2026 EMPLOYEE BENEFITS GUIDE

Your Comprehensive Guide to Company Benefits

OASIS SOLUTIONS

Employee Benefits & Compensation Summary

(This information is subject to change at any time, based on vendor arrangements and/or market conditions, etc.)

Salary

- Paid semi-monthly via direct deposit
- In the onboarding process, we will collect:
  - W-2
  - I9
  - Direct Deposit information

Discretionary PTO (Paid Time Off)

- Oasis feels vacation is vital to employee health and a sustainable and balanced life.
- Oasis puts no limits on PTO, as long as our core purpose and values are being observed, and you obtain supervisor approval.

$1,250 Employee Travel Voucher/Benefit

- An incentive to take vacation
- After you've been with Oasis 6 months, you're eligible to receive one $1250 (gross pay) benefit per calendar year, which is to be used to fund or otherwise enhance your vacation experience.

Gross Profit Share Bonus Program

- Available to all employees who have been employed for at least one year. The vesting policy is as follows:
  - You are vested one year from your start date.
  - On your first eligible year, your revenue share will be prorated based on the date you are vested.
  - You must be an employee of Oasis at the time of payment to collect the revenue share bonus.
  - Proration calculation:
    - [profit share amount (full year)] * ([days in year] – [days not vested]) / [days in year]
    - Example: If you would have been eligible for $1000.00 for the full year in 2026:
      - Start date 3/10/2025: Not vested between 1/1/2026 and 3/9/2026 (68 days), vested on 3/10/2026 (297 days), prorated: 1000 * (365-68) / 365 = 813.70
      - Start date 11/27/2025: Not vested between 1/1/2026 and 11/26/2026 (330 days), vested on 11/27/2025 (35 days), prorated: 1000 * (365-330) / 365 = $95.89
- The Gross Profit Share Program allows employees to earn additional income based several factors, both company performance and longevity related:
  - Company performance against the defined gross profit target
  - Company performance against the defined top-line revenue target
  - Seniority/longevity
  - Vested status
  - Role definition

- Based a sliding scale of Gross Profit targets, and a Revenue % to goal calculation, Oasis generates a Profit-Sharing Pool of funds, which are distributed across the organization.
- Distribution is based on a calculation of your assigned and vested Profit Share Units, as a percentage of the total assigned, and eligible units.
- Payment of the revenue share bonus will be some portion (usually, but not always half) around Mid-December, and the true-up in Mid-February after Oasis year-end close.
- As stated, Employees must be actively employed with Oasis at the time of payment to collect this bonus.

401(k)

- Oasis offers a 401(k)
- Oasis provides a 3% non-elective contribution
- This is administered via our 401(k) partner, Accrue, via their web Portal.
- Deductions are handled via payroll.

Insurance

- Medical: Oasis provides single coverage on HSA plans and one PPO plan to our employees at zero cost to them. Oasis also provides single coverage on another PPO plan that has a nominal premium paid by the employee via a payroll deduction. The actual employer paid benefit is equal across all plans. Additional coverages (spouse, children, or family) are paid by the employee via a payroll deduction.
  - Total premium – employer paid premium = amount paid by the employee
  - Oasis offers 3 options. Two PPO plans and one HDHP HSA plan.
- Dental: Oasis provides single dental coverage on one dental plan to most employees at zero cost to them. Oasis also provides single coverage on another dental plan that has a nominal premium paid by the employee via payroll deduction. The actual employer paid benefit is equal across all plans. Additional coverages (spouse, children, family) are paid by the employee via a payroll deduction.
- Vision: Oasis offers this benefit as a voluntary option, paid by the employee via a payroll deduction.
- Life/AD&D: Oasis provides a $50,000 life/AD&D insurance policy to our employees at zero cost to them.
- Voluntary Life/AD&D: Oasis provides this benefit as a voluntary option, paid by the employee via a payroll deduction.
- Short-Term Disability: Oasis provides this benefit to our employees at zero cost to them.
- Long-Term Disability: Oasis provides this benefit to our employees at zero cost to them.
- Hospital Indemnity: Oasis provides this benefit as a voluntary option, paid by the employee via a payroll deduction.
- Critical Illness: Oasis provides this benefit as a voluntary option, paid by the employee via a payroll deduction.
- Accident: Oasis provides this benefit as a voluntary option, paid by the employee via a payroll deduction

Benefits Overview

We take pride in our ability to offer a benefits program designed exclusively for you and your family members. This catalog of tools has been cultivated and assembled to provide a competitive and comprehensive package designed to help you stay well, physically, mentally, and financially, and provide support and financial protection if the need arises. Your family is unique, and you are the only one that knows which benefits are the best fit; consider your options for all coverages offered during the 2026 plan year.

Employee Eligibility

Active employees working **30 or more hours** weekly are considered full-time & eligible for benefits.
New Hires will be eligible on the **1st of the month following or coinciding with their date of hire.**

Dependent Eligibility

Eligible Dependents include:

- Your lawful spouse
- Your dependent child from birth to age 26
- Your dependent child of any age who are disabled.

