



2026 Team Member Benefits Guide

MAKE THE MOST OF YOUR BENEFITS



If you and/or your dependent have Medicare or will be eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Review our plan's Medicare Part D creditable coverage disclosure included in this brochure in the Important Notices section.

Care Synergy Benefits

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This Benefits Guide is for general educational purposes and is based on information provided by the employer, summary plan descriptions, and other sources. In case of discrepancy, plan documents will prevail over information presented in this Guide. Please treat this information as confidential and only share it with your dependents. Contact Human Resources with questions.

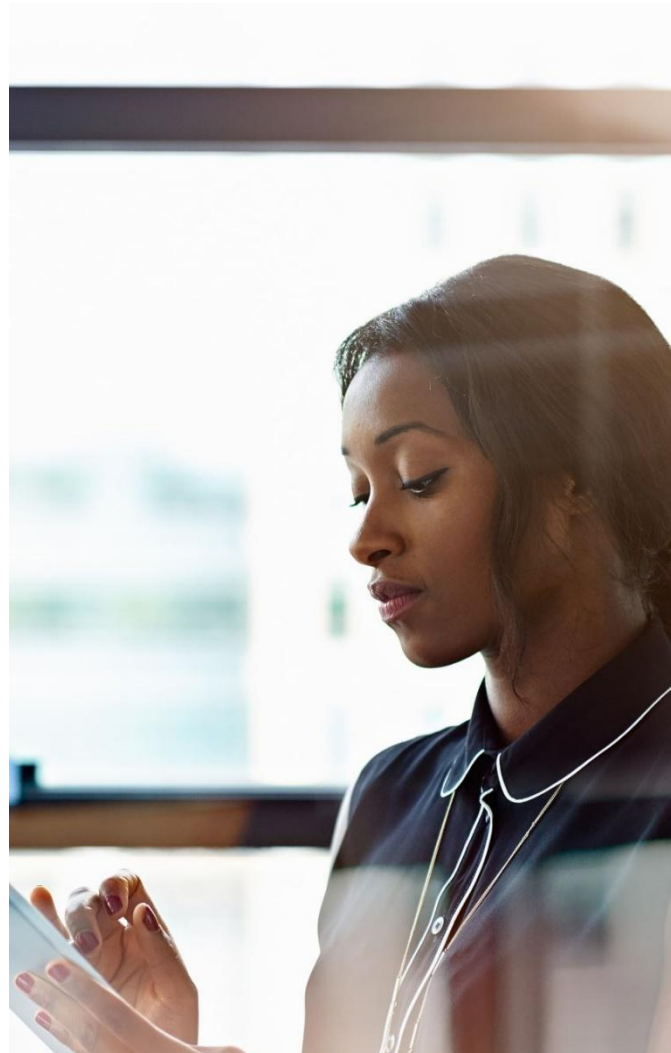
Welcome To The Care Synergy Benefits Guide

Our benefit plans have been designed to provide you with a comprehensive and responsive package that meets the needs of all our Team Members. This booklet is designed to help you navigate your benefits choices. The descriptions included in this summary are based on the documents that legally govern the operation of these plans. In the event of a discrepancy between the descriptions in this summary and the controlling contracts and/or plan documents, the language in the controlling contracts or plan documents will govern. To request a copy of the plan documents, please contact your Human Resources Department.

Our open enrollment period is November 3, 2025 through November 17, 2025.

Open enrollment requires benefit eligible Team Members to log into UKG actively and either re-enroll in their current benefits, enroll in new benefits, or decline benefits.

ENROLLMENT REQUIRES A PC OR LAPTOP
Enrollment cannot be completed on a mobile device.



Who is Eligible for Benefits?

For new hires, your coverage will be effective the first of the month following 30 days of continuous employment (example: if you're hired on June 3, your benefits will begin on August 1). If you enroll during open enrollment, your coverage is effective January 1 of the following year.

Team Members classified as full-time, regularly scheduled to work at least 30 hours per week, are eligible (along with eligible family members) to participate in the Care Synergy benefit plans.

Eligible family member.

For purposes of these benefits, eligible family members include:

- Your legal spouse.
- Legally-Recognized Domestic Partner (notarized affidavit required).
- Your child(ren), less than 26 years of age. Child(ren) shall include a natural or legally adopted child(ren), stepson or stepdaughter, and/or a child who is less than 26 years of age and has been placed under your legal guardianship.
- Your child who is 26 years of age or over, and who is:
 - Mentally or physically incapable of earning a living;
 - Primarily supported by you.

What’s New In 2026?

Medical Plan and Rate Changes

In response to rising healthcare costs, our medical plan premiums have increased this year. Through strategic adjustments to our plan design, Care Synergy has been able to minimize the impact on our 2026 premiums. The enterprise has consistently worked to insulate our team members from excessive increases over the years. Our Team Member rates continue to be lower than the average rate nationwide. Below is a high-level overview of the rate and plan changes for 2026.

HDHP deductibles and out-of-pocket maximums are increasing:

- The individual deductible will increase from \$3,500 to \$4,000
- The family deductible will increase from \$7,000 to \$8,000
- The individual maximum out-of-pocket will increase from \$4,000 to \$5,000
- The family maximum out-of-pocket will increase from \$8,000 to \$10,000
- The in-network coinsurance that Team Members will pay after the deductible is met will change from 90% to 80%

PPO plan design changes:

- The individual deductible will increase from \$3,000 to \$3,500.
- The family deductible will increase from \$6,000 to \$7,000.
- The individual out-of-pocket maximum will increase from \$4,500 to \$5,500.
- The family out-of-pocket maximum will increase \$9,000 to \$11,000.
- Brand-name prescriptions for formulary and non-formulary will now have a separate prescription deductible before the copays apply. The individual deductible is \$300, and the family deductible is \$600.
- The retail copay for preferred brand-name prescriptions has increased from a \$60 copay to a \$75 copay after the prescription deductible has been met.
- The mail order copay for preferred brand-name prescriptions will increase from \$100 to \$150 after the prescription deductible has been met.
- The retail non-preferred brand-name retail copay has increased from \$70 to \$95 after the prescription deductible has been met.
- The mail order copay for non-preferred brand-name prescriptions will increase from \$140 to \$190 after the prescription deductible has been met.
- Specialty prescriptions will still have a 20% coinsurance, but the most you will pay has increased from \$200 to \$300.

Medical Rates – below is an example of the employee-only coverage rate changes:

Plan Name	2025 Per Paycheck Rate	2026 Per Paycheck Rate	Difference
Medical HDHP	\$48.16	\$61.47	\$13.31
Medical PPO	\$93.67	\$119.58	\$25.91

What's New In 2026?

Vision Plan Changes

We are increasing our vision frame allowance from \$130 to \$150.

Health Savings Account

We are changing our HSA administrator from RMR to EBC. Team Members who currently have an HSA will need to complete an online transfer confirmation after open enrollment to move their RMR HSA account to an EBC account. See page 23 for additional information.

- The individual IRS maximum contribution increased from \$4,300 to \$4,400.
- The family IRS maximum contribution increased from \$8,550 to \$8,750.
- The catch-up contribution will remain at \$1,000 for individuals age 55 or older.

Flexible Spending Account

We are changing our FSA administrator from RMR to EBC. Team Members who have a rollover amount will experience a blackout period to allow funds from RMR to be transferred to their new EBC account. Refer to page 26 for further details regarding the run-out period and the transfer to EBC.

- The maximum IRS contribution increased from \$3,300 to \$3,400.
- The maximum amount that individuals can roll over up to \$660 into the 2026 plan year.

Dependent Care Spending Account

We are changing our DCFSFA administrator from RMR to EBC. Please see page 26 for additional information regarding the run-out and the transfer to EBC.

- The IRS maximum contribution for the DCFSFA has increased from \$5,000 to \$7,500. If you are married and file a separate tax return, you can each elect up to \$3,750.

Pasito Virtual Benefit Fair

Care Synergy will host a Virtual Benefit Fair on a new platform called Pasito. Through Pasito, you can:

- Compare plans
- Access plan documents
- Use their decision support tools
- And more!

Use Pasito during open enrollment to help you make the best decision for you and your family. Pasito is also available after open enrollment for you to access information about your benefits.

Additional Resources Available:

The Cigna Pre-Enrollment Benefit Hotline (1-800-564-7642) will be made available to all eligible Team Members to assist in answering questions regarding medical and dental plans, locating a doctor, and providing additional Cigna resources.

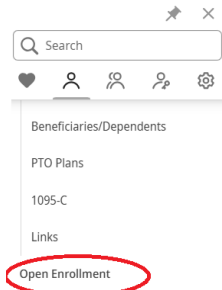
Keep an eye on Blink and check your email often to stay up to date on benefits and the open enrollment process!

Enrolling In Your Benefits

Completing your enrollment is easy using UKG! Just log in and get started.

Access your Open Enrollment session:

1. Log in to UltiPro using Single Sign On
2. Navigate to Menu > Myself > Open Enrollment (Menu options may vary depending on security level)



3. This will open the **About Open Enrollment** page
 - a. Left Pane: Lists all the Benefit Options
 - b. Middle Section: Welcome message, including the number of days to complete the online open enrollment process
 - c. Navigation Toolbar: Command buttons to navigate through the open enrollment process

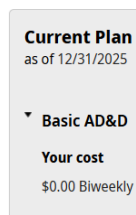


4. Click the Next button on the Navigation toolbar
5. This will open the *Verify Beneficiary and Dependent Information* page
 - a. Verify and/or correct all dependent and beneficiary information for each qualified dependent that you will be enrolling and each beneficiary that you will be designating by clicking on the person's name
 - b. If you need to add a dependent and/or beneficiary, click the Add button and enter the requested information
 - c. Make sure the correct Designation is checked next to the person's name

NOTE: You will need the dependent and/or beneficiaries Full Name, Date of Birth, and Social Security Number or you will be unable to proceed with coverage that requires a dependent, beneficiary or both.

6. Click Next to continue through the enrollment process
 - a. Simply navigate through each benefit by clicking the Next button on the navigation bar
 - b. Once you have enrolled in or declined a benefit coverage, click Next to move you to the next benefit option
 - c. Repeat the process for each benefit offered

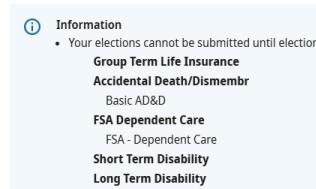
Helpful Tip: You will see a small box on the right side of the screen that will show your current plan, if any. You can click on the down arrow for more information.



Enrolling In Your Benefits

7. Confirm your Elections or Changes: You will see a message at the top of this page if there are outstanding tasks. These tasks will need to be completed before you can submit your elections. Review this information carefully and navigate to the correct section using the menu on the left side of the screen.

