2024 Benefits Decision Guide

Mercer Marketplace 365+℠

Benefits Effective Through:
December 31, 2024

Welcome to Your 2024 Benefits Enrollment

Choose Your Benefits Now!

2024 Benefit Elections:

- You can elect or change your benefits for the 2024 plan year during your enrollment period.

Changing Your Benefit Elections:

- You can make changes to some of your benefits in 2024 if you experience a Qualifying Life Event (QLE), such as getting married or having a baby. You must make the change within 60 days of the birth/adoption or within 31 days of any other QLE.
- You can enroll year-round in Pet Insurance, Commuter Benefits and Auto and Home Insurance.

Here's How It Works

You can review your current benefits at: www.mycare.com via Workday or at www.mercermarketplace365plus.com/aegistherapies

Review the benefits available to you, which are summarized in this guide and on the website.

Select the benefits plans that meet your needs and budget to create your own benefits package.

What If I Don't Enroll?

- **Remember, you must secure your benefits before your enrollment deadline.**
- **If you do not enroll by your enrollment deadline, you will have no coverage.**

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the creditable prescription drug coverage and Medicare notice in the legal notices at the back of this booklet for more details.

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365+

Questions?

Mercer Marketplace 365+ is ready to help you understand your options and make the right choices for your needs and budget.

www.mercermarketplace365plus.com/aegistherapies

CHAT

Click to Chat

Virtual assistant available 24/7
or chat with a live Benefits Counselor
Monday – Friday, 8 am – 7pm ET

Phone

855-207-1986

Benefits Counselors available
Monday – Friday, 7 am – 9 pm ET

This Benefits Decision Guide provides an overview of the benefits available to eligible employees and their dependents. It should not be relied on as a binding legal document. In the event of any discrepancy, the official plan documents will govern in all cases.

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How to Enroll

Visit www.mycare.com to Start Your Enrollment

- Review your options and enroll by logging into www.mycare.com using your assigned credentials. From there, click on the Workday link under "Quick Links" and select the "Benefits Enrollment" application. Click on the "Benefits Enrollment MM365" link to be connected to MM365+. You can also directly access MM365+ at: www.mercermarketplace365plus.com/aegistherapies

Need Help?

If you don't have access to a computer or need assistance, you can enroll with a Benefits Counselor by calling
855-207-1986

Help is available via phone:
Monday – Friday, 7 am – 9 pm ET

Multi-factor Authentication (MFA)

The security of your information is critical, which is why we use multi-factor authentication.

- MFA combines your username and password with a temporary numeric code sent to you as an additional security factor to confirm your identity and keep your information safe.
- As part of the registration process, you will need to provide the last four digits of your Social Security Number (SSN), your last name, date of birth and zip code.
- Once the above information is verified, you will be prompted to choose either the email and/or phone number you provided to Aegis Therapies. A verification code will be sent to the device you selected. You will then be able to complete the registration process by entering the code.
- If an email or phone number has not been provided by Aegis Therapies, you will need to add an email address at this time. You can input an alternate email or phone number to be used for future verification.
- You will be required to go through the MFA verification code process every time you log in.

Cost of Coverage

Aegis Therapies offers you a competitive benefits program that provides flexibility to select coverage that best fits your needs and your budget. Aegis Therapies pays a portion of your coverage costs. You pay for any remaining costs for the benefits you select, which will be shown as you shop on Mercer Marketplace 365+.

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Medical and Prescription Drug Coverage

Medical coverage offers valuable benefits to help you stay healthy and pay for care if you or your covered family members become sick or injured.

Which Medical Plan is Right for You?

When you go online, you will have two options to navigate and select your benefits:

- Mercer Marketplace 365+ will show you one or more medical plans that best match your situation. While the decisions are yours, these matches will help you make an appropriate choice.
- You will have an experience similar to shopping online, navigating through different categories and adding benefits to your shopping cart. Just click "check out" when you are finished!

As you prepare, think about:

- How much healthcare and what type of care do you need this year?
- Do you prefer to pay less from your paycheck or less out of your pocket when you need care?

Have You Considered a High Deductible Health Plan?

High deductible health plans have lower premiums and may result in lower annual medical costs. These plans offer several advantages to reward you for taking an active role in your healthcare spending.

- Lower paycheck costs: Allows you to keep control over more of your money
- Tax-advantaged savings account: Enrolling in a Health Savings Account (HSA) helps you pay your deductible and out-of-pocket costs
- Aegis Therapies will contribute to your HSA, if enrolled in the HSA Plus Medical Plan, helping you with your out-of-pocket costs
- Comparable benefits: In-network preventive care is still 100% covered

Need More Coverage?

You may want additional coverage that pays benefits directly to you to help cover deductibles and out-of-pocket expenses.

Consider combining your medical coverage with Supplemental Medical Insurance. These plans are a great complement to your medical plan and can help reduce the financial risk associated with illness and injury.

Depending on your situation, you may be able to save money by purchasing a lower cost medical plan and adding one or more supplemental plans to achieve effective protection at a lower plan cost. Refer to the Supplemental Medical section for more information.

Critical Illness

Accident

Hospital Indemnity

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Medical and Prescription Drug Coverage

Using In-Network Providers

You'll save money when receiving care from an in-network provider. To access a list of in-network providers, click on the link provided on the Mercer Marketplace 365+ enrollment site. Using an out-of-network provider could result in more out-of-pocket costs.

Helpful Information about Deductibles and Out-Of-Pocket Maximums

PLAN	DEDUCTIBLE	OUT-OF-POCKET MAXIMUM
All Plans	Once one family member meets the Individual Deductible, benefits begin to be paid for that individual	Once one family member meets the Individual Out-of-Pocket Maximum, the plan pays covered benefits in full for that individual

Prescription Drug Coverage

- Your prescription drug coverage depends on the medical plan you choose. Medications are grouped into tiers, which determine your portion of the drug cost.
- High deductible health plan members pay 100% of the prescription drug costs until the annual deductible is met.
- The applicable coinsurance per prescription applies after the annual deductible has been met.

YOU PAY	WHAT'S COVERED*
Lowest Cost Sharing	**Most Generic Prescription Drugs** Generic drugs that are equivalent to a brand product in dosage form, strength, quality and intended use
Second-Lowest Cost Sharing	**Preferred Brand Name Drugs** Drugs sold under specific trade names that are favorably priced by the pharmacy plan
Highest Cost Sharing	**Non-Preferred Brand Name Drugs** Drugs sold under specific trade names that have a more cost-effective alternative compared to the lowest or the second-lowest cost sharing

*Some plans have additional prescription tiers. See plan documents for details.

