



BENEFITS ENROLLMENT GUIDE

Plan Year: 2026

EGS Inc.



The purpose of this enrollment guide is to provide a summary of benefits to assist eligible plan participants in the decision making process of selecting available benefits for themselves and eligible family members. This guide also provides legal notices and insurance carrier contact information and highlights the main features of many benefit plans sponsored by EGS Inc.

Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. EGS reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

BENEFITS OVERVIEW

OUR BENEFITS PROGRAM HAS YOU COVERED

Most days, we all count on our simple routines to get us through. Getting the kids to school, beating the traffic to work, and finishing dinner in time to enjoy a favorite hobby. But sometimes things don't always go as planned. Like when your head cold turns into the flu and you have to be out of work. Or your son's football game ends with a broken leg. Or even when your spouse learns he or she needs an extensive root canal. That's when Empowered Global Solutions' benefits are there to help you.

Below is an overview of our benefits program, which gives you the coverage you need for all types of things life brings your way. Empowered Global Solutions' benefit plans allow you to choose the options that work best for your own needs — and your wallet. The key to getting the most from our benefits program is to take an active role in understanding and using the plans so that you are getting the best value for the money you spend.

You are eligible to enroll in Empowered Global Solutions benefit plans if you are a regular, full-time employee scheduled to work at least 30 hours per week. As a regular, full-time employee, you are eligible for benefits on the 1st of the month following 30 days from the date you become a full-time employee.

DEPENDENT ELIGIBILITY

You may also cover your eligible dependents, including:

- Your legal spouse
- Your registered domestic partner
- Your eligible children up to age 26
 - "Children" are defined as your natural children, stepchildren, legally adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.



WHEN COVERAGE BEGINS

NEW HIRE ENROLLMENT

Benefits must be elected within 30 days from date of hire. Coverages are effective on the 1st day after 30 days from your hire date. Insurance carrier ID cards will be accessible on the carrier's member portals on your effective date of coverage.

ANNUAL OPEN ENROLLMENT

Coverage you elect during annual Open Enrollment takes effect on January 1, 2026.



MAKING CHANGES TO COVERAGE

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment unless you have a qualified status change or you or your eligible dependents become eligible for coverage through special enrollment rules.

If you have a qualified status change or you have another allowable event, you can make certain changes during the plan year.

Qualified status changes include, but are not limited to:

- Change in number of eligible dependents due to birth, adoption, placement for adoption, or death
- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in residence or workplace that changes your or your dependent's eligibility for coverage
- Change in employment status, such as starting or ending employment, for you, your spouse, or your children
- End of the maximum period for COBRA coverage

For a more complete list of qualified status changes, refer to the Summary Plan Description.

You must notify your Human Resources Manager within 30 days of the Qualified Life Event and complete any necessary forms.

SPECIAL ENROLLMENT RULES

If you choose not to enroll yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents at a later date if:

- You or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must enroll within 60 days of the qualified events shown in the "Special Enrollment Rules" above.

If your dependent also had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents to this coverage if the other coverage was terminated "for cause" (including failure to pay the required premiums on time).

MEDICAL PLANS

EGS's medical plan provides coverage for doctor's office visits, preventive care, prescription drugs, and hospitalization. Cigna administers EGS's medical plan.

Preferred Provider Organizations (PPO)

The PPO plans offer in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because network providers discount their fees. In-network providers provide some additional advantages if you choose these plans; for example, you generally do not have to file claims.

High Deductible Health Plan

The High Deductible Health Plan (HDHP) works much like a PPO plan in that you can choose to receive care from in-network or out-of-network providers when you need medical care, and it covers the same types of services. However, the HDHP has higher deductibles and no office visit copays. Once you've met the in-network or out-of-network deductible, you and the plan begin sharing expenses. Your portion of the expense is the coinsurance. **This also applies to prescription drugs, which are subject to the plan's deductibles. Once the deductible is met, you pay the applicable prescription drug cost or copay amount.**

In addition, the HDHP offers a tax-savings feature called the Health Savings Account (HSA). With this account, you can pay for certain out-of-pocket medical, dental and vision expenses throughout the year.

The providers in the Cigna network may change at any time. To find out if your doctor participates in the Open Access Plus network, go to www.cigna.com, or once you become a member go to www.mycigna.com

If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses.

