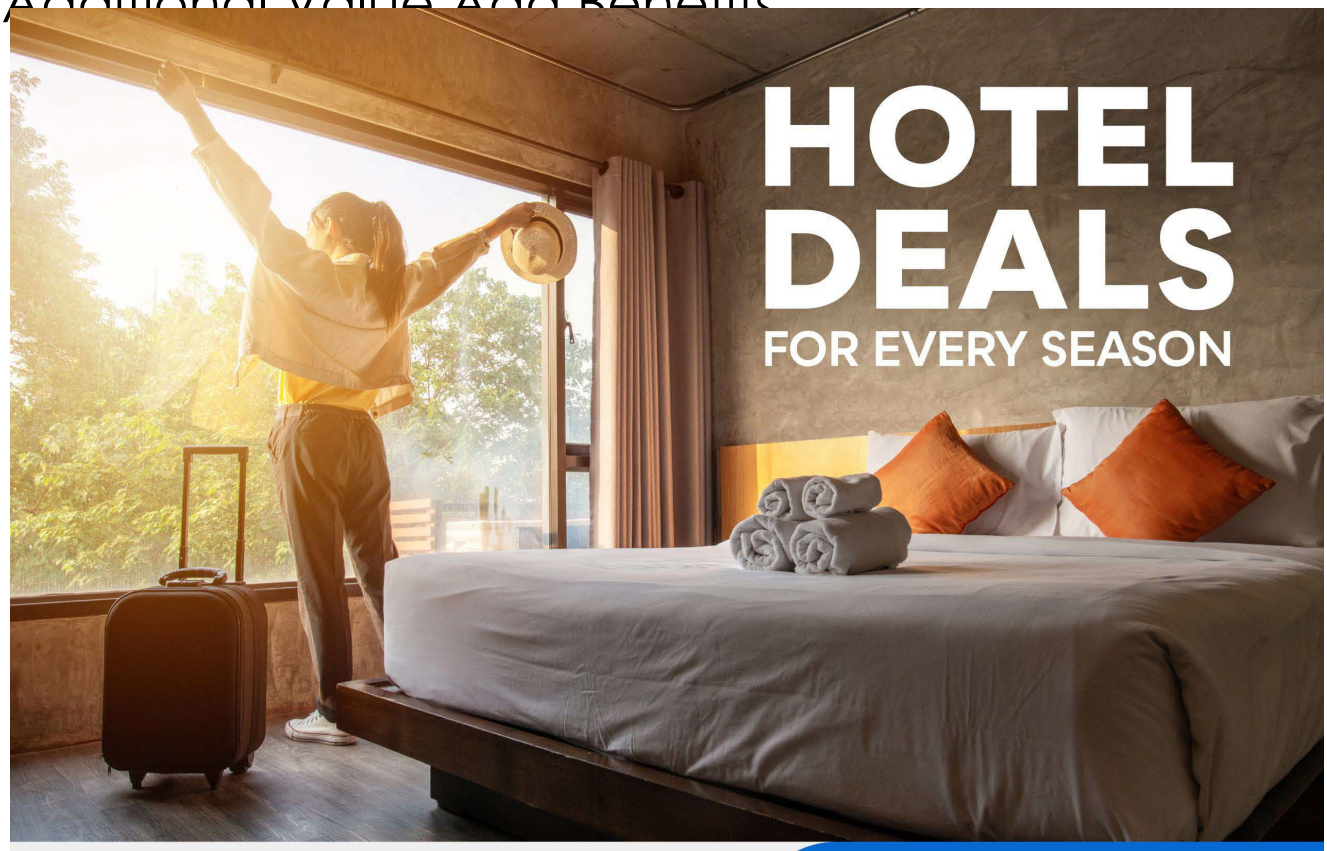
Service and Support - 24/7/365 100% US Based Customer Care, White Glove Resolution Services, one MetLife account team, and much more.