Termination of Coverage

Your benefit coverage will end on the last day of the month in which your employment terminates.

Election Change Requests

Due to IRS regulations, once you have made your elections for the plan year, you cannot change your benefits until the next annual open enrollment period. The only exception is if you experience a **qualifying life event**. Election changes must be consistent with your life event.
Enrollment changes can only be made within 31 days of the qualifying event and must be consistent with the change in status. After the 31-day time frame, you are only able to change your elections during the annual open enrollment period.

Some of the most common Qualifying Life Events are:

- Marriage, divorce, or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status
- Change in your child's eligibility for benefits
- Child loses eligibility for Medicaid or CHIP
- Qualified Medical Child Support Order
- Eligible for Medicare

For more information on qualifying events, **CLICK HERE**.

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Be assured.

Collier Insurance Disclaimer: Every effort has been made to accurately disclose the terms and provisions of each plan presented. Each company's actual policy/certificate will prevail. In providing this summary we make no representations, either expressly or implied as to its competence, sufficiency, integrity, exactness or its lack of defect of any kind.

Medical & RX Benefits

MEDICAL BENEFITS	$0 PPO PLAN	$2,000 PPO PLAN	$3,400 HSA PLAN
Individual Deductible	$0	$2,000	$3,400
Family Deductible	$0	$4,000	$6,800
Coinsurance Percentage	90%	70%	100%
Individual Out of Pocket Max	$3,000	$5,500	$5,000
Family Out of Pocket Max	$6,000	$11,000	$10,000
Primary Care Visit	$30	$30	$50 After Deductible
Specialist Care Visit	$60	$60	$100 After Deductible
Preventive Wellness	100%	100%	100%
Inpatient Services	10% After Deductible	30% After Deductible	$750 After Deductible
Outpatient Services	10% After Deductible	30% After Deductible	$500 After Deductible
Emergency Room	$500	$500	$500 After Deductible

RX BENEFITS	$0 PPO PLAN	$2,000 PPO PLAN	$3,400 HSA PLAN
Tier 1	$10	$10	$10 After Deductible
Tier 2	$35	$35	$35 After Deductible
Tier 3	$70	$70	$70 After Deductible
Tier 4	25% up to $400	25% up to $400	25% up to $400

Anthem $0 PPO SBC | Anthem $2,000 PPO SBC | Anthem $3,400 HSA SBC

This table is a brief summary of benefits. Consult your Policy and/or the Plan Document for a full description of benefits.

MONTHLY COST	$0 PPO PLAN	$2,000 PPO PLAN	$3,400 HSA PLAN
Employee Only	$159.21	$0	$0
Employee + Spouse	$966.41	$632.07	$485.66
Employee + Child(ren)	$746.27	$459.69	$353.21
Family	$1,553.47	$1,091.76	$838.87

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Register with us

for quick, secure, digital access to all your plan information

Keep on top of your health, dental, and vision benefits with24/7 access to your plan details. Register on our Sydney Health app or through our website at **anthem.com/register** so your account is ready to use when you need it. **There is no cost, and it only takes a few minutes.**

Once you're registered, you'll have one place you can go for all your plan and benefits information. You can review coverage and claims, find care, estimate cost of care, manage your prescriptions, and access your digital plan ID card.

Have your plan ID card ready to get started

- ☐ Download our free Sydney Health app and select **Register new account** *or* go to **anthem.com/register**.
- ☐ Select your identification type (in most cases, this is your member ID).
- ☐ Enter your plan ID number, full name, and date of birth.
- ☐ Follow the one-time security prompt and create a username and password. (You'll use the same login information when you log in to either the app or website.)
- ☐ Review your information to complete your registration.

Scan this QR code with your phone's camera to **download our Sydney Health app** today.

sydney℠

Download on the App Store

GET IT ON Google Play

On-screen experiences may vary due to personalization, benefit plans, and ongoing enhancements.

Sydney Health is offered through an arrangement with Carelon Digital Platforms, a separate company offering mobile application services on behalf of your health plan. ©2024

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Wellbeing Solutions

Focus on your well-being and earn rewards up to $200

The more activities you complete, the greater your reward.