Did you know your medical plan covers telemedicine? You can use your computer or smart phone 24/7 to immediately see a doctor at www.mycigna.com or by downloading the app on the App Store and Google Play!

MEDICAL PLAN SUMMARY

CIGNA	In-Network Coverage* (You Pay)		
All plan options utilize the Open Access Plus provider network	OAP HDHP \$5,000	OAP Base \$4,500	OAP Buy-Up \$0
Calendar Deductible			
Individual	\$5,000	\$4,500	\$0
Family	\$10,000 (\$5000 per Individual in a family)	\$9,000 (\$4,500 per Individual in a family)	\$0
Calendar Year Out-of-Pocket Maximum			
Individual	\$6,500	\$10,000	\$5,000
Family	\$13,000 (\$6,500 per Individual in a family)	\$20,000 (\$10,000 per Individual in a family)	\$10,000 (\$5,000 per individual in a family)
Lifetime Maximum	Unlimited		
Coinsurance/Copays			
Preventive Care	\$0 in all three plans		
Primary Care Physician	20% after deductible	\$30 copay	\$5 copay
Telemedicine	20% after deductible	\$30 copay	\$5 copay
Specialist	20% after deductible	\$50 copay	\$10 copay
Diagnostics, X-Ray, Lab Services, and Imaging	20% after deductible	20% after deductible	0% after deductible
Urgent Care	20% after deductible	\$75 copay	\$5 copay
Emergency Room	20% after deductible	\$500 copay	\$250 copay
Outpatient Surgery	20% after deductible	20% after deductible	0% after deductible
Inpatient Hospital Care	20% after deductible	20% after deductible	0% after deductible

**This summary is for illustrative purposes for your in-network coverage. Out-of-network benefits are also available on all plans. For coverage details for out-of-network benefits, please refer to your plan documents.*

PRESCRIPTION DRUG COVERAGE

If you enroll in EGS's medical plan, you will automatically receive prescription drug coverage through Cigna. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order program.



Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. Prescriptions you fill at non-participating pharmacies require you to satisfy the out-of-network deductible before any coverage is available.

Mail Order Program

The mail order program offers a convenient and cost-effective way to fill prescriptions for medications you take on a regular basis (maintenance medications). When you use the mail order program, you receive a 3-month supply of medication for the cost of a 2-month supply. Your medications are mailed directly to your home. To order prescriptions through the mail order program, you must fill out a mail order form and return it with a 90-day prescription from your doctor and your payment.

Prescription Drug Plan Highlights

	In-Network Coverage* (You Pay)		
	OAP HDHP \$5,000	OAP Base \$4,500	OAP Buy-Up \$0
Retail Prescriptions (up to 31-day supply)			
Preferred Generic	20% After Deductible	\$10 Copay	\$5 Copay
Preferred Brand-Name	20% After Deductible	\$50 Copay	\$75 Copay
Non-Preferred	20% After Deductible	\$70 Copay	\$100 Copay
Specialty	20% After Deductible	20% After Deductible	\$125 Copay
Mail Order Prescriptions (up to 90-day supply)			
Preferred Generic	20% After Deductible	\$25 Copay	\$13 copay
Preferred Brand-Name	20% After Deductible	\$125 Copay	\$188 copay
Non-Preferred	20% After Deductible	\$172 Copay	\$250 copay
Specialty	20% After Deductible	20% After Deductible	\$312.50 copay

**This summary is for illustrative purposes for your in-network coverage.*

Cigna's Behavioral Programs

If you are enrolled in a EGS Medical Plan, then you have access to a variety of behavioral health programs through Cigna. Challenges to mental well-being come in many forms, and so do the ways we can work through them. Whether you need help reducing stress, are feeling motivated to make a change in your life, or need to talk to someone, Cigna offers a variety of behavioral support tools and services to help ensure you get the support that works best for you.

MDLive Virtual Behavioral Health – Cigna's virtual health provider, MDLive, also offers virtual behavioral health visits. This is subject to the same co-pay/cost sharing as an in-network office visit for Mental Health/Substance Abuse. For any individual on an HDHP costs can range from \$45-\$250 depending on the type of the provider and the length of the visit. Individuals will see the estimated cost when they make their appointment.

Self-service digital tools and resources



iPrevail[®] offered through Cigna provides on-demand coaching, personalized learning and caregiver support. Complete an assessment, receive a program tailored to your needs, and get connected to a peer coach.