Spousal Surcharge

If you cover your spouse on the BCBSTX medical insurance in 2024, you must complete the Spousal Surcharge attestation within MM365+ during Open Enrollment. The Spousal Surcharge will be $46.15 biweekly or $23.08 weekly, depending on your pay frequency.

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Medical and Prescription Drug Coverage

Review Your Medical Plan Options

Blue Cross Blue Shield of TX

Network: Blue Cross and Blue Shield of Texas Blue Choice PPO

Medical Plan Summary

The following benefits are included in your plan options. Unless otherwise noted, benefits are per insured person and after deductible.

	BLUE CROSS BLUE SHIELD OF TX PPO PLAN		BLUE CROSS BLUE SHIELD OF TX HSA PLUS PLAN		BLUE CROSS BLUE SHIELD OF TX HSA BASIC PLAN	
HEALTH SAVINGS ACCOUNT						
HSA Eligible	No		Yes		Yes	
HSA Employer Funding	N/A		$500 Individual $1,000 Family		None	
	IN-NETWORK	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
ANNUAL DEDUCTIBLE						
Individual	$3,000	$3,000	$3,200	$9,000	$4,500	$13,500
Family	$6,000	$6,000	$6,400	$18,000	$9,000	$27,000
OUT-OF-POCKET MAXIMUM						
Individual	$6,500	$6,500	$6,000	$18,000	$7,000	$21,000
Family	$13,000	$13,000	$12,000	$36,000	$14,000	$42,000
MEDICAL BENEFIT COVERAGE: EMPLOYEE COST SHARE RESPONSIBILITY						
Plan Coinsurance	20%	40%	20%	50%	30%	50%
Preventive Care	0%*	40%	0%*	50%	0%*	50%
Primary Care Visit	$35 copay*	40%	20%	50%	30%	50%
Specialist Visit	$50 copay*	40%	20%	50%	30%	50%
Inpatient Hospital	20%	40%	20%	50%	30%	50%
Outpatient Hospital	20%	40%	20%	50%	30%	50%
Urgent Care	$50 copay*	40%	20%	50%	30%	50%
Emergency Room	$250 copay, plus 20%	20%	20%	20%	30%	30%
RETAIL PRESCRIPTIONS (30-DAY SUPPLY): EMPLOYEE COST SHARE RESPONSIBILITY**						
Tier 1	20%	20%	20%	20%	20%	20%
Tier 2	35%	35%	35%	35%	35%	35%
Tier 3	50%	50%	50%	50%	50%	50%
MAIL-ORDER PRESCRIPTIONS (90-DAY SUPPLY): EMPLOYEE COST SHARE RESPONSIBILITY**						
Tier 1	10%	Not covered	10%	Not covered	10%	Not covered
Tier 2	25%	Not covered	25%	Not covered	25%	Not covered
Tier 3	35%	Not covered	35%	Not covered	35%	Not covered

*Deductible does not apply.

**Prescription deductible: PPO $50 individual/$100 family; HSA Plus and HSA Basic subject to medical deductible.

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Medical and Prescription Drug Coverage

Hawaii-HMSA

Network: HMSA HMO

Medical Plan Summary

The following benefits are included in your plan options if you live in Hawaii. Unless otherwise noted, benefits are per insured person and after deductible.

	HAWAII HMSA HMO PLAN	
	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE		
Individual	$350	Not covered
Family	$1,050	Not covered
OUT-OF-POCKET MAXIMUM		
Individual	$3,000 (Medical) / $3,600 (Pharmacy)	Not covered
Family	$9,000 (Medical) / $4,200 (Pharmacy)	Not covered
MEDICAL BENEFIT COVERAGE: EMPLOYEE COST SHARE RESPONSIBILITY		
Plan Coinsurance	20%	Not covered
Preventive Care	0%*	Not covered
Primary Care Visit	$20 copay*	Not covered
Specialist Visit	$20 copay*	Not covered
Inpatient Hospital	20%	Not covered
Outpatient Hospital	20%	Not covered
Urgent Care	$20 copay*	Not covered
Emergency Room	20%	20%
RETAIL PRESCRIPTIONS (30-DAY SUPPLY): EMPLOYEE COST SHARE RESPONSIBILITY		
Tier 1	$7 copay*	$7 copay*
Tier 2	$30 copay*	$30 copay*
Tier 3	$30 copay*	$30 copay* (all subject to 80% of remaining charge)
Tier 4	Preferred Specialty: $100 copay* Non-Preferred Specialty: $200 copay*	Not covered
MAIL-ORDER PRESCRIPTIONS (90-DAY SUPPLY): EMPLOYEE COST SHARE RESPONSIBILITY		
Tier 1	$11 copay*	Not covered
Tier 2	$65 copay*	Not covered
Tier 3	$65 copay*	Not covered
Tier 4	Not covered	Not covered

*Deductible does not apply

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Medical and Prescription Drug Coverage

Globe Life Limited Medical Plan

Network: Non-Standard

NOTE: This plan is NOT major medical insurance and has limited benefits. It is important that you read the plan details before choosing to enroll in this plan.

Medical Plan Summary

GLOBE LIFE GROUP LIMITED INDEMNITY	
DEFINITION OF BENEFIT	**BENEFIT AMOUNTS & MAXIMUMS**
HOSPITAL INDEMNITY BENEFITS	
Hospital Confinement For treatment in a hospital due to sickness or injury for 23 or more continuous hours (not less than a day)	$300 per day 5 days per year
Hospital Admission Lump sum benefit for a hospital admission, due to sickness or injury. Hospital Admission benefit for delivery of a healthy newborn child is payable for the mother only, unless the child is admitted due to sickness or injury.	$750 per admission 1 admission per year
SURGERY BENEFITS	
Outpatient Major Surgery For outpatient surgery in hospital or freestanding surgery center, due to sickness or injury.	$450 per day 1 day per year
Outpatient Minor Surgery For minor outpatient surgery due to sickness or injury; must be an eligible CPT code.	$75 per day 1 day per year
EMERGENCY ROOM	
Emergency Room For treatment in an ER due to sickness	$275 per day 2 days per year
Physician's Office/Urgent Care For services rendered by a physician at a physician's office or urgent care facility.	$75 per day 8 days per year
DIAGNOSTIC LAB, X-RAY AND TESTING BENEFITS	
Outpatient Lab For lab test, ordered by a physician	$100 per day 3 days per year
Outpatient X-ray For x-ray, ordered by a physician	$100 per day 3 days per year
OTHER BENEFITS	
Accident Lump Sum Benefit Rider - Option 2 Pays a percent of maximum benefit amount, based on the facility where treatment is received: • 100% for Hospital ICU Confinement • 50% for Hospital Confinement • 15% for Treatment in Emergency Room • 10% for treatment in Urgent Care/ Physician's Office Only one benefit is payable per accident. If an insured receives care in more than one facility for the same Accident, we will pay the highest applicable benefit. Treatment of injuries must begin within 72 hours of an accident and be received within an Incurral Period of 7-14 days of an Accident.	Up to $2,500