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

Activity Type	Activities	Amount
Preventive care	Have an annual preventive wellness exam or well woman exam with your doctor	$25
	Get an annual cholesterol test[1]	$20
	Have a colorectal cancer screening (ages 45 and older)	$25
	Have a routine mammogram (women ages 40 to 74)	$25
	Get a routine dental exam[2]	$25
	Have an annual eye exam[2]	$25
	Get an annual flu shot	$20
Condition management programs	ConditionCare: Work one-on-one with your health coach and earn rewards for participating in and completing the program[3]	Up to $50 ($20/$30)
	Future Moms: Moms-to-be can receive support from a registered nurse and earn rewards for completing initial, interim, and postpartum assessments[4]	Up to $40 ($20/$10/$10)
	Well-being Coach —Weight Management: Receive one-on-one coaching by phone as you complete your goal to earn a reward.[5]	$25
	Well-being Coach —Tobacco Cessation: Receive one-on-one coaching by phone as you complete your goal to earn a reward.[6]	$25

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Activity Type	Activities	Amount
Digital & wellness activities	Log in to your Anthem account	$5
	Connect a fitness or lifestyle device	$5
	Complete a health assessment and receive tailored health recommendations	$20
	Complete action plans around eating healthy, weight management, and physical activity	Up to $25 ($5 per action plan)
	Track your steps	Up to $60 ($2 per 50,000 steps tracked)
	Complete Well-being Coach digital daily check-ins[7]	Up to $20 ($4 per milestone)
	Update your contact information	$10

Well-being Coach can help you meet your goals

The Well-being Coach digital coaching app from Lark offers you 24/7 personalized support. Well-being Coach can help you maintain a health weight, quit tobacco, and improve your nutrition, exercise habits, mindfulness, and sleep. If you need extra support with weight management or quitting tobacco, you can also talk to a certified health coach.

Access Well-being Coach in the Sydney Health App or at **anthem.com**.

Earn rewards

Here's how and when you'll earn rewards for completing the activities already mentioned.

- **Preventive care:** Simply visit your doctor for any of the screenings or appointments listed in the chart. Your rewards are added to your account after your claim is processed, which may take up to 60 days.
- **Condition management:** Rewards are added to your account as you meet certain benchmarks or complete a program. Programs include: ConditionCare (for asthma, diabetes, and heart or lung conditions), Future Moms, and Well-being Coach for weight management and tobacco cessation.
- **Digital and wellness activities:** Log in to the Sydney Health app or **anthem.com** to complete available activities, such as taking a health assessment, participating in the Well-being Coach Digital program, and tracking your steps. Rewards are added to your account as activities are completed.

Dental Benefits

BENEFIT	HIGH PLAN	LOW PLAN
Deductible Type	Annual	Annual
Individual / Family	$50 / $150	$50 / $150
Contract Year Maximum	$2,500	$1,000
SERVICES		
Preventive Services	100%	100%
Basic Services	90%	90%
Major Services	60%	60%
Orthodontics	50% up to $2,500	N/A
ROLLOVER		
MaxRewards Program	Rollover up to $700 with a maximum rollover balance of $1,500	Rollover up to $350 with a maximum rollover balance of $1,000
	Lincoln Dental Plan - High	Lincoln Dental Plan - Low

This table is a brief summary of benefits. Consult your Policy and/or the Plan Document for a full description of benefits.

MONTHLY COST	HIGH PLAN	LOW PLAN
Employee Only	$15.02	$0
Employee + Spouse	$66.49	$36.46
Employee + Child(ren)	$95.44	$48.26
Family	$159.79	$91.16

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Vision Benefits

BENEFIT	SUMMARY OF IN-NETWORK COVERAGE
Vision Exam Copay	$10
Materials Copay	$10
Frames Allowance	$130 Allowance
Elective Contacts Allowance	$125 Allowance
Medically Necessary Contacts	Covered 100%
FREQUENCY	
Vision Exam	Every 12 Months
Frames	Every 12 Months
Lenses	Every 12 Months
Contacts	Every 12 Months

Lincoln Vision

This table is a brief summary of benefits. Consult your Policy and/or the Plan Document for a full description of benefits.

MONTHLY COST	
Employee Only	$7.53
Employee + Spouse	$14.24
Employee + Child(ren)	$14.51
Family	$22.97

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Life & AD&D Benefits

BASIC LIFE/AD&D	LIFE BENEFIT	AD&D BENEFIT	COST	AGE REDUCTION SCHEDULE
Eligible Full Time Employees	$50,000	$50,000	Provided at No Cost	Reduces by 50% @ 70

Lincoln Basic Life & AD&D

Basic life & AD&D benefits are 100% EMPLOYER PAID.

Voluntary Life & AD&D

VOLUNTARY EMPLOYEE LIFE/AD&D	GUARANTEED ISSUE	MAXIMUM AMOUNT	AGE REDUCTION SCHEDULE
Eligible Full Time Employees	$200,000	$300,000 up to 5x Annual Salary in $10,000 increments	Reduces by 35% @ 65 Reduces by 60% @ 70 Reduces by 75% @ 75 Reduces by 85% @ 80

VOLUNTARY DEPENDENT LIFE/AD&D	GUARANTEED ISSUE	MAXIMUM AMOUNT	AGE REDUCTION SCHEDULE
Spouse	$50,000	$50,000 up to 50% of EE Benefit in $5,000 increments	Reduces by 35% @ 65 Reduces by 60% @ 70 Reduces by 75% @ 75 Reduces by 85% @ 80
Child(ren) 6 Months to 26 Years	$10,000	$10,000	N/A

- If you elect any amount over the Guaranteed Issue amount, you will need to submit Evidence of Insurability.
- You can secure term life coverage on your spouse and child(ren) if you elect coverage for yourself.
- It is important to name one or more beneficiaries so that your life insurance benefits can be paid quickly and according to your wishes.
  - You are always the sole beneficiary for any dependent life insurance for your spouse or child(ren)
  - You can now update your beneficiaries anytime online.

