

Kirkman Beck
corporate



2026

Employee Benefits



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ANCO
INSURANCE

A **HUB International** Company

WELCOME LETTER

TO: Kirkman Beck, LLC Employees
FROM: Scott Estill and Lauren Kettle,
ANCO Insurance, a HUB International Company

We are excited to partner with Kirkman Beck, LLC as your benefits broker. This Benefits Guide provides the information you'll need when making decisions about your benefit selections for the 2026 plan year (12/01/2025 through 11/30/2026) from the following providers:

- Anthem & Kaiser Permanente: Medical
- Unum: Dental, Vision, Term Life/AD&D

Please note that certain benefits may require the completion of additional forms, and benefits could be reduced if enrolling for the first time after the initial new hire enrollment period; especially for life and worksite plans.

Should difficulties arise requiring resolution with any carrier, Madison Banuelos can be reached at ANCO via:

Direct: (979) 774-6268 // Email: madison.banuelos@hubinternational.com

ANCO is happy to assist with any issues or questions concerning the benefit programs. For some claims research, the following items are often requested:

- Member authorization to disclose health information
- Date-of-service, provider information, amount of charges, and explanation of the problem
- Explanation of Benefits (EOB) from carrier and statement from provider's office

Our continuing effort is to provide any assistance and support as needed. Please feel free to contact our team.

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GLOSSARY

BENEFICIARY - The person or entity entitled to receive the claim amount and other benefits upon the death of the benefactor (person covered under the policy) or on the maturity of the policy.

CLAIM - A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

COINSURANCE - The percentage of costs of a covered health care service insurance pays after you've paid your deductible.

COPAYMENT (COPAY) - A fixed dollar amount you pay for a covered health care service.

DEDUCTIBLE - An amount you could owe during a coverage period for covered health care services before your plan begins to pay. An overall deductible applied to all or almost all covered items and services. Copayments do not count towards the deductible.

DEPENDENT - A child or other individual (under the age of 26) for whom a parent, relative, or other person may claim a personal exemption tax deduction.

DISABILITY RESOURCE SERVICES - Provides convenient resources to help address emotional, legal, and financial issues.

ELECTIVE DEFERRAL - A percentage of an employee's salary that's withheld and transferred into a 401(k). Elective-deferrals can be made on a pre-tax or after-tax (Roth) basis.

EVIDENCE OF INSURABILITY (EOI) - An application process through which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage.

FLEXIBLE SPENDING ACCOUNT (FSA) - A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan.

GUARANTEE ISSUE - A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some states, guarantee issue doesn't limit how much you can be charged if you enroll.

HEALTH SAVINGS ACCOUNT (HSA) - A tax-free financial account where you gain interest and save money while spending on qualified health expenses. Funds in your account roll over from year to year.

HEALTH MAINTENANCE ORGANIZATION (HMO) - A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency.

IN-NETWORK - Refers to a health care provider that has a contract with your insurance plan to provide health care services to its plan members at a pre-negotiated rate. Because of this relationship, you pay a lower cost-sharing when you receive services from an in-network doctor.

OPEN ENROLLMENT - The annual period before a new plan year commences that eligible individuals may enroll in or change coverage elections in a job-based insurance plan.

OUT-OF-NETWORK - Refers to a health care provider who does not have a contract with your insurance plan. If you use an out-of-network provider, health care services could cost more since the provider doesn't have a pre-negotiated rate with your health plan. Or, depending on your health plan, the health care services may not be covered at all.

OUT OF POCKET MAXIMUM/LIMIT - The most you must pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits.

PREFERRED PROVIDER ORGANIZATION (PPO) - A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.

PREMIUM - The amount you pay for your health insurance every month. In addition to your premium, you usually have to pay other costs for your health care, including a deductible, copayments, and coinsurance.

QUALIFYING EVENT - A change in your situation — like getting married, having a baby, or losing health coverage — that can make you eligible for a Special Enrollment period, allowing you to enroll in health insurance outside of the yearly Open Enrollment period.

WAITING PERIOD - The time that must pass before coverage can become effective for an employee or dependent who is otherwise eligible for coverage under a job-based health plan.

ELIGIBILITY

If you are an internal full-time Kirkman Beck employee working 30 hours a week, you are eligible to enter the plan after a 30-day orientation period the first of the month following 60 days of continuous employment.

Kirkman Beck will pay 80%, and the employee will pay 20% of premiums for employee only coverage. For spouse and/or dependent coverage, the employer will pay 50% of premiums.

TEMPORARY Employees who work on average 30 hours per week or 120 hours per month are considered full time equivalent employees. Coverage begins on the first of the month following continuous employment after a continuous five-month measurement period and 30-day administrative period.

Kirkman Beck will pay 80%, and the employee will pay 20% of premiums for employee only coverage. For spouse and/or dependent coverage, the employee will pay 100% of premiums.

HOW TO ENROLL

Are you ready to enroll? The first step is to review your current benefits. Did you move recently or get married? Verify all of your personal information and make any necessary changes.

Once all of your information is up to date, it's time to make your benefit elections. The decisions you make when enrolling for benefits can have a significant impact on your life and finances, so it is important to weigh your options carefully.

WHEN TO ENROLL

Open enrollment begins on November 1 and runs through November 14, 2025. The benefits you choose during open enrollment will become effective on December 1, 2025. For the initial enrollment you will use ADP to make benefit elections.

ENROLLMENT CHANGES

Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next Open Enrollment period.

Qualifying events include things like:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in residence
- Change in employment status or coverage under another employer sponsored plan
- Loss of coverage on yourself or dependents during the year

Request for qualifying events must be submitted to the carrier within 30 days of the event.

	Anthem Gold PPO	Anthem Silver PPO
Network:	Prudent Buyer PPO	Prudent Buyer PPO
Coinsurance Level (In/Out):	80% / 50%	60%/50%
Lifetime Maximum:	Unlimited	
Calendar Year Deductible:		
<ul style="list-style-type: none"> • Individual (IN/OUT) • Family (IN/OUT) 	\$500 / \$2,000 \$1,500 / \$4,000	\$1,750 / \$3,500 \$3,500 / \$7,000
Out-of-Pocket Maximum:		
<ul style="list-style-type: none"> • Individual (IN/OUT) • Family (IN/OUT) 	\$7,900 / \$15,800 \$15,800 / \$31,600	\$9,100 / \$18,200 \$18,200 / \$36,400
Office Visit Copay:		
<ul style="list-style-type: none"> • Primary Care • Specialist • Urgent Care 	\$30 \$60 \$30	\$45 \$95 \$45
Preventative Care:	100% of allowable amount	100% of allowable amount
Emergency Room Services:	\$250/visit + 20% Coinsurance after Deductible	\$300/visit + 40% Coinsurance after Deductible
Inpatient Hospitalization:	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Surgery:		
<ul style="list-style-type: none"> • Facility Fee • Physician/Surgeon Fees 	\$200/visit + 20% Coinsurance after Deductible	\$250/visit + 40% Coinsurance after Deductible
PRESCRIPTION DRUGS		
Calendar Year Deductible:	\$150/\$300	\$300/\$600
Retail (30 Day Supply):		
<ul style="list-style-type: none"> • Generic • Preferred Brand • Non-Preferred Brand • Specialty 	\$15 (Deductible does not apply) \$50 (Copay after Deductible) \$90 (Copay after Deductible) 30% Coinsurance up to \$250	\$15 (Deductible does not apply) \$70 (Copay after Deductible) \$110 (Copay after Deductible) 30% Coinsurance up to \$250
Mail Order (90 Day Supply):		
<ul style="list-style-type: none"> • Generic • Preferred Brand • Non-Preferred Brand • Specialty 	\$25 \$150 \$270 N/A	\$38 \$210 \$330 N/A

