The choice is yours.

2024

Benefit Guide

29TH STREET

BENEFITS FOR A HEALTHY LIFE

Your 2024 benefit choices

WELCOME TO YOUR BENEFITS ENROLLMENT

We recognize how important benefits are to you. That's why we're committed to helping you and your family enjoy the best possible physical, financial, and emotional well-being. It's also why we provide you with a comprehensive, highly competitive benefits package, with the flexibility to make the choices that best meet your needs.

Use this guide to better understand your 2024 benefits options. Then, be sure to make your choices by the enrollment deadline to receive coverage for the coming year.

Inside this guide

Important Reminders

- **Enroll within 30 days from your date of hire.** If you don't enroll within this time period, you will not have benefits coverage, except for plans and programs that are fully paid by the Company, such as Basic Life insurance and short-term disability
- **After your enrollment opportunity ends, you will not be able to make changes to your benefits** until the next Open Enrollment, unless you experience a qualifying life event, such as marriage, divorce, birth of a child, adoption, or a change in your or your spouse's employment status that affects benefits eligibility.
- **There will be no exceptions for those who miss the deadline and want to change their coverage.**

Benefit Eligibility

All full-time employees working 30+ hours a week are eligible for benefits on their first day of employment, except for Aflac voluntary benefits which become effective first day of the month after enrollment.

To enroll in benefits, employees must sign in to Paycom and select coverage within the first 30 days of employment. Please see page 13 on instructions on how to enroll.

Need to add a dependent?

Be sure to submit the appropriate documentation (such as marriage certificate, birth certificate, etc.) to Human Resources. Timely submission and approval of these documents affects when your benefits become effective!

Virtual Benefits Fair

Walk through the Virtual Benefits Fair to see all of the exciting benefits 29th Street has to offer!
Enter the fair at https://www.virtualfairhub.com/haven
and come back anytime throughout the year. Save this link as a Favorite on your web browser.

Summary of Benefits and Coverage

The Health section of this guide provides an overview of your medical plan options. You can find detailed information about each plan, including a breakdown of costs, in each plan's Summary of Benefits and Coverage (SBC). The SBCs summarize important information about your health coverage options in a standard format to help you compare costs and features across plans. The SBCs are available on Paycom.

HEALTH

Quality health coverage is one of the most valuable benefits you enjoy as a 29th Street employee. Our benefits program offers plans to help keep you and your family healthy and also provide important protection in the event of illness or injury.

Medical

For 2024, you have a choice of Anthem medical plans giving you the flexibility to choose what's best for your needs and your budget.

- **$5,000 HDHP with an HSA,** a medical plan with the lowest paycheck deductions and highest out-of-pocket costs. 29th Street will contribute $500 towards your Health Savings Account (HSA) in 2024.
- **$3,750 PPO plan** a medical plan with lower paycheck deductions than the $1,500 PPO plan but higher out-of-pocket costs.
- **$1,500 PPO plan**, a medical plan with the highest employee paycheck deduction but the lowest medical out-of-pocket cost.

Key features

All of 29th Street medical plans offer:

- Comprehensive, affordable coverage for a wide range of health care services.
- Flexibility to see any provider you want, although you'll save money when you stay in-network.
- In-network preventive care, with services covered at 100%, including annual physicals, recommended immunizations, well-woman and well-child exams, flu shots, and routine cancer screenings.
- Prescription drug coverage included with each medical plan.
- Financial protection through annual out-of-pocket maximums that limit the amount you'll pay each year.

Anthem

LiveHealth Online

What is LiveHealth Online?
LiveHealth Online lets you have a video visit with a board-certified doctor using your smartphone, tablet or computer with a webcam. No appointments, no driving and no waiting at an urgent care center. Doctors are available 24/7 to assess your condition and, if it's needed, they can send a prescription to your local pharmacy.

Use LiveHealth Online if you have pinkeye, a cold, the flu, a fever, rashes, infections, allergies or another common health condition. It's faster, easier and more convenient than a visit to an urgent care center.

Why would I use LiveHealth Online instead of going to visit my doctor in person?
LiveHealth Online isn't meant to replace your primary care doctor. It's a convenient option for care when your doctor isn't available. LiveHealth Online connects you with a doctor in minutes. Plus, you can get a LiveHealth Online visit summary from the MyHealth tab at livehealthonline.com to print, email or fax to your primary care doctor

When is LiveHealth Online available?
Doctors are available 24/7, 365 days a year.

What if I still have questions about using LiveHealth Online?
Send an email to customersupport@livehealthonline.com or call too free at **1-888-548-3432**

Medical plan costs

You and 29th Street share the cost of your medical benefits — 29th Street pays a generous portion of the total cost and you pay the remainder through payroll deductions. Your specific cost is based on the plan and coverage level you select.