Lincoln Voluntary Life

Your rates & benefit amounts will be prepopulated for you in Rippling.

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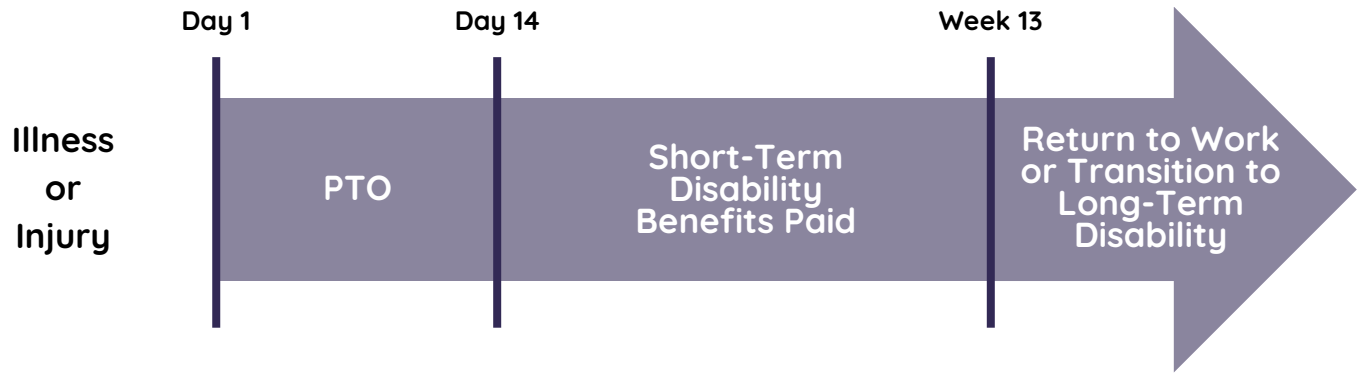
Disability Benefits

SHORT-TERM DISABILITY	WEEKLY BENEFIT	MAXIMUM BENEFIT	ELIMINATION PERIOD	DURATION OF BENEFITS
All Full Time Eligible Employees	50% of Weekly Earnings	$1,500	14 Days	11 Weeks

- This table is a brief summary of benefits. Consult your policy and/or the plan document for a full description of benefits.

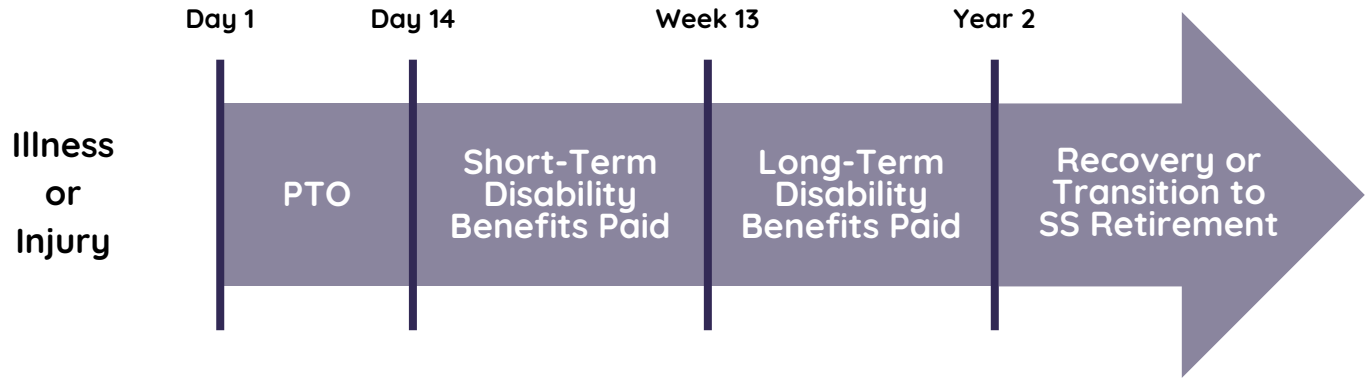
Lincoln Short Term Disability



LONG-TERM DISABILITY	MONTHLY BENEFIT	MAXIMUM BENFIT	ELIMINATION PERIOD	DURATION OF BENEFITS
All Full Time Eligible Employees	60% of Monthly Earnings	$12,000	90 Days	2 Years

- If you receive treatment for a condition within the 3 months prior to your coverage start date, you may not be eligible for benefits for that condition until you've been covered by the plan for 12 months.
- This table is a brief summary of benefits. Consult your policy and/or the plan document for a full description of benefits.