MEDICAL



	GOLD 80 HMO 250/35*	SILVER 70 HMO 1900/65*
Network:		
Coinsurance Level (In/Out):	65%/N/A	55% / N/A
Lifetime Maximum:	Unlimited	
Calendar Year Deductible:		
<ul style="list-style-type: none"> • Individual (IN/OUT) • Family (IN/OUT) 	\$250 \$500	\$1,900 \$3,800
Out-of-Pocket Maximum:		
<ul style="list-style-type: none"> • Individual (IN/OUT) • Family (IN/OUT) 	\$7,800 \$15,600	\$8,750 \$17,500
Office Visit Copay:		
<ul style="list-style-type: none"> • Primary Care • Specialist • Urgent Care 	\$35 \$55 \$35	\$65 \$100 \$65
Preventative Care:	100% of allowable amount	100% of allowable amount
Emergency Room Services:	\$250/visit after Deductible	45% Coinsurance after Deductible
Inpatient Hospitalization:	\$600 per day up to 5 days after admission (after Deductible)	45% Coinsurance after Deductible
Outpatient Surgery:		
<ul style="list-style-type: none"> • Facility Fee • Physician/Surgeon Fees 	\$335/visit after Deductible	45% Coinsurance after Deductible
PRESCRIPTION DRUGS		
Calendar Year Deductible:	None	None
Retail (30 Day Supply):		
<ul style="list-style-type: none"> • Generic • Preferred Brand • Non-Preferred Brand • Specialty 	\$15 \$40 20% per prescription up to 250 maximum (after plan deductible)	\$20 \$100 20% per prescription up to 250 maximum (after plan deductible)
Mail Order (90 Day Supply):		
<ul style="list-style-type: none"> • Generic • Preferred Brand • Non-Preferred Brand • Specialty 		

Unum[®] Hire Up Staffing Service

Unum Dental[™]



Dental Insurance can help you pay for dental exams, cleanings and other services.

How does it work?

Good dental care is critical to your overall well-being. With Unum Dental insurance, you can get the attention your teeth need — at a cost you can afford.

Unum Dental allows you to see any dentist you choose. To get the most from your benefits and reduce out-of-pocket costs, choose an in-network provider by utilizing our large national network. These providers have agreed to file your claims and uphold the highest quality standards. You can find in-network providers at unumdentalcare.com.

What else is included?

Pregnancy benefit

An extra cleaning for expecting mothers in their 2nd or 3rd trimester.

Wellness benefits

Oral cancer screenings for patients 40 and older with high risk factors.

Unumdentalcare.com

Use unumdentalcare.com to search for providers, manage your benefits and learn about good dental health. Features include easy access to ID Cards, claims history and coverage information.

Virtual Dental Visits

24/7 dental care for dental emergencies when an in-person visit isn't an option. Available for active dental members*.

Visit unumdentalcare.com and click Virtual Dental Visits to get started.

Carryover benefits

Members who take care of their teeth, but use only part of their annual maximum benefit during a benefit period are rewarded with extra benefits in future years! Carryover benefits will be accrued and stored in the insured's carryover account to be used in the next benefit year.



Why is this coverage so valuable?

- ✓ Routine dental care keeps your mouth and whole body healthy.
- ✓ Your plan is backed by Unum's commitment to excellence in customer service.
- ✓ Personalized website to manage your benefits including claims information, ID cards and more.
- ✓ There's no waiting period for preventive and basic services.

The limits for this policy/certificate are:	Active PPO
Carryover benefit	\$400
Threshold limit	\$800
Carryover account limit	\$1,500

*Virtual dental visits are a preventive service and subject to policy year benefit maximum.

Coverage details and costs

Overview	Active PPO	
Benefit Year Maximum*	\$2,000	
Deductible**	\$50 in-network and out-of-network Maximum 3 per family	
Plan Coinsurance	In-network	Out-of-Network
Class A Preventive	100%	100%
Class B Basic	90%	80%
Class C Major	60%	50%
Class D Orthodontics	50%	50%

*Applies to Class A, B and C Services, if applicable

**Waived for Class A (applies to Class B and C Services)

Dental carryover benefit and how it works

Each benefit year a member must have:

- One cleaning,
- One regular exam, and
- Total dental claims for preventive, basic and major covered procedures paid during the year below the threshold limit.
- If all three criteria above are met, a portion of the annual maximum will carry over to the next year.

Other Specifications:

- Each covered family member receives their own carryover benefit.
- Group carryover benefit rider must be in effect for one benefit year before any members can utilize carryover benefits.
- A member must be on the plan for a minimum of three months before accruing carryover benefits.
- Carryover benefit may be used toward preventive, basic and major covered services only
- A member's carryover account will be eliminated, and the accrued carryover benefits lost if the insured has a break in coverage for any length of time or any reason.

Dependent children

Dependent age guidelines vary by state. Please refer to your policy certificate or call our Contact Center at (888) 400-9304.

Services not listed

If you expect to require a dental service not included on this brochure, it may still be covered. Please call our Contact Center at (888) 400-9304 to confirm your exact benefits.

Alternate treatment

Unum covers the least expensive most commonly used and accepted American Dental Association treatments. Plan members may elect a more expensive treatment, but will be responsible for the cost difference resulting from the more expensive procedure.



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Unum Vision[®] Powered by EyeMed



Plan features:

Members have the freedom to choose any provider from EyeMed's Insight Network. Our network offers the right mix of independent, national retail and regional retail providers like Lens Crafters, Pearle Vision, Target Optical and many more. Members can also purchase glasses and contact lenses online at [Glasses.com](https://www.glasses.com) and [ContactsDirect.com](https://www.contactsdirect.com).

Covered benefits:

Exam: Each member is entitled to a comprehensive vision exam. An exam co-pay applies and is outlined in the grid at right.

Materials: Each member has coverage for covered services and materials. Purchases are subject to benefit frequencies and co-pays. Plan features include:

- **Frame benefit:** You may choose any frame within a provider's collection, subject to the retail frame allowance listed at right. If the cost is greater than the plan's benefits, you are responsible for the difference.
- **Eyeglass lens benefit:** Standard plastic (CR-39 Plastic Material) single vision, bifocal, trifocal, and specialty lenses are generally covered after any applicable materials copay. If covered by plan allowance, you are responsible for any cost greater than the plan's benefit.
- **Contact lens benefit:** Members electing contact lenses instead of eye glass lenses may apply the contact lens allowance to any lenses in the provider's collection. If the cost is greater than the plan's benefits, you are responsible for the difference.

Laser vision correction: Discounts are available with participating surgery providers across the country (not an insured benefit)

EyeMed benefits:

Vision Care Services	In-network Member Cost	Out-of-network Reimbursements
Exam (1 per 12 months)	\$10 co-pay	Up to \$40
Retinal Imaging Benefit	Up to \$39	Not covered
Standard Plastic Lenses (1 per 12 months)		
Single Vision	\$25 co-pay	Up to \$30
Bifocal	\$25 co-pay	Up to \$50
Trifocal	\$25 co-pay	Up to \$70
Lenticular	\$25 co-pay	Up to \$70
Standard Progressive	\$90 co-pay	Up to \$50
Premium Progressive Lens		
Premium Progressive Tier 1	\$110 co-pay	Up to \$50
Premium Progressive Tier 2	\$120 co-pay	Up to \$50
Premium Progressive Tier 3	\$135 co-pay	Up to \$50
Premium Progressive Tier 4	\$90 co-pay (80% of charge less than \$120 allowance)	Up to \$50
Lens Options		
Polycarbonate Lenses (under age 19)	Covered	Up to \$32
Frames (1 per 12 months)		
Members may select any frame available	\$130 allowance	Up to \$91
Contact Lenses (1 per 12 months)		
In lieu of eyeglass lenses		
Elective	\$130 allowance	Up to \$130
Non-Elective	Covered	Up to \$210
Standard Contact Lens Fitting Exam Fee*	Up to \$40	Not covered

*The standard contact lens fitting exam fee applies to a new or existing contact lens user who wears spherical disposable, daily wear, or extended wear lenses only.

Unum Vision Powered by EyeMed members will receive the following discounts on materials at in-network providers only:

- 40% off for a complete second pair of glasses.
- 20% off non-prescription sunglasses.
- 20% off remaining balance beyond plan coverage.