2024 per bi-weekly paycheck cost

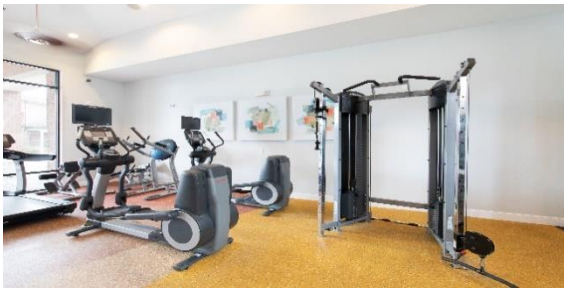
Coverage Tier	$5,000 HDHP	$3,750 PPO	$1,500 PPO
	Employee Pays	Employee Pays	Employee Pays
Employee Only	$35.49	$60.49	$108.87
Employee + Spouse	$267.03	$319.53	$421.12
Employee + Child(ren)	$226.60	$271.59	$358.68
Employee + Family	$406.90	$486.90	$641.71

Compare Anthem medical plans

The chart below provides a comparison of key coverage features and costs.

	$1,500 PPO Plan		$3,750 PPO Plan		$5,000 HDHP*	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Annual deductible						
Per person/per family	$1,500/$3,000	$4,500/$9,000	$3,750/$7,500	$11,250/$22,500	$5,000/$10,000	$12,500/$25,000
Out-of-pocket maximum						
Per person/per family	$7,500/$15,000	$15,000/$30,000	$8,550/$17,100	$15,000/$30,000	$5,000/$10,000	$15,000/$30,000
Medical coverage						
Doctor's office visits	$20 Preferred PCP/ $30 PCP/ $50 SPC copay	50% after deductible	$20 Preferred PCP/ $30 PCP/ $60 SPC copay	50% after deductible	0% after deductible	30% after deductible
Preventive care	No charge	50% after deductible	No charge	50% after deductible	No Charge	30% after deductible
Specialist visits	$50 copay	50% after deductible	$60 copay	50% after deductible	0% after deductible	30% after deductible
Telemedicine	$20 Preferred PCP/ $30 PCP/ $50 SPC copay	50% after deductible	$20 Preferred PCP/ $30 PCP/ $60 SPC copay	50% after deductible	0% after deductible	0% after deductible
Outpatient surgery	20% after deductible	50% after deductible	20% coinsurance	50% after deductible	0% after deductible	30% after deductible
Inpatient hospital (per stay)	20% after deductible	50% after deductible	20% coinsurance	50% after deductible	0% after deductible	30% after deductible
Urgent Care/ Emergency room	$50 copay/ $300 copay	50% after deductible/ $300 copay	$60 copay/ $300 copay	50% after deductible/ $300 copay	0% after deductible	30% after deductible
Outpatient Labs and X-rays	20% after deductible	50% after deductible	20% coinsurance	50% after deductible	0% after deductible	30% after deductible
Retail prescription drugs (30-day supply)						
Generic	$15 copay	50% coinsurance	$15 copay	50% coinsurance	0% after deductible	30% after deductible
Preferred Brand	$35 copay	50% coinsurance	$35 copay	50% coinsurance	0% after deductible	30% after deductible
Non-Preferred Brand	$60 copay	50% coinsurance	$60 copay	50% coinsurance	0% after deductible	30% after deductible
Specialty (retail and mail order)	25% coinsurance up to $350	50% coinsurance	25% coinsurance up to $350	50% coinsurance	0% after deductible	30% after deductible
Mail-order prescription drugs (90-day supply)						
Generic	$38 copay	Not covered	$38 copay	Not covered	0% after deductible	Not covered
Preferred Brand	$88 copay	Not covered	$88 copay	Not covered	0% after deductible	Not covered
Non-Preferred Brand	$150 copay	Not covered	$150 copay	Not covered	0% after deductible	Not covered

*Enrollment in the $5,000 HDHP qualifies you for a Health Savings Account (HSA) account. 29th Street will provide a $500 employer contribution to the HSA account in 2023 to pay for qualified health expenses.



A closer look at High Deductible Health Plan (HDHP)

The high deductible health plan (HDHP) costs you less from your paycheck, so you keep more of your money. This rewards you for taking an active role as a health care consumer and as a result could save you on your health care costs.

HDHP advantages

1. Lower paycheck costs

Your per-paycheck costs are lower compared to 29th Street's other health plans, giving you the opportunity to contribute the cost savings to a tax-free (federal taxes) Health Savings Account (HSA). You pay for your initial medical costs until you meet your annual deductible, and then you pay a percentage of any further costs until you reach the annual out-of-pocket maximum.

2. Tax-advantaged savings account

To help you pay your deductible and other out-of-pocket costs, the HDHP qualifies you to open a Health Savings Account (HSA) and make tax-free contributions directly from your paycheck. 29th Street will also contribute $500 to your HSA in 2024.

All withdrawals from your HSA are tax-free, as long as you use the money to pay for eligible health care expenses. In addition, all the money in the account is yours and will never be forfeited. It rolls over from year to year, and you can take it with you if you leave the Company or retire. After age 65, you can withdraw funds for any reason without a tax penalty — you pay ordinary income tax only if the withdrawal isn't for eligible health care expenses.