Happify[®] offered through Cigna is a self-directed program with activities, science-based games and guided meditations, designed to help reduce anxiety, stress and boost overall health.

Additional Resources

- > [Find a provider](#)
- > [Managing Stress Toolkit](#)
- > [Changing Lives by Integrating Mind and Body[®] \(CLIMB\) stress management podcasts](#)
- > [Veterans support](#)
- > [My Health Assistant](#) (under the Wellness tab)

Virtual Preventive Care – MDLive now offers a virtual preventive care option. A couple of things to note:

- Cost – just like an in-person preventive care visit, this is covered 100%, so there is no cost to individual. This will appear as a standard visit with a primary care physician for the claims billed to the plans.
- Appointment only – individuals must make appointments at least 10 days in advance
- Biometric screenings – individuals will be asked to complete their biometric lab screening at least 3 days before their appointment.



Virtual
Counseling



Emotional
Health &
Well-being



Mental
Health



Substance
Use



Coaching
& Support



Lifestyle
Management
Programs

Emotional Well-being Capabilities - These tools and resources are great for individuals who are struggling but may not be ready or at a point where dedicated professional help will serve them best. These tools are self-directed and are available at no cost to the member.

- **3 Free Employee Assistance Program (EAP) visits** - call **1-800-538-3543**
- **Free 30-minute legal/financial consult**
- **Free 60-minute consult with fraud resolution specialist for ID theft support**
- **iPrevail:** Digital therapeutics program with interactive video lessons and 1:1 coaching
- **Happify:** Self-directed programming designed to build resiliency [NOTE: **Happify is accessible to employees both enrolled on Cigna medical and those that are not.**]

Expanded Mental Health Resources – mental health and emotional well-being resources added to the network.

- **Talkspace** - online therapy platform where individuals ages 13+ are able to connect with a dedicated, licensed therapist over text and video conferencing. Available to Cigna members nationwide
- **Meru Health** - 12-week virtual counseling program for depression, anxiety or burnout. Offers live virtual counseling and private texting with a dedicated, licensed therapist.
- **Ginger** – mental health care through behavioral health coaching, self-guided learning activities and content. Support available 24/7/365.





MAKE THE MOST OF YOUR BEHAVIORAL HEALTH BENEFITS

myCigna.com makes it easy

We're committed to making it easy to get the behavioral health support you need, when you need it. That's why your health plan comes with access to **myCigna.com** – your personalized website that puts all your plan information and resources right at your fingertips.

On myCigna.com, you can:

- › Find in-network behavioral health and substance use providers, including **virtual and Fast Access** providers
- › Learn what provider types are most appropriate for your needs based on your search criteria
- › Search for **Centers of Excellence** facilities for mental health, substance use, eating disorders, and child and adolescent care



To search the provider directory for in-network behavioral health providers, log in to myCigna.com and click on the "Find Care & Costs" tab.

Having trouble finding a provider or getting an appointment?

We are here to help, 24/7/365.

Our team will reach out to providers and help you find appointments based on your schedule.

Non-Medicare customers: Call **800.274.7603**

Medicare customers: Call **800.866.6534**

What is a virtual visit?

Many of our in-network behavioral providers offer the convenient option to receive care via video. Your out-of-pocket cost is the same as an in-office visit.

To find a list of virtual providers who can see you quickly:

- › Log in to **myCigna.com**
- › Click the blue "Connect Now" button
- › Select "Connect" under "Counseling"

What is a Behavioral Fast Access provider?

Fast Access providers offer our customers first-time appointments faster, including:

- › Therapy appointments (counselor, social worker or psychologist) within five business days
- › Prescriber appointments (psychiatrist or psychiatric nurse practitioner) within 15 business days

Most of these providers also offer virtual visits and will even coordinate care with your primary care provider (PCP) and other medical providers.

DENTAL PLANS

EGS's Dental Plan is administered through Mutual of Omaha and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays and fillings for adults and children.



Dental PPO Plan

The Dental PPO allows you the freedom to visit any dentist, without referrals, for all of your dental care. If you receive care from one of Mutual of Omaha in-network dentists, you'll pay less for your care. If you choose an out-of-network dentist, your share of costs will generally be higher and you may need to file your own claims. For a list of Mutual of Omaha preferred dentists, go to www.mutualofomaha.com/dental and click on "Visit Member Portal" on the left hand side of the page. On the Employee Web Portal at the right hand side of the page, you can do a Provider Quick Search or login to access your account on the left hand side of the page.