Lincoln Long Term Disability



Disability benefits are 100% EMPLOYER PAID.

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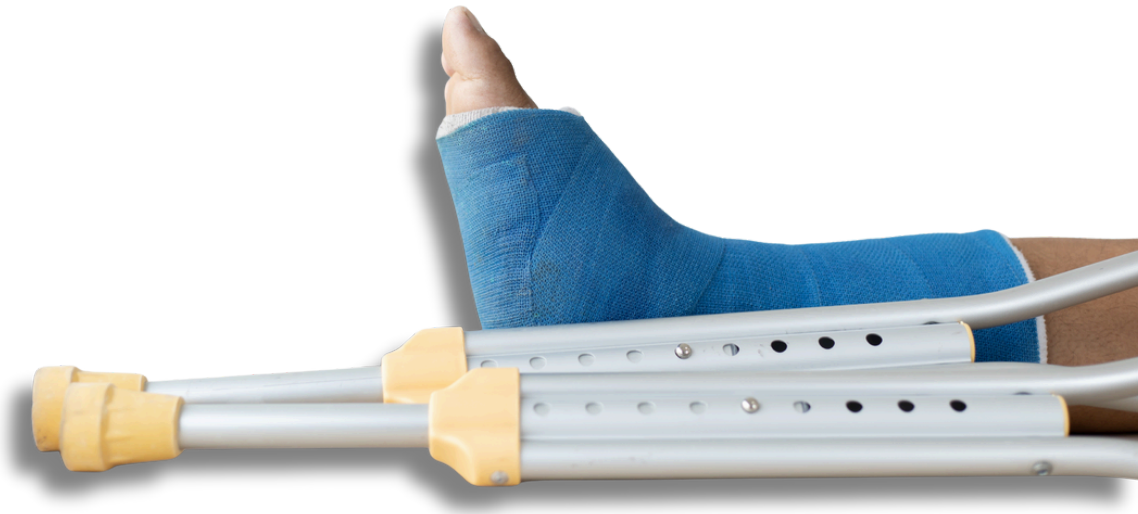
Accident Benefits

COVERAGE	BENEFIT
AD&D Benefit	$25,000
Ambulance (Air & Ground)	$1,200 / $300
Burns (2nd or 3rd Degree)	up to $10,000
Concussion	$200
Dislocations (Surgical & Non-Surgical)	up to $3,375
Cuts/Lacerations	up to $750
Fractures (Surgical & Non-Surgical)	up to $3,375
Hospital Admission	$1,000
Hospital Confinement	$200/day
Prosthesis	$750
Wellness Benefit	$50
	Lincoln Accident Plan

This table is a brief summary of benefits. Consult your policy and/or the plan document for a full description of benefits.

MONTHLY COST	
Employee Only	$7.62
Employee + Spouse	$15.57
Employee + Child(ren)	$16.73
Employee + Family	$24.60



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Hospital Indemnity Benefits

COVERAGE	BENEFIT
Non-ICU Admission	$500/day for 2 days per year
Non-ICU Confinement	$100/day for 15 days per year
ICU Admission	$1,000/day for 1 day per year
ICU Confinement	$200/day for up to 15 days per year
Newborn Nursery Confinement	$100/day up to 2 days
	Lincoln Hospital Indemnity

This table is a brief summary of benefits. Consult your policy and/or the plan document for a full description of benefits.

MONTHLY COST	
Employee Only	$14.99
Employee + Spouse	$32.44
Employee + Child(ren)	$23.51
Employee + Family	$42.78

Critical Illness Benefits

COVERAGE	BENEFIT
Employee	$10,000 or $20,000
Spouse	Up to 100% of Employee Benefit
Dependent Child(ren)	Up to 100% of Employee Benefit

Critical illness coverage pays a lump sum if you are diagnosed with a covered illness or condition.
All benefits are paid directly to you and you may use the funds as you see fit.

Lincoln Critical Illness

This table is a brief summary of benefits. Consult your policy and/or the plan document for a full description of benefits.

Your rates & benefit amounts will be prepopulated for you in Rippling.

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Glossary of Terms

This glossary defines many commonly used terms but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some terms also might not have the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

•**Annual Maximum**- the total dollar amount that a plan will pay for care incurred by an individual enrollee or family (under a family plan) is a specified benefit period.

•**Allowed Amount**- This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

•**Benefit Year**- a period in which covered expenses are accrued and are counted toward the annual maximums, deductibles, and/or our-of-pockets limited.

•**Benefits**- items or services covered under an insurance plan.

•**Beneficiary**- A person or entity entitle to received the claim amount and other benefits upon the death of the benefactor 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**- Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

•**Copayment** (Copay)- A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

•**COVERED**- This means that some portion of the allowable cost of a health service will be considered for payment by the insurance company. It does not mean that the service will be paid at 100%. For example, in a plan under which hospitalization' is 'covered', a deductible might apply.