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NBFSA Prescription Discount Benefits

Included with Globe Life GLI Plan

Prescription Plan Summary

NBFSA PRESCRIPTION DISCOUNT BENEFITS OPTION 7*	
PREFERRED DRUG FORMULARY PRICING TIERS	**GENERICS AND BRAND**
Tier 1	$0
Tier 2	$10 or less
Tier 3	$25 or less
Tier 4	$50 or less
Non-formulary drugs	Discounts averaging $78 per prescription or 67% of U&C
Individual/ Family Limit per Month	None

*Pharmacy benefits provided by NBFSA. This is not offered or underwritten by Globe Life accident and Insurance Company

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Additional Medical Benefits

Aegis Therapies Offers You the Following Additional Health Benefits:

Musculoskeletal Digital Therapy

Hinge Health provides education and exercise therapy to help you overcome chronic back, knee, hip, neck or shoulder pain without drugs or surgery. Hinge Health is a no-cost digital program with access to a free tablet, wearable sensors and a personal coach. To access benefits: Visit Hingehealth.com/aegistherapies. Available to employees and covered family members enrolled in BCBSTX medical coverage.

Diabetes Management

Livongo Diabetes Management is a no-cost benefit that offers you an interactive blood glucose meter to sync with your phone, unlimited blood glucose test strips, personalized Health Nudges to support behavior change, digital tools across mobile, web and email, as well as expert coaching and monitoring. To access benefits: Visit join.livongo.com/aegistherapies/register. Available to employees and covered family members enrolled in BCBSTX medical coverage.

Telehealth

MDLive offers 24/7/365 telephonic or virtual visits with a board-certified physician for employees and covered dependents enrolled in the HSA Basic Medical Plan, HSA Plus Medical Plan, or the PPO Medical Plan. Connect with a physician from the comfort and convenience of your home through online video, mobile app, or phone. To access benefits: Download the MDLive app in your mobile device store. Available to employees and covered family members enrolled in a BCBSTX medical plan.

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Spending and Savings Accounts

Save money on your healthcare and dependent care costs through the use of tax-advantaged accounts that allows you to use before-tax dollars to pay for eligible expenses. For additional details about the following accounts, visit www.mercermarketplace365plus.com/aegistherapies.

What Are Eligible Healthcare Expenses?

For a complete list of eligible expenses, visit www.irs.gov and see Publication 502. Some examples may include out-of-pocket expenses for:

- Office visits and lab work
- Prescription drugs
- Hospital stays
- Speech/occupational/physical therapy
- Dental and vision care
- Eligible over the counter medications and supplies

Reminder: Keep documentation to support your use of the money in these accounts for tax purposes.

The FSA/HSA Store

The FSA/HSA Store is an online resource that allows you to easily access an extensive FSA and HSA Eligible Expenses list and a variety of health and wellness related articles. You can also make online purchases of FSA and/or HSA eligible medications, supplies and products. Look for the link in your Mercer Marketplace 365+ personal dashboard and use the FSA/HSA Store to ensure you are getting the most out of your benefits.

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Spending and Savings Accounts

Health Savings Account (HSA) – HSA Bank

With the Blue Cross Blue Shield HSA Basic and HSA Plus Plans, you may qualify to contribute money to a Health Savings Account. HSAs are tax-advantaged savings accounts you can use to help pay for eligible healthcare expenses as your contributions are accrued.

Key Features:

- **Even if you aren't planning to contribute, you must open an HSA account** in order to receive your employer's contribution (see HSA Contributions section below for details).
- **Works like a bank account**. You decide how much to contribute to your HSA (up to the IRS maximum) and can change that amount at any time. Access account funds to pay for eligible healthcare expenses by using your debit card when you receive care, or submit a claim for reimbursement for payments you've made (up to the available balance in your account).
- **It's tax-advantaged**. You don't pay taxes on contributions made from your paycheck or on reimbursements for qualified medical expenses. Plus, you can earn tax-free interest on your HSA balance.
- **It's your money**. Unused funds can be carried over each year. Once your account reaches a certain balance you will be able to choose how your money is invested. You can even take the account with you if you leave Aegis Therapies, or save it to use during retirement.

Please note, you do **not** qualify to contribute to an HSA if you:

- Are enrolled in Medicare or TRICARE
- Are covered by any health insurance other than a qualified high deductible health plan
- Can be claimed as a dependent on another person's tax return
- Will have access to funds in a Healthcare FSA established for you or another family member, including under a grace period from the prior plan year. This is a period of time after the end of the plan year during which you can continue to incur expenses in order to spend down the remaining account balance.

HSA Contributions

To help you start your HSA, Aegis Therapies will contribute:

- Individual coverage: $500/year
- Family coverage: $1,000/year

For 2024, you can make pre-tax contributions from your paycheck up to the following amounts, or to the maximum indexed amount announced by the IRS for the plan year, if different:

- Individual coverage: $4,150
- Family coverage: $8,300
- If you're age 55 or older, you can contribute an additional $1,000 per year.

The amounts listed above include both Aegis Therapies and your contributions, which cannot exceed the maximum allowable amount defined by the IRS. Proration rules may apply. Contributions are only provided for employees enrolled in the HSA Plus Medical Plan. HSA contributions made by both Aegis Therapies and you are accrued per pay period.

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Spending and Savings Accounts

Flexible Spending Accounts (FSA)

Flexible Spending Accounts provide a great way to save money on your health and dependent care expenses.

