

Akorbi®

Employee Benefits


People


Technology




Language

A comprehensive guide to your
2024-2025
employee benefits program

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Welcome

We are pleased to offer a full benefits package to help protect your wellbeing and financial health. Read this guide to learn about the benefits available to you and your eligible dependents starting **May 1, 2024**.

Each year during Open Enrollment, you may make changes to your benefit plans. The benefit choices you make this year will remain in effect through **April 30, 2025**. Take time to review these benefit options and select the plans that best meet your needs. After Open Enrollment, you may only make changes to your benefit elections if you have a Qualifying Life Event.

Availability of Summary Health Information

Your plan offers three health coverage options. To help you make an informed choice and compare your options, a Summary of Benefits and Coverage (SBC) is available on the web in **Paycom** or by contacting Human Resources.

Important Contacts

| Program | Carrier | Phone Number | Website / Email |
|--|---------------|------------------------------|--|
| Medical | EBMS | 800-777-3575 | www.ebms.com/services/members |
| Telemedicine/Virtual Visits | Reкуро Health | 855-673-2876 | member.reкуроhealth.com |
| Pharmacy | Liviniti | 800-710-9341 | www.liviniti.com |
| Health Savings Account (HSA) | Ameriflex | 888-868-3539 | www.ameriflex.com service@Ameriflex.com |
| Flexible Spending Accounts (FSA) | Ameriflex | 888-868-3539 | www.ameriflex.com service@Ameriflex.com |
| Dental | Guardian | 800-627-4200 | www.guardiananytime.com |
| Vision | Guardian | 877-393-9363 | www.guardiananytime.com |
| Basic and Voluntary Life and AD&D | Guardian | 800-541-7846 | www.guardiananytime.com |
| Short and Long Term Disability | Guardian | 800-541-7846 | www.guardiananytime.com |
| Accident | Guardian | 800-541-7846 | www.guardiananytime.com |
| Critical Illness | Guardian | 800-541-7846 | www.guardiananytime.com |
| Hospital Indemnity | Guardian | 800-541-7846 | www.guardiananytime.com |
| Employee Assistance Plan (EAP) - Guardian | Guardian | 800-386-7055 | www.worklife.uprisehealth.com Access Code: worklife |
| Employee Assistance Plan (EAP) - LifeWorks | Lifeworks | 800-433-7916 | www.lifeworks.com |
| Company Human Resources | Akorbi | Gail Crowson 214-256-9222 | gcrowson@akorbi.com |

MEDICARE NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices for your prescription drug coverage. Please see page 5 for more details.

Eligibility

You are eligible for benefits if you are a regular, full-time employee working an average of 30 or more hours per week. New hire coverage is effective on the first of the month following 30 days of full-time employment. You may also enroll eligible dependents for benefits coverage. The cost for coverage depends on the number of dependents you enroll and the benefits you choose. When covering dependents, you must select and be on the same plans.

Eligible Dependents

- Your legal spouse
- Children under the age of 26, regardless of student, dependency, or marital status
- Children over the age of 26 who are fully dependent on you for support due to a mental or physical disability and who are indicated as such on your federal tax return

Qualifying Life Events

Once you elect your benefit options, they remain in effect for the entire plan year until the following Open Enrollment. You may only change coverage during the plan year if you have a Qualifying Life Event, some of which include:

- Marriage, divorce, legal separation, or annulment
- Birth, adoption, or placement for adoption of an eligible child
- Death of your spouse or child
- Change in your spouse's employment status that affects benefits eligibility
- Change in your child's eligibility for benefits
- Significant change in benefit plan coverage for you, your spouse, or child
- FMLA leave, COBRA event, court judgment, or decree
- Becoming eligible for Medicare, Medicaid, or TRICARE
- Receiving a Qualified Medical Child Support Order (QMCSO)

If you have a Qualifying Life Event and want to change your elections, you must notify Human Resources and **complete your changes within 30 days of the event**. You may be asked to provide documentation to support the change. Contact Human Resources for specific details.



Medical Coverage

The medical plan options through EBMS protect you and your family from major financial hardship in the event of illness or injury. You have a choice of three plans which utilize Aetna’s PPO (ASA) network of providers throughout the country:

- **High Plan** – This is a PPO plan with a \$1,000 individual or \$2,000 family in-network deductible.
- **Mid Plan** – This is a PPO plan with a \$2,000 individual or \$4,000 family in-network deductible.
- **HDHP Base Plan** – This is a HDHP plan with a \$5,000 individual or \$10,000 family in-network deductible.

Preferred Provider Organization (PPO)

A PPO allows you to see any provider when you need care. When you see network providers for care, you will pay less and get the highest level of benefits. You will pay more for care if you use non-network providers. When you see network providers, your office visits, urgent care, and prescription drugs are covered with a copay and most other network services are covered at the deductible and coinsurance level.

High Deductible Health Plan (HDHP)

An HDHP also allows you to see any provider when you need care, but you will pay less for care when you go to network providers. In exchange for a lower per-paycheck cost for medical benefits, you must satisfy a higher plan deductible that applies to almost all health care expenses, including prescription drugs. If you enroll in the HDHP, you may be eligible to open a Health Savings Account (see page 9).



Find a Network Provider

- Visit: www.aetna.com/asa
- Call: 866-326-7994
- Group Number: #00411



Employee Response Center

Employee benefits can be complicated. The Higginbotham Employee Response Center can assist you with the following:

- Enrollment
- Benefit information
- Claims or billing questions
- Eligibility issues

Call **866-419-3518** to speak with a representative Monday through Friday from 8:00 a.m. to 5:00 p.m. CT. If you leave a voicemail message after 3:00 p.m., your call will be returned the next business day. You can also email questions or requests to helpline@higginbotham.net. Bilingual representatives are available.