•**Deductible**- An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)

•**Diagnostic Test**- Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

•**Excluded Services**- Health care services that your plan doesn't pay for or cover.

•**Formulary**- A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amounts will apply to each tier.

•**Guaranteed Issue**- A predetermined benefit amount allowed by an insurance plan without requiring EOI. This allows you to enroll regardless of health status, however, this does not preclude the application of a pre-existing condition exclusion.

•**Hospitalization**- Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

•**Maximum Out-of-pocket Limit**- The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

•**Medically Necessary**- Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

•**Network**- The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services. (i.e., 'in-network').

•**Non-Preferred Provider-** A provider who does not have a contract with your insurance carrier or plan to provide services to you. Your patient responsibility will be higher is you see a non-preferred provider (i.e., 'out-of-network').

•**Out-of-network Coinsurance**- Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

•**Preauthorization**- A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called "prior authorization," "prior approval," or "precertification." Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

•**Preventive Care** (Preventive Service)- Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems, designated under Grades A or B by the U.S. Preventive Task Forces.

General Information About the Plan

Plan Name: Oasis Computer Solutions, Inc. (Employee Benefits Program (the "Plan")
Contact: Oasis Computer Solutions, Inc.
9401 Williamsburg Plaza Ste 101, Louisville, KY 40222 502.429.6902

The Plan Administrator has the sole discretionary authority and responsibility to control and administer the Plan in accordance with its terms and has, without limitation, the discretionary authority to interpret the Plan or its terms. The Plan Administrator's powers include making and enforcing rules it deems necessary or proper for the efficient administration of the Plan, allocating its responsibilities under the Plan to other persons, and deciding all questions concerning the Plan, including determining eligibility for benefits under the Plan.
With respect to the coverage described in this Summary Plan Description (SPD), the Plan Administrator has delegated to Anthem the discretionary authority related to medical and prescription drug coverage to make determinations on eligibility and claims for benefits under the Plan, and, as such, Anthem is a claims review fiduciary of the Plan. The Plan Administrator has delegated to Lincoln Financial the discretionary authority related to dental, vision, disability and life coverage to make determinations on eligibility and claims for benefits under the Plan, and, as such, Lincoln Financial is a claims review fiduciary of the Plan.

Group/Policy Number:	TBD	Group/Policy Number:	1318183
Claims Administrator:	Anthem	Claims Administrator:	Lincoln Financial
Medical Coverage:	www.Anthem.com	Ancillary Coverage:	www.Lincolnfinancial.com

The Plan Administrator keeps the records for the Plan and will also answer any questions you may have about the Plan. If you have general questions about the Plan, you may contact Human Resources, which acts on behalf of the Plan Administrator with respect to day-to-day matters, and whose contact information is provided immediately below.

Plan Contact/Sponsor Information: Oasis Computer Solutions, Inc. Attn: *Human Resources*
9401 Williamsburg Plaza Ste 101, Louisville, KY 40222 502.429.6902

Plan Sponsor's Employer ID Number (EIN): 61-1317535 ERISA Plan Number: 501

Agent for Service of Legal Process: Oasis Computer Solutions, Inc.
9401 Williamsburg Plaza Ste 101, Louisville, KY 40222

January 1st the Plan is operated on as follows:
January 1st through December 31st referred to as the "Plan Year"

The Plan is an employee welfare benefit plan, and includes the medical, prescription, drug, dental, vision, disability, and life coverage described in this SPD.

Type of Funding/Administration: Medical & Prescription Drug Coverage
The medical and prescription drug portion of the Plan described in this SPD is fully insured and is administered in accordance with the provisions of the administrative services agreement with the Claims Administrator named above. Plan benefits are funded through the employer's general assets. No amounts are held in trust or are otherwise segregated from the general assets of the Employer.
Participants are required to contribute to the cost of the coverage.

Type of Funding/Administration: Dental, Vision, Disability & Life Coverage
The dental, vision, disability, life coverage is insured and is administered in accordance with the provisions of the insurance policy issued by the Insurer named above. Plan benefits are provided pursuant to an insurance policy, the premiums for which are paid from the employer's general assets. The Insurer(s), not the group, is responsible for paying claims under the Plan. Participants are required to contribute to the cost of coverage.

Amendment or Termination of the Plan
The Plan may, at any time, in the Plan Sponsor's sole discretion, be amended or terminated, without advance notice to any person (except as may be required by law). Any amendment or termination of the Plan (or any coverage(s) under the Plan) will not affect any proper entitlement to benefits incurred prior to the effective date of such amendment or termination. No person shall have any vested right to continue benefits under the Plan.

Effect of the Plan Document
This SPD provides a summary of the terms, conditions, and benefits under the Plan for eligible employees and their eligible dependents. It does not give the details on all the terms of the official Plan documents (including the insurance policy). If there is any conflict between the information in this SPD and the provisions of the Plan documents, the Plan documents control.