Confirm Your Elections or Changes



- a. Review your selections carefully to ensure that everything is accurate. Verify that dependents are listed for each plan where applicable and confirm your beneficiary information.
8. Once you are ready to finalize your elections, click the Submit button.

TIP: You can use the Quick Tours and Tips links to the right of your screen to assist you through the process. There is also a "Help" button to answer questions regarding the current screen.

Surcharge Information:

If you are enrolling a spouse in the medical plan, please complete the "Spousal Surcharge Affidavit" that is located on the medical plan page. If your spouse has other group medical coverage available and chooses not to enroll in that coverage, you will be charged a Spousal Surcharge. You may be required to provide additional documentation. Additionally, Team Members enrolling in a medical plan who are not able to attest that they are tobacco-free or have not completed a Tobacco Cessation Program will be charged a Tobacco Use Surcharge.

If you have any questions/issues regarding this process, or the benefit options available, please contact: cshr@caresynergynetwork.org.

Making changes to your benefits during the year

The only time you may make a change in your coverage during the plan year is when you have a qualified change in your family or employment status, also known as a Qualifying Life Event (QLE). You may change from one coverage type to another upon the occurrence of one of the qualifying events listed below, provided you apply for the change in coverage within 30 days of the qualifying event and provide supporting documentation.

Qualifying Life Event (QLE): A change in your situation, such as marriage, birth of a child, or loss of health coverage, allows you to be eligible for a special enrollment period to enroll in health insurance outside the annual open enrollment period.

- Change in marital status
- Change in number of dependents
- Change in employment
- Change in dependent eligibility due to plan requirements (e.g., loss of student status, age limit reached)
- Change in residence (e.g., Team Member or dependent moves out of plan service area)
- Significant cost changes in coverage
- Significant curtailment of coverage
- Addition or improvement to the benefits package option
- Change in coverage of spouse or dependent under another employer plan (e.g., spouse's employer had no insurance coverage before but now offers a plan)
- Loss of certain other health coverage (e.g., plans provided by governmental or educational institutions)
- Health Insurance Portability and Accountability Act (HIPAA) special enrollment rights
- Judgements, decrees, or orders
- Entitlement to Medicare or Medicaid
- Change in hours worked to less than 30 hours per week on average if the team member and covered family members enroll in another plan providing minimum essential coverage
- Enrollment in the marketplace exchange plan during an exchange special or open enrollment period. Team Members and others covered must enroll in the exchange plan by the first day after coverage ends under the employer plan

This qualifying life event list is not all-inclusive; please refer to the IRS Section 125 Qualifying Event Checklist. Supporting documentation of a life event will be required. Changes to your benefits must be made within 30 days of the event and must be consistent with your change in status.

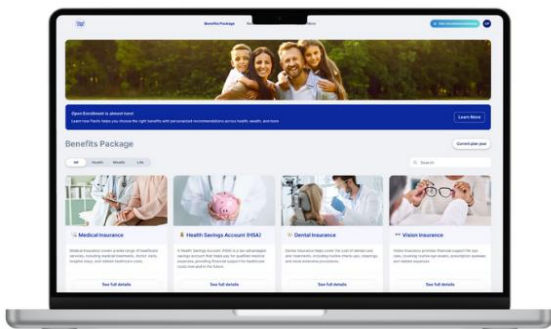
Pasito Virtual Benefits Fair

Personalized guidance and benefits information, all-in-one place

pasito

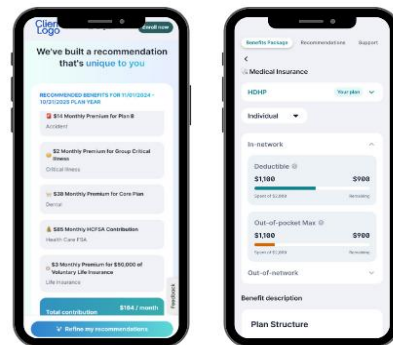
Care Synergy is committed to your health and financial well-being. We've partnered with **Pasito** to host all our benefits on an AI-powered benefits microsite and deliver smart, confidential benefits guidance.

Benefits Microsite



- Access your benefits and plans digitally, anytime
- Ask questions to explore videos, articles, FAQs and more
- Share benefits with your family

Personalized Benefits Recommendations



- Access your benefits recommendation
- Connect your health plan and answer a few questions
- Explore benefits, scenarios and estimate your out-of-pocket medical costs.

 **Private Support:** Pasito never shares your data with Care Synergy or your colleagues.

How to Access Pasito

Scan the QR code or click on this link:

app.joinpasito.com/caresynergynetwork.com



Medical Insurance - Cigna

Care Synergy offers two medical plans through Cigna, both of which use the LocalPlus network. These plans provide **in-network coverage only**, with **no out-of-network benefits**. To locate a LocalPlus provider, visit <http://www.myCigna.com>. The table below outlines the key features of the LocalPlus Consumer Health Plan (HDHP) with HSA. Under this plan, you must meet the calendar-year deductible before certain services are covered. Preventive care is an exception and is covered without needing to meet the deductible.

This HDHP includes a Health Savings Account (HSA), which allows you to save pre-tax dollars for qualified healthcare expenses. You can contribute to your HSA through convenient payroll deductions, and Care Synergy will also contribute to your account to help it grow. Please note that combined contributions from you and Care Synergy must not exceed the IRS annual maximum. For more details, refer to page 22. The coinsurance percentages listed in the table represent the portion of the total cost you are responsible for after meeting your deductible. For complete information on coverage and exclusions, please consult the official plan documents. **Deductibles and out-of-pocket maximums reset every January 1.**

	Local Plus Consumer Health Plan (HDHP) w/ HSA Plan	
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	\$4,000 \$8,000	Not covered
Coinsurance Plan Member	80% 20%	Not covered
Maximum Out-of-Pocket Individual Family	\$5,000 \$10,000	Not covered
Out-of-Pocket Includes	Deductible and Coinsurance	Not covered
Office Visit Copay Primary Specialist	20% after deductible	Not covered
Preventive Care (Including lab as defined by ACA)	\$0 deductible waived	Not covered
MDLive Telehealth	20% after deductible	Not covered
Urgent Care	20% after deductible	Not covered
Emergency Room	20% after deductible	
Diagnostic Lab/X-ray	20% after deductible	Not covered
Advanced Imaging (MRI, CT, PET)	20% after deductible	Not covered
Inpatient/Outpatient Hospital	20% after deductible	Not covered
Outpatient Mental Health	20% after deductible	Not covered
Spinal Manipulation	20% after deductible 20 visit maximum	Not covered
Prescription Deductible	Medical deductible	Not covered
Tier 1 – Generic	20% after deductible	Not covered
Tier 2 – Preferred Brand Name	20% after deductible	Not covered
Tier 3 – Non-Preferred Brand Name	20% after deductible	Not covered
Specialty Drug	20% after deductible	Not covered

Medical Insurance - Cigna

The table below highlights the key features of the LocalPlus PPO Plan. This plan follows a traditional copay structure, meaning you pay a fixed dollar amount for certain medical services, while the plan covers the remaining costs. For other services, you must first meet your deductible before the plan begins to pay.

The listed coinsurance and copay amounts represent the portion of the total cost you are responsible for. For complete details on coverage, exclusions, and benefits, please refer to the official plan documents.

	LocalPlus PPO Plan	
	In-Network	Out-of-Network
Calendar Year Deductible Individual Family	\$3,500 \$7,000	Not covered
Coinsurance Plan Member	80% 20%	Not covered
Maximum Out-of-Pocket Individual Family	\$5,500 \$11,000	Not covered
Out-of-Pocket Includes	Deductible, Copays and Coinsurance	Not covered
Office Visit Copay Primary Specialist	20% deductible waived+	Not covered
Preventive Care (Including labs as defined by the ACA)	\$0	Not covered
MDLive Telehealth	\$15 copay	Not covered
Urgent Care	20% after deductible	Not covered
Emergency Room	20% after deductible	Not covered
Diagnostic Lab/X-ray	20% after deductible	Not covered
Advanced Imaging (MRI, CT, PET)	20% after deductible	Not covered
Inpatient/Outpatient Hospital	20% after deductible	Not covered
Outpatient Mental Health	20% deductible waived+	Not covered
Spinal Manipulation	20% after deductible, 20 visit maximum	Not covered
Prescription Deductible	Individual: \$300 Family: \$600	Not covered
Tier 1 – Generic*	Retail: \$15 Mail: \$30	Not covered
Tier 2 – Preferred Brand Name*	Retail: \$75 Mail: \$150 after Rx. deductible	Not covered
Tier 3 – Non-Preferred Brand Name*	Retail: \$95 Mail: \$190 after Rx. deductible	Not covered
Specialty Drug*	20% to \$300	Not covered

* If your Doctor prescribes a medication where a generic equivalent is available, you may be responsible for the difference in cost if “dispense as written” is not indicated.

† The deductible is only waived for the PPO plan for the office visits with a primary care or specialist physician. This does not apply to the HDHP plan and may not apply to all services received during the office visit.

Medical Plan Rates and Information

Cigna Consumer Health Plan (HDHP)

Monthly	Team Member Only	Team Member + Spouse/ Domestic Partner	Team Member + Child(ren)	Team Member + Family
Total Cost	\$1,071.58	\$1,925.09	\$1,818.40	\$2,671.93
Care Synergy Contribution	\$948.63	\$1,458.21	\$1,422.94	\$2,002.87
Team Member Contribution	\$122.94	\$466.87	\$395.46	\$669.06

Cigna PPO

Monthly	Team Member Only	Team Member + Spouse / Domestic Partner	Team Member + Child(ren)	Team Member + Family
Total Cost	\$1,171.34	\$2,122.15	\$2,001.77	\$2,952.48
Care Synergy Contribution	\$932.19	\$1,425.74	\$1,392.71	\$1,956.63
Team Member Contribution	\$239.16	\$696.41	\$609.07	\$995.85

Domestic Partner coverage is subject to imputed income.

Surcharge

If a Team Member's spouse/legally recognized domestic partner has other group medical coverage available and chooses not to enroll in that coverage, you will be charged a Spousal Surcharge. For 2026, the surcharge amount will be:

	Spousal Surcharge
Monthly	\$200.00

Team Members enrolling in the medical plan who are not eligible to attest that they are tobacco-free or have not completed a Tobacco Cessation Program will be charged a Tobacco Use Surcharge. For 2026, the surcharge amount will be:

	Tobacco Surcharge
Monthly	\$50.00

Decision Support

Which Plan is Right for Me?