Dental Plan Highlights

Plan Feature	Dental PPO In-and Out-of-Network*
Calendar Year Deductible Individual Family	\$50 \$150
Calendar Year Benefit Maximum	\$1,000 per person
Preventive Services (Exams, routine cleanings, fluoride treatments, space maintainers, sealants)	\$0 (deductible does not apply)
Basic Services (Fillings, oral surgery)	20% after Deductible
Major Services (Crowns, inlays, onlays, bridges, dentures, implants)	50% after Deductible
<i>*Additional charges may apply to services received out-of-network</i>	

VISION PLAN

EGS's Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through Mutual of Omaha.

Vision Coverage

If you enroll in vision coverage, you can go to any eye care provider you choose for care. To find a network provider, go to www.mutualofomaha.com/vision and click on "View my vision benefits" at the very bottom of the page under "Easy, online tools and resources. Click "Find an eye doctor" or login to access your account. You can search by location, by doctor or online & Lasik.

The Vision Plan is designed to cover necessary eye care needs. Be sure to ask your eye doctor what items are covered by the plan before you purchase materials.



Vision Plan Highlights

Plan Feature	Preferred Provider
Exam	\$10 Copay
Lenses (Single, Bifocals, Trifocal)	\$25 Copay
Frames	\$130 allowance, and 20% off the balance
Contacts Medically Necessary	\$130 allowance and 15% off the balance \$0 Copay, paid in full
Benefit Frequency	
Exam OR Standard Contact Lens Fit	Every 12 Months
Frames	Every 24 Months
Lenses (Single, Bifocal, Trifocal)	Every 12 Months
Contacts	Every 12 Months

Call the Benefit Resource Center (“BRC”) We’re Here To Help!



(866) 468 - 7272
BRCWest@usi.com

Monday - Friday 9:00am to 6:00pm PT

Our Benefit Specialists can help you with:

- Deciding Which Plan Is Best For You
- Benefit Plan & Policy Questions
- Eligibility & Claim Problems With Carriers
- Information About Claim Appeals & Process
- Allowable Family Status Election Changes

- Claim Escalation, Appeal & Resolution
- Medicare Basics With Your Employer Plan
- Coordination Of Benefits
- Finding In-network Providers
- Access To Care Issues
- Obtaining Case Management Services
- Transition Of Care When Changing Carriers



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Live Well, Live Balanced, Live Life

Call or Text 800.873.7138 | www.MINESandAssociates.com

What's Included?



Counseling

- **Up to 3 sessions** per life situation*, per contract year, for **you and each household member**
- **In-person, phone, video, or message-based options**
- **Support** for stress, anxiety, depression, family, relationships, substance use, grief, work issues, career coaching, and more

Legal & Financial

- **Free** 30-minute consult per issue
- **25% discount** on select services after consult
- **EAP sessions** can be used for financial and Medicare coaching

Work/Life

- **Unlimited** help finding childcare, eldercare, convenience services
- Includes nutrition classes, pet care, and more

Wellness

- **4 sessions** with an accredited personal wellness coach
- **4 sessions** with a parental coach or lactation consultant
- **6-week** virtual reality smoking cessation and stress reduction programs

Online Resources

- **PersonalAdvantage:** Articles, assessments, training, financial tools
- **eM Life:** Live and on-demand guided mindfulness sessions, tools, and expert instructors
- **Supportiv:** 24/7 peer group chats, moderated and confidential
- **Sukhi Wellbeing:** Interactive tools for personal resilience and professional growth

How to Access

Call or text: 800-873-7138

Email: info@minesandassociates.com

Scan the QR or visit: minesandassociates.com

Use your company code: egseap

to register for online services & free eM Life app

Contract Year: 6/1 - 5/31



*Per Life Situation: A distinct, separate and new life event. A MINES case manager will review requests for additional sets of sessions. Continuation of counseling is not a separate, distinct and new life event. This guide is for informational purposes only. Contact MINES for further details.

VOLUNTARY DISABILITY COVERAGES

EGS offers you two disability plans that work together to keep part of your paycheck coming if you cannot work because of illness, injury, or pregnancy. Disability benefits are administered through Lincoln Financial.