	HEALTHCARE FSA	DEPENDENT CARE FSA
Do You Have an HSA?	Not available if you or Aegis Therapies contribute to an HSA.	Eligible for a Dependent Care FSA whether or not you contribute to an HSA.
Eligible Expenses*	Medical, dental and vision expenses.	Child/elder care for eligible dependents that allow you and/or your spouse to work (medical, dental and vision expenses are not eligible for reimbursement with this account).
How It's Funded	• Paycheck contributions up to $3,050 per year (or to the maximum indexed amount announced by the IRS for the plan year, if different). • Your annual election amount is made during your enrollment period. You cannot change it unless you have a qualifying life event during the year (such as getting married or having a baby). • Your entire annual contribution is available to you at the beginning of the plan year.	• Paycheck contributions up to $5,000 per year per household (or to the maximum indexed amount announced by the IRS for the plan year, if different) to use for qualified dependent care or elder care expenses. Aegis Therapies matches 20 % of your contribution up to $833 per year. • Your election is made during your enrollment period. You cannot change it unless you have a qualifying life event during the year (such as having a baby or a change in dependent care expenses). • Your funds are only available to you after they have been deposited into your account each pay period.**
Unused Funds	Up to $610 of unused money can be carried over to the next plan year, as long as you re-enroll in the benefit. Amounts above $610 will be forfeited.	You should estimate your expenses carefully before enrolling because unused funds in your account do not carry over at the end of the plan year and are forfeited.
How to Access	You will receive a benefits debit card that you can use to pay for eligible expenses. Or, you can submit claims for reimbursement of eligible expenses. You may also download the HSA Bank app from the App Store or Google Play. NOTE: You'll receive one debit card to use for all of your Mercer Marketplace 365+ supported accounts.	

*Eligible expenses as defined by the IRS.

**Your contribution could be impacted by other reimbursements and your tax filing status. Consult your tax advisor for more information.

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Supplemental Medical Coverage

Aflac

Supplemental medical plans provide cash payments to help offset the cost of a covered medical event. These plans pay in addition to existing medical insurance benefits. ***Benefits and covered conditions vary by state. Review plan documents to verify covered benefits.***

Critical Illness

Recovering from a critical illness often brings significant expenses other than medical costs. Critical Illness insurance can help with the treatment costs of covered critical illnesses and complement your medical plan by helping to pay out-of-pocket expenses.

- Pays a lump-sum cash benefit directly to you if you are diagnosed with a covered critical illness
- You can qualify for coverage without having to answer any health questions
- Direct payment to you upon diagnosis of a covered condition
- Examples of conditions that may be covered include: cancer, heart attack, stroke, major organ transplant and end-stage renal failure
- Some programs offer additional wellness incentive

Accident Insurance

Accident insurance can help you bounce back quicker by providing cash benefits if you experience a covered accident outside of work.

- Examples of covered services include emergency room, hospitalization, doctor's visits and physical therapy*
- Additional benefits available for certain injuries, such as dislocations, fractures, burns and lacerations*
- Pays benefits for each covered occurrence directly to you

Hospital Indemnity

A hospital stay can cause serious financial setbacks due to medical costs or loss of income. Hospital Indemnity insurance provides benefits to help pay hospital and other bills related to a covered illness or injury.

- Benefits are provided for hospital admission and daily hospital confinement*
- Collect a lump-sum benefit each day you are in the hospital**
- No coinsurance, copays, waiting periods or deductibles

*Not a guarantee of coverage
**Limits apply

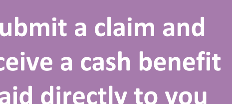
Benefit Examples

A supplemental medical policy is selected

You experience symptoms of a critical illness, are injured in an accident or are admitted to a hospital

You are treated by a physician or are admitted to a hospital

You are diagnosed with a critical illness, treated for injuries or spend several days in the hospital



Submit a claim and receive a cash benefit paid directly to you

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Mercer Marketplace 365+ HUB

Once you enroll in a medical plan, you are eligible to elect Mercer Marketplace 365+ HUB. With 365+ HUB, you will get personalized support to help improve the quality and cost of your care, 365 days a year.

Mercer Marketplace 365+ HUB Advantages Include:

- **Support for claims and billing issues, test results and treatments**

  A Personal Health Advocate (PHA) will guide you and your family through medical-related questions or concerns. PHAs can assist with finding a provider or facility and provide unbiased support throughout all phases of medical care. They are also available to help clarify and resolve medical claims and related paperwork issues.

- **Access to negotiation experts to help lower medical bills**

  Anytime you have a medical bill that is over $400 and not covered by insurance, a skilled negotiation team will work with your providers to get a discount. Successful negotiations can save hundreds of dollars.

- **Help finding doctors who provide high-quality care for your needs**

  With 365+ HUB, you can review the quality scores of doctors in your area. In-network physicians are ranked by data-driven quality scores for easy selection. You are more likely to get the care you need to recover faster and save money.

- **The best price for your healthcare services**

  The cost of healthcare can vary widely, even within the same area. It is important to know how much a service can cost in advance and compare costs.

- **An expert second opinion for peace of mind**

  Never hesitate to get another opinion, especially if it's for a serious condition. 365+ HUB gives you and your family access to world-class specialists that will review your case and give you an expert opinion on your diagnosis and treatment plan.

All this and more! Sign up for 365+ HUB to find out what other valuable assistance is just a phone call or a click away!

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Regular dental check-ups and good oral hygiene are an essential part of your general health and well-being.

Review Your Dental Plan Options

MetLife

(PDP Plus)

Dental Plan Summary

The following benefits are included in your plan options. Unless otherwise noted, benefits are per insured person and after deductible.

	METLIFE PDP PLUS DENTAL PLAN
ANNUAL DEDUCTIBLE	
Individual	$50
Family	$150
BENEFIT MAXIMUM	
Annual Maximum	$1,500
DENTAL BENEFIT COVERAGE	
Preventive Services	Plan pays 100%*
Basic Services	Plan pays 80%
Major Services	Plan pays 50%
ORTHODONTIA	
Benefit Coverage	Plan pays 50%
Lifetime Maximum	$1,250
Eligibility	Eligible children to age 19 and adults

*Deductible does not apply

In-network and out-of-network benefit provisions are the same, but may be applied differently for out-of-network services. Please refer to plan documents for additional details.

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Regular eye exams can help keep your eyes healthy, while monitoring, preventing and treating easily correctable vision problems, which can cause permanent vision impairment.

Review Your Vision Plan Options

VSP

Network: Advantage

Vision Plan Summary

The following in-network benefits are included in your plan options. Unless otherwise noted, benefits are per insured person.

	VSP ADVANTAGE VISION PLAN	
	COPAY	FREQUENCY
Exam	$10	Once every calendar year
Lenses	$20	Once every calendar year
Contact Lens Fitting	15% off contact lens exam	Once every calendar year
	RETAIL ALLOWANCE	FREQUENCY
Frames	Up to $140**	Every other calendar year
Contact Lenses*	Up to $130**	Every calendar year

*Contact lens coverage provided in lieu of frames and lenses
**20% off any amount over the retail allowance

Please refer to plan documents for out-of-network benefits and additional details.