When deciding between Medical plans, it's important to keep in mind the potential annual overall costs, including premiums (what you pay to access benefits through the plans), the amount Care Synergy deposits into an HSA (for those members on the HDHP or looking to enroll into it), and the plan Out of Pocket Maximum (the yearly limit before the plan pays 100% of remaining costs). Below is a helpful grid that shows the maximum cost of your healthcare, per plan and per coverage tier.

Annual Maximum Cost of Healthcare	Team Member	Team Member + Spouse / Domestic Partner	Team Member + Child(ren)	Team Member + Family
HDHP w/HSA				
Annual Premiums	\$1,475.28	\$5,602.49	\$4,745.54	\$8,028.68
<u>PLUS</u>	+	+	+	+
Annual Out of Pocket	\$5,000.00	\$10,000.00	\$10,000.00	\$10,000.00
<u>MINUS</u>	-	-	-	-
Annual CSN HSA Contribution	\$1,000.00	\$2,000.00	\$2,000.00	\$2,000.00
Total Max Annual Cost	\$5,475.28	\$13,602.49	\$12,745.54	\$16,028.68
PPO				
Annual Premiums	\$2,869.87	\$8,356.95	\$7,308.82	\$11,950.21
<u>PLUS</u>	+	+	+	+
Annual Co-Insurance	\$5,500.00	\$11,000.00	\$11,000.00	\$11,000.00
Total Max Annual Cost	\$6,975.34	\$16,602.49	\$15,745.54	\$19,028.68

Care Synergy has partnered with Pasito to provide all Team Members with access to an AI-powered Decision Support Tool that provides personalized benefit recommendations. Pasito's Decision Support Tool lets you explore benefit scenarios and estimate your out-of-pocket costs. Pasito is 100% confidential and will never share your data with Care Synergy.

How to Access Pasito:

Scan the QR code or use this link:

app.joinpasito.com/caresynergynetwork/login



When your plan begins, register on myCigna.com and download the app. That way, you'll be ready whenever you need to find in-network healthcare providers, estimate costs, or use My Health Assistant.

Once you're registered, you can:

- ✓ Access your digital ID cards for yourself and any dependents. You can download the card images to save, share, print, or email directly to your dependents and to your providers
- ✓ Understand what's covered in your plan
- ✓ Find in-network doctors, hospitals, and facilities. You can sort them by location, reviews, and Cigna's quality rating
- ✓ Get cost estimates for appointments, procedures, and medications
- ✓ Compare costs for 30- and 90-day supply
- ✓ Manage and track claims
- ✓ Get alerts when new plan documents are available
- ✓ Access a variety of health and wellness resources, including an online health assessment, health tracking tools, and My Health Assistant digital coaching



Tips to help you save money



Find where to get prescription drugs

- › Find the complete list of covered medications on myCigna.com
- › Use cost-comparison tools on myCigna to compare prices and purchase mail-order prescriptions¹³
- › Use generics when possible
- › Know what brand-name drugs are covered in your plan
- › Ask your doctor about a 90-day supply for your maintenance medication(s) through our home delivery pharmacy service



Know where to go for care

- › Use an emergency room for true emergencies
- › Don't wait: Locate an in-network convenience care clinic, sometimes found within a grocery store, or urgent care center near you, before you need it
- › For minor medical conditions, connect with a board-certified doctor via video or phone when, where and how it works best for you. Visit myCigna.com, or call MDLIVE at 888.726.3171 to talk with a doctor 24/7²
- › Don't be fooled: Some emergency rooms look like urgent care centers, so know what type of facilities are in your area



Choose the right provider

- › Know which providers are in your network by going to myCigna.com > Find Care & Costs
- › Choose providers who have received the Cigna Care Designation – high-performance recognition given to physicians in certain specialties who meet Cigna quality and medical cost-efficiency standards¹⁴
- › Opt to connect with a board-certified doctor, therapist or psychiatrist via video or phone²
- › Use in-network national labs to help save money



Be proactive about your health

- › Get information on the cost of medications and treatments to avoid surprises
- › Use your preventive care benefits, learn your core health numbers (blood pressure, cholesterol and blood glucose), and make use of the health improvement tools at myCigna.com

Find your way to better health.

Get more information on all the programs that are available to you.



When your plan year begins, register on myCigna.com.



Call the 24/7 customer service number on your ID card.



Download the myCigna App.⁷



Have your ID card handy?

With myCigna, the answer is always “yes.”



Big news: You never have to worry about misplacing your ID card. It's always right there on myCigna®, whenever and wherever you need it.*

Accessing your digital ID cards is easy.



Log in to **myCigna.com** or the **myCigna® App**



Click or tap “ID Cards”



View your card(s), as well as any dependents' card(s)**



Email cards directly to doctors



Save your digital ID cards in your Apple Wallet



Not registered on myCigna yet?

It's quick and easy.

Visit **myCigna.com®** or scan the QR code to download the **myCigna® App** and register now.



Your Pharmacy Benefits

When it comes to prescription medications, you and your doctor usually have a choice between a brand-name medication and its generic equivalent. Generics offer the same strength and active ingredients as the brand name medication but often cost much less – sometimes up to 85% less.

Use the myCigna App or website 24/7 access to your coverage information

- Easily order, manage, track, and pay for your home delivery prescription orders.
- Find out how much your medications costs
- See which medications you plan covers
- Find an in-network pharmacy
- Ask a pharmacist a question
- See your pharmacy claims and coverage details

Tip: When you're at your provider's office, use your myCigna app to look up medications you're discussing with your provider to ensure they're covered, determine whether a pre-authorization is required, and if there is a generic alternative. Watch this [video](#) to learn more about Rx cost management.

Use Express Scripts Pharmacy, Cigna's home delivery pharmacy

Home delivery is a convenient option if you're taking medication regularly. Express Scripts Pharmacy helps make it easy for you to get your medication. With just a few simple clicks of your mobile phone, tablet, or computer, your important medications will be on their way to your door (or location of your choice).

In most cases, you can get a 90-day supply of your medication for 2.5x's the 30-day supply copay.

- Easily order, manage, track, and pay for your medications on your phone or online
- Standard shipping at no extra cost
- Fill up to a 90-day supply at one time
- Helpful pharmacists available 24/7
- Automatic refills and refill reminders so you don't miss a dose
- Flexible payment options

Three easy ways to switch to home delivery

1. Log in to the myCigna app or myCigna.com to move your prescription electronically. Click on the Prescriptions tab and select My Medications from the dropdown menu. Then, click the button next to your medication name to move your prescription.
2. Call your doctor's office. Ask them to electronically send a 90-day prescription (with refills) to Express Scripts Home Delivery.
3. Call Express Scripts Pharmacy at 800-835-3784. They'll contact your doctor's office to help transfer your prescription.



Cigna Member Choice

When it comes to getting access to the right pharmacies, customers want options and convenience.¹

A pharmacy network designed to boost engagement and avoid surprises.

Member Choice Cigna 90 Now puts customers in control of where they fill their 30- and 90-day maintenance medications, so they can choose the pharmacy location and pharmacist care team that works best for them.

With pharmacists playing an increasingly important role on the care team, there's opportunity to drive better patient adherence, clinical outcomes, satisfaction and overall health care savings.

Did You Know?

77% of people see pharmacists as an integral member of their health care team.²

FAQ.

How does it work? Customers choose from two complete 30- and 90-day networks, with either CVS Pharmacy or Walgreens as the main retail anchor.

- **30-day network:** Access to more than 55,000 in-network regional and independent pharmacies.⁵
- **90-day network:** Access to more than 30,000 in-network regional and independent pharmacies.⁶

Are network selections made at the subscriber level, or the individual level? Every covered member in the household can choose the pharmacy network that works best for them.⁷

When can customers switch networks? Customers have the option to change anchors once during the plan year and at other certain events, such as relocation.

How are networks determined?

- **Clients:** Clients have an option to choose a designated anchor. Cigna HealthcareSM will review six months of utilization data to assign a default network. This network will be assigned to customers who have no personal utilization.
- **Customers:** Cigna Healthcare will review six months of customers' utilization data and assign them the network they use most often. If there is no utilization, we will place the customer in the client assigned network.

Can a customer change the assigned network? Existing customers can make a change before renewal or go-live* by calling Cigna Healthcare or by visiting MyCigna.com post go-live. Customers can also change their network chain (CVS or Walgreens) upon certain events, such as relocation. And then they can change their network on a yearly basis.

Are 90-day benefit designs available? Yes, clients can elect either a voluntary or exclusive benefit design for 90-day maintenance medications. This plan design feature determines whether filling the 90-day supply is required at one of the 30,000+ pharmacies in the network.

- **In-store and home delivery options:** Customers can fill 90-day maintenance medications at an in-network retail 90-day pharmacy, including Express Scripts® Pharmacy.
- **Opportunities for savings:** Moving to 90-day fills for maintenance medications can drive cost savings³ for customers and improved prescription adherence.⁴



MDLive – Virtual Care

It's not always easy to find time for the health care you need. After all, doctors' appointments traditionally involve time and travel. That can lead to putting off care until problems become more serious and potentially more expensive.

That's why Cigna has partnered with MDLive to offer a comprehensive suite of convenient virtual care options – available by phone or video whenever works for you. MDLive board-certified doctors, dermatologists, psychiatrists, and licensed therapists have an average of over 10 years of experience and provide personalized care for hundreds of medical and behavioral health needs. Using MDLive services is a low-cost alternative for urgent care and ER visits. Member cost share information can be found on [page 5](#), and it will also be shown before you confirm your appointment.

Primary Care

Preventative care, routine care, and specialist referrals

- Preventative care checkups/wellness screenings available at no additional cost to identify conditions early
- Routine care visits allow you to build relationships with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work, and screenings at local facilities

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology

Fast, customized care for skin, hair, and nail conditions – no appointment required

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair, and nail conditions, including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours

3 easy steps to connect to care

1. Access MDLive by logging into [myCigna.com](https://mycigna.com) and clicking on "Talk to a doctor." You can also call MDLive at **888-726-3171** (no phone calls for dermatology).
2. Select the type of care you need: medical care or counseling; cost will be displayed on [myCigna.com](https://mycigna.com) and MDLive.
3. Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care.

MDLIVE



Mental Health Resources

Each medical plan includes inpatient and outpatient mental health coverage. When you need behavioral support, myCigna makes it easy to connect with the right care—in person or virtually.

Once you log into the myCigna website or app, you can select “therapist” or “virtual” for a list of virtual behavioral health providers. You can also click on “Find Care & Costs.” From there, you can search “Doctor by Type” and select a behavioral health provider in your network.