Medical Coverage

| PLAN NAME | HIGH PLAN PPO | | MID PLAN PPO | | BASE PLAN HDHP | |
|--|--|----------------------------|---|----------------------------|------------------------------|----------------------|
| | In-Network | Out-of-Network | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Calendar Year Deductible • Individual • Family | \$1,000 \$2,000 | \$2,000 \$4,000 | \$2,000 \$4,000 | \$4,000 \$8,000 | \$5,000 \$10,000 | \$10,000 \$20,000 |
| Calendar Year Out-of-Pocket Maximum (includes deductible) • Individual • Family • Coinsurance | \$1,000 \$2,000 100% | \$5,500 \$11,000 70% | \$4,500 \$9,000 80% | \$9,000 \$18,000 50% | \$6,550 \$13,100 | \$20,000 \$40,000 |
| | You Pay | | You Pay | | You Pay | |
| Preventive Care | \$0 | Not covered | \$0 | Not covered | \$0 | Not covered |
| Telemedicine | \$0 with RECURO | Not covered | \$0 with RECURO | Not covered | \$0 with RECURO | Not covered |
| Primary Care Physician | \$20 copay | 30%* | \$20 copay | 50%* | \$0* | 50%* |
| Specialist | \$35 copay | 30%* | \$35 copay | 50%* | \$0* | 50%* |
| Urgent Care | \$50 copay | 30%* | \$50 copay | 50%* | 30%* | 50%* |
| Diagnostic X-ray and Lab | Covered under OV copay | 30%* | Covered under OV copay | 50%* | \$0* | 50%* |
| Complex Imaging (CT/PET scan, MRI) | \$0* | 30%* | 20%* | 50%* | 30%* | 50%* |
| Emergency Room | \$150 copay | \$150 copay | \$150 copay | \$150 copay | 30%* | 30%* |
| Inpatient Hospital Services | \$0* | 30%* | 20%* | 50%* | 30%* | 50%* |
| Outpatient Services | \$0* | 30%* | 20%* | 50%* | 30%* | 50%* |
| Retail Pharmacy (up to a 30-day supply) • Generic • Preferred Brand Name • Non-Preferred Brand Name • Specialty | \$10 copay \$35 copay \$60 copay \$0* | Not covered | \$10 copay \$35 copay \$60 copay 20% | Not covered | \$0* \$0* \$0* \$0* | Not covered |
| Mail Order Pharmacy (31-90-day supply) • Generic • Preferred Brand Name • Non-Preferred Brand Name | \$20 copay \$95 copay \$170 copay | Not covered | \$60 copay \$315 copay \$510 copay | Not covered | \$0* \$0* \$0* | Not covered |
| Retail Pharmacy (31-90- supply) • Generic • Preferred Brand Name • Non-Preferred Brand Name | \$30 copay \$105 copay \$180 copay | Not covered | \$90 copay \$315 copay \$540 copay | Not covered | \$0* \$0* \$0* | Not covered |

*after deductible

Per Pay Period Medical Rates

| | HIGH PLAN PPO | MID PLAN PPO | BASE PLAN HDHP |
|------------------------------|---------------|--------------|----------------|
| Employee Only | \$168.44 | \$105.98 | \$21.91 |
| Employee + Spouse | \$603.91 | \$456.66 | \$263.26 |
| Employee + Child(ren) | \$440.68 | \$319.74 | \$156.32 |
| Employee + Family | \$905.05 | \$690.95 | \$418.15 |

Virtual Visits

Your medical coverage offers telemedicine services through **EMBS** powered by **Recuro**. Connect anytime day or night with a board-certified doctor via your mobile device or computer.



When to Use Virtual Visits

- While **telemedicine does** not replace your primary care physician, it is a convenient and cost-effective option when you need care and:
- Have a non-emergency issue and are considering an after hours health care clinic, urgent care clinic, or emergency room for treatment
- Are on a business trip, vacation or away from home
- Are unable to see your primary care physician

Use **telemedicine** services for minor conditions such as:

- Sore throat
- Headache
- Stomachache
- Cold/Flu
- Mental health issues
- Allergies
- Fever
- Urinary tract infections

Do not use telemedicine for serious or life-threatening emergencies.

Registration is Easy

Register with **RECURO** so you are ready to use this valuable service when and where you need it.

- **Online:**
member.recurohealth.com
- **Phone:** 855-673-2876 (6RECURO)
- **Mobile:** download the mobile app to your smartphone or mobile device



“Did You Know”

Your regular provider may offer telehealth services, so it is best to ask now and know what your options are before you need care. They may offer telehealth consultations by phone or video during or after normal office hours.

Understanding Your Plan

Plan Administration

Employee Benefit Management Systems (EBMS) is the third-party administrator (TPA) for Akorbi's health plan. The TPA is responsible for verification of all benefits, handling claim requests, and payments for services. All providers should call the EBMS number on the card, or visit the EBMS provider online portal to verify benefits. Once enrolled, you will have access to all of your benefits information, request ID cards, and view coverage & claims through the myBenefits member portal: <https://www.ebms.com/services/members/>

Finding Providers

The Akorbi health plan utilizes the extensive national Aetna PPO network of providers. To find an in-network provider, just utilize the Aetna website <https://aetna.com/asa> and search based on geography, names, or specialty.