Laser Vision Correction Network

Membership provides access to preferred pricing. Transactions are handled directly between members and providers. Refractive surgery is an elective procedure and may involve potential risks to patients. This is not an insured benefit. Unum cannot and does not guarantee the outcome of any refractive surgical procedure or a total elimination of the need for glasses or contacts. Providers may not be available in all metropolitan areas. Login to www.eyemedvisioncare.com/unum for a list of participating laser vision correction providers.

Hearing Savings Plan included at no additional cost to the member!

Unum offers a Hearing Savings Plan at no additional cost, to all of its Unum Vision Powered by EyeMed members. Partnering with Amplifon, the Hearing Savings Plan provides:

- 40% off hearing exams at thousands of convenient locations nationwide
- Discounted set pricing on thousands of hearing aids, including those with the newest, most advanced technology
- Low price guarantee – if you find the same product at a lower price elsewhere, Amplifon will beat it by 5%
- 60-day hearing aid trial period with no restocking fees
- Free batteries for 2 years with initial purchase
- 3-year warranty plus loss and damage coverage

Other Unum Vision Specifications

Dependent children: Dependent age guidelines vary by state. Please refer to your policy certificate or contact customer service at (855) 652-8686.

Services not listed: If you expect to require a vision service not included on this brochure, it may still be covered. Refer to the member portal at www.eyemedvisioncare.com/unum, to confirm your exact benefits. This is a primary vision care benefit and is intended to cover only eye examinations and/or corrective eyewear. Medical or surgical treatment of eye disease or injury is not provided under this plan. Coverage may not exceed the lesser of actual cost of covered services and materials or the limits of the policy.

No benefits will be paid for services, materials connected with, or charges arising from:

Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; Medical

and/or surgical treatment of the eye, eyes or supporting structures; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states, members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.

Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time. Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

A Network Access plan is available.

THIS POLICY PROVIDES LIMITED BENEFITS

This brochure is not intended to be a complete description of the insurance coverage available. The policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form Series VI-2002, VI-2007 and VI-2019 or contact your Unum Vision representative.

Vision plans are marketed by Unum and EyeMed, administered by First American Administrators and underwritten by Starmount Life Insurance Company, Baton Rouge, LA.

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Term Life and Accidental Death & Dismemberment (AD&D) Insurance



How does it work?

You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more. AD&D Insurance is also available, which pays a benefit if you survive an accident but have certain serious injuries. It pays an additional amount if you die from a covered accident.

Why is this coverage so valuable?

If you buy a minimum of \$10,000 of coverage now, you can increase your coverage in the future up to \$50,000 to meet your growing needs. There would be no medical underwriting to qualify for coverage.

What else is included?

A 'Living' Benefit — If you are diagnosed with a terminal illness with less than 12 months to live, you can request 100% of your life insurance benefit (up to \$250,000) while you are still living. This amount will be taken out of the death benefit, and may be taxable. **These benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements, and may be taxable.** Recipients should consult their tax attorney or advisor before utilizing living benefit payments.

Waiver of premium — Your cost may be waived if you are totally disabled for a period of time.

Portability — You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Who can get Term Life coverage?

If you are actively at work at least 30 hours per week, you may apply for coverage for:

You:	Choose from \$10,000 to \$500,000 in \$10,000 increments, up to 5 times your earnings. You can get up to \$50,000. This is the amount of coverage you can qualify for with no medical underwriting.
Your spouse:	Get up to \$500,000 of coverage in \$5,000 increments. Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself. Your spouse can get up to \$15,000 with no medical underwriting, if eligible (see delayed effective date).
Your children:	Get up to \$10,000 of coverage in \$2,000 increments if eligible (see delayed effective date). One policy covers all of your children until their 26th birthday. The maximum benefit for children live birth to 6 months is \$1,000.

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You:	Get up to \$500,000 of AD&D coverage for yourself in \$10,000 increments to a maximum of 5 times your earnings.
Your spouse:	Get up to \$500,000 of AD&D coverage for your spouse in \$5,000 increments, if eligible (see delayed effective date).
Your children:	Get up to \$10,000 of coverage for your children in \$2,000 increments if eligible (see delayed effective date).

No medical underwriting is required for AD&D coverage.

How much coverage can I get?

Calculate your costs

1. Enter the coverage amount you want.
2. Divide by the amount shown.
3. Multiply by the rate.
Use the rate table (at right) to find the rate based on age.
(Choose the age you will be when your coverage becomes effective. See your plan administrator for your plan effective date. To determine your spouse rate, choose the age the employee will be when coverage becomes effective. See your plan administrator for your plan effective date.)
4. Enter your cost.

	1	2	3	4
Employee	\$____,000	÷ \$1,000 = \$____	X \$____	= \$____
Spouse	\$____,000	÷ \$1,000 = \$____	X \$____	= \$____
Child	\$____,000	÷ \$1,000 = \$____	X \$____	= \$____
Total cost				

Employee monthly rate		Spouse monthly rate	Child monthly rate
Age	Per \$1,000 of coverage Cost	Per \$1,000 of coverage Cost	\$0.452 per \$1,000 of coverage
15-24	\$0.080	\$0.080	
25-29	\$0.080	\$0.080	
30-34	\$0.100	\$0.100	
35-39	\$0.130	\$0.130	
40-44	\$0.180	\$0.180	
45-49	\$0.260	\$0.260	
50-54	\$0.430	\$0.430	
55-59	\$0.650	\$0.650	
60-64	\$0.920	\$0.920	
65-69	\$1.930	\$1.930	
70-74	\$3.440	\$3.440	
75+	\$3.440	\$3.440	

1. Enter the AD&D coverage amount you want.
2. Divide by the amount shown.
3. Multiply by the rate.
Use the AD&D rate table (at right) to find the rate.
4. Enter your cost.

AD&D				
	1	2	3	4
Employee	\$____,000	÷ \$1,000 = \$____	X \$0.034	= \$____
Spouse	\$____,000	÷ \$1,000 = \$____	X \$0.038	= \$____
Child	\$____,000	÷ \$1,000 = \$____	X \$0.063	= \$____
Total cost				

AD&D monthly rates		
	Coverage amount	Rate
Employee	per \$1,000 of coverage	\$0.034
Spouse	per \$1,000 of coverage	\$0.038
Child	per \$1,000 of coverage	\$0.063

Billed amount may vary slightly.

If you apply for coverage above the guaranteed issue amount, you may be subject to medical underwriting which may affect your ability to get the larger coverage amount. In order to purchase coverage for your dependents, you must buy coverage for yourself. Coverage amounts cannot exceed 100% of your coverage amounts.

Exclusions and limitations

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.

An unmarried handicapped dependent child who becomes handicapped prior to the child's attainment age of 26 may be eligible for benefits. Please see your plan administrator for details on eligibility.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths caused by suicide occurring within 24 months after the effective date of coverage. The same applies for increased or additional benefits.

AD&D specific exclusions and limitations:

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Committing or attempting to commit a crime under state or federal law
- The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your or your dependent's doctor. This exclusion does not apply to you or your dependent if the chemical substance is ethanol.
- Intoxication – 'Being intoxicated' means your or your dependent's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Delayed Effective Date: if your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Age Reduction

Coverage amounts for Life and AD&D Insurance for you and your dependents will reduce to 50% of the original amount when you reach age 70. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage and your dependents' coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends
- The date your dependent ceases to be an eligible dependent
- For a spouse, the date of a divorce or annulment
- For dependents, the date of your death

Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.

Life Planning Financial & Legal Resources services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by:

Unum Life Insurance Company of America, Portland, Maine

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Hire Up Staffing Service

Term Life with Accidental Death & Dismemberment (AD&D) Insurance



How does it work?

You keep coverage for a set period of time, or “term.” If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more. AD&D Insurance is also available, which can pay a benefit if you survive an accident but have certain serious injuries. It can pay an additional amount if you die from a covered accident.

Why Choose Unum?

Your employer is offering you this coverage at no cost to you.

What else is included?