- ✓ There are over 10,000 providers in Cigna’s virtual care network
- ✓ Cigna’s Fast Access Network guarantees you can lock in a first-time behavioral support appointment within five* business days.
- ✓ [Mental Health FAQ](#)

Cigna Employee Assistance Program (EAP)

Members are entitled to three in-person or virtual visits with a licensed mental health provider in Cigna’s EAP network at no additional cost. To find a provider in Cigna’s EAP network, call Cigna or click to chat from myCigna to obtain an authorization code to give your provider. **Please note** that you must obtain an authorization code from Cigna to utilize your three free visits.

Digital Resources

Using the myCigna website or app, individuals can access a range of dedicated resources that help support behavioral health. Here’s how to get started:

1. Log in to myCigna
2. Click on “Find Care & Costs”
3. Choose “Doctor by Type”
4. Select “Telehealth/Virtual Health Counselor”
5. Go to “View Results” under “Digital App-based Care”



Provides in-the-moment emotional care – including coaching, therapy, psychiatry, and self-care resources – all from the privacy of a smartphone. It helps you manage anxiety, depression, and daily stressors.



Licensed therapists and board-certified psychiatrists offer talk therapy and coping strategies, as well as psychiatric services to assist in assessments and medication management.



The combination of science, technology, and human support helps you overcome mental health challenges.



Personalized care for all – by making mental health access safe, quick, and easy. You can expect immediate, responsive care to support your diverse needs.



Dental - Cigna

Care Synergy offers two dental plans through Cigna. A traditional dental plan through Cigna's Total DPPO Network and a DHMO dental plan that is based on a fee schedule and has flat copays dependent on the service you receive.

Why go in-network? Network dentists have agreed to reduce their fees for Cigna customers. They will also file claims for you, and they cannot "balance bill" you for the difference between their regular fees and the reduced fees they have agreed to accept from Cigna when you see an in-network provider for preventative care services like cleanings, exams, and routine x-rays at no additional cost.

The table below is a high-level summary of the DPPO Dental Plan. The listed coinsurance amounts represent the amount the plan will pay.

	PPO Plan		DHMO
	Network	Non-network	In-Network Only
Calendar Year Deductible (individual/family)	\$50/\$150	\$50/\$150	N/A
Calendar Year Maximum Benefit	\$2,000	\$2,000	N/A
Dependent (Unmarried) Child Age Limit	26	26	N/A
Orthodontia Lifetime Maximum per covered member	\$1,500	\$1,500	N/A
Orthodontia	Child & Adult	Child & Adult	N/A
Type I – Diagnostic & Preventive -Exams -Cleanings -X-rays	100% no ded.	100% no ded.	Copay Schedule*
Frequency of Exams/Cleanings	Twice Per Year	Twice Per Year	N/A
Type II – Basic Services -Fillings -Periodontic/Endodontics -Oral Surgery	80% after ded.	80% after ded.	Copay Schedule*
Type III – Major Services -Inlays/Onlays -Implants -Crowns	50% after ded.	50% after ded.	Copay Schedule*
Type IV - Orthodontic Services	50%	50%	Copay Schedule*
Reasonable and Customary**	N/A	90%	N/A
Waiting Period (12 months)	50% coverage on Type III and IV	50% coverage on Type III and IV	None
Waiting Period Applies To:	Late Entrants	Late Entrants	N/A

* See HR for a Copay Schedule of Benefits, or go to MyCigna.com

** Reasonable and customary refers to the average cost of dental services in a given geographic area. If you are seeing an out-of-network provider, Cigna will use the 90th percentile of all provider charges in the geographic area to determine the plan payment amount for your dental services.

*** The DHMO network will differ slightly from the PPO plan. It is recommended that you confirm the network status of your dentist before selecting this plan.



Cigna Dental Rates

PPO Plan

Monthly	Team Member Only	Team Member + Spouse / Domestic Partner	Team Member + Child(ren)	Team Member + Family
Total Cost	\$52.87	\$104.98	\$126.21	\$196.51
Care Synergy Contribution	\$5.93	\$10.81	\$15.18	\$17.08
Team Member Contribution	\$46.94	\$94.17	\$111.03	\$179.43

DHMO Plan

Monthly	Team Member Only	Team Member + Spouse / Domestic Partner	Team Member + Child(ren)	Team Member + Family
Total Cost	\$14.55	\$26.90	\$36.79	\$44.20
Care Synergy Contribution	\$9.75	\$18.02	\$24.65	\$29.61
Team Member Contribution	\$4.80	\$8.88	\$12.14	\$14.59

Reminder: It is the Team Member’s responsibility to confirm the dentist’s participation in the DHMO plan.

Vision Insurance - VSP

Care Synergy offers vision insurance through VSP. The vision insurance allows you to visit a provider of your choice. However, you will save the most when you visit a VSP network provider. When you visit an out-of-network provider, you will need to pay out of pocket at the provider's office and then submit for reimbursement.

PROVIDER CHOICES YOU WANT.

It's easy to find a nearby in-network doctor. Maximize your coverage with bonus offers and savings exclusive to Premier Program locations, including thousands of private practice doctors and over 700 Visionworks retail locations nationwide.

USING YOUR BENEFIT IS EASY!

Create an account on vsp.com to view your in-network coverage, find the VSP network doctor who's right for you, and discover savings with exclusive member extras. At your appointment, just tell them you have VSP.

QUALITY VISION CARE YOU NEED.

You'll get great care from a VSP network doctor, including a WellVision Exam®—a comprehensive exam designed to detect eye and health conditions.

	In-Network	Frequency
Exam	\$10 copay	Every calendar year
Frame	- \$150 featured frame allowance - \$150 frame allowance - 20% discount on balance over allowance	Every other calendar year
Lenses - Single - Lined bifocal - Lined trifocal	\$25 materials copay	Every calendar year
Lens Enhancements - Standard progressive - Premium progressive - Custom progressive	- \$0 - \$95-\$105 - \$150-\$175	Every calendar year
Contacts - Exam (fitting & evaluation) - Lens	- \$20 per exam - \$130 allowance	Every calendar year

Monthly	Team Member Only	Team Member + Spouse / Domestic Partner	Team Member + Child(ren)	Team Member + Family
Total Cost	\$8.62	\$13.79	\$14.08	\$22.70
Team Member Cost	\$8.62	\$13.79	\$14.08	\$22.70

Health Savings Account - EBC

Care Synergy offers a high-deductible health plan (HDHP) through Cigna that allows you eligibility to open a health savings account (HSA) with EBC. The HSA lets you save and accumulate money and use the savings to pay for qualified medical, pharmacy, dental, and vision expenses now or in the future. If you change health plans or employers, that money goes with you.

Features of an HSA

- ✓ You can contribute tax-free money into your account.
- ✓ Savings can be used, tax-free, to pay for qualified medical, pharmacy, dental, and vision expenses, as identified by the IRS. Using the savings toward other expenditures may result in penalties and/or taxes.
- ✓ EBC offers investment options to help your account grow.
- ✓ You may continue to deposit money in the HSA as long as you are enrolled in an HSA-eligible plan.
- ✓ There is no use-it-or-lose-it rule – the money you save and earn on your investments is yours to keep, and it remains in the account year to year.

How an HSA works

With an HSA, you contribute tax-free money to an account. You can start using the money right away to pay for current qualified expenses or let the account grow over time to help cover future expenses. Watch this [video](#) to learn more.

Q. How much can I contribute?

A. Your total annual contribution, plus contributions from any other sources, can't exceed:

	IRS Maximum Contribution	Care Synergy's Annual Contribution	Team Member's Maximum Annual Contribution*
Team Member Only	\$4,400	\$1,000	\$3,400
Team Member + Dependent(s)	\$8,750	\$2,000	\$6,750
55+ Catch up	-	Additional \$1,000	Additional \$1,000

If you're age 55 or older, you can make an additional catch-up contribution of up to \$1,000.

Q. When can I make contributions?

A. Typically, contributions may be made at any time of the year in one lump sum or through payroll deductions. If you make your contributions in one lump sum and are no longer enrolled in an HDHP, you must withdraw any excess to avoid penalties.

Q. What if I change health plans?

A. All the money in your HSA is yours to keep. If you are no longer enrolled in a qualified HDHP, you cannot make any more contributions to the account but can use the accumulated money to pay medical expenses. If you enrolled in an HSA midyear and contributed the maximum annual amount, you may be subject to additional taxes and penalties if you don't maintain your HSA eligibility through the following year.

*The most an employee can contribute annually *after* Care Synergy's annual contribution
See [irs.gov](#), *IRS Publication 502 and 969*, for additional information about qualified medical expenses and helpful information about HSAs.

Health Savings Account - EBC

Effective January 1, 2026, Care Synergy will partner with Employee Benefits Corporation (EBC) as its new HSA administrator. When you enroll in the Cigna Consumer Health Plan (HDHP), an HSA will be automatically opened for you through EBC. Team Members who have an HSA with Rocky Mountain Reserve will have an opportunity to consolidate their HSAs.

Consolidating Your HSA Funds

To support your financial wellbeing, we are working with EBC and a new HSA custodian, WealthCare Saver, to transfer funds to your new HSA account seamlessly. Below are the steps you need to complete by **1/21/2026** to initiate a transfer. **Failure to do so could result in monthly admin fees.**

Please note: if you have an investment balance with Rocky Mountain Reserve, you must liquidate these funds and transfer the investment balance before 1/29/2026. If you do not liquidate your investment balance by this date, your entire account balance may not transfer over to your new HSA.

Instructions to complete your HSA transfer:

1. Log in to your EBC online account and select your HSA tile after 1/2/2026.
2. Select the Easy HSA transfer button in the banner at the top of your account.
3. Follow the prompts to select RMR, your previous HSA custodian and account, then authorize the transfer.

Details to know about your transfer:

- A blackout period with our previous custodian will begin on 2/05/2026 and end on 2/12/2026. During this time, you will not have access to funds, card usage, online bill pay or claim submission.
 - Keep receipts for any out-of-pocket expenses to file for reimbursement after the blackout date.
- Your HSA funds will be transferred and available for use by 2/19/2026.

If you do not consolidate your HSAs at this time, you can initiate an individual transfer later. Please note that you will be responsible for any fees associated with completing an individual transfer and any monthly administration fees. For additional information about individual transfers, please refer to your online account.

Benefits of consolidating your HSA accounts:

- **Simplified Account Management**
Consolidating HSA funds means that you only need to manage one account and one debit card.
- **No Unnecessary Monthly Fees**
Most individual HSAs, or retail HSAs, charge a monthly administrative fee to keep an HSA open. Consolidating HSAs reduces any unnecessary monthly fees.
- **Simplified Tax Reporting**
Consolidating HSA funds reduces the number of tax forms that you receive annually.
- **Maximized Interest Earned**
With EBC's high-yield interest option, you can earn more tax-free interest when you transfer your funds to EBC's HSA custodian and increase your available cash balance.
- **Maximized Investment Earnings**
EBC's HSA offers a modern and personalized investment experience to accountholders who have a minimum \$1,000 cash balance. Consolidating HSA funds helps you reach that \$1,000 cash balance quicker and allows you to invest and meet your long-term investment goals.