Note: You won't pay federal taxes on HSA contributions. However, you may pay state taxes depending on your residence. Consult your tax advisor to learn more.

3. Free in-network preventive care

As with all 29th Street health plans, preventive care is fully covered under the HDHP — you pay nothing toward your deductible and no copays as long as you receive care from in-network providers. Preventive care includes annual physicals, well-child and well-woman exams, immunizations, flu shots, and cancer screenings.

4. Extensive provider network

The HDHP uses Anthem's large network of doctors and other health care providers.

Using a HDHP

1 **Free Preventive Care**	You pay nothing for in-network preventive care.
2 **Deductible**	You pay 100% of your medical expenses up to the annual deductible amount. Use your HSA to plan ahead for these costs.
3 **Coinsurance**	You and the plan share costs once you meet your deductible, until you reach the out-of-pocket maximum.
4 **Out-of-pocket Maximum**	You're protected by an annual limit on costs. The plan starts to pay 100% once you've paid this amount during the year.

Money-saving tip

If you enroll in the HDHP, put the money you save through lower paycheck deductions into your tax-free HSA so you'll have money available when you need to pay out-of-pocket costs.

Health Savings Account (HSA)

If you enroll in the HDHP, you are eligible to open an HSA. An HSA is a tax-free savings account you can use to pay for eligible health expenses anytime, even in retirement.

How does an HSA work?

- **Build tax-free savings for health care.** You can make before-tax deductions from your paycheck into your HSA, allowing you to save money by using tax-free dollars to pay for eligible medical, prescription, dental, and vision expenses. The total amount that can be contributed to your HSA each year is limited by the IRS. The following limits for 2024 include any company contributions you receive:
  - Up to $4,150 for employee-only coverage.
  - Up to $8,300 if you cover dependents.
  - Add $1,000 to these limits if you're age 55 or older.

- **Receive Company contributions.** For 2024, 29th Street will make the following contributions to your account if you enroll in the 29th Street HDHP:
  - $500 total yearly contribution

Important: 29th Street will contribute $19.23 per paycheck. New hires between contribution dates will receive a pro-rated contribution amount.

- **Keep your money.** The money in your HSA is always yours to keep and can be rolled over from year to year. You can take your unused balance with you when you retire or leave 29th Street.
- **Use it like a bank account**. Pay for eligible medical, prescription, dental, and vision expenses for yourself and your family by swiping your HSA debit card, or reimburse yourself for payments you've made (up to the available balance in your account). Keep in mind that you may only access money that is actually in your HSA when making a purchase or withdrawal. There's no need to turn in receipts (but keep them for your records).
- **Earn interest and invest for the future.** Once your interest-bearing HSA reaches a minimum balance, you can invest in a variety of no-load mutual funds similar to 401(k) investments.
- **Never pay taxes.** Contributions are made on a before-tax basis, and your withdrawals will never be subject to federal income taxes when used for eligible expenses. Any interest or earnings on your HSA balance build tax-free, too.
- **Money in an HSA grows tax-free** and can be withdrawn tax-free if it is used to pay for qualified health care expenses (for a list of eligible expenses, see IRS Publication 502, available at www.irs.gov). If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn plus a 20% penalty tax if you withdraw the money for ineligible expenses before age 65. After age 65, withdrawals for ineligible expenses are only subject to ordinary income tax. Please review your state regulations as you may have to pay state taxes depending on your residency.

HSA eligibility

In order to establish and contribute to an HSA, you:

- Must be enrolled in a high deductible health plan, like 29th Street's HDHP.
- Cannot be covered by any other medical plan that is not a qualified high deductible plan. This includes a spouse's medical coverage unless it's an HSA-qualified plan.
- Cannot be enrolled in a traditional health care FSA in 2024.
- Cannot be enrolled in Medicare, including Parts A or B, Medicare, or TRICARE.
- Cannot be claimed as a dependent on another person's tax return.
- Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months.

Dental

Healthy teeth and gums are important to your overall wellness. That's why it's important to have regular dental checkups and maintain good oral hygiene. Learn about the dental plan available to help you maintain your oral health.

Delta Dental	In-Network	Out-of-Network
Annual deductible (per person/per family)	$50/$150	$50/$150
Calendar-year maximum	$1,500	$1,500
Preventive/diagnostic services	100%	100%
Basic services	80%	80%
Major services	50%	50%
New in 2024! Orthodontia	$1,500 (Dependent children only, up to end of the month of age 19)	$1,500 (Dependent children only, up to end of the month of age 19)

Benefits shown are for in-network providers and are based on negotiated fees. Out-of-network coverage is based on a Delta Dental fee schedule and you could be billed by the provider for the difference.

Dental 2024 bi-weekly deductions

	Employee	Employee + Spouse	Employee + child(ren)	Family
You Pay	$1.18	$12.86	$18.51	$34.33

Vision

Having vision coverage allows you to save money on eligible eye care expenses, such as periodic eye exams, eyeglasses, contact lenses, and more for you and your covered dependents.