A “Living” Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 100% of your life insurance benefit (up to \$250,000) while you are still living. This amount will be taken out of the death benefit and may be taxable.

Waiver of premium

Your cost may be waived if you are totally disabled for a period of time.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Who can get Term Life coverage?

If you are actively at work at least 30 hours per week, you can receive coverage for:

You:	You can receive a benefit amount of \$75,000. You can get up to \$75,000 with no medical underwriting.
------	--------------------------------------------------------------------------------------------------------

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You:	You can receive an AD&D benefit amount of \$75,000.
------	-----------------------------------------------------

No medical underwriting is required for AD&D coverage.

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.

Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage.

Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths that are caused by suicide occurring within 24 months after the effective date of coverage or the date that increases to existing coverage becomes effective. This exclusion standardly applies to all medically written amounts and contributory amounts that are funded by the employee including shared funding plans.

AD&D specific exclusions and limitations:

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Committing or attempting to commit a crime under state or federal law
- The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your doctor. This exclusion does not apply to you if the chemical substance is ethanol.
- Intoxication – "Being intoxicated" means your blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Delayed effective date of coverage

Employee: Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Age reduction

Coverage amounts for Life and AD&D Insurance for you will reduce to 50% of the original amount when you reach age 70. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.

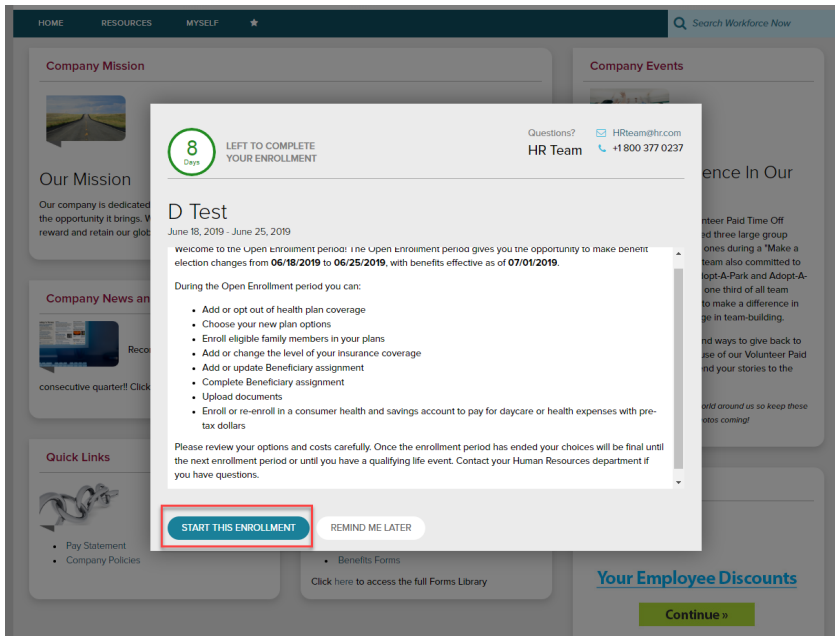
Life Planning Financial & Legal Resources services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

Underwritten by: Unum Life Insurance Company of America, Portland, Maine

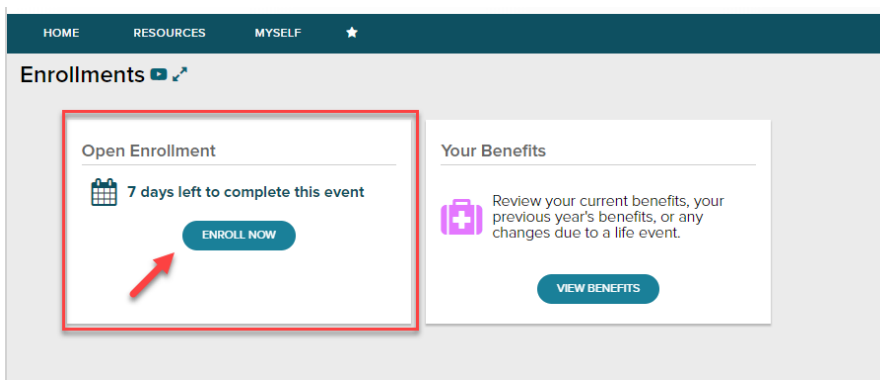
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ADP ENROLLMENT

Upon logging in, you will be presented with a pop-up showing important information about this Open Enrollment period. You can click **Start This Enrollment** or **Remind Me Later**. This pop-up is displayed each time you log in during the Open Enrollment period until you complete your selections.



You will be routed to the Enrollments page, where you have the option to either start the Open Enrollment process or review your current benefits.



ADP ENROLLMENT



To start, click **Enroll Now** in the Open Enrollment card. You will be brought back to the Welcome Note and Introduction page. Please review all information on this page, as there are often important references for your Open Enrollment options. If any tobacco attestation requirements are in place, you must provide the information as indicated before clicking **Continue**.

HOME RESOURCES MYSELF ★ Search Workforce Now

Enrollments 📄 🔖 Add to Favorites ☆

Welcome to D Test

📅 7 days left to complete this event

Welcome Select Benefits Summary

Welcome to the Open Enrollment period! The Open Enrollment period gives you the opportunity to make benefit election changes from **06/18/2019** to **06/25/2019**, with benefits effective as of **07/01/2019**.

During the Open Enrollment period you can:

- Add or opt out of health plan coverage
- Choose your new plan options
- Enroll eligible family members in your plans
- Add or change the level of your insurance coverage
- Add or update Beneficiary assignment
- Complete Beneficiary assignment
- Upload documents
- Enroll or re-enroll in a consumer health and savings account to pay for daycare or health expenses with pre-tax dollars

Please review your options and costs carefully. Once the enrollment period has ended your choices will be final until the next enrollment period or until you have a qualifying life event. Contact your Human Resources department if you have questions.

Are you a Tobacco User? *

No

Yes

Is Kate Albright a Tobacco User? *

No

Yes

Is George Albright a Tobacco User? *

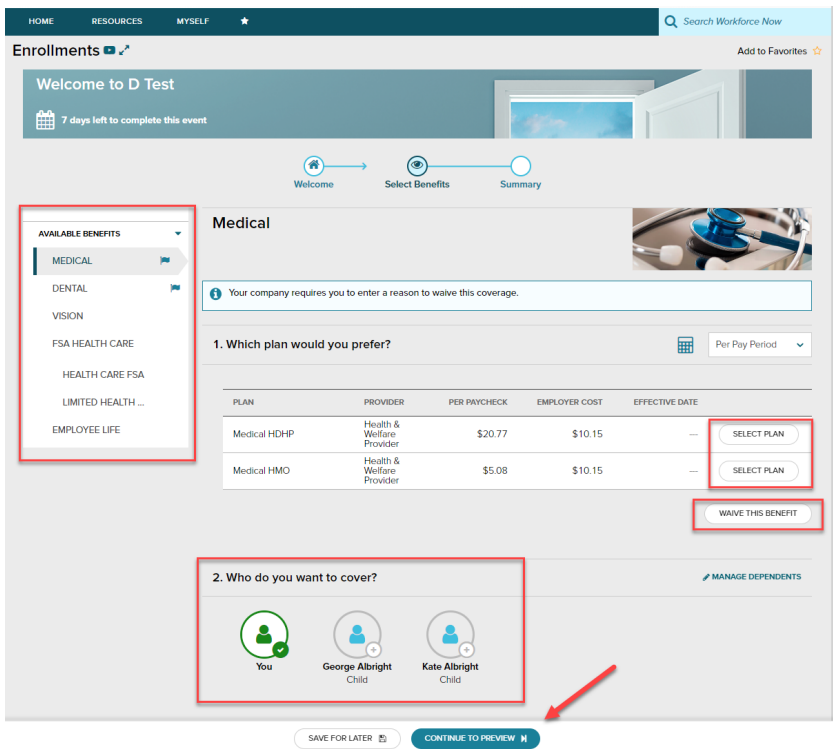
No

Yes

CONTINUE ▶

ADP ENROLLMENT

The left side of the page indicates the different plan types that are available to enroll in. When you are on the selected plan type, all enrollment options are displayed.