Health Savings Account - EBC

Pro Tips to Get the Most from Your HSA

1. Create Your Online Account

You'll create your online account the first time you visit www.ebcflex.com.

1. Click Log In > Participants.
2. Click the Register button and follow the on-screen prompts.
3. Once you've registered and logged into your account, click on the HSA tile for more details.

Note: To create a new account, you must provide a valid email address and set up two-factor authentication (two-step verification). We recommend using your personal email address instead of your work email to minimize disruptions if you are unable to access your work email account. You can also add your personal phone number to your account as an additional method of authentication.

2. Add Beneficiaries

Once you have registered your online account, designate a beneficiary for your HSA.

1. After you log in to your online account, select your HSA level.
2. Click on your HSA balance.
3. Select View Beneficiaries.

3. Learn More About Investing

Once your HSA reaches a \$1,000 cash balance, you can start investing your HSA funds. There are three investment models to choose from based on your experience—Managed, Self-Directed, and Brokerage. Whether you're new to investing and are looking for a guided experience or are a seasoned investor looking to research and trade stocks and ETFs, you will have an investment model that best fits your needs. If your investment needs ever change, you can switch your investment model at any time.

You can also transfer funds between your HSA cash balance and investment balance at any time. Learn more about your investment opportunities in your online account:

1. After you log in to your online account, select your HSA.
2. Click on your HSA balance.
3. Select Learn More About Investments.

Tip: You also have access to an HSA Investments User Guide, which is available in the main menu of your HSA portal under Forms and Documents.

4. Download EBC Mobile

Download EBC Mobile in the App Store or Google Play.

- Use your online account information to log in.
- Track your balance and see all of your transactions.
- Manage your Benefits Care – request additional cards, replace, lock, or close your card.

5. Identify Eligible Expenses

Access www.ebcflex.com/eligibleexpenses to verify the types of expenses that are eligible for payment from your HSA.

Flexible Savings Account

Care Synergy offers three flexible spending account (FSA) options through EBC. Using a flexible spending account (FSA) saves you money by allowing you to pay for eligible expenses on a tax-free basis. When you contribute to an FSA, you save approximately 30%* on eligible expenses, making a \$100 eligible purchase cost you about \$70. You get these savings because the contributions you make to an FSA are exempt from Federal, State, and FICA payroll taxes.

Health Care FSA

Allows you to pay for eligible **medical, vision, and dental** expenses that are not covered by another health plan. As long as you (or a covered spouse) are not contributing to a health savings account (HSA), you can use a health care FSA to supplement out-of-pocket costs.

- **IRS Maximum Contribution: \$3,400**
- **Maximum Rollover to 2027: \$680**

Limited Health FSA

Allows you to pay for eligible **vision** and **dental** expenses that are not covered by another health plan. This is a great option if you (or your spouse) contribute to a health savings account (HSA) , as you can maximize savings by participating in both plans simultaneously.

- **IRS Maximum Contribution: \$3,400**
- **Maximum Rollover: \$680**

Both the Health Care FSA and Limited Health FSA allow you to carry over up to a specified amount of funds from one plan year to the next. Rollover funds are not included in your annual maximum contribution amount, so any funds rolled over will be in addition to your election amount for the new plan year. Any amount over the allowed rollover will be forfeited at the end of the plan year.

\$2,500 Election		
\$1,800 Used	\$660 Rollover	\$40 Forfeited
<u>New Plan Year</u>		
New election Amount: \$2,550	\$660 Rollover	
Total FSA funds (election with rollover): \$3,210		

 Benefit Tip:

Prior to the end of your plan year, review your FSA balance and your benefit deadlines to make sure that you use all of your FSA funds. Don't risk having any unused funds forfeited.

Dependent Care FSA

Allows you to set aside pre-tax funds to pay for daycare expenses for eligible children or other eligible dependents. You (and your spouse if you're married) must be working, looking for work, or be a full-time student to use this account.

- **IRS Maximum Contribution: \$7,500**
- **Dependent Care FSA funds do not roll over**

*This tax example is a broad approximation of tax liability. Further, your contributions may be subject to state income tax in some states. Your specific savings depend on your tax bracket. You should consult a tax advisor for help with your own situation. Current IRS tax laws control all pre-tax payment and contribution matters and are subject to change.

Flexible Savings Account

Effective January 1, 2026, Care Synergy will partner with Employee Benefits Corporation (EBC) as its new FSA administrator. When you elect to contribute to an FSA, an account will be automatically opened for you through EBC. EBC will provide all claims processing, record keeping, and customer service associated with your new FSA Plan and Benefits Card.

To help make a smoother transition, below are important dates in the transition timeline, instructions on how to log into your account, and guidelines on how to submit claims.

Transition Timeline

January 1, 2026

- Your Rocky Mountain Reserve debit card will no longer be active on this date.
- Rocky Mountain Reserve will no longer accept claims from your current FSA for processing.
- Employee Benefits Corporation (EBC) begins the administration of the 2026 FSA Plan, and participants can begin submitting claims.
- For 2026 Plan Year participants, a NEW debit card will be in your hands by January 1, 2026

January 15, 2026

- EBC will administer the 2025 FSA Runout Plan, and participants can submit claims to their 2025 FSA for reimbursement.
- FSA runout claims can be submitted through the Participant Portal or Mobile App

March 31, 2026

- The last day to submit claims for reimbursement to EBC for the 2025 plan year

Getting Started with EBC

1. Create your account the first time you use My Account Assistant

- Go to www.ebcflex.com
- Choose "Participants" from the login dropdown list
- Choose "First Time User," and follow the prompts to create your username, password and security question/answer

2. Log into your account

- Go to www.ebcflex.com
- Choose "Participants," from the Log In dropdown list
- Enter your Username and Password

How to Submit Claims

1. Using My Account Assistant

- To submit claims and documentation online, log into your account at www.ebcflex.com and choose "Submit a claim" from the menu.

2. Using EBC Mobile

- You can also submit claims and documentation using our mobile app.
- Download the app for your Android phone from Google Play or for your iPhone from the Apple App Store. Use "EBC App" as your search query to locate the app in the stores.



3. Using a Paper Claims Form

- An EBC claims form is also available on www.ebcflex.com.

Flexible Spending Account - FAQ

What should I know about submitting claims for Health Care FSA-eligible expenses?

Once your total election amount is approved and you are enrolled in the plan, you can submit claims for eligible Health Care FSA expenses up to the total of your Health Care FSA election amount.

What should I know about submitting claims for Dependent Care FSA-eligible expenses?

Per IRS regulations, claims for eligible Dependent Care FSA expenses cannot be reimbursed until after the expense is incurred and after the service is provided. If you pay out-of-pocket for a daycare expense and later submit a Dependent Care FSA claim for that expense, we cannot reimburse the claim until after you receive the service.

- Also, unlike the Health Care FSA, your current balance in the Dependent Care FSA, not your total election amount, is the maximum reimbursement you can receive.
- If we receive a properly documented claim for an unreimbursed eligible expense before **January 1, 2026**, it will be held and processed starting on **January 1, 2026**.

Who will handle my Runout?

EBC will be administering your FSA runout.

- EBC will receive the FSA Balances from the 2025 FSA plan year in the first week of January.
- You will be able to submit FSA runout claims on January 15, 2026

What happens to the claims I've submitted to my previous FSA administrator?

Rocky Mountain Reserve will not transfer any unreimbursed claims you may have submitted to them to EBC.

If you have submitted a claim to your previous administrator for any unreimbursed eligible expenses that will be incurred in your new plan year, you will need to resubmit the claim and any documentation to EBC.

Using the Benefits Card

The Benefits Card is a prepaid debit card that you use instead of paying out-of-pocket for eligible Health Care FSA expenses.

- **The card cannot be used to pay for Dependent Care FSA expenses.**
- A NEW card will be mailed to you by **January 1, 2026**.
- Save your BenefitsCard, even after depleting Health Care FSA funds or after your plan year ends. You only receive a new card at no cost every five years.

What happens if I pay for an ineligible or unsubstantiated expense using the card?

If you make an ineligible or unsubstantiated purchase from a merchant without an inventory information approval system (IIAS) or you use the card to pay for medical, dental, or vision expenses (see item 8), you'll receive a **Documentation Request** asking you to either submit expense documentation or reimburse the plan for the expense. **Remember always to save your expense documentation.**

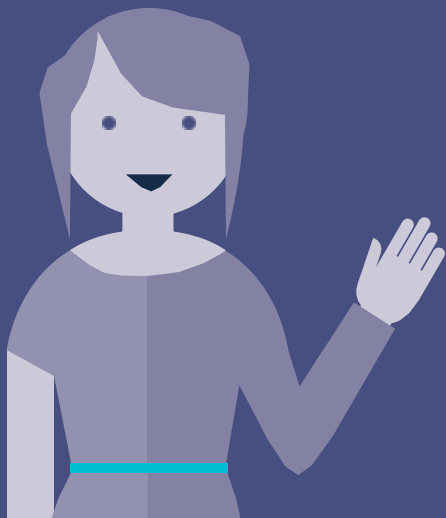
What does substantiation mean?

Substantiation describes the process of verifying that an expense is eligible under the FSA Plan when using the Benefits Card. When you use the card to pay for an eligible Health Care FSA expense, it is either verified as an eligible expense and the sale will go through, or it is declined, and you must use an alternative form of payment.

Who should I call if I have questions?

Please contact our Participant Services Team between 7 a.m. and 7 p.m. CST at **800-346-2126** and choose option 1.

Retirement Savings with Principal



Welcome!

We're so glad you're here.

There's a retirement plan waiting for you! In just a few steps, you'll be on your way. Here's what to expect.



Get your account set up

Visit principal.com/Welcome or use the Principal® app. You can also text **ENROLL** to **78259**.

Sitio web disponible en Español.

Begin by:

- Setting security preferences
- Reading important plan notices



Set your contribution

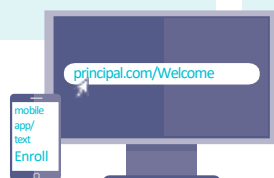
Contributions are one way to help your savings work hard for you. To learn more, visit principal.com/MatchEnrollmentWebinar.



Check out the plan's investments

Each investment is different, and you can choose based on your goals and how you feel about risk. You can also pick from the plan's investment options later. But by picking it later, you understand that until you make a new investment selection, you're directing contributions to the plan's default.*

For a full listing, refer to the Investment Option Summary.