Pharmacy

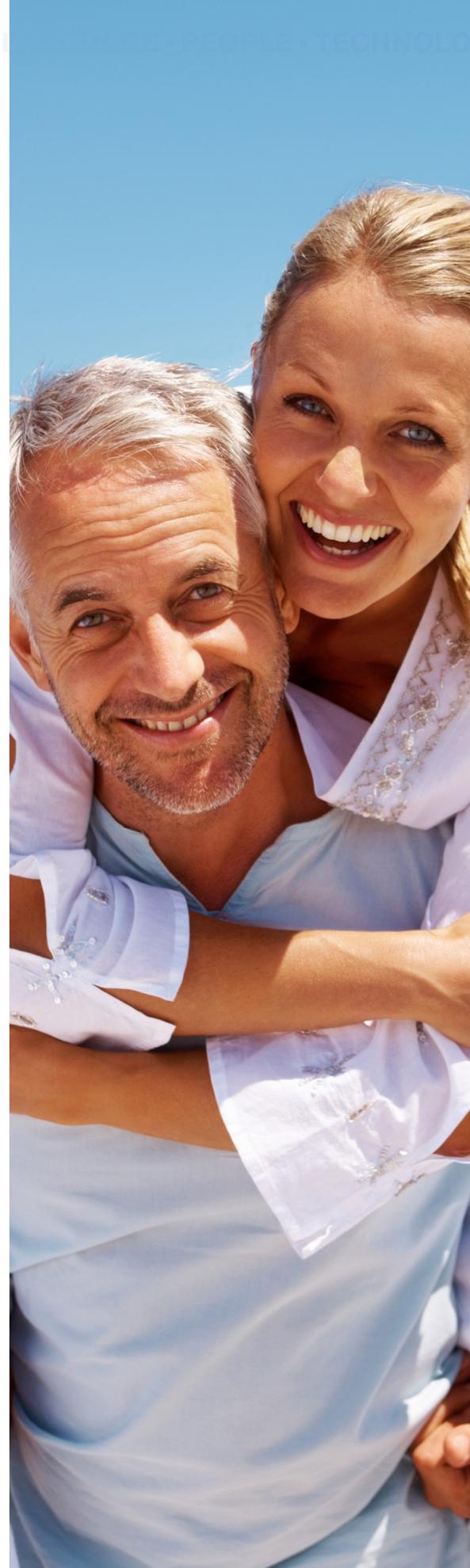
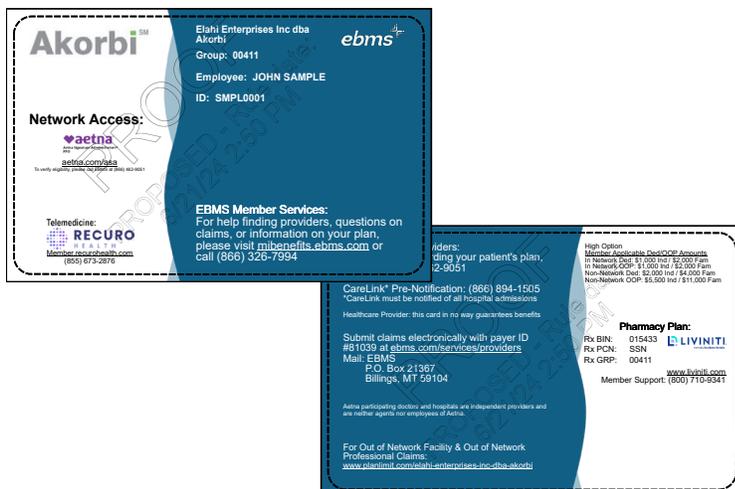
All pharmacy benefits are managed by **Liviniti**, your health plan's new pharmacy benefit manager (PBM). All drug coverage will be verified through Liviniti at the pharmacy. For further information go to www.liviniti.com and select "Member" at the top of the page. You can also call **800-710-9341** or email support@liviniti.com with any questions.

The Liviniti mobile app is available to download from your smart device's app store.

Mail-order prescriptions for non-specialty medications are delivered through **miRx**, your contracted Mail Order Pharmacy.

ID Cards

All health benefit ID cards will be mailed to your home address. Digital versions are always available in the MiBenefits portal.



Health Care Options

Becoming familiar with your options for medical care can save you time and money.

| HEALTH CARE PROVIDER | SYMPTOMS | AVERAGE COST | AVERAGE WAIT |
|---|--|---|---|
| NON-EMERGENCY CARE | | | |
|  <p>VIRTUAL VISITS/TELEMEDICINE</p> | <p>Access to care via phone, online video or mobile app whether you are home, work or traveling; medications can be prescribed</p> <p>24 hours a day, 7 days a week</p> | <ul style="list-style-type: none"> • Allergies • Cough/cold/flu • Rash • Stomachache | <p>\$</p> <p>2-5 minutes</p> |
|  <p>DOCTOR'S OFFICE</p> | <p>Generally, the best place for routine preventive care; established relationship; able to treat based on medical history</p> <p>Office hours vary</p> | <ul style="list-style-type: none"> • Infections • Sore and strep throat • Vaccinations • Minor injuries, sprains and strains | <p>\$</p> <p>15-20 minutes</p> |
|  <p>RETAIL CLINIC</p> | <p>Usually lower out-of-pocket cost than urgent care; when you can't see your doctor; located in stores and pharmacies</p> <p>Hours vary based on store hours</p> | <ul style="list-style-type: none"> • Common infections • Minor injuries • Pregnancy tests • Vaccinations | <p>\$</p> <p>15 minutes</p> |
|  <p>URGENT CARE</p> | <p>When you need immediate attention; walk-in basis is usually accepted</p> <p>Generally includes evening, weekend and holiday hours</p> | <ul style="list-style-type: none"> • Sprains and strains • Minor broken bones • Small cuts that may require stitches • Minor burns and infections | <p>\$\$</p> <p>15-30 minutes</p> |
| EMERGENCY CARE | | | |
|  <p>HOSPITAL ER</p> | <p>Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility</p> <p>24 hours a day, 7 days a week</p> | <ul style="list-style-type: none"> • Chest pain • Difficulty breathing • Severe bleeding • Blurred or sudden loss of vision • Major broken bones | <p>\$\$\$\$</p> <p>4+ hours</p> |
|  <p>FREESTANDING ER</p> | <p>Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher</p> <p>24 hours a day, 7 days a week</p> | <ul style="list-style-type: none"> • Most major injuries except trauma • Severe pain | <p>\$\$\$\$\$\$</p> <p>Minimal</p> |

Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

Health Savings Account (HSA)

A Health Savings Account (HSA) is more than a way to help you and your family cover current medical costs – it is also a tax-exempt tool to supplement your retirement savings and to cover future health costs.

An HSA is a type of personal savings account that is always yours even if you change health plans or jobs. The money in your HSA (including interest and investment earnings) grows tax-free and spends tax-free if used to pay for current or future qualified medical expenses. There is no “use it or lose it” rule — you do not lose your money if you do not spend it in the calendar year — and there are no vesting requirements or forfeiture provisions. The account automatically rolls over year after year.