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Employee Contributions

The per pay period contributions may differ slightly from what is shown on the enrollment site due to rounding. View additional rates for plans not listed below at www.mercermarketplace365plus.com/aegistherapies.

Medical Plan Rates (Per Bi-Weekly Pay Period)

	BCBSTX PPO	BCBSTX HSA PLUS	BCBSTX HSA BASIC	HMSA HMO	GLOBE LIFE LIMITED MEDICAL
Employee Only	$237.76	$74.91	$35.78	$0.00	$12.32
Employee + Spouse	$538.15	$171.14	$84.30	$223.60	$30.19
Employee + Child(ren)	$470.85	$149.85	$74.72	$185.52	$26.45
Employee + Family	$796.41	$233.41	$109.32	$311.47	$36.24

Dental Plan Rates (Per Bi-Weekly Pay Period)

	METLIFE DENTAL
Employee Only	$8.18
Employee + Spouse	$16.26
Employee + Child(ren)	$16.18
Employee + Family	$25.92

Vision Plan Rates (Per Bi-Weekly Pay Period)

	VSP VISION
Employee Only	$3.23
Employee + Spouse	$5.09
Employee + Child(ren)	$5.20
Employee + Family	$8.38

Medical Spousal Surcharge Rates (Per Bi-Weekly Pay Period)

	BCBSTX PPO	BCBSTX HSA PLUS	BCBSTX HSA BASIC
Employee Only	$237.76	$74.91	$35.78
Employee + Spouse	$584.30	$217.30	$130.45
Employee + Child(ren)	$470.85	$149.85	$74.72
Employee + Family	$842.56	$279.56	$155.48

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Life and Accidental Death and Dismemberment Insurance

Life and Accidental Death and Dismemberment (AD&D) insurance can provide important financial protection for your family.

Employer-Paid Term Life and AD&D Insurance

MetLife

Aegis Therapies provides you with a base level of employee term life and AD&D insurance at no cost to you. The Basic Life coverage provides a benefit of one times your annual base salary. The Basic AD&D coverage provides $25,000 for non-executives and $250,000 for executives.

Optional Employee-Paid Term Life and AD&D Insurance

MetLife

PLAN	DETAILS
Employee Term Life*	Elect in $10,000 increments, up to $500,000
Employee AD&D**	Elect in $50,000 increments, up to the lesser of times your salary or $1,000,000
Spouse Term Life	Elect in $5,000 increments, up to $200,000, not to exceed 50% of employee coverage
Child Term Life†	Elect in $2,000 increments, up to $10,000 Coverage ends at age 26

*Benefit reduction due to age may apply. Review plan documents for additional details.

**You may elect Optional AD&D coverage for yourself, or for yourself and your family. If Family AD&D is elected, dependent coverage is a portion of employee coverage and all of your eligible dependents are covered under one rate. No EOI is required for Optional AD&D coverage.

†All eligible children are covered for Child Term Life.

This coverage is tied to your employment and typically ends if you leave your employer. However, you may be offered the opportunity to retain coverage on your own with the same insurance carrier.

Evidence of Insurability (EOI):
Life insurance amounts over guaranteed issue coverage may require a statement of health and approval from the insurance carrier. After electing coverage, you will receive more information.

Don't Forget to Select a Beneficiary!
Choose a beneficiary to receive the policy's benefit payment in the event of the insured person's death. The employee is automatically listed as the beneficiary for dependent coverage.

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Disability Insurance

If you become disabled and are unable to work, disability insurance can replace a percentage of your lost income to help you continue to pay living expenses.

Disability Benefits Summary

Metlife

Optional Employee-Paid Disability

	EMPLOYEE-PAID SHORT TERM DISABILITY*	EMPLOYEE-PAID LONG TERM DISABILITY*
Benefit Provided	50% of salary	50% or 60% of salary
Maximum Benefit Amount	$500 per week	$20,000 per month
Maximum Benefit Period (including waiting period)	13 weeks	Until you no longer meet the definition of disability as defined by the policy
Waiting Period	14 days	90 days

*Evidence of insurability and/or pre-existing condition clause may apply.

If your employer is required under state law to offer you short term disability benefits, your disability benefits will be coordinated between your employer and the state. Check with your employer if this applies to you. Employees in CA, WA, NJ, RI, MA, and HI will not be offered short term disability.

For additional plan details, visit **www.mycare.com**

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Additional Benefits

Aegis Therapies provides access to a variety of additional programs that can help you save money and provide important assistance with everyday needs. For detailed benefits information, log on to www.mycare.com and visit the "Benefit Plan Information" link.

Employee Assistance Program

Magellan

Find solutions for the everyday challenges of work and home, as well as for your emotional and physical well-being issues.

This program can assist with:

- Childcare and/or eldercare referrals
- Personal relationship information and counseling
- Health management support and referrals
- Financial planning assistance
- Stress management

Help is easy to access:

- Telephone consultation: Speak confidentially with a master's-level consultant to clarify your need, evaluate options and create an action plan
- Face-to-face consultations: You and your dependents can consult with a local counselor up to 5 times per issue for short-term problem resolution
- Educational materials: Receive information on a variety of issues through a library of CDs and booklets
- Online resources: Access interactive tools, articles and free materials online

Legal Plan

ARAG

Finding an affordable attorney can be a challenge. This plan helps you find legal representation for you and your family for legal matters including:

- Wills and Estate Planning
- Family Law (Name Change, Adoption)
- Consumer Protection (Auto Repair, Consumer Fraud)
- Juvenile Court Matters (Includes Criminal Matters)
- Debt-Related Matters (Bankruptcy, Tax Audits)
- Elder Law Matters (Consultations, Document Review)
- Home and Real Estate Matters (Purchase or Sale of a Home, Security Deposits)

The plan is easy to use — no copayments, deductibles or waiting periods!

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Additional Benefits

Payroll Purchasing *Available year-round!*

Purchasing Power®

The need for major purchases can happen when you least expect it. This financing program makes it possible to buy products using payroll deduction when you may not have cash on hand or have limited credit options.

It's easy to shop for a new item from a selection of more than 50,000 options, featuring the latest technology and the name brands you want. There's no up-front cash or credit check required, and you'll enjoy manageable payments that come out of your paycheck in equal installments over 12 months.