Anthem	In-Network	Out-of-Network
Exam (once per calendar year)	$10 copay	Up to $42
Lenses (once per calendar year) Single Bifocal Trifocal	 • $15 copay • $15 copay • $15 copay	 • Up to $40 • Up to $60 • Up to $80
Frames (once per every other calendar year)	$130 allowance	Up to $45
Contact lenses (medically necessary)	Materials 100%	Materials up to $210
Contact lenses (elective)	$130 materials allowance	Materials up to $105
Corrective Vision Services (e.g. Laser Surgery)	LASIK & PRK 15%-20% discount	Not covered

Vision 2024 bi-weekly deductions

	Employee	Employee + Spouse	Employee + child(ren)	Family
You Pay	$0.32	$3.44	$3.12	$6.52

Money-saving tip

Remember, you can use your health savings account (HSA) for qualified out-of-pocket dental, vision, and pharmacy drug expenses.

Wellness

Your benefits include programs to help keep you and your family healthy. See below the Anthem programs you can participate in free of charge.

Anthem Wellbeing Solutions Program

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

Activity Type	Activities	Amount
Preventative Care	Have an annual preventive wellness exam or well woman exam with your doctor	$25
	Get an annual cholesterol test	$20
	Have a colorectal cancer screening (ages 45 and older)	$25
	Have a routine mammogram (women ages 40 to 74)	$25
	Have an annual eye exam	$25
	Get an annual flu shot	$20
	Get an annual dental exam	$25
Condition Management	ConditionCare: Work one-on-one with your health coach and earn rewards for participating in and completing the program	Up to $50
	Future Mons: Moms-to-be can receive support from a registered nurse and earn rewards for completing initial, interim, and postpartum assessments	Up to $50
	Well-being Coach- Weight management: Receive one-on-one coaching by phone as you complete your goal to earn a reward	$25
	Well-being Coach- Tobacco Cessation: Receive one-on-one coaching by phone as you complete your goal to earn a reward	$25

**View the additional activities you can complete to earn rewards on the Sydney App or at anthem.com

Use your rewards

1. To view your rewards, open the Sydney Health app or go to **anthem.com**. Next, go to *My Health Dashboard*
2. Select **My Rewards**
3. Select **Redeem Rewards** to see how much you've earned. Use your rewards toward electronic gift cards from popular retailers, including: Amazon, Bed Bath & Beyond, Gap Options (all brands), Apple, Target, The Home Depot, and TJ Maxx.

Sydney Health Mobile App

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

FINANCIAL

Your benefits include programs to help ensure financial security for you and your family. We also provide access to voluntary benefits designed to help you save money on valuable supplemental insurance coverage.

Employee basic life and AD&D insurance

You automatically receive basic life and accidental death and dismemberment (AD&D) insurance so that you can protect those you love from the unexpected. There is no cost to you for this coverage. Your benefit amount will be $25,000. Your basic life benefit will be reduced by 35% at age 65 and 50% at age 70.

Employee voluntary life and AD&D insurance

If you want added protection, you can purchase supplemental life and/or AD&D insurance for yourself. You may elect coverage in $15,000 increments up to the lesser of 5 times your base annual salary or $500,000.

Spouse voluntary life and AD&D insurance

You may also purchase life and/or AD&D insurance for your spouse in $5,000 increments up to $250,000 (not to exceed 100% of approved employee coverage). Your supplemental life benefit will be reduced by 35% at age 65 and 50% at age 70.

Voluntary Life insurance rates

Monthly rates per $1,000 of coverage (before-tax)		
	Employee voluntary life	Spouse voluntary life
Under 25	$0.075	$0.065
25-29	$0.075	$0.065
30-34	$0.075	$0.075
35-39	$0.105	$0.085
40-44	$0.145	$0.125
45-49	$0.215	$0.185
50-54	$0.325	$0.285
55-59	$0.515	$0.445
60-64	$0.715	$0.645
65-69	$1.255	$1.255
70-74	$2.285	$2.045
75+	$4.385	$3.795
Child Life	Monthly rate per $10,000	$1.489

AD&D insurance rates (all ages)	
Employee voluntary AD&D	Monthly rate per $1,000 = $0.015
Spouse AD&D	Monthly rate per $1,000 = $0.015
Child AD&D	Monthly rate per $10,000 = $0.30

Child voluntary life insurance

Optional child life insurance provides $10,000 of life insurance for newborn children through 26 years old.

Federal tax law requires 29th Street to report the cost of company-paid life insurance in excess of $50,000 as imputed income. AD&D benefits are paid in addition to any life insurance if you die in an accident or become seriously injured or physically disabled.

You may have to complete an evidence of insurability (EOI) medical questionnaire to determine whether you or your spouse is insurable for voluntary life insurance amounts. If required, one will be provided to you.

What is AD&D insurance?

Should you lose your life, sight, hearing, speech, or use of your limb(s) in an accident, AD&D provides additional benefits to help keep your family financially secure. AD&D benefits are paid as a percentage of your coverage amount — from 50% to 100% — depending on the type of loss.