Availability of Summary Health Information—Summary of Benefits and Coverage (SBC)
As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.
Choosing a health coverage option is an important decision. To help you make an informed choice, the Plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

Patient Protection Notices Required by the Affordable Care Act
The plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members.
For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your provider.

Portability and Conversion
Portability and conversion of certain policies are available upon termination from the applicable ancillary/worksite carrier. If you are interested in finding out more information, you must contact the carrier directly within 31 days of termination.
Lincoln Financial: www.LincolnFinancial.com Refer to your member ID (ssn) and your plan number: 1318183

Your Rights Under ERISA and Other Applicable Law
This statement of ERISA rights is required by federal law and regulation.

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

Receive Information About Your Plan and Benefits
- Examine, without charge, at the office of the Plan Administrator and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan (if applicable) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report (if applicable). If applicable, the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continuation of Coverage – General Notice and Qualifying Event Notice
- 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 or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the group health plan (if applicable), if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when: (i) you lose coverage under the Plan; (ii) you become entitled to elect COBRA continuation coverage; (iii) your COBRA continuation coverage ceases; or (iv) you request a certificate of creditable coverage before losing coverage, or within 24 months after losing coverage.
- Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of 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, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision (or lack thereof) concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 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, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

KENTUCKY SPECIAL ENROLLMENT DUE TO PREGNANCY
- The Commonwealth of Kentucky has issued a state mandate which is effective January 1, 2025, that requires medical plans, including self-insured ones, to provide a special enrollment period to pregnant women and any individual who is eligible for coverage because of a relationship to a pregnant woman to enroll for coverage under the plan
- In addition to the special enrollment period, a plan must provide coverage to pregnant and postpartum women for an in-home program, and for telehealth or digital health services that are related to maternity care associated with pregnancy, childbirth, and postpartum care
- Coverage must begin no later than the first day of the first calendar month in which a medical professional determines that the pregnancy began unless a pregnant woman directs coverage to begin on the first day of any month occurring after that date but during her pregnancy
- The mandate applies to Plan Sponsors situsted in Kentucky or who have a facility located in Kentucky

Your 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*.
Also, a special enrollment period for group health plan coverage may be available if (i) you or your dependent child(ren) lose coverage under a Medicaid or CHIP plan, if that coverage is terminated due to loss of eligibility; or (ii) you or your dependent child(ren) become eligible for financial assistance under Medicaid or CHIP with respect to coverage under the Plan. However, *you must request enrollment within 60 days of the occurrence of one of these events*.

You may be required to provide supporting documentation when requesting special enrollment. To request special enrollment or obtain more information, contact Human Resources.

Procedures for Requesting a Certificate of Creditable Coverage (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires a Certificate of Creditable Coverage be issued to individuals losing health coverage. A Certificate of Creditable Coverage will be issued automatically when you or your dependent's applicable group health plan coverage (including continuation coverage) under the Plan terminates. You may also request a Certificate of Creditable Coverage, free of charge, at any time while covered and up to 24 months after the date coverage terminates. A third party whom you designate in writing may also obtain a copy of the certificate on your behalf. All requests for a Certificate of Creditable Coverage should include your full name, home address, and, if the certificate is to be delivered to a third party other than yourself, the name and address of that party. Requests for a certificate should be in writing, mailed to the Plan Administrator at the following address:

Oasis Computer Solutions, Inc. ‖ 9401 Williamsburg Plaza Ste 101, Louisville, KY 40222 ‖ PH 502.429.6902

If you designate a plan or issuer of health insurance (such as that offered by a subsequent employer) to receive the certificate on your behalf and the plan or issuer agrees to accept the information contained in the certificate by non-written means (for example, by telephone), the Plan may provide the information exclusively in that manner.

Statement of Rights Under the Newborns' and Mothers' Health Protection 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 normal 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 as applicable). The laws of your state related to hospital stays in connection with childbirth may differ from these federal requirements. For more information, refer to the SPD.

Privacy of Protected Health Information—Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

The Plan maintains a HIPAA Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's HIPAA Notice of Privacy Practices, please contact the number located on the back of your member ID card.

Women's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. For more information, refer to the SPD or contact the Plan Administrator (contact information is provided under "General Information About the Plan" above).

Annual Notice: Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides 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? Call your plan administrator for more information.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA), protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to Be Free from Discrimination and Retaliation

If you are a past or present member of the uniformed service; have applied for membership in the uniformed service; or are obligated to serve in the uniformed service; then an employer may not deny you: initial employment; reemployment; retention in employment; promotion; or any benefit of employment because of this status. In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

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.

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm. If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

Qualified Medical Child Support Orders (QMCSOs)

The Plan will comply with the terms of a qualified medical child support order (QMCSO). A QMCSO is an order or a judgment from a court or administrative body (including a National Medical Support Notice) directing the Plan to cover a child of a participant under the group health plan coverage provided through the Plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Plan's procedures for determining if the order is valid. Coverage under the applicable coverage(s) of the Plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO.