Discount Program *Available year-round!*

PerkSpot

PerkSpot is a one-stop shop for exclusive discounts at many of your favorite national and local merchants. It's completely free and optimized for use on any device: desktops, tablets and phones. Take advantage of online offers and discover discounts in your neighborhood with PerkSpot's streamlined Local Map. Filter your map results by categories like restaurants, health and fitness, retail and more.

Opt in to PerkSpot's weekly email to receive a curated selection of discounts. Each week's email features both new and popular deals, as well as seasonal, holiday and group offers.

Commuter Benefits *Can be changed monthly!*

Commuter benefits can lower your costs by using before-tax dollars to pay for qualified transportation expenses, such as transit passes and parking. You decide how much to contribute, and the money will be automatically deducted from your paycheck and placed on a debit card for your use.

Medicare Assistance

SmartConnect

SmartConnect provides free Medicare resources, guidance, and enrollment assistance to employees and spouses aged 64 ½ years or above. Explore and access Medicare resources to compare options and get started confidently. A licensed insurance agent will help compare the costs and benefits of Medicare against your current coverage. Visit https://gps.smartmatch.com/aegis to get started!

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Additional Benefits

Auto/Home Insurance *Can be elected year-round!*

Farmers GroupSelect℠

Most auto and home insurance experts suggest you review your coverage annually to make sure you're getting the best coverage for your rates.

Purchasing auto and home insurance through Mercer Marketplace 365+ could provide you with savings of up to 15%. Farmers GroupSelect gives you access to a variety of personal insurance policies, including automobile, home*, condo*, landlord's rental dwelling, mobile home, renters, recreational vehicle, boat and personal excess liability.

You can elect auto/home insurance during open enrollment or throughout the year. Visit the link provided in the MM365+ enrollment system. Payment is available through direct billing.

Note: The Mercer Marketplace 365+ confirmation statement, which is generated once you have completed your 2024 elections, will not immediately show the Auto/Home Insurance election or the cost of the coverage.

*Home and condo coverage is not offered in Florida. There are coastal restrictions and volatility management plans (i.e. wildfires) in states across the US including Massachusetts, California and Louisiana.

Pet Insurance *Can be elected year-round!*

Nationwide Pet®

Pets are unpredictable. While it's hard to anticipate accidents and illnesses, Nationwide Pet Insurance makes it a little easier to be prepared for them. Nationwide Pet provides coverage for unexpected and significant medical incidents by providing protection for your pets when you need it.

Nationwide Pet policies cover many medical problems and conditions related to accidents and illnesses, including cancer. You are free to use any veterinarian worldwide—even specialists and emergency care providers. Best of all, Mercer Marketplace 365+ participants receive preferred pricing.

You will have the opportunity to elect pet insurance during your enrollment. If you choose "I'm interested," once you have confirmed your benefit elections, you will receive a link to enroll in or change your pet insurance coverage. Note: The Mercer Marketplace 365+ confirmation statement, which is generated once you have completed your 2024 elections, will not immediately show the pet insurance election or the cost of the coverage.

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Contact Information

You will find many details about the Aegis Therapies benefit plans on the Mercer Marketplace 365+ website. However, you can use this table if you need to contact a benefit provider directly. **Please note that some websites and phone numbers may not be accessible until your benefits take effect**.

BENEFIT	ADMINISTRATOR	PHONE NUMBER	WEBSITE
Enrollment Support	Mercer Marketplace 365+ Benefits Center	855-207-1986	www.mercermarketplace365plus.com/aegistherapies
Medical and Prescription	Blue Cross Blue Shield of TX	800-521-2227	www.bcbstx.com
	Hawaii-HMSA	800-776-4672	www.hmsa.com
	Globe Life Limited Medical	888-585-9038	www.firsthealth.com
Musculoskeletal Digital Therapy	Hinge Health	855-902-2777	www.hingehealth.com/aegis-oe
Diabetes Management	Livongo	800-945-4355 Access code: BCBSTX	join.livongo.com/BCBSTX/
Spending and Savings Accounts	HSA Bank	855-731-5220	www.myhsabankaccount.com
Supplemental Medical	Aflac	800-433-3036	www.aflacgroupinsurance.com
Mercer Marketplace 365+ HUB	Mercer Marketplace 365+	866-385-8032	www.mercermarketplace365plus.com/aegistherapies
Dental	Metlife	844-793-1451	www.metlife.com
Vision	VSP	800-877-7195	www.vsp.com
Term Life/AD&D	MetLife	844-793-1451	www.metlife.com/mercermarketplace
Disability	MetLife	844-793-1451	www.metlife.com/mercermarketplace
Legal	ARAG	800-247-4184	www.ARAGlegal.com/myinfo Access Code: 18321aeg
Commuter	HSA Bank	855-731-5220	www.myhsabankaccount.com
Auto/Home	Farmers GroupSelect	800-438-6381	www.myautohome.farmers.com
Pet Insurance	Nationwide Pet	844-208-1108	https://benefits.petinsurance.com/aegistherapies
Discount Program	PerkSpot	866-606-6057	www.perkspot.com
Purchasing Program	Purchasing Power	800-903-0801	www.purchasingpower.com/?domain=aegistherapies
MercerWise	MercerWise 401(k) & Roth 401(k)	833-637-2379	www.mercerwise.com
Employee Assistance Program (EAP)	Magellan Health	800-327-6764	Member.MagellanHealthcare.com
Medicare Assistance	SmartConnect	833-656-3005	gps.smartmatch.com/aegis

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Key Words to Know

Medical Insurance

- **Coinsurance:** Percentage of the charge **you pay**, typically after you have met the deductible
- **Copay:** An amount **you pay** for a covered service each time you use that service, which usually does not apply toward the deductible
- **Deductible:** The amount **you pay** before the plan begins to pay
- **Out-of-Pocket Costs:** Expenses **you pay**, such as deductibles, copays and the remaining amounts after plan coinsurance is paid
- **Out-of-Pocket Maximum:** The maximum amount **you pay** for covered services in a year (you may need to pay additional amounts if you receive care from an out-of-network provider)

Dental Insurance

The service definitions below are not guarantees of coverage; refer to Plan Documents to confirm covered services.