Short-Term Disability

Short-Term Disability (STD) benefits are provided to eligible employees. Your benefits will replace 60% of your base pay, up to a weekly maximum of \$2,500, for up to 11 weeks.

Long-Term Disability

If you are totally disabled and unable to work for more than 90 days, you may be eligible for Long-Term Disability (LTD) benefits. The LTD benefits replace up to 60% of your base pay, up to a maximum of \$10,000 per month. Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers' Compensation).

Employee Assistance Program (EAP) – Lincoln Financial

Life has its share of ups and downs – and sometimes you need a little guidance through the “downs.” EAP through Lincoln is provided to all employees and offers an array of confidential services to help you and your loved ones meet the challenges that life, work, and relationships can bring. All employees receive up to five sessions per person, per issue, per year at no cost.

Counselors can help with concerns about things like:

- Emotional well-being and mental health
- Relationships and parenting
- Addiction and recovery
- Marital and family problems
- Legal and financial issues



IMPORTANT CONTACTS

Resource	Vendor	Phone Number	Website
Medical and Prescription	Cigna	(866) 494-2111	www.mycigna.com
Dental	Mutual of Omaha	(800) 927-9197	www.mutualofomaha.com/dental
Vision Plan	Mutual of Omaha	(833) 279-4358	www.mutualofomaha.com/vision
Short and Long Term Disability	Lincoln Financial	(877) 275-5462	www.lincolffinancial.com
EAP	MINES	(800) 873 - 7138	https://minesandassociates.com/

Important Health Coverage Notices

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, deductibles and coinsurance apply.

NEWBORNS ACT DISCLOSURE – FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

PATIENT PROTECTION MODEL DISCLOSURE

Empowered Global Solutions generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Empowered Global Solutions. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Joan Peterson at 303-477-6800.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called “fiduciaries” of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the



person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.



CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Joan Peterson
333 W Hampden Ave
Englewood, Colorado United States 80110-2330
303-477-6800
joan@egs-partners.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice.

Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us.

Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

- In these cases, we never share your information unless you give us written permission:

Marketing purposes

Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Uses and Disclosures of Substance Use Disorder (SUD) Treatment Information

- If we receive or maintain records about you from a SUD treatment program subject to 42 CFR part 2 (a "Part 2 Program") through consent you provide the Part 2 Program to use or disclose the records, or testimony relaying the content of such records, they are given extra protection. These records shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless you provide written consent, or a court order is issued after notice and an opportunity to be heard is provided by you or the holder of the records.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

MODEL INDIVIDUAL **CREDITABLE COVERAGE** DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

Important Notice from Empowered Global Solutions 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 Empowered Global Solutions 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. Empowered Global Solutions has determined that the prescription drug coverage offered by the medical plan for the plan year 2026 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. 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, the following options may apply:

- If otherwise eligible under the terms of the plan, you may stay in the medical plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
 - During the Medicare prescription drug annual enrollment period, or
 - If you lose medical plan creditable coverage.
- COBRA may be terminated when, *after* having elected COBRA continuation coverage, you enroll in Medicare. Otherwise, you may stay in the medical plan and also enroll in a Medicare prescription drug plan. The medical plan **will be the secondary payer** and Medicare Part D will become the primary payer.
- You may decline coverage in the medical plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do decide to join a Medicare drug plan and drop your current

medical plan coverage, be aware that you and your dependents (if they elect to drop COBRA coverage as well) 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 Empowered Global Solutions 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 Empowered Global Solutions 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).

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, 2025. 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
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	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
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid

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)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-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)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RItE Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	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://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIP (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, 2025, 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)



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.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 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:

Name of Entity/Sender:	Empowered Global Solutions
Contact--Position/Office:	Joan Peterson
Address:	333 W Hampden Ave Englewood, CO 80110-2330
Phone Number:	(303)-477-6800

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		4. Employer Identification Number (EIN)	
5. Employer address		6. Employer phone number	
7. City	8. State	9. ZIP code	
10. Who can we contact about employee health coverage at this job?			
11. Phone number (if different from above)		12. Email address	

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:

- With respect to dependents:
☐ We do offer coverage. Eligible dependents are:

- ☐ 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? ☐ Quarterly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly
Yearly

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