HSA Eligibility

You are eligible to open and contribute to an HSA if you are:

- Enrolled in an HSA-eligible HDHP (HDHP Base Plan)
- Not covered by another plan that is not a qualified HDHP, such as your spouse’s health plan
- Not enrolled in a Health Care Flexible Spending Account
- Not eligible to be claimed as a dependent on someone else’s tax return
- Not enrolled in Medicare, Medicaid, or TRICARE
- Not receiving Veterans Administration benefits

You can also use HSA funds to pay health care expenses for your dependents, even if they are not covered by the HDHP.

Maximum Contributions

Your HSA contributions may not exceed the annual maximum amount established by the Internal Revenue Service. The annual contribution maximum is based on the coverage option you elect:

- **Individual** - \$4,150
- **Family (filing jointly)** - \$8,300
- You decide whether to use the money in your account to pay for qualified expenses or let it grow for future use. If you are 55 or older, you may make a yearly catch-up contribution of up to \$1,000 to your HSA. If you turn 55 at any time during the plan year, you are eligible to make the catch-up contribution for the entire plan year.



Opening an HSA

If you enroll in the HDHP Base medical plan, Akorbi will open an HSA account for you, which is administered by Ameriflex. You will receive a debit card to manage your HSA account reimbursements. Keep in mind, available funds are limited to the balance in your HSA.

Important HSA Information

Always ask your network doctor to file claims with your medical, dental, or vision carrier so you will get the highest level of benefits. You can pay the doctor with your HSA debit card for any balance due.

You, not your employer, are responsible for maintaining ALL records and receipts for HSA reimbursements in the event of an IRS audit.

You may open an HSA at the financial institution of your choice, but only accounts opened through Ameriflex are eligible for automatic payroll deduction.



Flexible Spending Accounts (FSA)

A Flexible Spending Account (FSA) allows you to set aside pretax dollars from each paycheck to pay for certain IRS-approved health and dependent care expenses. We offer two different FSAs: one for health care expenses and one for dependent care expenses. **Ameriflex** administers our FSAs.

Health Care FSA

The Health Care FSA covers qualified medical, dental, and vision expenses for you or your eligible dependents. You may contribute up to **\$3,200** annually to a Health Care FSA and you are entitled to the full election from day one of your plan year. Eligible expenses include:

- Dental and vision expenses
- Medical deductibles and coinsurance
- Prescription copays
- Hearing aids and batteries

You may not contribute to a Health Care FSA if you enrolled in a High Deductible Health Plan (HDHP) and contribute to a Health Savings Account (HSA).

How the Health Care FSA Works

You can access the funds in your Health Care FSA two different ways:

- Use your FSA debit card to pay for qualified expenses, doctor visits, and prescription copays.
- Pay out-of-pocket and submit your receipts for reimbursement:
 - **Email** – service@ameriflex.com
 - **Online** – www.Ameriflex.com



Dependent Care FSA

The Dependent Care FSA helps pay for expenses associated with caring for elder or child dependents so you or your spouse can work or attend school full time. You can use the account to pay for day care or baby sitter expenses for your children under age 13 and qualifying older dependents, such as dependent parents. Reimbursement from your Dependent Care FSA is limited to the total amount deposited in your account at that time. To be eligible, you (and your spouse, if married) must be gainfully employed, looking for work, a full-time student, or incapable of self-care.

Dependent Care FSA Guidelines

- Overnight camps are not eligible for reimbursement (only day camps can be considered).
- If your child turns 13 midyear, you may only request reimbursement for the part of the year when the child is under age 13.
- You may request reimbursement for care of a spouse or dependent of any age who spends at least eight hours a day in your home and is mentally or physically incapable of self-care.
- The dependent care provider cannot be your child under age 19 or anyone claimed as a dependent on your income taxes.

Important FSA Rules

- The maximum per plan year you can contribute to a Health Care FSA is \$3,200. The maximum per plan year you can contribute to a Dependent Care FSA is \$5,000 when filing jointly or head of household and \$2,500 when married filing separately.
- You cannot change your election during the year unless you experience a Qualifying Life Event.
- You can continue to file claims incurred during the plan year for another 30 days (up until 90 days).
- Your Health Care FSA debit card can be used for health care expenses only. It cannot be used to pay for dependent care expenses.
- The IRS has amended the “use it or lose it rule” to allow you to carry over up to \$640 in your Health Care FSA into the next plan year. The carry-over rule does not apply to your Dependent Care FSA.

FLEXIBLE SPENDING ACCOUNTS

| Account Type | Eligible Expenses | Annual Contribution Limits | Benefit |
|--------------------|--|---|--|
| Health Care FSA | Most medical, dental, and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses, and doctor-prescribed over-the-counter medications) | Maximum contribution is \$3,200 per year | Saves on eligible expenses not covered by insurance, reduces your taxable income |
| Dependent Care FSA | Dependent care expenses (such as day care, after-school programs, or elder care programs) so you and your spouse can work or attend school full-time | Maximum contribution is \$5,000 per year (\$2,500 if married and filing separate tax returns) | Reduces your taxable income |



Abbreviated List of Qualified HSA and FSA Expenses

The products and services listed below are examples of medical expenses eligible for payment under your Health Care FSA or HSA. This list is not all-inclusive; additional expenses may qualify and the items listed are subject to change in accordance with IRS regulations. Please refer to IRS *Publication 502, Medical and Dental Expenses* at www.irs.gov for a complete description of eligible medical and dental expenses.