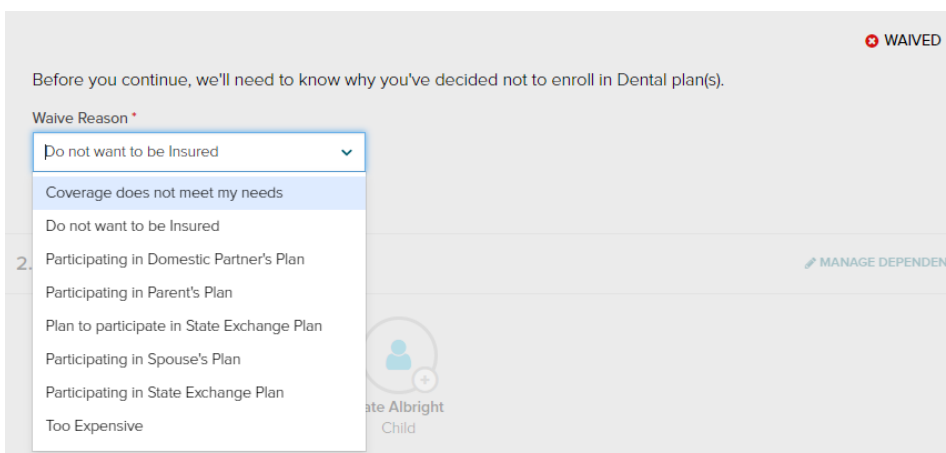


The screenshot shows the ADP Enrollment interface. On the left, a sidebar lists available benefits: MEDICAL, DENTAL, VISION, FSA HEALTH CARE, HEALTH CARE FSA, LIMITED HEALTH..., and EMPLOYEE LIFE. The 'Medical' section is active. A message states: "Your company requires you to enter a reason to waive this coverage." Below this, a question asks "1. Which plan would you prefer?" with a "Per Pay Period" dropdown. A table lists two plans:

PLAN	PROVIDER	PER PAYCHECK	EMPLOYER COST	EFFECTIVE DATE	
Medical HDHP	Health & Welfare Provider	\$20.77	\$10.15	—	SELECT PLAN
Medical HMO	Health & Welfare Provider	\$5.08	\$10.15	—	SELECT PLAN

Below the table is a "WAIVE THIS BENEFIT" button. The next question is "2. Who do you want to cover?" with options for "You", "George Albright Child", and "Kate Albright Child". A red arrow points to the "CONTINUE TO PREVIEW" button at the bottom.

You may choose to **Select Plan** for the desired enrollment or **Waive This Benefit**. If you choose to waive a benefit, you may be required to select a waive reason.



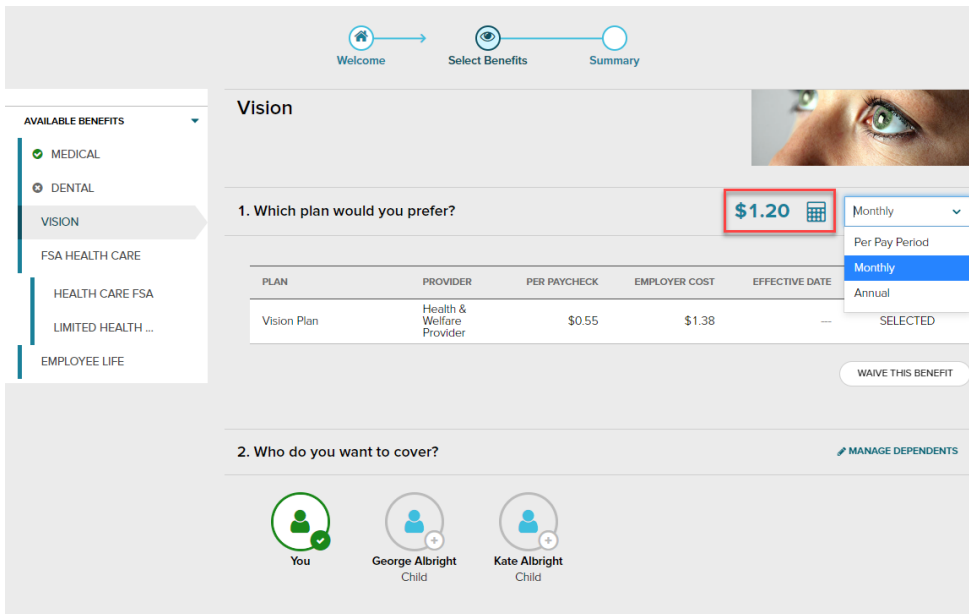
The screenshot shows the ADP Enrollment interface with a "WAIVED" status. A message states: "Before you continue, we'll need to know why you've decided not to enroll in Dental plan(s)." Below this, a "Waive Reason" dropdown menu is open, showing the following options:

- Do not want to be Insured
- Coverage does not meet my needs
- Do not want to be Insured
- Participating in Domestic Partner's Plan
- Participating in Parent's Plan
- Plan to participate in State Exchange Plan
- Participating in Spouse's Plan
- Participating in State Exchange Plan
- Too Expensive

The background shows the "2. Who do you want to cover?" section with the "George Albright Child" option selected.

ADP ENROLLMENT

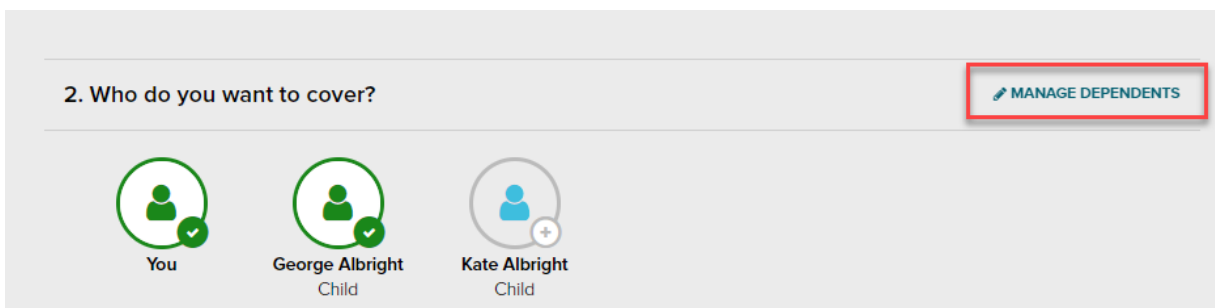
When you choose to enroll in a plan, you can review your costs on a **Per Pay Period, Monthly,** or **Annual** basis by selecting the desired view in the calculator drop-down. The rate displayed on the left is updated based on your selection, and it also changes if dependents are added for coverage.



The screenshot shows the 'Vision' enrollment page. At the top, there are navigation tabs: 'Welcome', 'Select Benefits', and 'Summary'. On the left, a sidebar lists 'AVAILABLE BENEFITS' with 'VISION' selected. The main content area is titled 'Vision' and features a progress indicator for '1. Which plan would you prefer?'. A cost of '\$1.20' is displayed next to a calculator icon. A dropdown menu is open, showing options for 'Monthly', 'Per Pay Period', 'Monthly', 'Annual', and 'SELECTED'. Below this is a table with columns: PLAN, PROVIDER, PER PAYCHECK, EMPLOYER COST, and EFFECTIVE DATE. The table lists 'Vision Plan' with a provider 'Health & Welfare Provider', a per paycheck cost of '\$0.55', and an employer cost of '\$1.38'. A 'WAIVE THIS BENEFIT' button is located below the table. The second step, '2. Who do you want to cover?', is partially visible at the bottom, showing icons for 'You', 'George Albright Child', and 'Kate Albright Child'.

While you enroll in a plan, be sure to indicate which dependents should be covered when you get to step 2 on this page, if applicable. If you need to update or add a dependent, click the **Manage Dependents** link.

* **Note:** The coverage level for your enrollment (Employee Only, Employee + Spouse, Employee + Child(ren), Employee + Family) is driven by the dependents you select to enroll.