*The plan's participant level default is: American Funds Target Retirement Fund R6. See Investment Option Summary for important information. If the default is a target date fund series, the applicable target date fund will be based on the plan's normal retirement date.

Keep going!

You've got this, and we've got your back when it comes to educational resources.

To learn more, visit **principal.com/Welcome** or use the Principal mobile app. You can also text **ENROLL** to **78259**.

Sitio web disponible en Español.



See your retirement savings in one place

We'll help you roll eligible outside retirement savings into your retirement account.



Designate a beneficiary

Don't leave the decision up to someone else if something happens to you before retirement. Always designate a beneficiary to ensure the money in your account goes to a loved one.



Keep in touch

Staying in the know when it comes to retirement planning is a pretty good idea. We'll send you educational information about what's important to you.



Eligibility for Participation

Eligible Employee-Elective Deferrals

You are an "Eligible Employee" if you are employed by Comfort Bridge dba Care Synergy or any affiliate that has adopted the Plan. However, you are not an "Eligible Employee" if you are a member of any of the following classes of employee:

1. Employees who are non-resident aliens.
2. Employees who are students performing services described in Code section 3121(b)(10).

Eligible Employee-Other Contributions

For purposes of Matching Contributions, the term "Eligible Employee" will have the same meaning as specified above under "Eligible Employee-Elective Deferrals."

Time of Participation-All Contributions

If you are an Eligible Employee, you will become a participant eligible for purposes of Elective Deferrals and Matching Contributions on the first day of your employment, coincident with the date you first perform an Hour of Service as an Eligible Employee.

Matching Contributions

- If you make an Elective Deferral, the Company will make a Matching Contribution on your behalf in an amount equal to 50% of your contributions that are not in excess of 8% of your compensation.
- Matching Contributions are allocated to your account at the discretion of the Company. Complicated provisions of the Internal Revenue Code may also further restrict matching contributions for highly compensated employees.

Vesting

Participant Contributions

Vesting = Ownership. You are always vested in what you contribute – your money is yours! When does the company match in your account belong to you?

1. At your Date of Hire two-year anniversary you are 50% invested, upon reaching your three-year anniversary, you are 100% vested.
2. If you leave/change jobs/retire and you worked here two years but didn't hit your three-year anniversary, you can take all of what you contributed and HALF of the company match in your account. Once you reach your three-year anniversary, your entire account balance is yours.
3. The number of years you work will dictate how much of the company match you get to take with you when you leave: if you work here less than two years, you don't take the match with you; if you work here two years you can take half the match with you; if you work here three years (or more) you can take all the match.

Matching Contributions

Your interest in your Matching Contribution Account will vest based on your Years of Vesting Service (defined below) in accordance with the following schedule:

Years of Vesting	Vesting Percentage
Less than one year	0%
One year but less than two years	0%
Two years but less than three years	50%
Three years but less than four years	100%
Four years but less than five years	100%
Five years but less than six years	100%
Six or more years	100%

Notwithstanding the foregoing, you will become fully (100%) vested upon (1) your attainment of Normal Retirement Age while an employee of the Company, (2) your death while an employee of the Company, or (3) the date you suffer a disability while an employee of the Company.



Disability Insurance - SunLife

Care Synergy offers you the opportunity to purchase short- and long-term disability insurance through SunLife. The amount you pay for these plans is deducted from your paycheck on a post-tax basis. This ensures that any benefit payments you receive are not taxed.

	Short Term Disability	Long Term Disability
Benefit after your claim is approved	You will receive a check for your benefits on a weekly basis. It will replace 60% of your Total Weekly Earnings, up to \$1,500 each week.	You will receive a check for your benefits monthly. It will replace 60% of your Total Monthly Earnings, up to \$11,000 each month.
When benefits begin	Benefits begin as soon as 15 days from the date you are unable to work due to an injury and 15 days due to an illness.	Benefits begin as soon as 90 days from the date of your disability.
Benefits may be paid for	Up to 11 weeks , as long as you are still unable to work due to a covered disability.	Up to your Social Security Normal Retirement Age or longer, depending on your age at disability.
Additional plan info	This plan provides a benefit for covered disabilities resulting from illness or injury that are not work-related .	This plan provides a benefit for covered disabilities resulting from illness or injury that occur on or off the job.

Common Causes Of Short-term Disability

- ☒ Pregnancy
- ☒ Back disorders
- ☒ Injuries
- ☒ Digestive disorders
- ☒ Joint disorders

Common Causes Of Long-term Disability

- ☒ Musculoskeletal conditions
- ☒ Nervous system disorders
- ☒ Circulatory condition
- ☒ Injuries
- ☒ Cancer



SunLife Disability Premium Rates

Monthly Short-Term Disability Rate

Short-Term Disability coverage is contributory. You are responsible for paying for all or a part of the cost through payroll deduction.

Find your age bracket (as of the effective date of coverage) to see your rate. Follow the example below to figure out your monthly and pay period costs.

Your Age	STD Rate*
Under 25	\$1.055
25 - 29	\$1.203
30 - 34	\$0.950
35 - 39	\$0.741
40 - 44	\$0.637
45 - 49	\$0.593
50 - 54	\$0.698
55 - 59	\$0.889
60 - 64	\$1.081
65 - 69	\$1.203
70+	\$1.203

Monthly Long-Term Disability Rate

Long-Term Disability coverage is contributory. You are responsible for paying for all or a part of the cost through payroll deduction.

Find your age bracket (as of the effective date of coverage) to see your rate. Follow the example below to figure out your monthly and pay period costs.

Your Age	LTD Rate*
Under 25	\$0.210
25 - 29	\$0.347
30 - 34	\$0.526
35 - 39	\$0.878
40 - 44	\$1.222
45 - 49	\$1.561
50 - 54	\$1.691
55 - 59	\$1.902
60 - 64	\$2.175
65 - 69	\$1.876
70+	\$1.034

STD Rate calculation table

Example weekly benefits earnings	Divide by 10		Multiply by rate	Example (60% of monthly cost)		
\$350	/ 10 = 35	x	1.055	= \$36.93		
Your weekly benefit (60% of earnings)	Divide by 10		Multiply by rate	Your monthly cost		
\$ _____	/ 10 = _____	x	\$ _____	= \$ _____		
Your monthly cost	Multiply by 12 months		Annual cost	Divide by your number of pay periods per year (ex: 12,24,26,52,etc.)		Your estimated cost per pay period
\$ _____	x 12	=	\$ _____	/ _____	=	\$ _____

LTD Rate calculation table

Example monthly earnings	Divide by 100		Multiply by rate	Example monthly cost		
\$2,500	/ 100 = 25	x	0.210	= \$5.25		
Your monthly earnings	Divide by 100		Multiply by rate	Your monthly cost		
\$ _____	/ 100 = _____	x	\$ _____	= \$ _____		
Your monthly cost	Multiply by 12 months		Annual cost	Divide by your number of pay periods per year (ex: 12,24,26,52,etc.)		Your estimated cost per pay period
\$ _____	x 12	=	\$ _____	/ _____	=	\$ _____

*Contact Human Resources to confirm your part of the cost.

Life and AD&D Insurance - SunLife

Care Synergy provides you with a Basic Life and Accidental Death & Dismemberment plan at no cost to you. It is important to have up-to-date beneficiary information on file. Please update your beneficiaries in UKG.

PROTECTS YOUR LOVED ONES

Life insurance provides your loved ones with money they can use for household expenses, tuition, mortgage payments, and more.

HELPS PAY YOUR FINAL EXPENSES

Your beneficiaries may use this money to cover the costs of your burial or cremation and pay any outstanding medical expenses.

Basic Life	
Life Benefit Amount	1x Annual Earnings Up to \$500,000*
AD&D Benefit Amount	Same as Life
Minimum Benefit	\$25,000
Rounding Method	To the \$1,000
Other Benefit Information	
Reduction of Benefits – Level 1	To Age 65: To 65%
Reduction of Benefits – Level 2	At Age 70: To 50%
Reduction of Benefits – Level 3	At Age 75: To 35%

*Even among people who have life insurance, about **1 in 5** say they don't have enough.*

What is my AD&D benefit?

We will pay your beneficiaries an Accidental Death insurance amount that matches your Basic Life insurance amount, if you die from a covered accident. Additional benefits are available for accidental injuries (i.e., dismemberment) such as loss of limbs, fingers, or sight. Refer to your Certificate for a full list of covered accidental injuries.



Voluntary Life and AD&D - SunLife

Care Synergy provides you with the option to purchase an additional Life and Accidental Death & Dismemberment plan. This plan allows you to cover your spouse and dependent children.

Voluntary Life Benefits

For you	You can choose from \$1,000 to \$500,000 —in increments of \$1,000 not to exceed 5 times your Basic Annual Earnings. No medical questions asked up to the Guaranteed Issue amount of \$180,000 . Benefits are reduced at age 65 and may reduce again in subsequent years as noted in your Certificate.
For your spouse	If you elect coverage for yourself, you can choose from \$1,000 to \$500,000 —in increments of \$1,000. No medical questions asked up to the Guaranteed Issue amount of \$25,000 . The amount you select for your spouse cannot exceed 100% of your coverage amount. Benefits may reduce as noted in your Certificate.
For your child(ren)	If you elect coverage for yourself, you can choose \$1,000 to \$10,000 —in \$1,000 increments. No medical questions asked. The amount you select for your child(ren) cannot exceed 100% of your coverage amount. Benefits may reduce as noted in your Certificate.

Voluntary AD&D Benefits

Voluntary Accidental Death & Dismemberment may be purchased separately from Voluntary Life at the same schedule as above. See the Voluntary AD&D plan certificate by contacting HR or logging in on the Pasito Virtual Benefits Showcase.

Do I need to answer any health questions to enroll?

Yes, if you request an amount higher than the Guaranteed Issue amount. To answer health questions, please fill out our Evidence of Insurability application. Health questions must be approved by Sun Life before coverage takes effect. Please see your Certificate for details.



Voluntary Life and AD&D - SunLife

Monthly Rates (per \$1,000 of Volume)		
Life Rate (per \$1,000)	Employee/Spouse ^{†1}	
Age <24	\$0.05	
Age 25-29	\$0.06	
Age 30-34	\$0.08	
Age 35-39	\$0.09	
Age 40-44	\$0.13	
Age 45-49	\$0.25	
Age 50-54	\$0.35	
Age 55-59	\$0.50	
Age 60-64	\$0.66	
Age 65-69	\$1.27	
Age 70-74	\$4.00	
Age 75+	\$4.00	
AD&D Rate (per \$1,000)	\$0.028	
^{†2} Child Life Rate	\$0.20 per \$1,000	
^{†2} Child AD&D Rate	\$0.028	
Full child benefit begins at	6 months	
Child benefit younger than 6 months	Birth to 14 days	\$1,000
	14 days to 6 months	\$1,000

[†] Employee must elect Voluntary coverage in order to extend coverage to spouse or child(ren)

¹ Spouse rate per \$1,000 is based upon employee’s age

² Child age limit is 26 years of age.