If you have any questions or would like to receive, without charge, a copy of the Plan's written procedure for determining whether an order is a QMCSO, contact your carrier.

MEDICARE PART D NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage 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. Your employer has determined that the prescription drug coverage offered 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.

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 through your employer 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) if 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 coverage will not be affected. Please refer to your plan documents regarding coordination of benefits. If you do decide to join a Medicare drug plan and drop this plan 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 under your Employer Health Plan 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 permanently 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:

State Systems, LLC 1861 Vanderhorn Dr Memphis TN 38134 1-866-931-5751. 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. After you become eligible for Medicare, Medicare will send you a copy of the handbook in the mail every year. 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).

Notice of Extended Coverage to Participants Covered Under a Group Health Plan

"Michelle's Law" prohibits a group health plan, or a health insurance issuer that provides health insurance coverage in connection with a group health plan, from terminating coverage of a Dependent Child due to a qualifying "Medically Necessary Leave of Absence" from, or other change in enrollment at, a postsecondary educational Institution prior to the earlier of:

1. The date that is one year after the first day of the Medically Necessary Leave of Absence.
2. The date on which such coverage would otherwise terminate under the terms of the Plan.

In order to be a Medically Necessary Leave of Absence the student's leave must meet all of the following requirements:

1. Commence while the Dependent Child is suffering from a serious Illness or Injury.
2. Be Medically Necessary.
3. Cause the Dependent Child to lose student status for purposes of coverage under the terms of the parents' plan or coverage.

A Child is a "Dependent Child" under the law if he or she meets all of the following requirements:

1. Is a Dependent Child of a Participant under the terms of the Plan or coverage.
2. Was enrolled in the Plan or coverage, on the basis of being a student at a postsecondary educational Institution, immediately before the first day of the Medically Necessary Leave of Absence.

A treating Physician of the Dependent Child must certify that the Dependent Child is suffering from a serious Illness or Injury and that the Leave of Absence (or other change of enrollment) described is Medically Necessary.

Your Rights and Protections Against Surprise Medical Bills

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or must pay the entire bill if you see a provider or visit a health care facility that is not in your health plan's network.

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

"Surprise billing" is an unexpected balance bill. This can happen when you cannot 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 are protected from balance billing for:
Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

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

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

You are <u>never</u> required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.
When balance billing is not allowed, you also have the following protections:

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

If you believe you have been wrongly billed, you may contact the Department of Health and Human Services to reach the entity responsible for enforcing the federal balance or surprise billing protection laws at 1-800-985-3059.

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

Newborns & Mothers Health Protection Act (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section). This law was effective for group health plans for plan years beginning on or after January 1, 1998.

On October 27, 1998, the Department of Labor, in conjunction with the Departments of the Treasury and Health and Human Services, published interim regulations clarifying issues arising under the Newborns' Act. The changes made by the regulations are effective for group health plans for plan years beginning on or after January 1, 1999.

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

The type of coverage provided by the plan (insured or self-insured) and state law will determine whether the Newborns' Act applies to a mother's or newborn's coverage.

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on State law. Based on a recent preliminary review of State laws, if the coverage is in Wisconsin and several U.S. territories, it appears that the Federal Newborns' Act applies to the plan. If the coverage is in any other state or the District of Columbia, it appears that State law applies in lieu of the Federal Newborns' Act.

All group health plans that provide maternity or newborn infant coverage must include a statement in their summary plan description (SPD) advising 'Act requirements.

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 –

See next page for chart.

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/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Service
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.

ALABAMA – Medicaid

Website: http://myalhipp.com/ Phone: 1-855-692-5447

ARKANSAS – Medicaid

Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website: www.myakhipp.com
Email: CustomerService@MyAKHIPP.com

Medicaid Eligibility: www.health.alaska.gov/dpa/Pages/default.aspx
Phone: 1-866-251-4861

CALIFORNIA – Medicaid

Website: www.dhcs.ca.gov/hipp Phone: 916-445-8322
Email: hipp@dhcs.ca.gov Fax: 916-440-5676

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado: www.healthfirstcolorado.com/ Phone:1-800-221-3943 Relay 711
CHP+: www.hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): www.mycohibi.com HIBI Customer Service: 1-855-692-6442

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program All other Medicaid Website: www.in.gov/medicaid Family and Social Services Administration Phone: 1-800-403-0864
Family and Social Services Website: www.in.gov/medicaid Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: Iowa Medicaid | Health & Human Services Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms Phone: 1-877-524-4718

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov Toll free number for the HIPP program: 1-800-852-3345, ext. 15218

NEW JERSEY – Medicaid and CHIP

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)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

PENNSYLVANIA – 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)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS– Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

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

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/ Medicaid Phone: 304-558-1700
Website: http://mywvhipp.com/ CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269