- Abdominal supports
- Acupuncture
- Air conditioner (when necessary for relief from difficulty in breathing)
- Alcoholism treatment
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Autoette (when used for relief of sickness/disability)
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Contact lenses
- Convalescent home (for medical treatment only)
- Crutches
- Dental treatment
- Dental X-rays
- Dentures
- Dermatologist
- Diagnostic fees
- Diathermy
- Drug addiction therapy
- Drugs (prescription)
- Elastic hosiery (prescription)
- Eyeglasses
- Fees paid to health institute prescribed by a doctor
- FICA and FUTA tax paid for medical care service
- Fluoridation unit
- Guide dog
- Gum treatment
- Gynecologist
- Healing services
- Hearing aids and batteries
- Hospital bills
- Hydrotherapy
- Insulin treatment
- Lab tests
- Lead paint removal
- Legal fees
- Lodging (away from home for outpatient care)
- Metabolism tests
- Neurologist
- Nursing (including board and meals)
- Obstetrician
- Operating room costs
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Organ transplant (including donor's expenses)
- Orthopedic shoes
- Orthopedist
- Osteopath
- Oxygen and oxygen equipment
- Pediatrician
- Physician
- Physiotherapist
- Podiatrist
- Postnatal treatments
- Practical nurse for medical services
- Prenatal care
- Prescription medicines
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium therapy
- Registered nurse
- Special school costs for the handicapped
- Spinal fluid test
- Splints
- Surgeon
- Telephone or TV equipment to assist the hard-of-hearing
- Therapy equipment
- Transportation expenses (relative to health care)
- Ultraviolet ray treatment
- Vitamins (if prescribed)
- Wheelchair
- X-rays

Dental Coverage

Our dental plans through **Guardian** help you maintain good oral health through affordable options for preventive care, including regular checkups and other dental work.

You have two dental plans to choose from. Both options use the **DentalGuard Preferred Network Access Plan (NAP)** – This option reimburses in-network dentists based on a negotiated fee schedule. Although the coinsurance for the NAP plan is higher than the Value Plan, the out-of-network payments are based on Usual and Customary (U&C) charges. This will typically result in a better reimbursement if you receive services from dentists that do not participate in the Guardian DentalGuard Preferred network.

In-Network or Out-of-Network Providers

As a participant in the NAP dental plan, you may see any dentist and receive benefits. However, using in-network Guardian dentists will save you money. Out-of-network dentists do not have to accept discounted fees.

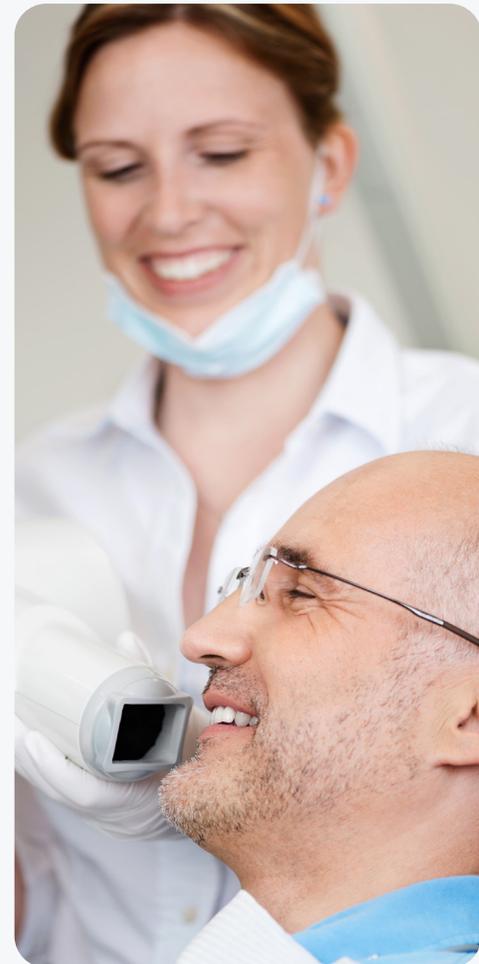
| DENTAL PLAN SUMMARY | | |
|--|------------------------|------------------------|
| | High Plan | Low Plan |
| | In-Network* | In-Network* |
| Calendar Year Deductible | | |
| • Individual | \$50 | \$50 |
| • Family | \$150 | \$150 |
| Calendar Year Benefit Maximum | | |
| • Per Individual | \$1,500 | \$1,000 |
| | You Pay | You Pay |
| Preventive Care – Exams, cleanings, X-rays, space maintainers, fluoride (to age 14), sealants (to age 16) | \$0, deductible waived | \$0, deductible waived |
| Basic Restorative Care – Filling, periodontics, endodontics | 20% after deductible | 30% after deductible |
| Major Restorative Care – Bridges, dentures, crowns, complex extractions, anesthesia, inlays, onlays, veneers, TMJ | 50% after deductible | 60% after deductible |
| Orthodontia Child(ren) to age 26 | 50%, deductible waived | 60%, deductible waived |
| Orthodontia Lifetime Maximum | \$1,000 | \$750 |

*See your plan for details about out-of-network coverage.

Find a Network Provider

- Visit: www.guardiananytime.com
- Call: 800-647-4200
- Group Number: #065570

| GUARDIAN DENTAL RATES | | |
|-----------------------|-----------|----------|
| | High Plan | Low Plan |
| Employee Only | \$8.37 | \$6.87 |
| Employee + Spouse | \$25.89 | \$21.25 |
| Employee + Child(ren) | \$35.97 | \$28.37 |
| Employee + Family | \$50.90 | \$42.37 |



Vision Coverage

Our vision plan offers quality care to help preserve your health and eyesight. Regular exams can detect certain medical issues such as diabetes and high cholesterol, in addition to vision and eye problems. You may seek care from any vision provider, but the plan will pay the highest level of benefits when you see a network provider. Coverage is provided through **Guardian**.