Accident Insurance - SunLife

When you, your spouse, or child has a covered accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs. Accident Insurance can be used as you see fit, and it pays in addition to any other coverage you may already have. **Benefits are payable directly to you.** And get this – there are no health questions or limitations on pre-existing conditions. While health plans may cover direct costs associated with an accident, you can use accident benefits to help cover related expenses like lost income, childcare, deductibles, and co-pays. Additionally, all family members on your plan are eligible for a wellness-screening benefit, which is also paid directly to you once each year per covered person.

Sample table of reimbursements per injury occurrence. See plan details for full schedule.

Dislocations	Open (Surgery)	Closed (No Surgery)
Hip	\$6,000	\$3,000
Knee, ankle, or bones of the foot	\$3,000	\$1,000
Elbow, wrist, Shoulder or Lower jaw	\$1,000	\$500
Finger(s) or toe(s)	\$400	\$200
Fractures	Open (Surgery)	Closed (No Surgery)
Bones of the face, Nose or Multiple ribs	\$1,500	\$750
Leg	\$2,500	\$1,250
Vertebrae, Sternum or Pelvis	\$2,400	\$1,200
Lower jaw, Shoulder, Forearm, Hand, Wrist, Foot, Ankle, Kneecap, Elbow or Heel	\$900	\$450
Collarbone	\$900	\$350
Rib or Coccyx	\$600	\$300
Finger or Toe	\$300	\$150
Additional Injuries		
Eye Injury - surgical repair object remove	\$300 \$300	
Paralysis—paraplegia quadriplegia	\$25,000 \$50,000	
Coma	\$10,000	
Concussion	\$150	
Burns	2nd Degree	3rd Degree
20 square centimeters – 225 square centimeters	\$400 - \$2,000	\$1,000 - \$20,000
Skin graft	50% of the applicable Burn Benefit	
Lacerations		
No sutures and treated by doctor - Greater than 15 cm with sutures (total of all lacerations)	\$35 - \$700	
WELLNESS – Get \$50 each year with your annual preventive care exam (\$0 on both plans)	\$50	

Coverage	Cost per month
Team Member	\$12.38
Team Member + Spouse	\$20.20
Team Member + Child(ren)	\$23.34
Team Member + Family	\$31.16

Hospital Indemnity Insurance - SunLife

If you, your spouse, or children suffer an injury or illness that requires hospital admission or an overnight stay, Hospital Indemnity coverage from SunLife can help offset those expenses. Just like Accident and Critical Illness, this valuable benefit pays directly to you, to use how you see fit.

Hospital Indemnity Benefits

Benefits are payable for hospital stays due to:

Sickness
Accidents
Routine pregnancy
Complications of pregnancy
Newborn complications
Mental and nervous disorders
Substance abuse

First Day Benefits Payable per benefit year

First day hospital confinement –

This benefit pays the first day you stay in a regular hospital bed.

\$1,500 per day up to 1 day

First day ICU confinement –

This benefit pays the first day you stay in an ICU bed.

\$1,500 per day up to 1 day

Confinement benefits - Payable per benefit year

Hospital confinement –

This benefit covers the cost of a hospital stay in a standard room. Payable with:

- First day hospital confinement benefit

\$200 per day up to 30 days

Intensive Care Unit (ICU) confinement –

This benefit pays for a hospital ICU stay. Payable with:

- First day hospital confinement benefit

\$200 per day up to 30 days

Wellness screening benefit –

This benefit pays for a covered wellness test or exam, even without a hospital stay.

\$50

Coverage	Monthly Rate
Team Member	\$25.90
Team Member + Spouse	\$54.90
Team Member + Child(ren)	\$42.85
Team Member + Family	\$71.85

Critical Illness Insurance - SunLife

Helps Protect Your Finances From An Illness.

When you, your spouse, or child is diagnosed with a covered condition, you can receive a cash benefit to help pay unexpected costs not covered by your health plan.

Helps Cover Related Expenses.

Use your benefit to help cover related expenses, such as lost income, childcare, travel to and from treatment, deductibles, and co-pays.

Pays A Cash Benefit Directly To You.

Critical Illness insurance can be used as you see fit, and it pays in addition to any other coverage you may already have.

Critical Illness Benefits	
For you	You can choose \$10,000 or \$20,000 of coverage. No medical questions asked.
For your spouse	If you elect coverage for yourself, you can choose \$5,000 or \$10,000 of coverage. No medical questions asked. Not to exceed 50% of your coverage amount.
For your child(ren) – to age 26	If you elect coverage for yourself, you can choose \$5,000 or \$10,000 of coverage. No medical questions asked. Not to exceed 50% of your coverage amount.

Covered conditions – The plan pays 100% of the benefit amount unless stated otherwise		
Core Conditions	Heart Attack End-Stage Kidney Disease Occupational HIV/Hepatitis B, C, or D	Stroke ^R Coronary Artery Bypass Graft ^R (pays 25%) Major Organ Failure ^R
Cancer Conditions	Invasive Cancer Non invasive Cancer (Pays 25%) Skin Cancer (Pays 5%)	
Other Conditions	Complete Blindness Complete Loss of Hearing Loss of Speech Benign Brain Tumor Coma	Severe Burns Advanced ALS/Lou Gehrig’s Disease Advanced Parkinson’s Disease (pays 25%) Advanced Alzheimer’s Disease (pays 25%)

^R Recurrence benefit available. See plan certificate for details.

SunLife Critical Illness Rate

Rates are effective as of January 1, 2026.

The chart below shows possible coverage amounts and their **monthly** costs.

Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount

Employee Critical Illness - Non-tobacco rates | Age and monthly cost

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$10,000	3.00	3.60	4.50	5.90	7.70	9.80	12.20	16.20	22.40	32.70	51.20	76.00
\$20,000	6.00	7.20	9.00	11.80	15.40	19.60	24.40	32.40	44.80	65.40	102.40	152.00

Employee Critical Illness - Tobacco rates | Age and monthly cost

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$10,000	3.00	4.20	5.40	7.60	10.10	14.20	18.20	25.30	35.10	45.60	67.20	93.50
\$20,000	6.00	8.40	10.80	15.20	20.20	28.40	36.40	50.60	70.20	91.20	134.40	187.00

Spouse Critical Illness - Non-Tobacco rates | Age and monthly cost

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$5,000	1.50	1.80	2.25	2.95	3.85	4.90	6.10	8.10	11.20	16.35	25.60	38.00
\$10,000	3.00	3.60	4.50	5.90	7.70	9.80	12.20	16.20	22.40	32.70	51.20	76.00

Spouse Critical Illness - Tobacco rates | Age and monthly cost

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
\$5,000	1.50	2.10	2.70	3.80	5.05	7.10	9.10	12.65	17.55	22.80	33.60	46.75
\$10,000	3.00	4.20	5.40	7.60	10.10	14.20	18.20	25.30	35.10	45.60	67.20	93.50

Child(ren) Critical Illness

Coverage Amounts	Monthly Costs
\$5,000	\$0.50
\$10,000	\$1.00

Long-term Care Insurance

What is LTC Insurance?

Long-term care insurance is designed to pay for custodial care once you are in need of assistance with two or more Activities of Daily Living or have a cognitive impairment like dementia or Alzheimer's.

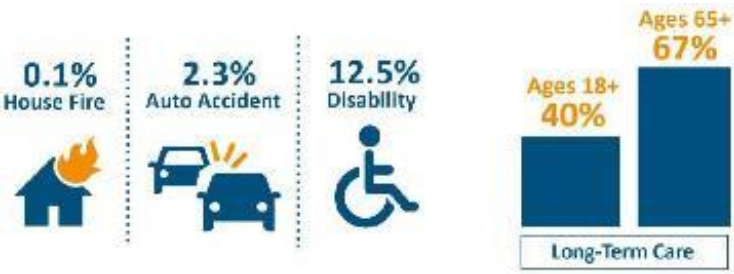
Long-term care insurance will pay for care received at home, in a nursing home or assisted living facility.

The Cost

Nursing home costs are averaging \$127,750 per year. With an average length of stay at 2.4 years, total costs can exceed \$306,800.



The Risk



56% of couples without long-term care insurance spend their income down to the poverty level after one partner has spent 6 months in a nursing home.³ Compared to using other lines of personal insurance, long-term care is the highest risk.

Care Synergy's Plan Highlights

Benefit Features	Available Plan Options
Total Benefit Bank - Nursing Home Facility (100%) - Assisted Living Facility (100%) - Professional Home Care (100%)	\$50,000 \$200,000 or \$300,000
Monthly Access Limit	2% of Total Benefit Bank
Inflation Protection	None, 1% compound, 3% or 5% compound
Elimination Period	90 days

Long-term Care Insurance

Care Synergy's LTC Plan

Care Synergy has partnered with LTC Solutions, Inc., an expert in the long-term care insurance marketplace and LifeSecure, a well-established carrier in the industry. Together, we bring you the opportunity to purchase a valuable long-term care insurance plan with discounted group rates.

How Much Does a Plan Cost?

Every benefit dollar makes a difference when you need care. LifeSecure offers many plan choices, allowing you to choose a plan that offers enough coverage to be meaningful to you and your family at an affordable rate.

To give you an idea of pricing, here are some *examples* of monthly premiums for a \$100,000 benefit bank, 2% monthly access limit, no inflation plan, no marital discount.

****Actual rates will vary based on state of residence, age of applicant, plan design, and applicable marital discount.****

AGE	MONTHLY PREMIUM
30	\$29.25
35	\$34.00
40	\$40.17
45	\$47.42
50	\$58.17
55	\$73.17
60	\$96.83
65	\$140.08

How Are Premiums Paid?

Employee and spouse / domestic partner premiums will be payroll deducted.

If you leave Care Synergy, you will have the opportunity to continue your coverage at the same rate.