Have you named a beneficiary?

Be sure you've selected a beneficiary for all your life and accident insurance policies. The beneficiary will receive the benefit paid by a policy in the event of the policyholder's death. It's important to designate a beneficiary and keep that information up-to-date.

Aflac Wellness Visit Reimbursement

Receive $25 under the Aflac Accident Insurance and $50 per plan under the Aflac Critical Illness and Hospital Indemnity per calendar year for health screening tests performed as a result of preventive care, including:

- Annual physical exams
- Flexible Sigmoidoscopy
- Mammograms
- PSA Tests
- Pap Smears
- Ultrasounds
- Eye Examinations
- Blood Screening
- Immunizations

Disability Insurance

The loss of income due to illness or disability can cause serious financial hardship for your family. Our disability insurance programs work together to replace a portion of your income when you're unable to work. The disability benefits you receive allow you to continue paying your bills and meeting your financial obligations during this difficult time.

Summary of disability benefits

	Short-Term Disability	Voluntary Long-Term Disability
Who pays	Employer-paid	Employee-paid
Benefit provided	Up to 60% of your weekly salary	60% of base monthly salary
Maximum benefit payable	$1,500 per week	$ 6,500 per month
Maximum benefit duration	12 weeks	From 13 weeks until you're no longer considered disabled or you reach normal retirement age, whichever comes first
Waiting period	7 days	3 months

Rates per $100 of covered salary	
Employee Voluntary Long-term Disability	
Under 25	$0.12
25-29	$0.14
30-34	$0.19
35-39	$0.40
40-44	$0.55
45-49	$0.85
50-54	$1.25
55-59	$1.25
60-64	$1.25
65+	$0.85

Additional voluntary benefits

As part of your Company benefits package, you have access to a variety of additional programs that can help save you money and provide important assistance with everyday needs.

Aflac Accident insurance

You can't always avoid accidents — but you can help protect yourself from accident-related costs that can strain your budget. Accident insurance supplements your primary medical plan and disability programs by providing cash benefits in cases of accidental injuries. You can use this money to help pay for uncovered medical expenses, such as your deductible or coinsurance, or for ongoing living expenses, such as your mortgage or rent. Benefits are paid in addition to other coverages you may have, such as medical or an AD&D plan.

	Employee	Employee + Spouse	Employee + Child(ren)	Family
Monthly Cost	$18.95	$31.10	$40.83	$52.98

Aflac Critical Illness insurance

This plan protects against the financial impact of certain covered illnesses such as a heart attack or cancer. You receive a direct lump-sum benefit to cover out-of-pocket expenses for your treatments that are not covered by your medical plan. You can also use the money to take care of your everyday living expenses, such as housekeeping services, special transportation services and day care.

Employee Critical Illness rates				
Non-Tobacco (tobacco rates not shown)				
	$5,000	$10,000	$15,000	$20,000
18-25	$2.83	$4.29	$5.74	$7.20
26-30	$3.48	$5.58	$7.68	$9.78
31-35	$3.89	$6.41	$8.92	$11.44
46-40	$4.81	$8.24	$11.67	$15.10
41-45	$5.63	$9.88	$14.13	$18.39
46-50	$6.55	$11.73	$16.90	$22.08
51-55	$9.68	$17.97	$26.27	$34.57
56-60	$9.45	$17.51	$25.58	$33.64
61-65	$18.64	$35.91	$53.17	$70.44
66+	$32.40	$63.42	$94.44	$125.46

Spouse Critical Illness rates			
Non-Tobacco (tobacco rates not shown)			
	$5,000	$7,500	$10,000
18-25	$2.83	$3.56	$4.29
26-30	$3.48	$4.53	$5.58
31-35	$3.89	$5.15	$6.41
46-40	$4.81	$6.53	$8.24
41-45	$5.63	$7.76	$9.88
46-50	$6.55	$9.14	$11.73
51-55	$9.68	$13.83	$17.97
56-60	$9.45	$13.48	$17.51
61-65	$18.64	$27.28	$35.91
66+	$32.40	$47.91	$63.42

Aflac Hospital indemnity insurance

A trip to the hospital can be stressful, and so can the bills. Even with a major medical plan, you may still be responsible for copays, deductibles, and other out-of-pocket costs. A hospital indemnity plan provides supplemental payments directly to you — unless assigned to someone else — that you can use to cover expenses that your medical plan doesn't cover for hospital stays.

	Employee	Employee + Spouse	Employee + Child(ren)	Family
Monthly Cost	$23.16	$42.44	$34.68	$53.96

NEW 2024 Benefits

29th Street is committed to supporting your and your family's financial wellness and security. That is why we will now be offering Identity Theft Protection through Allstate, Legal Insurance through MetLife, and employee discounts trough PerkSpot.

Identity Theft Protection

42 million people were victims of identity crime last year. Today's threats are omnipresent and always evolving. Viruses, phishing attacks, and malware are targeting every device your team uses — whether in the office, at home, or in the field. Allstate believes in delivering the best protection available, and that means personalized protection. Allstate offers the best family protection in the employee benefits space, comprehensive financial protection, and 24/7 support from US-based remediation experts. Allstate helps keep your employees connected and protected.