Vision Benefits Summary

| VISION PLAN | | |
|--|--|---|
| | In-Network You Pay | Out-of-Network Reimbursement |
| Exam – Once every 12 months Retinal Imaging | \$10 copay \$39 copay | Up to \$50 N/A |
| Lenses – Once every 12 months • Single Vision • Bifocals • Trifocals • Lenticular | \$25 copay \$25 copay \$25 copay \$25 copay | Up to \$48 Up to \$67 Up to \$86 Up to \$126 |
| Frames – Once every 24 months | \$130 allowance + 20% off balance | Up to \$48 |
| Contacts – Once every 12 months (In lieu of frames and lenses) • Fitting and Evaluation • Elective • Medically Necessary | Included with Davis Vision contact lens purchase \$130 allowance + 15% off balance \$0 | N/A Up to \$105 Up to \$210 |
| Benefit Frequency | | |
| Exam | Once every 12 months | |
| Lenses | Once every 12 months | |
| Frames | Once every 24 months | |
| Contacts | Once every 12 months | |

Find a Network Vision Provider

- Website: www.guardiananytime.com
- Phone: 800-541-7846
- Group Number: 065570

| GUARDIAN VISION RATES | |
|-----------------------|--------|
| Employee Only | \$2.65 |
| Employee + Spouse | \$5.31 |
| Employee + Child(ren) | \$5.68 |
| Employee + Family | \$9.08 |



Life and AD&D Insurance

Life and Accidental Death and Dismemberment (AD&D) insurance through **Guardian** are important to your financial security, especially if others depend on you for support or vice versa. With Life insurance, you or your beneficiary(ies) can use the coverage to pay off debts, such as credit cards, loans, and bills. AD&D coverage provides specific benefits if an accident causes bodily harm or loss (e.g., the loss of a hand, foot, or eye). If death occurs from an accident, 100% of the AD&D benefit would be paid to you or your beneficiary(ies).

Basic Life and AD&D

Basic Life and AD&D insurance are provided at no cost to you. You are automatically covered at **200% of your salary to a maximum of \$500,000** for each benefit. Basic Life and AD&D coverage amounts reduce by 66% at age 70.

Note: Benefit amounts over \$395,000 may be subject to Evidence of Insurability (EOI)

Voluntary Life and AD&D

You have the option to purchase **additional** Life and AD&D insurance for you and your eligible dependents. If you do not elect Voluntary Life and AD&D insurance when first eligible or if you want to increase your benefit amount at a later date, you may need to show proof of good health. You must elect Voluntary Life and AD&D coverage for yourself before you may elect coverage for your spouse or children. If you leave the company, you may be able to take the insurance with you. Voluntary Life and AD&D coverage **amount** reduce by 35% at age 65 and by 50% at age 70.

| MONTHLY VOLUNTARY LIFE AND AD&D RATES PER \$1,000 | |
|---|---------|
| Age | Rates |
| <30 | \$0.074 |
| 30-34 | \$0.093 |
| 35-39 | \$0.117 |
| 40-44 | \$0.153 |
| 45-49 | \$0.267 |
| 50-54 | \$0.454 |
| 55-59 | \$0.819 |
| 60-64 | \$1.062 |
| 65-69 | \$1.661 |
| 70+ | \$2.481 |
| Child(ren) | \$0.200 |
| AD&D - All | \$0.020 |

| LIFE AND AD&D AVAILABLE COVERAGE | |
|----------------------------------|---|
| Employee | <ul style="list-style-type: none"> • Increments of \$10,000 up to \$500,000 • Guaranteed Issue \$200,000 |
| Spouse | <ul style="list-style-type: none"> • Increments of \$5,000 up to 50% of employee amount to a maximum of \$250,000 • Guaranteed Issue \$25,000 |
| Child(ren) | <ul style="list-style-type: none"> • Birth to 14 days - \$500 • 14 days to age 26 – Increments of \$1,000 to a maximum of \$10,000 |

Designating a Beneficiary

A beneficiary is the person or entity you elect to receive the death benefits of your Life and AD&D insurance policies. You can name more than one beneficiary and you can change beneficiaries at any time. If you name more than one beneficiary, you must identify how much each beneficiary will receive (e.g., 50% or 25%).



Disability Insurance

Disability insurance provides partial income protection if you are unable to work due to a covered accident or illness. We provide Short Term Disability (STD) and Long Term Disability (LTD) insurance at **no cost to you** through **Guardian**.

Short Term Disability

STD coverage pays a percentage of your weekly salary if you are temporarily disabled and unable to work due to an illness, pregnancy or non-work related injury. STD benefits are not payable if the disability is due to a job-related injury or illness. If a medical condition is job-related, it is considered Workers' Compensation, not STD.

| SHORT TERM DISABILITY | |
|------------------------------------|---------------------------|
| Benefits Begin | 15th day |
| Percentage of Earnings You Receive | 60% of weekly base salary |
| Maximum Weekly Benefit | \$2,000 |
| Maximum Benefit Period | 11 weeks |

Long Term Disability

LTD insurance pays a percentage of your monthly salary for a covered disability or injury that prevents you from working for more than 90 days. Benefits begin at the end of an elimination period and continue while you are disabled up to Social Security Normal Retirement Age (SSNRA).

| LONG TERM DISABILITY | |
|------------------------------------|----------|
| Benefits Begin | 91st day |
| Percentage of Earnings You Receive | 60% |
| Maximum Monthly Benefit | \$10,000 |
| Maximum Benefit Period | SSNRA |
| Pre-existing Condition Exclusion | 3/12* |

*Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.



Supplemental Benefits

You and your eligible family members have the opportunity to enroll in additional coverage that complements our traditional health care programs. Health insurance covers medical bills, but if you have an emergency, you may face unexpected out-of-pocket costs, such as deductibles, coinsurance, travel expenses, and non-medical related expenses. All of these plans are offered through **Guardian** and are portable.