This close-up screenshot focuses on the '2. Who do you want to cover?' section. It shows three dependent selection options: 'You' (with a green checkmark), 'George Albright Child' (with a green checkmark), and 'Kate Albright Child' (with a plus sign). A red box highlights the 'MANAGE DEPENDENTS' link in the top right corner of this section.

ADP ENROLLMENT



When you finish selecting your benefits for the current category, click **Continue to Preview**.

Review your enrollment, costs, and covered individuals carefully. Then click **Save and Continue to Next Benefit** to continue making your desired selections.

Save Your Election ✕

YOU ARE ENROLLING IN
Health & Welfare Provider: Medical HDHP, Eligible Employees

PER PAYCHECK	COSTS
PLAN COST	\$34.62
TOTAL PER PAYCHECK	\$34.62

COVERED INDIVIDUALS

- AA Anthony Albright
You
- GA George Albright
Child

SAVE AND CONTINUE TO NEXT BENEFIT

Company-Paid/Voluntary Life Elections and Beneficiaries:

When you elect Voluntary Life, you will also need to select your beneficiaries. Start by clicking **Select Plan**, and then choose the amount of coverage you want to elect.

PLAN	PROVIDER	PER PAYCHECK	EMPLOYER COST	EFFECTIVE DATE	
EE Vol Life	Guardian Life	\$0.00	\$0.92	---	SELECT PLAN ⓘ

If the amount selected is over the Guarantee Issue amount, an approval will be required and you will be asked to collect an **Evidence of Insurability** (EOI) and submit it to your employer. Your full election amount will not be approved until this document is received.

EE Vol Life	Guardian Life	\$0.00	\$7.38	---	SELECTED
-------------	---------------	--------	--------	-----	----------

WAIVE THIS BENEFIT

1. How much coverage would you like? **\$0.00** Per Pay Period ▾

▾ Additional Amount

\$80,000.00 Total Elected coverage

Over The Limit - Approval Required
The additional amount of coverage is over the guarantee issue amount of \$50,000.00. The amount over the limit will be subject to the approval of the plan administrator and/or the insurance carrier.

ADP ENROLLMENT



Next, select your **beneficiaries**, including **Primary** and **Secondary**, if applicable. All beneficiary delegation percentages combined must equal 100% for each category (Primary or Secondary).

2. Who would you like to assign as your beneficiaries? [MANAGE BENEFICIARIES](#)

You can select as many beneficiaries as you would like as long as the total equals 100%.

Select your Primary beneficiaries

Alice Albright Spouse 100.00 %

Anthony Albright Child

Maggie Albright Child

Randy Albright Child

-100.00% (total must equal 100%)

Joanna Anthony Child

Do you want to add Secondary beneficiaries?

Alice Albright Spouse

Anthony Albright Child 25.00 %

Maggie Albright Child 25.00 %

Randy Albright Child 25.00 %

-100.00% (total must equal 100%)

Joanna Anthony Child 25.00 %

SAVE FOR LATER

CONTINUE TO PREVIEW

Click **Continue to Preview** and review your selection and beneficiary delegations. Then click **Save and Continue to Next Benefit**.

Save Your Election

YOU ARE ENROLLING IN
Guardian Life: EE Vol Life, Eligible Employees

Total Elected coverage: \$80,000.00

PER PAYCHECK	COSTS
Employer Pays	\$7.38
You Pay	\$0.00

PRIMARY ALLOCATIONS

AA Alice Albright Spouse 100.00%

SECONDARY ALLOCATIONS

AA Anthony Albright Child 25.00%

MA Maggie Albright Child 25.00%

RA Randy Albright Child 25.00%

JA Joanna Anthony Child 25.00%

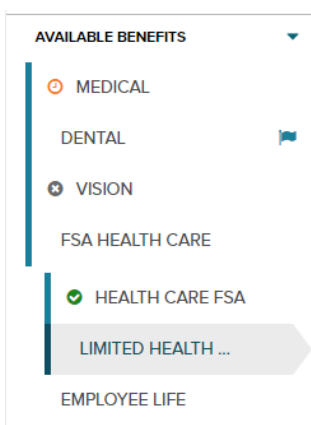
SAVE AND CONTINUE TO NEXT BENEFIT

ADP ENROLLMENT

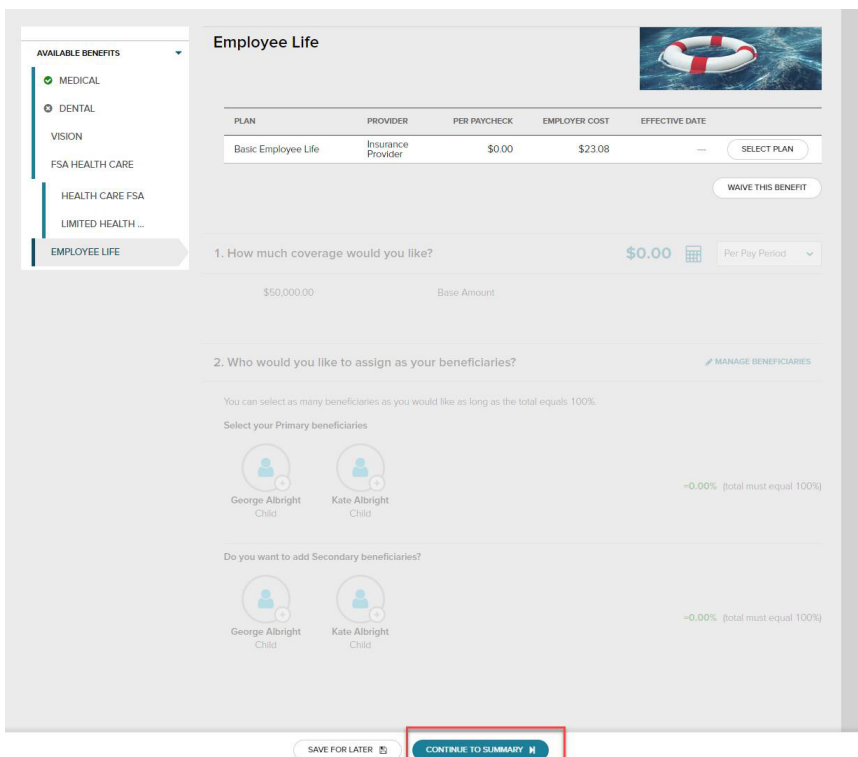


In the Open Enrollment flow, the following visual indicators are displayed to show different steps taken, action items, or enrollment statuses:

Symbol	Meaning
🚩 (flag icon)	The plan needs your attention.
✅ (green check mark)	This is a current plan that you are enrolled in.
⊗ (gray X)	This plan has been waived.
🕒 (orange clock icon)	This plan is pending approval.



Continue through each step until all elections are complete and the **Continue to Summary** button is activated.



ADP ENROLLMENT



Review all of your selections. When you have confirmed them, click **Submit Enrollment**. Note that your benefit elections will not be processed until you click **Submit Enrollment**. If you click **Save for later** instead, these enrollments will not be submitted to your HR team until you fully submit the enrollment.

Welcome to D Test

7 days left to complete this event

Welcome → Select Benefits → Summary

Please review this summary of your D Test.

Warning: Your benefit elections will not be processed until you click "SUBMIT ENROLLMENT". You will still be able to make changes until June 25, 2019 11:59 PM EDT

SAVE FOR LATER | **SUBMIT ENROLLMENT**

Enrollment Summary

Per Pay Period

Plan	Effective Date	Coverage	Employer Cost	Your Cost
Medical			\$30.46	\$34.62
Health & Welfare Provider: Medical HDHP, Eligible Employees				
Surveys Employee Tobacco User Question: I attest that I am a tobacco user. Answer: No	July 1, 2019	You George Albright		
			Per Pay Period:	\$30.46 \$34.62

Waived Benefits

Dental	Waive Reason: Do not want to be Insured
--------	-----------------------------------------

SAVE FOR LATER | **SUBMIT ENROLLMENT**

Ensure that you receive the confirmation note indicating that your elections have been submitted.