Plan highlights:

- Family coverage is for "Everyone under the Roof" plus deceased family members, and senior family members over the age of 65, regardless of where they live or whether they are financial dependents
- Family safety tools powered by Bark
- Financial monitoring
- Credit and debt monitoring
- Restoration assistance
- Bank account transaction monitoring
- 401(k) and HSA monitoring
- Lost wallet protection
- Dark web monitoring

	Employee only	Family
Bi-weekly Cost	$3.44	$6.44

Legal Insurance

Legal issues occur throughout life, when you're getting married, buying a home, becoming a caregiver, or handling financial matters like debt or tax audits. Dealing with these matters can be costly and time consuming, taking time away from work and impacting your overall well-being. MetLife provides you with the cost-effective, multi-channel access to legal help they need to easily handle costly legal matters in your life—helping you to feel more financially and emotionally secure.

Plan highlights:

- Free tax preparation services through TurboTax
- Telephone advice, office consultations, demand letters and document review on an unlimited number of personal legal matters.
- Reduced fees for personal injury, probate, and estate administration matters, provided by network attorneys.
- Access to a digital estate planning solution for wills, living wills, power of attorney and living trusts.
- Assistance with real estate or rental issues
- Student loan debt assistance
- Assistance with immigration issues
- Traffic tickets and driving privileges restoration

	Coverage for the entire family
Bi-weekly Cost	$8.88

PerkSpot

Your Mercer Discount Program is a one-stop-shop for thousands of exclusive discounts in more than 25 different categories. That means there's something for everyone! Whether you're needing a Costco membership or taking a trip to Disney, PerkSpot has a discount for you. Visit Mercerperks.perkspot.com or scan the QR code to download the app.

Download the PerkSpot App from Apple App Store and the Google Play Store

Focus on Wellness for you and your whole family

29th Street is committed to helping you feel your best and live well. We offer benefits and programs that support your mental health as well as the health of your furry family members.

Employee Assistance Program

The 29th Street Employee Assistance Program (EAP) is available throughout the year to assist with your everyday needs confidentially and at no cost to you. It's all part of our commitment to supporting your total well-being. Get help with work-life issues, referrals for clinical, legal, and financial services, and more!

- **Identify issues and provide practical strategies**. Get advice on relationship issues, whether it be family, parenting, or marital, and job issues, such as burnout and coworker conflicts.
- **Build coping skills to support emotional/mental health**. When life challenges and setbacks arise, get help with depression, anxiety, grief, loss, addiction, and substance abuse.
- **Connect to the right support resources.** Find services to help make your life easier, no matter what you're going through.
    - **Personal** – emotional / mental health, time management, life transitions, domestic violence, addiction, bereavement
    - **Family / Relationships** – childcare services, summer camps, eldercare services, caregiving, special needs, adoption, family relocation
    - **Financial** – debt, credit issues, bankruptcy, retirement planning, taxes

Get Support:

https://www.supportlinc.com/ group code: haven

Available 24/7 at 1-888-881-5462

Pet Insurance

Nationwide® Pet Insurance
You work hard to provide your family with everything they need. So whether your family includes kids with two feet or kids with four paws, you know what responsibility looks like.

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. From preventive care visits to significant medical incidents, Nationwide® provides protection for pets when you need it most.

Nationwide® policies cover a multitude of 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.

How to Enroll

Employees can enroll by visiting our website via https://benefits.petinsurance.com/havenresidential or by calling and speaking to one of our licensed sales agents at 877-738-7874.

Retirement savings

29th Street 401(k) Savings Plan

Your 401(k) Savings Plan provides advantages you may not get with other types of savings plans and helps you meet one of life's important goals — saving for a financially secure retirement. The 29th Street 401(k) is managed by John Hancock.

Eligibility

You are eligible to participate the 1st of the month following 60 days of employment if you are at least 21 years of age and are a full-time employee.

Your contributions

You can contribute to your 401(k) with before-tax money or Roth after-tax money. The type of contributions you make will depend on your financial goals and circumstances.

Both before-tax and Roth after-tax contributions count toward the IRS maximum of $23,000 in 2024.

If you are age 50 or older, you may make additional catch-up contributions — up to $7,500 in 2024.

** IRS limits for 2025 are not available.*

Company matching contributions

To support your retirement saving efforts, 29th Street matches up to 4% of your eligible pay. Eligible pay includes your base salary, bonuses, and commissions.

Investment elections

The plan offers you a variety of investment options to choose from. It's important to carefully consider your investment goals, retirement timeframe, and risk tolerance when deciding how to invest your plan contributions. Visit www.johnhancock.com/myplan to learn more about your investment options.

Vesting

Vesting refers to your ownership of the money in your account. You are always 100% vested in your own contributions the company contributions.

Enrolling in the plan

You should receive notification, along with an enrollment kit once you become eligible to enroll in the 401(k) Savings Plan. If you don't receive notification within 30 days of your hire date, please contact your HR Department.