Protection Individual	Protection Family	Protection Plus Individual	Protection Plus Family
$8.95	$12.95	$10.95	$18.95



Financial Fraud Protection	Protection	Protection Plus
Credit Monitoring & Alerts	1 Bureau	3 Bureau
Annual Credit Report	1 Bureau	3 Bureau
Monthly Credit Score Tracker[5]	✓	✓
In-Platform Credit Dispute	✓	✓
Credit, Bank & Utility Account Freeze Assistance	✓	✓
Home & Vehicle Title Monitoring	✓	✓
Financial Account Opening & Takeover Monitoring	✓	✓
Financial Transaction Monitoring	✓	✓
High-Risk Transaction Alerts	✓	✓
Utility Account Monitoring	✓	✓
PayDay/Specialty Loan Block	✓	✓
Experian Credit Lock		✓
Credit Score Simulator		✓
Identity Theft Protection	**Protection**	**Protection Plus**
Privacy Assistant	✓	✓
Dark Web Monitoring	✓	✓
Digital Vault	✓	✓
SSN & Identity Authentication Alerts	✓	✓
Criminal, Court & Public Records Monitoring	✓	✓
USPS Address Monitoring	✓	✓
Social Media Monitoring & Takeover Alerts		✓
Gamertag Monitoring		✓
Social Media Privacy Checkup		✓
Privacy & Device Protection	**Protection**	**Protection Plus**
Password Manager & Automated Password Change	✓	✓
Email Alias	✓	✓
Safe Web Browsing	✓	✓
IP Address Monitoring	✓	✓
Wi-Fi Security/VPN	2 Devices	Unlimited Devices
Antivirus	2 Devices	Unlimited Devices
AI-Powered Call & Text Screening[7]		✓
Family Safety (Family Plans Only, Unlimited #of Children Covered)	**Protection**	**Protection Plus**
Parental Controls	✓	✓
Child Cyberbullying Protection	✓	✓
3-Bureau Child Credit Freeze Wizard	✓	✓
Child SSN Monitoring & Alerts	✓	✓
Sex Offender Geo Alerts	✓	✓
Secure Family Onboarding	✓	✓
Family Sharing	✓	✓
Child Safety Checklist	✓	✓
Unrestricted Family Definition	✓	✓
Services and Support	**Protection**	**Protection Plus**
$5M Insurance Policy per Enrolled Adult[6] • 401K & HSA • Senior & deceased family member identity theft • Home title identity theft • Cyber extortion/ ransomware	✓	✓
Lost Wallet Protection with $500 Emergency Cash	✓	✓
24/7/365 100% US-based Customer Care	✓	✓
White Glove Fraud Resolution Services	✓	✓
Restoration Services for Pre-Existing Fraud Events	✓	✓
Mobile App (iOS & Android)	✓	✓
Aura Account Security (2FA)	✓	✓

Additional Value Add Benefits



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401k Benefits

Community Care Partners (CCP) offers a robust 401(K) Plan to help you better prepare for retirement. Team members are eligible to participate in the plan on the first day of the month following 30 days of service or attaining age 18, whichever comes later.

Plan participants can contribute the lesser of 100% of their compensation or **$23,500** ($31,000 if age 50 or older) for the 2025 plan year. These contributions can be made as a Traditional Pre-Tax contribution, a Roth after-tax contribution, or any combination of the two.

CCP will also match your employee contributions at 100% of the first 3% you defer after 90 days of employment.

The employer contributions are deposited to your account each pay period and are immediately 100% vested. **This is free money, don't leave it sitting on the table!**

The plan is administered by John Hancock and enrollment must be completed via the John Hancock website at http://www.johnhancock.com/myplan. For additional information on enrolling in the plan please review the following pages.

Accessing John Hancock

With John Hancock, you'll find simple suggestions to help you in your journey to retirement. Contact us to access your account 24 hours a day, seven days a week.

Online

johnhancock.com/myplan

Once logged in, check out the personalized retirement planning tool. It's a unique and meaningful way to plan for your retirement.

Mobile Device

Download the free **mylifenow**® mobile application for your iOS or Android device or scan the QR code. Launch the app to log into your account using your username and password. Enroll in the retirement plan, and view your account balance, asset allocation and personal rate of return.

One-on-one Support

800-294-3575

For general account needs, call to access the Automated Voice Response Service or speak with a John Hancock representative. Representatives are available from 8 a.m. to 10 p.m. Eastern time on New York Stock Exchange business days.