✓ You have completed your enrollment.

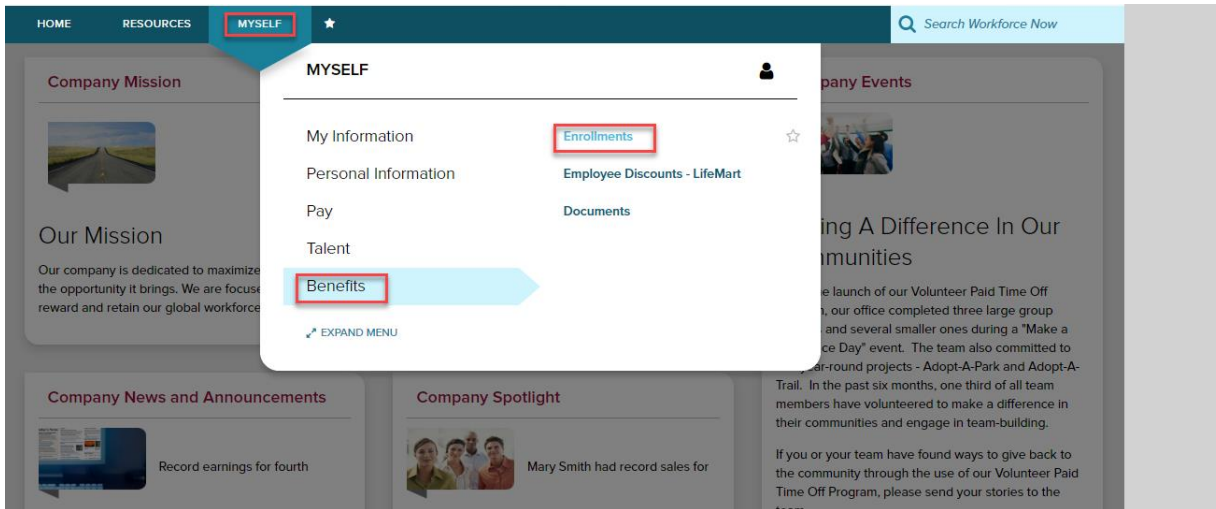
You have successfully completed your D Test enrollment. Contact your administrator if you have questions.

CLOSE

ADP ENROLLMENT



If you want to make additional changes during the Open Enrollment period, you can log in and navigate to **Myself > Benefits > Enrollments** and click the **Enroll Now** option again. This will bring you back to the beginning of the profile to make any desired election changes.



CONTACTS

	<p>Rebecca Kirkman HR/Safety WC Manager</p>	<p>(559) 579-1332 rebecca@hireupss.com</p>
	<p>Madison Banuelos Account Manager</p>	<p>(979) 774-6268 madison.banuelos@hubinternational.com</p>
	<p>Medical <i>Group Number: F36854</i></p>	<p>1-800-676-2583 anthem.com</p>
	<p>Medical <i>Group Number: 728061</i></p>	<p>1-888-901-4636 healthy.kaiserpermanente.org</p>
	<p>Dental/Vision/Life <i>Dental Network: UNUM Vision UNUM DENTAL Group Number: 920656</i></p>	<p>1-866-679-3054 unum.com</p>

HIPAA Notice of Privacy Practices Reminder Protecting Your Health Information Privacy Rights

[Applicable for Self-Funded/Level Funded Plans – *carriers* can provide this for Fully Insured Plans but best practice would include this for all plans. More information on this is included the Employer Resources Section of this document.]

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. This information is known as protected health information (PHI) and includes all individually identifiable health information held by a health plan; whether received in writing, in an electronic medium or as oral communication. This notice describes the privacy practices of the Employee Benefits Plan (Plan), sponsored by your employer (plan sponsor). The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. It is important to note that these rules apply to the Plan, not the plan sponsor as an employer. You have the right to inspect and copy protected health information which is maintained by and for the Plan for enrollment, payment, claims and case management.

Kirkman Beck, LLC is committed to the privacy of your health information. The administrators of the Kirkman Beck, LLC Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting: **[F**

Rebecca Kirkman | rebecca@hireupss.com | (559) 579-1332

HIPAA Special Enrollment Rights

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (*Excluding* Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, **you must request enrollment within 30 days** after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, **you must request enrollment within 60 days** after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, **you must request enrollment within 30 days** after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, **you must request enrollment within 60 days** after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, please contact:

Rebecca Kirkman

rebecca@hireupss.com | (559) 579-1332

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining

eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Women's Health and Cancer Act of 1998 (WHCRA)

Under Women's Health and Cancer Rights Act of 1998 (WHCRA), group health plans are required to provide benefits for mastectomy-related services. If you have had or are going to have a mastectomy, you may be entitled to certain benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema.

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 resulting from a mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Please review your plan materials regarding any deductibles and/or coinsurance or call your Plan Administrator/benefits contact representative with any questions, concerns and/or more information on WHCRA benefits.

Notice for Newborns' and Mothers' Health Protection Act (Newborns' Act)

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours)

USERRA Notice

HEALTH INSURANCE PROTECTION ☆☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. ☆☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

For your full Uniformed Service Employment and Reemployment Rights Act protections, please visit:

<https://www.dol.gov/agencies/vets/programs/userra>

Summary of Material Modifications Disclosure

This Employee Benefits Communication serves as notice of material changes to your employer sponsored health benefits plan(s). It describes the changes that affect your benefits plans and updates the Summary Plan Description (SPD). Please read this information thoroughly and keep it with your group health plan SPD. You can request a copy of your SPD by contacting your group health plan administrator.

Grandfathered Health Plan Disclosure

[Applicable if Plan is Grandfathered]

Employer Reminder: *To maintain status as a grandfathered health plan, a plan or health insurance coverage must include a statement, in any plan materials provided to a participant or beneficiary describing the benefits provided under the plan or health insurance coverage, that the plan or coverage believes it is a grandfathered health plan within the meaning of section 1251 of the Patient Protection and Affordable Care Act and must provide contact information for questions and complaints.*

This group health plan is considered to be a "grandfathered health plan" under the Patient Protection and Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator or the employer's benefits point of contact.

If your group health plan is subject to the Employee Retirement Income Security Act (ERISA), you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.healthcareform.gov.

No Surprise Billing 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 balance 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, you may contact Federal No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services at 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

[If applicable: Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed language regarding applicable state law requirements as appropriate including a website link or contact to the appropriate state agency – Texas example below.]

For Patients and Plans that have protections under the State Law by the Texas Department of Insurance, please visit <https://www.tdi.texas.gov/medical-billing/index.html> for more information.

insurance coverage know of their rights to (1) choose a primary care provider or a pediatrician when a plan or issuer requires designation of a primary care physician; or (2) obtain obstetrical or gynecological care without prior authorization. Accordingly, the interim final regulations regarding patient protections under section 2719A of the Affordable Care Act require plans and issuers to provide notice to participants of these rights.

Model Notice for plans and issuers that **require or allow for the designation of primary care providers** by participants or beneficiaries:

Kirkman Beck HMO option generally requires the designation of a primary care provider (PCP). You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. You must designate a PCP during the enrollment process using the issuer and network instructions provided.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Sponsor or Issuer directly.

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

You do not need prior authorization from The Plan, The Issuer, or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a healthcare professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact:

Rebecca Kirkman

rebecca@hireupss.com | (559) 579-1332

You can also provide link to Issuers website for provider finder tool [here](#)

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

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

Introduction

You're 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 doesn't 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 the full monthly premium for COBRA continuation coverage.

If you're an employee, you'll 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're the spouse of an employee, you'll 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."

[If the Plan provides retiree health coverage, add the following paragraph:]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [enter name of employer sponsoring the Plan], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- *[add if Plan provides retiree health coverage: Commencement of a proceeding in bankruptcy with respect to the employer;]* or
- 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 coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs by contacting Ameriflex

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.

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 this 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.