It's always the right time

Saving for retirement is important for your financial future, whether you are retiring soon or years from now. The 29th Street 401(k) Savings Plan is designed to assist you in meeting your retirement goals.

Investing involves risk, including the risk of loss. Before investing, carefully consider the funds' or investment options' objectives, risks, charges, and expenses. Call 1-855-543-6765 for a prospectus and, if available, a summary prospectus, or an offering circular containing this and other information. Please read them carefully.

ENROLL

After you've carefully considered your benefit options and anticipated needs, it's time to make your benefit selections. Follow the instructions to enroll yourself and any eligible dependents in health and insurance benefits for 2024.

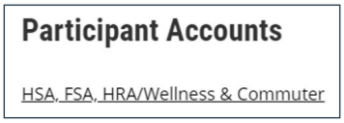
How to enroll in benefits online

1. Go to the Paycom app
2. From the Notifications Center, tap the "2023 Benefits Enrollment"
3. Review information and tap "Edit" to make changes or "Next" to continue
4. Complete Pre-Enrollment Questions and tap "Save and Next"
5. Choose to enroll in or decline a plan by checking the appropriate option
6. When finished, tap "Enroll". Continue for each benefit plan
7. When all elections are finished, review your enrollment and tap "Finalize"
8. Then, tap "Sign and Submit" to complete your enrollment

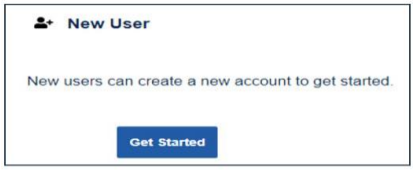
How to enroll in the HSA online

1. Go to www.wex.com, and select "login" at the top of the page.

2. Then select "wex Benefits". Under "participant Accounts" select "HSA, FSA, HRA/Wellness & Commuter."



3. Under "New User" select "Get Started."



4. Complete the required fields to verify your identity and select "Next."
5. Check your email, provide the one time password you received, and then select, "Next."
6. Complete the required fields for your personal information and select "Next."
7. Enter all applicable contact information as this will help recover your account if you forget your username or password. Select "Next."
8. Set up your five security questions and select "Next."
9. Change your username and set up your password, and then select "Submit."
10. Add a mobile number and any authorized representatives, if desired, and finalize your account setup.

Changing Your Enrollment Elections

The benefit elections you make during open or initial enrollment are binding for the plan year or remainder of the plan year, as applicable, unless you experience a "qualified life event," or "special enrollment event," or fall under some other exception that permits mid-year changes.

Qualified Life Event

A qualified life event is a life status change that allows you to make adjustments to your current benefit elections during the plan year. The type of life event you experience will dictate the changes you are able to make. Examples of life events are shown in the box below. In order to make changes, you must log in to Paycom within 30 days after the qualified life event, make your changes and provide the appropriate supporting documentation to Human Resources for review and approval. The effective date of this change will be the first of the month following 29th Street Benefits Department's receipt and acceptance of the completed form. Timely submitted changes in coverage for newborns and children who are newly adopted or placed for adoption will be effective retroactive to the date of birth, adoption or placement. If you do not go online to make your plan election changes within the 30-day period, (60 days for eligibility changes under Medicaid or CHIP, as described below), you will not be able to make the change until the next Open Enrollment.

HIPAA Special Enrollment Rights

This permits certain health plan changes if other coverage is lost due to loss of eligibility, discontinuation of employer contributions under another employer's plan, or exhaustion of a COBRA period of coverage. In addition, HIPAA grants rights to add coverage upon marriage or acquiring a new dependent child, if previously waived. You must request coverage within 30 days after losing the coverage or within 30 days after acquiring a dependent through marriage, birth, adoption or placement for adoption.

CHIPRA and Other Rights

This permits certain health plan changes if you or your dependent loses coverage under a state CHIP or Medicaid program, or you or your dependent become eligible for a premium assistance subsidy from the state. You must request coverage within 60 days after the CHIPRA event. Cost or coverage changes within the employer's plan may result in contribution changes or an alternative election (if the change is significant).

Please refer to the 29th Street Summary Plan Description for a more complete description of the events permitting mid-year changes like Qualified Life Event, HIPAA, CHIPRA, and Other Rights.

Qualifying Life Event Examples:

Includes marriage, divorce, legal separation, birth, adoption, death, dependent becoming eligible or ineligible for coverage, termination of spousal coverage, becoming eligible and enrolling in Medicare, Medicaid, or CHIP.

Contacts

Please contact the appropriate provider listed below to learn more about a specific benefit plan.