- **Annual Maximum Benefit:** Maximum total amount the plan will pay during the plan year
- **Basic Services:** Restorations, some oral surgery, endodontics and periodontics
- **Deductible:** The amount you pay before the plan begins to pay
- **Major Services:** Crowns, dentures, implants and some oral surgery
- **Orthodontia:** Straightening or moving misaligned teeth and/or jaws with braces and/or surgery
- **Preventive Services:** Designed to prevent or diagnose dental conditions, including oral evaluations, routine cleanings, X-rays, fluoride treatments and sealants

Vision Insurance

- **Copay:** An amount you pay for a covered service each time you use that service
- **Retail Allowance:** Maximum allowance paid toward the cost of vision materials; you are required to pay any amounts in excess of the retail allowance

Life Insurance

- **Accidental Death & Dismemberment Insurance:** Pays a benefit upon the accidental death of an insured person; also provides benefits for certain covered accidental dismemberments
- **Beneficiary:** Person or legal entity designated as the recipient of benefits from life or AD&D insurance
- **Evidence of Insurability (EOI):** Statement of health proving a person’s eligibility for certain amounts of coverage
- **Guaranteed Issue:** An amount of insurance that does not require evidence of insurability
- **Life Insurance:** Pays a benefit upon the death of an insured person

Disability Insurance

- **Actively at Work:** You are considered to be actively at work if you are performing all of the usual and customary duties of your job at your employer’s place of business (or an alternate place approved by your employer). Use of normal time off provided by your employer does not impact your actively at work status. If you are not working due to an illness, injury or leave of absence, you are not considered to be actively at work. If you are not actively at work you cannot enroll in or increase life, disability or supplemental medical coverage.
- **Short Term Disability:** When you are unable to work for a period of time due to a disabling illness or injury, short term disability insurance can replace a percentage of your lost income (up to a maximum weekly benefit) for a period of time as defined by the policy.
- **Long Term Disability:** When you are unable to work for an extended period of time due to a disabling illness or injury, long term disability insurance can replace a percentage of your lost income (up to a maximum monthly benefit) for a period of time as defined by the policy.

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Legal Notices

AEGIS THERAPIES RESERVES THE RIGHT TO CHANGE, AMEND OR TERMINATE ANY BENEFITS PLAN AT ANY TIME FOR ANY REASON. PARTICIPATION IN A BENEFITS PLAN IS NOT A PROMISE OR GUARANTEE OF FUTURE EMPLOYMENT. RECEIPT OF BENEFITS DOCUMENTS DOES NOT CONSTITUTE ELIGIBILITY.

The Benefits Decision Guide, combined with these legal notices, provides an overview of the benefits available to eligible employees and their dependents. In all cases, the official plan documents govern and this Benefits Decision Guide is not, and should not be relied upon as a governing document. In the event of a discrepancy between the information presented in the Benefits Decision Guide and official plan documents, the official plan documents will govern.

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) or Summary of Material Reductions (SMR), as applicable, to the Aegis Therapies Associate Group Health Plan summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

SUMMARY OF BENEFITS COVERAGE

A Summary of Benefits Coverage (SBC) for each of the employer-sponsored medical plans is available at www.mycare.com by clicking on the "Benefit Plan Information" link. You may also request a paper copy by calling Mercer Marketplace 365+.

MERCER'S ROLE AND COMPENSATION

Mercer Health & Benefits LLC facilitates the placement of insurance coverage on behalf of its clients.

Mercer is compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. This compensation may include payment from insurers for marketing-related expenses, technology investments or service fees. Our compensation may vary depending on the type of insurance purchased, the insurer selected and other factors such as the volume, growth and/or retention of Mercer's book of business with the insurer or service provider.

You may obtain additional information regarding our compensation by sending an email to mercermarketplace.compensation@mercer.com.

TAXATION OF BENEFITS

The taxation of certain benefits may vary at the local, state and federal level. You should consult your tax advisor if you have any questions about the proper treatment of any benefits.

IMPORTANT NOTICE FROM AEGIS THERAPIES ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Aegis Therapies medical plans is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2024. This is known as "creditable coverage."

Why this is important: If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2024 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty — as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Aegis Therapies and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

NOTICE OF CREDITABLE COVERAGE

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

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If you are covered by one of the Aegis Therapies prescription drug plans listed below, you'll be interested to know that the prescription drug coverage under the plan is, on average, at least as good as standard Medicare prescription drug coverage for 2024. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

- Blue Cross Blue Shield of TX PPO Plan
- Blue Cross Blue Shield of TX HSA Basic Plan
- Blue Cross Blue Shield of TX HSA Plus Plan
- Hawaii HMSA HMO Plan

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Aegis Therapies plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Aegis Therapies coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Aegis Therapies plan, assuming you remain eligible.
You should know that if you waive or leave coverage with Aegis Therapies and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future — such as before the next period you can enroll in Medicare prescription drug coverage, if this Aegis Therapies coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the *Medicare & You* handbook for the telephone number) or visit the program online at https://www.shiptacenter.org.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Aegis Therapies Benefits Department
4933 Old Greenwood Road
Fort Smith, AR 72903
855-207-1986
aegis-benefits@aegistherapies.com

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) SPECIAL ENROLLMENT NOTICE

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE
If you have declined enrollment in Aegis Therapies's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under these plans without waiting for the next Open Enrollment period, provided you request enrollment within 30 days after your other coverage ends.

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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Aegis Therapies will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

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For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Aegis Therapies group health plan. Note that this 60-day extension does not apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for special enrollment rights, you may add the dependent to your current coverage or change to another medical plan.

To request a HIPAA special enrollment based on the events described above or obtain more information, contact Aegis Therapies Benefits Department at aegis-benefits@aegistherapies.com.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA) NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your medical carrier at the phone number listed on the back of your ID card.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT NOTICE

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your medical carrier at the phone number listed on the back of your ID card.

MICHELLE'S LAW NOTICE

EXTENDED DEPENDENT MEDICAL COVERAGE DURING STUDENT MEDICAL LEAVES

The Aegis Therapies plan may extend medical coverage for dependent children if they lose eligibility for coverage because of a medically necessary leave of absence from a post-secondary educational institution (including a college or university). Coverage may continue for up to a year, unless the child's eligibility would end earlier for another reason.

Extended coverage is available if a child's leave of absence from school — or change in school enrollment status (for example, switching from full-time to part-time status) — starts while the child has a serious illness or injury, is medically necessary, and otherwise causes eligibility for student coverage under the plan to end. Written certification from the child's physician stating that the child suffers from a serious illness or injury and the leave of absence is medically necessary may be required.

If the coverage provided by the plan is changed during this one-year period, the plan will provide the changed coverage for the remainder of the leave of absence.