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

Rebecca Kirkman

rebecca@hireupss.com | (559) 579-1332

Medicare Part D – Notice of CREDITABLE Coverage

[Applicable for Drug Plans that are considered CREDITABLE]

ETC NOTE: if the Medicare Part D Notice combined with other benefit materials, there must be a separate bold box on the **first page of the materials** referencing the pages where these notices can be found on in at least 14 -point font!

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **Kirkman Beck** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **Kirkman Beck** has determined that the prescription drug coverage offered by the **Anthem and Kaiser** is, on average for all plan participants on Plans **Anthem Silver PPO 45/1750/40%, Anthem Gold PPO 30/500/20%, Kaiser 80 HMO 250/35 AND Silver 70 HMO 1900/65**, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Kirkman Beck coverage will or will not be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription coverage. If they select Medicare Part D prescription drug coverage, the group health plan drug

coverage *will* coordinate with Medicare Part D prescription coverage

If you do decide to join a Medicare drug plan and drop your current **Kirkman Beck** coverage, be aware that you and your dependents *[will not]* be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through {**Kirkman Beck**} changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage: Visit

www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

CONTACT INFORMATION:

Kirkman Beck

Plan Effective Date: 12/01/2024-11/30/2025

Plan Administrator Contact: Rebecca Kirkman

rebecca@hireupss.com | (559) 579-1332

Medicare Part D – Notice of NONCREDITABLE Coverage

[Applicable for Drug Plans that are considered NONCREDITABLE]

ETC NOTE: if the Medicare Part D Notice combined with other benefit materials, there must be a separate bold box on the **first page of the materials** referencing the pages where these notices can be found on in at least 14 -point font!

Important Notice About Your Prescription Drug Coverage and Medicare

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

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. [Kirkman Beck] has determined that the prescription drug coverage offered by the [Anthem and Kaiser] is, on average for all plan participants of Plans Anthem Silver PPO 45/1750/40%, Anthem Gold PPO 30/500/20%, Kaiser 80 HMO 250/35 AND Silver 70 HMO 1900/65, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Kirkman Beck This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from Kirkman Beck However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

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

Kirkman Beck: However, if you decide to drop your current coverage with [Kirkman Beck], since it is employer/union sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under **Kirkman Beck**

Kirkman Beck: Since you are losing creditable prescription drug coverage under the Kirkman Beck, you are also eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.]

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

Since the coverage under [Insert Name of Plan], is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, your current **Kirkman Beck** coverage *[will not]* be affected. Plan participants can keep their prescription drug coverage under the group health plan if they select Medicare Part D prescription coverage. If they select Medicare Part D prescription drug coverage, the group health plan drug coverage *will* coordinate with Medicare Part D prescription coverage.

If you do decide to join a Medicare drug plan and drop your current **Kirkman Beck** coverage, be aware that you and your dependents will not be able to get this coverage back.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through **Kirkman Beck** changes. You also may request a copy of this notice at any time.

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

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

Visit www.medicare.gov

• Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

CONTACT INFORMATION:

Kirkman Beck

Plan Effective Date: 12/01/2024-11/30/2025

Plan Administrator Contact: Rebecca Kirkman

rebecca@hireupss.com | (559) 579-1332

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 July 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)	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) & 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

<p>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</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihhip.aspx Phone: 1-855-459-6328 Email: KIHIP.PPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>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</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>

MONTANA – Medicaid	NEBRASKA – Medicaid
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<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov</p>
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
<p>Website: https://www.pa.gov/en/services/dhs/apply-for-medicoid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)</p>	<p>Website: http://www.cohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)</p>
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
<p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>

TEXAS – Medicaid	UTAH – Medicaid and CHIP
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Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhpp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since **July 31, 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.

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

Wellness Program Disclosure

[Applicable depending on Wellness Plan exists and its factors]- Required for incentive-based wellness programs!]

Employer Reminder: For group health plans offering a wellness program that requires an individual to satisfy a standard related to a health factor, the following is model language that may be used to satisfy the requirement that the availability of a reasonable alternative standard be disclosed:

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Plan Administrator and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

[Name of wellness program] is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and [name of employer] may use aggregate information it collects to design a program based on identified health risks in the workplace, [name of wellness program] will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) [indicate who will receive information such as "a registered nurse," "a doctor," or "a health coach" in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact The Plan Administrator.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) NOTICE

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

GINA expands the genetic information nondiscrimination protections included in Title I of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under GINA, group health plans cannot base premiums for a plan or a group of similarly situated individuals on genetic information. GINA generally prohibits plans from requesting or requiring an individual to undergo genetic tests, and prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes.

GINA applies generally to group health plans. Unlike the provisions under Title I of HIPAA, there is no exception for very small health plans with less than two participants who are current employees.

Full details of your protections of Genetic Information and your Health Plan Discrimination Protections, please visit:

[your-genetic-information-and-your-health-plan.pdf \(dol.gov\)](#)

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the 2025 Plan Year with respect to mental health or substance use disorder benefits, please contact your plan administrator:

Kirkman Beck

Plan Effective Date: 12/01/2024-11/30/2025

Plan Administrator Contact: Rebecca Kirkman

rebecca@hireupss.com | (559) 579-1332

Michelle's Law

[Applicable if employer extends coverage to dependents beyond age 26 and requires student status]

Employer Reminder: *Under the Affordable Care Act, plans cannot deny or restrict coverage for a child under the age of 26 based on student status. The written notice requirements of Michelle's Law no longer apply to employer-sponsored plans that only allow for dependent coverage up to age 26, however, those employer-sponsored **plans that extend coverage to dependents beyond age 26** will need to continue to comply with Michelle's Law notice requirements if eligibility for coverage requires the dependent to be a full-time student]*

Pursuant to Michelle's Law, you are being provided with the following notice because the **Kirkman Beck** group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of **Kirkman Beck** group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the **Kirkman Beck** group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the **Kirkman Beck** group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

- The **Kirkman Beck** group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and

To obtain additional information, please contact

Kirkman Beck

Plan Effective Date: 12/01/2024-11/30/2025

Plan Administrator Contact: Rebecca Kirkman

rebecca@hireupss.com | (559) 579-1332

REQUIRED FIXED INDEMNITY PLAN NOTICE (14-POINT FONT), FIRST PAGE OF PLAN ENROLLMENT MATERIALS AND TECHNOLOGY IF ELECTRONIC ENROLLMENT

EFFECTIVE 9/1/2024

**IMPORTANT: This is a fixed indemnity policy,
NOT health insurance**

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill
- There might be a limit on how much this policy will pay each year
- This policy isn't a substitute for comprehensive health insurance

Looking for comprehensive health insurance?

- **Visit [HealthCare.gov](https://www.healthcare.gov)** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options
- To find out if you can get health insurance through your job, or a family member's job, contact the employer

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.



Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1,2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution - as well as your employee contribution to employment-based coverage - is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is **offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact

Kirkman Beck

Plan Effective Date: 12/01/2024-11/30/2025

Plan Administrator Contact: Rebecca Kirkman

Rebecca@kirkmanbeck.com

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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.

3. Employer Name: Kirkman Beck		4. Employer Identification Number (EIN):
5. Employer Address: 100 Texan Trail Suite 125		6. Employer Phone Number
7. City: Grapevine	8. State: TX	9. Zip Code: 76051
10. Who can we contact about employee health coverage at this job?:		
11. Phone # (If different than above:		12. Email Address: rebecca@kirkmanbeck.com

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

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

All employees. Eligible employees are:

Some employees. Eligible employees are:

Spouses and Children up to age 26

- With respect to dependents:

We do offer coverage. Eligible dependents are:

Spouses 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

- Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
- No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

- Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

- a. How much would the employee have to pay in premiums for this plan? \$ _____
b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

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

- Employer won't offer health coverage
 Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
- a. How much would the employee have to pay in premiums for this plan? \$ _____
b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

ETC NOTE: Most Employers include this required notice in their Benefit Enrollment materials for convenience; however, the notice is supposed to be **provided to all new hires** (part time and full time) – regardless of benefits eligibility

* 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)



A **HUB International** Company