Hablamos español – Llame al 888.440.0022 para informacion en español. Representantes están disponibles de lunes a viernes, de 8 a.m. a 10 p.m. hora del Este en días hábiles de la Bolsa de Valores de Nueva York.

877-525-7655

Call a Consolidation representative if you have past accounts that you'd like to combine into your current retirement account at John Hancock. Representatives are available Monday through Friday, 8:30 a.m. to 7 p.m. ET.^

866-401-2472

Changing jobs or retiring? Our Rollover Education Specialists can review your options with you and help you make a choice that reflects your financial needs. Our team is available Monday through Friday, 8:30 a.m. to

Access your retirement savings plan at any time from anywhere.

johnhancock.com/myplan

800-294-3575

Take action!

Be sure to bookmark johnhancock.com/myplan and add it to your favorites.

Accessing John Hancock's website

Whether you're registering for the first time, or you need a refresher, follow these steps to access your account online.

Register

Go to **johnhancock.com/myplan** and click on **Register Now**.

Step 1: **Tell us about yourself.** Enter your last name, Social Security number, and birthdate. Click **Continue**.

Step 2: **Create your username and password.** You'll also enter your email address and mobile phone number. Click **Create Profile**.

You're registered!

You can now use your username and password to login. If you ever forget, click on **Forgot your Username or Password**?

Still need to enroll in the plan?

If you haven't enrolled, you'll be prompted to do so after the registration process. Click **Get Started Now!**

Your future is important and planning for your retirement is part of it. **Take control and get online today!**

To learn more about protecting your account and profile, click on **Account Security** located at the bottom of the login page.

^ As other options are available, you are encouraged to review all of your options to determine if combining your retirement accounts is suitable for you.

*There are advantages and disadvantages to all rollover options; you are encouraged to review your options to determine if staying in a retirement plan, rolling over to an IRA, or another option is best for you.

John Hancock Retirement Plan Services, LLC offers administrative or recordkeeping services to sponsors and administrators of retirement plans, as well as a platform of investment alternatives that is made available without regard to the individualized needs of any plan. Unless otherwise specifically stated in writing, John Hancock Retirement Plan Services, LLC does not, and is not undertaking to, provide impartial investment advice or give advice in a fiduciary capacity. John Hancock Trust Company LLC provides trust and custodial services to such plans.

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The information in this Enrollment Guide is presented for illustrative purposes and the text contained herein was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Guide and the actual plan, documents the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about your Guide, contact Human Resources.

Important Notices

Notice of Patient Protections & Prior Authorization Procedures
Your **BPA** plan allows you to visit any doctor or hospital you choose. However, Prior Authorization is required for certain services. Make sure Your Provider obtains Prior Authorization before any planned hospital stays (except maternity admissions), skilled nursing and rehabilitative facility admissions, certain outpatient procedures, Advanced Radiological Imaging services, certain Specialty Drugs, and Durable Medical Equipment costing $500 or more. Contact **BPA** Customer Service using the number on the back of your medical ID card or online at www.bpaco.com to find out which services require Prior Authorization. You can also call the customer service department to find out if your admission or other service has received Prior Authorization. For more information, please refer to your Evidence of Coverage document located online at www.bpaco.com.

Women's Health and Cancer Rights Act of 1998
Patients who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to coverage for:
- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including Lymphedemas, in a manner determined in consultation with the attending physician and the patient.

The coverage may be subject to Coinsurance and Deductibles consistent with those established for other benefits. For more information, please refer to your Evidence of Coverage document located online at www.bpaco.com.

Newborns' and Mothers' Health Protection Act
Under federal law, group health plans and health insurance issuers offering group health insurance coverage 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 delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your Out-of-Pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Notice of Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact Human Resources.