If your child will lose eligibility for coverage because of a medically necessary leave of absence from school and you want his or her coverage to be extended, call Mercer Marketplace 365+ at 1-855-207-1986 as soon as the need for the leave is recognized by Aegis Therapies. In addition, contact your child's health plan to see if any state laws requiring extended coverage may apply to his or her benefits.

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

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

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

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

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

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

<table>
<tr><th>ALABAMA – Medicaid</th><th>ALASKA – Medicaid</th></tr>
<tr><td>Website: http://myalhipp.com/
Phone: 1-855-692-5447</td><td>The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx</td></tr>
<tr><th>ARKANSAS – Medicaid</th><th>CALIFORNIA – Medicaid</th></tr>
<tr><td>Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)</td><td>Health Insurance Premium Payment (HIPP) Program Website:
http://dhcs.ca.gov/hipp
Phone: 916-445-8322 Fax: 916-440-5676
Email: hipp@dhcs.ca.gov</td></tr>
<tr><th>COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)</th><th>FLORIDA – Medicaid</th></tr>
<tr><td>Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442</td><td>Website:
https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268</td></tr>
<tr><th>GEORGIA – Medicaid</th><th>INDIANA – Medicaid</th></tr>
<tr><td>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2</td><td>Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584</td></tr>
<tr><th>IOWA – Medicaid and CHIP (Hawki)</th><th>KANSAS – Medicaid</th></tr>
<tr><td>Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562</td><td>Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660</td></tr>
<tr><th>KENTUCKY – Medicaid</th><th>LOUISIANA – Medicaid</th></tr>
<tr><td>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</td><td>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)</td></tr>
<tr><th>MAINE – Medicaid</th><th>MASSACHUSETTS – Medicaid and CHIP</th></tr>
<tr><td>Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 TTY: Maine relay 711</td><td>Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com</td></tr>
</table>

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MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

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PHYSICIAN DESIGNATION NOTICE

The Hawaii HMSA generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Hawaii HMSA at 1-800-776-4672

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

AEGIS THERAPIES HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Aegis Therapies health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium or as an oral communication. This notice describes the privacy practices of these plans: Blue Cross Blue Shield of TX PPO Plan, HSA Basic Plan, HSA Plus Plan and Healthcare Flexible Spending Account. The plans covered by this notice may share health information with each other to carry out treatment, payment or healthcare operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

THE PLAN’S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan’s legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It’s important to note that these rules apply to the Plan, not Aegis Therapies as an employer — that’s the way the HIPAA rules work. Different policies may apply to other Aegis Therapies programs or to data unrelated to the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of healthcare treatment, payment activities and healthcare operations. Here are some examples of what that might entail:

- **Treatment** includes providing, coordinating, or managing healthcare by one or more healthcare providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for healthcare. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing “behind the scenes” plan functions, such as risk adjustment, collection or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- **Healthcare operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service and internal grievance resolution. Healthcare operations also include evaluating vendors; engaging in credentialing, training and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses Personal Health Information (PHI) for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH AEGIS THERAPIES

The Plan, or its health insurer or Health Maintenance Organization (HMO), may disclose your health information without your written authorization to Aegis Therapies for plan administration purposes. Aegis Therapies may need your health information to administer benefits under the Plan. Aegis Therapies agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources (only on a need to know basis) are the only Aegis Therapies employees who will have access to your health information for plan administration functions.

Here’s how additional information may be shared between the Plan and Aegis Therapies, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose “summary health information” to Aegis Therapies, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants’ claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Aegis Therapies information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

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In addition, you should know that Aegis Therapies cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Aegis Therapies from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative. The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

- **Workers' compensation**: Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
- **Necessary to prevent serious threat to health or safety:** Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
- **Public health activities:** Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
- **Victims of abuse, neglect, or domestic violence:** Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
- **Judicial and administrative proceedings:** Disclosures in response to a court or administrative order, subpoena, discovery request or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
- **Law enforcement purposes:** Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
- **Decedents:** Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
- **Organ, eye or tissue donation:** Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
- **Research purposes:** Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
- **Health oversight activities:** Disclosures to health agencies for activities authorized by law (audits, inspections, investigations or licensing actions) for oversight of the healthcare system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
- **Specialized government functions**: Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
- **HHS investigations:** Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

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The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the Contact section at the end of this notice for information on how to submit requests.

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE PLAN'S RIGHT TO REFUSE

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or healthcare operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your healthcare provider) or its business associate must comply with your request that health information regarding a specific healthcare item or service not be disclosed to the Plan for purposes of payment or healthcare operations if you have paid out of pocket and in full for the item or service.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a healthcare provider; enrollment, payment, claims adjudication and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal or administrative proceedings).

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If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION
You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the Other Allowable Uses or Disclosures of your Health Information section earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment or healthcare operations.
- To you about your own health information.
- Incidental to other permitted or required disclosures.
- Where authorization was provided.
- To family members or friends involved in your care (where disclosure is permitted without authorization).
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances.
- As part of a "limited data set" (health information that excludes certain identifying information).

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE PLAN UPON REQUEST
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

CHANGES TO THE INFORMATION IN THIS NOTICE
The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2024. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice.

COMPLAINTS
If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact Aegis Therapies Benefits Department at aegis-benefits@aegistherapies.com.

CONTACT
For more information on the Plan's privacy policies or your rights under HIPAA, contact Aegis Therapies Benefits Department at aegis-benefits@aegistherapies.com.

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NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Note: References to the "Marketplace" in this notice refer to the federal public health insurance marketplace and not Mercer Marketplace 365+.

PART A: GENERAL INFORMATION

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

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

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 8.39% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

[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.

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

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact Aegis Therapies Benefits Department at aegis-benefits@aegistherapies.com.

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

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

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

1. Employer name	**Aegis Therapies**	2. Employer Identification Number (EIN)	**71-0811574**
3. Employer address	**2601 Network Blvd, Suite 102**	4. Employer phone number	**866-552-3913**
5. City	**Frisco**	6. State **TX**	7. Zip Code **75034**
8. Who can we contact about employee health coverage at this job?	**Aegis Therapies Benefits Department**		
9. Phone number (if different from above)	**479-201-6071**	10. Email address	**Aegis-benefits@aegistherapies.com**

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

As your employer, we offer a health plan to:

- ☐ All employees.
- ☑ Some employees. Eligible employees are: Full-time employees working 30 or more hours per week.

With respect to dependents:

- ☑ We do offer coverage. Eligible dependents are: Eligible dependents are: Spouse, Child(ren) (including disabled and court-ordered dependents) and Stepchild(ren).
- ☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

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