Accident Insurance

Accident insurance provides affordable protection against a sudden, unforeseen accident. The Accident plan helps offset the direct and indirect expenses resulting from an accident, such as copayments, deductible, ambulance, physical therapy, and other costs not covered by traditional health plans.

| Service | Benefit |
|--|---------------------------------|
| | Plan 1 |
| Emergency Room | \$200 |
| Urgent Card | \$100 |
| Ambulance – Ground/Air | \$200/\$1,500 |
| Initial Physician Office Visit | \$125 |
| Initial Hospitalization | \$2,000 |
| Hospital Confinement | \$200 per day – up 365 days |
| Intensive Care Unit | \$400 per day – up to 15 days |
| Specific Sum Injuries Dislocations, ruptured discs, eye injuries, fractures, lacerations, concussions, etc. | \$25 - \$10,000 |
| Accidental Death & Dismemberment* • Employee • Spouse • Child | \$25,000 \$25,000 \$5,000 |

*Percentage of benefit paid for dismemberment is dependent on type of loss.

| | Monthly Rates |
|-----------------------|---------------|
| Employee | \$13.98 |
| Employee + Spouse | \$22.08 |
| Employee + Child(ren) | \$22.97 |
| Employee + Family | \$31.07 |



Critical Illness

Critical Illness insurance helps pay the cost of non-medical expenses related to a covered critical illness or cancer. The plan provides a lump sum benefit payment to you upon first and second diagnosis of any covered critical illness or cancer. The benefit can help cover expenses, such as lost income, out-of-town treatments, special diets, daily living, and household upkeep costs.

| Benefit Amounts Available | |
|---|---------------------------------|
| Employee | \$25,000 |
| Spouse | \$12,500 or 50% of your benefit |
| Child | 50% of your benefit |
| Condition | First Occurrence Benefit |
| Full Coverage Bone Marrow Failure, Benign Brain Tumor, Invasive Cancer, Heart Attack, Heart Failure, Stroke, Kidney Failure, Major Organ Failure, Coma, Loss of Speech, Hearing or Sight, Permanent Paralysis, Severe Burns, Advanced Alzheimer’s Disease, ALS, Dementia, Advanced Multiple Sclerosis, Advanced Parkinson’s Disease | 100% of benefit amount |
| Partial Coverage Cancer in Situ, Coronary Bypass, Coronary Artery Disease, Pacemaker, and more | 10% - 50% of benefit amount |
| Child Only Conditions Autism, Cerebral Palsy, Cleft Lip or Palate, Clubfoot, Congenital Heart Defect, Cystic Fibrosis, Type I Diabetes, Down Syndrome, Hemophilia, MIS, Muscular Dystrophy, Spina Bifida | 100% of benefit amount |
| Pre-existing Condition Limitation | 3/12* |

*If you were treated for a condition three months prior to your effective date, benefits may not be paid until you have been covered under this plan for 12 months.

| CRITICAL ILLNESS MONTHLY PREMIUM FOR \$1,000 OF COVERAGE | | | | | | |
|--|---------|---------|---------|---------|----------|----------|
| Benefit Amounts | <30 | 30-39 | 40-49 | 50-59 | 60-69 | 70+ |
| Employee | | | | | | |
| \$5,000 | \$3.15 | \$5.35 | \$10.35 | \$19.95 | \$33.75 | \$57.30 |
| \$10,000 | \$6.30 | \$10.70 | \$20.70 | \$39.90 | \$67.50 | \$114.60 |
| \$15,000 | \$9.45 | \$16.05 | \$31.05 | \$59.85 | \$101.25 | \$171.90 |
| \$20,000 | \$12.60 | \$21.40 | \$41.40 | \$79.80 | \$135.00 | \$229.20 |
| \$25,000 | \$15.75 | \$26.76 | \$51.75 | \$99.75 | \$168.75 | \$286.50 |
| Spouse | | | | | | |
| \$2,500 | \$1.58 | \$2.68 | \$5.18 | \$9.98 | \$16.88 | \$28.65 |
| \$5,000 | \$3.15 | \$5.35 | \$10.35 | \$19.95 | \$33.75 | \$57.30 |
| \$7,500 | \$4.73 | \$8.03 | \$15.53 | \$29.93 | \$50.63 | \$85.95 |
| \$10,000 | \$6.30 | \$10.70 | \$20.70 | \$39.90 | \$67.50 | \$114.60 |
| \$12,500 | \$7.88 | \$13.38 | \$25.88 | \$49.88 | \$84.38 | \$143.25 |



Hospital Indemnity

The Hospital Indemnity Plan provided through **Guardian** helps you with the high cost of medical care by paying you a set amount when you have an inpatient hospital stay. Unlike traditional insurance which pays a benefit to the hospital or doctor, this plan pays you directly based on the care or treatment that you receive. These costs may include meals and transportation, childcare, or time away from work due to a medical issue that requires hospitalization.

| Service | Benefit | |
|----------------------------------|---|--|
| | Plan 1 | Plan 2 |
| Hospital/ICU Admission | \$1,000 per admission (maximum two per calendar year) | \$2,000 per admission (one per calendar year) |
| Hospital/ICU Confinement | \$100 per day, limited to 360 days per insured per year | \$200 per day, limited to 15 days per insured per year |
| Pre-existing Condition Exclusion | 3/12* | |

*Benefits may not be paid for any condition treated within three months prior to your effective date until you have been covered under this plan for 12 months.

| | Monthly Rates | |
|------------------------------|---------------|---------|
| | Plan 1 | Plan 2 |
| Employee Only | \$12.26 | \$24.44 |
| Employee + Spouse | \$22.82 | \$45.51 |
| Employee + Child(ren) | \$19.94 | \$39.92 |
| Employee + Family | \$30.50 | \$60.99 |



Employee Assistance Program

Welcome to **LifeWorks**. Feel supported and connected with a confidential Employee Assistance Program (EAP) and innovative well-being resource. The EAP through LifeWorks by Morneau Shepell helps you and family members cope with a variety of personal or work-related issues. This program provides confidential counseling and support services at little or no cost to you to help with:

- **Life** – Retirement, Midlife, Student life, Legal, Relationships, Disabilities, Crisis, Personal issues
- **Family** – Parenting, Couples, Separation/divorce, Older relatives, Adoption, Death/loss, Child or Elder care, Education
- **Health** – Mental health, Addictions, Fitness, Managing stress, Nutrition, Sleep, Smoking cessation, Alternative health
- **Work** – Time management, Career development, Work relationships, Work stress, Managing people, Shift work, Coping with change, Communication
- **Money** – Saving, Investing, Budgeting, Managing debt, Home buying, Renting, Estate planning, Bankruptcy

Contact the LifeWorks EAP any time you need help with any of life's concerns.

Call: **800-433-7916**

TTY: **800-772-0997**

Online:

<https://login.lifeworks.com> for support at any hour of the day or night.