Notice of Privacy Practices
BPA is required to maintain the privacy of all medical information as required by applicable laws and regulations; provide a notice of privacy practices to all Members; inform Members of the Plan's legal obligations; and advise Members of additional rights concerning their medical information. For more information, please refer to your Evidence of Coverage document located online at www.bpaco.com.
All Members will be notified of any changes by receiving a new notice of the Plan's privacy practices. You may request a copy of this notice of privacy practices at any time by contacting **BPA.**

Uniformed Services Employment and Reemployment Rights Act of 1994
A Subscriber may continue his or her Coverage and Coverage for his or her Dependents during military leave of absence in accordance with the Uniformed Services Employment and reemployment Rights Act of 1994. When the Subscriber returns to work from a military leave of absence, the Subscriber will be given credit for the time the Subscriber was covered under the Plan prior to the leave.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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

ALASKA – Medicaid	FLORIDA – Medicaid
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	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268

ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884

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

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

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739

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

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

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

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

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

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

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

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

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

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

NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

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

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20240 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Important Notice from **Community Care Partners** About Your Prescription Drug Coverage and Medicare for plans:

- **BPA HDHP (HSA)**
- **BPA PPO Plan**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage from ***Community Care Partners*** and about your options under Medicare's prescription drug coverage. This informationcan 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 coverageif 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. Community Care Partners has determined that the prescription drug coverage offered by the **BPA Plans** are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

Since the coverage under your **BPA Plan** is 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 didn't join, if you go 63 continuous days or longer without prescription drug coverage that's 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 **BPA Plan** coverage will not be affected. You can keep this coverageif you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current ***Community Care Partners*** coverage, be aware that you and your dependents will not be able to get this coverage back until next Annual Open Enrollment or a mid-year qualifying event.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	01/01/2025
Name of Entity/Sender:	***Community Care Partners***
Office Contact/Position:	Maria Pulido
Phone:	(458) 207-3657
Address:	600 Jefferson St, Ste 600,Lafayette LA 70501

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 6-30-2025)

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 eligiblefor a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact HUMAN RESOURCES DEPARTMENT.

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.

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

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 numberedto correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
COMMUNITY CARE PARTNERS	61-1849968
5. Employer address 600 Jefferson St, Ste 600	6. Employer phone number (458) 207.3657

7. City	8. State	9. ZIP code
Lafayette	La	70501

10. Who can we contact about team member health coverage at this job?	
Maria Pulido	
11. Phone number (if different from above)	12. Email address Maria.Pulido@ccpartners.com

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

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

☐ All employees. Eligible employees are:

Full-time employees working 30+ hours per week

☐ Some employees. Eligible employees are:

- With respect to dependents:

☑ We do offer coverage. Eligible dependents are:

☐
1. Legal Spouses
2. Domestic Partners (same and opposite sex)
3. Dependents up to age 26

☑ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to beaffordable, 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** will guide you through the process. Here's the employer information you'll enter when you visit **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 foremployers, but will help ensure employees understand their coverage choices.

13. **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** (don't 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 didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? $ 50.00

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 don't know, STOP and return form to employee.

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

☐ Employer won't 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 theplan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Carrier Contact	Contact Information
Medical **Benefits Plan Administrators (BPA)**	Phone: **1 (800) 236-7789** Medical Website: www.bpaco.com Rx Website: https://www.caremark.com/
Dental **MetLife**	Phone: **1 (800) 942-0854** Website: www.metlife.com
Vision **VSP**	Phone: **1 (800) 877-7195** Website: www.vsp.com
Life and AD&D, Voluntary Life and AD&D **MetLife**	Phone: **1 (866) 942-6983** Website: www.metlife.com
Disability **MetLife**	Phone: **1 (800) 300-4296** Website: www.metlife.com
Health Savings Account (HSA), Flexible Spending Accounts (FSAs) **Navia Benefit Solutions**	Phone: **1 (425) 452-3421** Website: www.naviabenefits.com
Team Member Assistance Program **MetLife**	Phone: **1 (800) 854-1446** Website: https://metlifeeap.lifeworks.com/ (**username**: metlifeassist **password**: support)
Legal Assistance (MetLaw) **MetLife**	Phone: **1 (800) 821-6400** Website: www.legalplans.com
Identity and Fraud Protections (Aura) **MetLife**	Phone: **1(844)931-2872** Website: https://my.aura.com/start

Your People & Organization Team

Contact Name	Title	Phone	Email
People & Organization			**benefits@ccpartners.com**

Community Care Partners