Benefit Plan	Provider	Phone number	Website
Medical	Anthem	833-578-4443	www.anthem.com
Prescription	Anthem	833-267-2133	www.anthem.com
Health Savings Account (HSA)	WEX	866-451-3399	www.wexinc.com/solutions/benefits
Dental	Delta Dental	800-955-2030	www.deltadentalky.com
Vision	Anthem	866-723-0515	www.anthem.com
Employee assistance program (EAP)	Curalinc	888-881-5462	www.supportlinc.com
Telemedicine services	LiveHealth Online	888-548-3432	livehealthonline.com
Life and AD&D insurance	Hartford	800-523-2233	www.thehartford.com
Disability insurance	Hartford	800-523-2233	www.thehartford.com
Accident insurance	AFLAC	800-433-3036	www.aflacgroupinsurance.com
Critical illness insurance	AFLAC	800-433-3036	www.aflacgroupinsurance.com
Hospital indemnity insurance	AFLAC	800-433-3036	www.aflacgroupinsurance.com
Pet Insurance	Nationwide	877-738-7874	https://benefits.petinsurance.com/havenresidential
Employee Discount Program	PerkSpot	866-606-6057	Mercerperks.perkspot.com
ID Theft	Allstate	800-789-2720	www.MyAIP.com
Legal Insurance	MetLife	833-214-4172	www.legalplans.com/
401(k)	John Hancock	855-543-6765	www.myplan.johnhancock.com/login

29th Street Property Management LLC DBA Haven Residential

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 plan administrator.

Newborns & Mother's Health Protection

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 plan administrator. (502) 805-5050.

HIPAA Privacy Reminder

The privacy rules under the Health Insurance Portability and Accountability Act (HIPAA) require 29th Street (the "Plan") to periodically send a reminder to participants about the availability of the Plan's Privacy Notice and how to obtain that notice. The Privacy Notice explains participants' rights and the Plan's legal duties with respect to protected health information (PHI) and how the Plan may use and disclose PHI. To obtain a copy of the Privacy Notice contact Human Resources at (502) 805-5050.

HIPAA Special Enrollment Rights

If you have declined enrollment in the 29th Street 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 this plan without waiting for the next open enrollment period, provided that 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 dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

CHIP Special Enrollment Rights

29th Street 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.

For these new enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in 29th Street's group health plan. Note that this 60-day extension does not apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

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 29th Street medical plan 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.

Notice of Creditable Coverage

Please read the notice below carefully. It has information about prescription drug coverage with 29th Street 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.

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.

If you are covered by the 29th Street prescription drug plan listed below, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2023. This is called creditable coverage. Coverage under this plan 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.

Anthem $1,500 PPO Plan, $3,750 PPO Plan and $5,000 High Deductible Health 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 29th Street 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 29th Street 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 29th Street plan.

You should know that if you waive or leave coverage with 29th Street 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 29th Street 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).

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:

29th Street – Human Resources

325 W Main Street 10th floor, Louisville 40202

(502) 805-5050

29th Street Property Management LLC DBA Haven Residential

General Notice Of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Human Resources at (502) 805-5050

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. Notice should be sent to: Human Resources, 29th Street. 325 W Main Street 10th floor, Louisville 40202 or (502) 805-5050.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a

spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information:
Human Resources
29th Street – Human Resources
325 W Main Street 10th floor, Louisville 40202
(502) 805-5050

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

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

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

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

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

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

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

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-766-9012
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ 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 http://www.oregonhealthcare.gov/index-es.html 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: http://gethipptexas.com/ 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://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp 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 January 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Exchange Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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% for 2024; 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.[2]

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 Human Resources at (502) 805-5050

[2] 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.

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

PART B: Information About Health Coverage Offered by Your Employer

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

<table>
<tr><td colspan="2">3. Employer Name: 29th Street Property Management DBA Haven Residential</td><td colspan="2">4. Employer Identification Number (EIN): 38-3955274</td></tr>
<tr><td colspan="2">5. Employer address:
325 W Main Street 10th floor</td><td colspan="2">6. Employer phone number: (502) 805-5050</td></tr>
<tr><td colspan="2">7. City: Louisville</td><td>8. State: Kentucky</td><td>9. Zip code: 40202</td></tr>
<tr><td colspan="4">10. Who can we contact about employee health coverage at this job?
Angela Barnett</td></tr>
<tr><td colspan="2">11. Phone number (if different from above)</td><td colspan="2">12. Email address:
Angela.barnett@havenresidential.com</td></tr>
</table>

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

As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are: Full-time working a minimum of 30 hours per week

With respect to dependents:

☒ We do offer coverage. Eligible dependents are: your legally married spouse and children up to age 26

☐ 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. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

No Surprises Act Notice

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

Emergency services

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

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

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

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

- Generally, your health plan must:

    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit No Surprises Act | CMS for more information about your rights under federal law.

This guide is intended to describe the eligibility requirements, enrollment procedures, plan highlights, and coverage effective dates for the benefits offered by 29th Street. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While the guide is a tool to answer many of your benefit questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plans' operation. The noted plan changes in this guide may serve as a Summary of Material Modifications (SMM) to the SPD. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will prevail. 29th Street's benefit practices are separate from its employment practices. Your participation in a 29th Street benefit plan is not a contract or a guarantee of employment. 29th Street reviews its plans regularly and reserves the right to amend or discontinue any plan at any time.