Download: **LifeWorks app** from your smart devices app store.



Glossary of Terms

Beneficiary – Who will receive a benefit in the event of the insured's death. A policy may have more than one beneficiary.

Coinsurance – Your share of the cost of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for health care services received.

Deductible – The amount you owe for health care services before your health insurance begins to pay its portion. For example, if your deductible is \$1,000, your plan does not pay anything until you meet your \$1,000 deductible for covered health care services. The deductible may not apply to all services, including preventive care.

Employee Contribution – The amount you pay for your insurance coverage.

Employer Contribution – The amount Akorbi contributes to the cost of your benefits.

Explanation of Benefits (EOB) – A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, what portion of the claim is your responsibility and information on how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

Flexible Spending Account (FSA) – An option that allows participants to set aside pretax dollars to pay for certain qualified expenses during a specific time period (usually a 12-month period).

Formulary Brand Name Drugs – Brand name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.

Generic Drugs – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding brand name versions. The color or flavor of a generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.

Health Savings Account (HSA) – A personal savings account that allows you to pay for qualified medical expenses with pretax dollars.

High Deductible Health Plan (HDHP) – A medical plan with a higher deductible in exchange for a lower monthly premium. You must meet the annual deductible before any benefits are paid by the plan.

In-Network – Doctors, hospitals, and other providers that contract with your insurance company to provide health care services at discounted rates.

Non-Formulary Brand Name Drugs – Brand name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.

Out-of-Network – Doctors, hospitals and other providers that are not contracted with your insurance company. If you choose an out-of-network provider, you may be responsible for costs over the amount allowed by your insurance carrier.

Out-of-Pocket Maximum – Also known as an out-of-pocket limit. The most you pay during a policy period (usually a 12-month period) before your health insurance or plan begins to pay 100% of the allowed amount. The limit does not include your premium, charges beyond the Reasonable & Customary (R&C) or health care your plan does not cover. Check with your health insurance carrier to confirm what payments apply to the out-of-pocket maximum.

Over-the-Counter (OTC) Medications – Medications typically made available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: Generic, Formulary Brand Name or Non-Formulary Brand Name.

Preventive Care – The care you receive to prevent illness or disease. It also includes counseling to prevent health problems.

Reasonable and Customary Allowance – (R&C) – Also known as an eligible expense or the Usual and Customary (U&C). The amount your insurance company will pay for a medical service in a geographic region based on what providers in the area usually charge for the same or similar medical service.

SSNRA – Social Security Normal Retirement Age

Important Notices

Women’s Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women’s Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women’s Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prosthesis and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children’s Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must enroll within 31 days after your or your dependents’ other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for, such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Akorbi
Human Resources
6010 W. Spring Creek Pkwy, Suite 328
Plano, TX 75024
214-256-9222

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Akorbi and about your options under Medicare’s prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Akorbi has determined that the prescription drug coverage offered by the Akorbi medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. The HSA plan is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide

to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D’s annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan’s summary plan description for a summary of the Plan’s prescription drug coverage. If you don’t have a copy, you can get one by contacting Akorbi at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current Akorbi prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan’s eligibility and enrollment rules. You should review the Plan’s summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

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

Contact the Human Resources Department at 214-256-9222.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

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

May 1, 2024
Akorbi
Human Resources
6010 W. Spring Creek Pkwy, Suite 328
Plano, TX 75024
214-256-9222

Notice of HIPAA Privacy Practices

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

Effective Date of Notice: September 23, 2013

Akorbi’s Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan’s uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan’s duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan’s privacy practices.

The term “Protected Health Information” (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1 – Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan’s compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan’s Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.
6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In which case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor’s parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor’s PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual’s agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual’s agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan’s best judgment.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers’ compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for

any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2 – Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan’s Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan’s Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

Protected Health Information (PHI)

Includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set

Includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan’s Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan’s decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan’s Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan’s privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan’s Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan’s Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child’s personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3 – The Plan’s Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan’s legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted, you will also receive a copy of the Notice or information about any material change and how to receive a copy of the Notice in the Plan’s next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan’s policies regarding the uses or disclosures of PHI, the individual’s privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request,

taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan’s compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose “summary health information” to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. “Summary health information” summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants’ PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4 – Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan’s Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5 – Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan’s Privacy Official. Such questions should be directed to the Plan’s Privacy Official at:

Akorbi
Human Resources
6010 W. Spring Creek Pkwy, Suite 328
Plano, TX 75024
214-256-9222

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

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 |
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| Website: http://www.myalhipp.com/ Phone: 1-855-692-5447 |
| Alaska – Medicaid |
| 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 |
| Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447) |
| California – Medicaid |
| 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 |
| Colorado – Health First Colorado (Colorado’s Medicaid Program) and Child Health Plan Plus (CHP+) |
| 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 |
| Florida – Medicaid |
| Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268 |
| Georgia – 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 |
| Indiana – Medicaid |
| 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) |
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| 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 |
| Kansas – Medicaid |
| Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660 |
| Kentucky – Medicaid |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms |
| Louisiana – Medicaid |
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) |
| Maine – Medicaid |
| 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 |
| Massachusetts – Medicaid and CHIP |
| Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com |
| Minnesota – 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 |
| Missouri – Medicaid |
| Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005 |
| Montana – Medicaid |
| Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov |
| Nebraska – Medicaid |
| Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178 |

Plan Contact Information

Akorbi
 Human Resources
 6010 W. Spring Creek Pkwy, Suite 328
 Plano, TX 75024
 214-256-9222

Your Rights and Protections Against Surprise Medical Bills

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

What is “balance billing” (sometimes called “surprise billing”)?

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

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

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

You are protected from balance billing for:

- Emergency services – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Certain services at an in-network hospital or ambulatory surgical center – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or

intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

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

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

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact your insurance provider. Visit www.cms.gov/nosurprises for more information about your rights under federal law.

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PEOPLE

TECHNOLOGY

LANGUAGE



This guide highlights the main features of the Akorbi employee benefits program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Akorbi reserves the right to change or discontinue its employee benefits plans at anytime.