For More Information



Online Benefit Guide:
www.myltcguide.com/caresynergy



Toll-Free:
(877) 286-2852



Email:
LTCiBenefitsTeam@ltc-solutions.com

1 2024 Genworth Cost of Care
2 Based on an 8-hour day for a homemaker at \$19/hour to a home health aide for \$21/hour.
3 Health Insurance Association of America
4 Karter, Michael J., Fire Loss in the United States during 2004, National Fire Protection Association.
5 Bureau of the Census Data, 2000 and 2000 data collected from the federal Highway Administration, November 2001.
6 US Department of Health and Human Services. "National Clearinghouse for Long Term Care Information." 2011.
7 Long-Term Care. AHRQ Focus on Research. AHRQ Pub No. 02-M028, March 2002. Agency for Healthcare Research & Quality
8 US Department of Health and Human Services. What is Long-Term Care? 2009.
9 Active employees ages 18-69 working at least 20+ hours per week.
10 Active employees ages 18-64 working at least 20+ hours per week. Eligible employees ages 65-69 may apply with full underwriting. Spouses ages 18-49 working 20+ hours per week for their employer may apply with reduced underwriting provided the eligible employee also applies for coverage. Spouses ages 50-69 may apply with full underwriting.

CO FAMLI Program Notice

Deductions from Employee Wages start January 1, 2023

- The employee share of FAMLI premiums is set at 0.45% of employee wages through 2024. For 2025 and beyond, the director of the FAMLI Division sets the premium rate according to a formula based on the monetary value of the fund each year. Employers with a total of ten or more employees nationwide must also contribute an additional 0.45% of wages for a total of 0.9%, but employers with nine or fewer employees are only responsible for sending the 0.45% employee share to the FAMLI Division.
- Starting in 2023, employers may begin deducting up to 0.45% from employees' wages for FAMLI contributions. This can be done through a simple payroll deduction, and employees will notice the deduction on their regular paychecks. Employers are responsible for collecting those deductions and sending them into the FAMLI Division on behalf of their employees once a quarter.

Benefits starts January 1, 2024

- Starting in 2024, paid family and medical leave benefits are available to most Colorado employees who have a qualifying condition and who earned \$2,500 over the previous year for work performed in Colorado.
- The qualifying conditions for paid family and medical leave are:
 - Caring for a new child during the first year after the birth, adoption, or foster care placement of that child.
 - Caring for a family member with a serious health condition.
 - Caring for your own serious health condition.
 - Making arrangements for a family member's military deployment.
 - Obtaining safe housing, care, and/or legal assistance in response to domestic violence, stalking, sexual assault, or sexual abuse.
- Covered employees are entitled to up to 12 weeks of paid family and medical leave per year. Individuals with serious health conditions caused by pregnancy complications or childbirth complications are entitled to up to 4 more weeks of paid family and medical leave per year for a total of 16 weeks.
- Leave may be taken continuously, intermittently, or in the form of a reduced schedule.
- Leave will be paid at a rate of up to 90% of the employee's average weekly wage, based on a sliding scale. Employees may estimate their benefits by using the benefits calculator available at famli.colorado.gov.
- You don't have to work for your employer a minimum amount of time in order to qualify for paid family and medical leave benefits.
- If FAMLI leave is used for a reason that also qualifies as leave under the federal FMLA, then the leave will also count as FMLA leave used.
- Employees may choose to use sick leave or other paid time off before using FAMLI benefits, but they are not required to do so.
- Employers and employees may mutually agree to supplement FAMLI benefits with sick leave or other paid time off in order to provide full wage replacement.

Filing Claims

- Benefits will be available starting January 2024. Instructions on how to apply for benefits are available at famli.colorado.gov.
- Employees or their designated representatives apply for FAMLI benefits by submitting an application and any required documentation through My FAMLI+, available at famli.colorado.gov.
- Applications may be submitted in advance of the absence from work, and in some circumstances, they may be submitted after the absence has begun.
- Approved applications will be paid by the FAMLI Division within two weeks after the claim is properly filed, and weekly thereafter for the duration of the approved leave.
- Employees can appeal claim determinations to the FAMLI Division.
- Individuals who attempt to defraud the FAMLI program may be disqualified from receiving benefits.

Job protection and continued benefits

- Employers may not interfere with employees' rights under FAMLI, and may not discriminate or retaliate against them for exercising those rights, including taking FAMLI leave, talking to others about FAMLI, and filing complaints of FAMLI violations.
- An employee who has worked for the employer for at least 180 days is entitled to return to the same position, or an equivalent position, upon their return from FAMLI leave.

Retaliation, Discrimination, and Interference Prohibited

- Employers may not interfere with employees' rights under FAMLI, and may not discriminate or retaliate against them for exercising those rights.
- Employees who suffer retaliation, discrimination, or interference may file suit in court, or may file a complaint with the FAMLI Division.

Other Important Information

- An employer may offer a private plan that provides the same benefits as the state FAMLI plan, and imposes no additional costs or restrictions. Private plans must be approved by the FAMLI Division.
- Employees and employers are encouraged to report FAMLI violations to the FAMLI Division.



HOW CAN WE HELP YOU TODAY?

The Cigna Employee Assistance Program (EAP) has you covered.

As an employee, you have access to the valuable Cigna Employee Assistance Program (EAP) at no cost to you.

EAP personal advocates will work with you and your household family members to help you resolve issues you may be facing, connect you with the right mental health professionals, direct you to a variety of helpful resources in your community and more.

Take advantage of a wide range of services offered at no cost to you

- **3** face-to-face counseling sessions with a counselor in your area, as well as video-based sessions.
- **Legal assistance:** 30-minute consultation with an attorney, face-to-face or by phone.*
- **Financial:** 30-minute telephone consultation with a qualified specialist on topics such as debt counseling or planning for retirement.
- **Parenting:** Resources and referrals for childcare providers, before and after school programs, camps, adoption organizations, child development, prenatal care and more.
- **Eldercare:** Resources and referrals for home health agencies, assisted living facilities, social and recreational programs and long-distance caregiving.
- **Pet care:** Resources and referrals for pet sitting, obedience training, veterinarians and pet stores.
- **Identity theft:** 60-minute consultation with a fraud resolution specialist.



We're here to listen. Contact us any day, anytime.

Call 877.622.4327

Or log in to myCigna.com.

Employer ID: caresynergy

(Needed for initial registration only)

If already registered on myCigna.com, simply log in and go to the EAP link under the Review My Coverage tab.

Together, all the way.®



*Employment-related legal issues are not covered.

Some work/life services offered under the Cigna Employee Assistance Program may be provided by a Cigna contracted third-party vendor.

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Confidential Emotional Support

Our highly trained clinicians will listen to your concerns and help you or your family members with any issues, including:

- Anxiety, depression, stress
- Grief, loss and life adjustments
- Relationship/marital conflicts



Work-Life Solutions

Our specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care



Legal Guidance

Talk to our attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts and more

Need representation? Get a free 30-minute consultation and a 25% reduction in fees.



Financial Resources

Our financial experts can assist with a wide range of issues.

- Retirement, taxes, mortgages, budgeting and more

For additional guidance, we can refer you to a local financial professional and arrange to reimburse you for the cost of an initial one-hour in-person consult.



Online Support

GuidanceResources® Online is your 24/7 link to vital information, tools and support. Log on for:

- Articles, podcasts, videos, slideshows
- On-demand trainings
- "Ask the Expert" personal responses to your questions



Help for New Parents

ParentGuidance™ supports you through the process of becoming a biological or adoptive parent, including:

- Preparing for the baby emotionally and financially
- Finding child care
- Planning for back-to-work and other issues



Free Online Will Preparation

EstateGuidance® lets you quickly and easily create a will online.

- Specify your wishes for your property
- Provide funeral and burial instructions
- Choose a guardian for your children

What happens when I call for counseling support?

When you call, you will speak with a GuidanceConsultant™, a master's- or PhD-level counselor who will collect some general information about you and will talk with you about your needs. The GuidanceConsultant will provide the name of a counselor who can assist you. You will receive counseling through the EAP up to 3 sessions per issue, per person, per calendar year. You can then set up an appointment to speak with the counselor over the phone or schedule a face-to-face visit.

What counseling services does the EAP provide?

The EAP provides free short-term counseling with counselors in your area who can help you with your emotional concerns.

If the counselor determines that your issues can be resolved with short-term counseling, you will receive counseling through the EAP. However, if it is determined that the problem cannot be resolved in short-term counseling in the EAP and you will need longer-term treatment, you will be referred to a specialist early on and your insurance coverage will be activated.

Contact EAPBusiness ClassSM Anytime

No-cost, confidential solutions to life's challenges.

Your ComPsych® GuidanceResources® program EAPBusiness Class offers someone to talk to and resources to consult whenever and wherever you need them.

Call: 877.595.5281

TTY: 800.697.0353

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant™, who will answer your questions and, if needed, refer you to a counselor or other resources.

Online: guidanceresources.com

App: GuidanceNowSM

Web ID: EAPBusiness

Log on today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos and other helpful tools.

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\$12.95

PER MONTH

— LEGALSHIELD & IDSHIELD —

EMPLOYEE PLAN

\$30.45

PER MONTH

FAMILY PLAN

\$36.45

PER MONTH

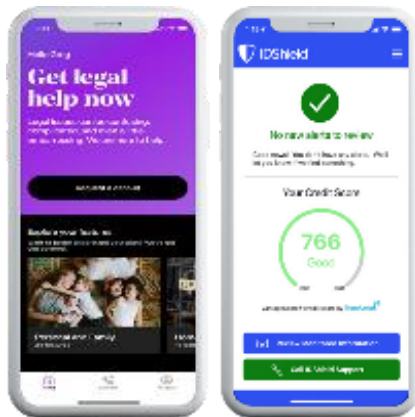
LegalShield Coverage Includes:

- Legal Consultation and Advice
- Court Representation
- Dedicated Provider Law Firm
- Legal Document Preparation and Review
- Will Preparation
- Letters and Phone Calls Made on Your Behalf
- Speeding Ticket Assistance
- Divorce
- 24/7 Emergency Legal Access

Identity Theft Services Include:

- Identity Consultation and Advice
- Dedicated Licensed Private Investigators
- Identity, Credit and Financial Account Monitoring
- Child Monitoring (Family Plan Only)
- Full-Service Identity Restoration
- Real-Time Alerts
- 24/7 Emergency Access
- Social Media Monitoring and Online Privacy Reputation Management

FOR MORE INFORMATION, VISIT
[benefits.legalshield.com/
caresynergy](https://benefits.legalshield.com/caresynergy)



On-the-go protection!

With the LegalShield and IDShield
mobile apps, you have on-the-go access, 24/7!



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Protecting What Matters Most

Employee Benefit Plans

Identity theft can have serious repercussions. It can hurt your credit score, taint your medical records and drain your college funds and retirement accounts —everything you've worked so hard to build.

IdentityForce[®], a TransUnion[®] brand, has been helping people protect their identity and credit for over 40 years, and our Certified Resolution Specialists work diligently to keep you and your family safe.



Three ways to activate your account¹

1. Visit: <https://cigna.identityforce.com/starthere>
2. Call: 833-580-2523
3. Scan this QR Code:



Questions?

Call Member Services at
1-833-580-2523

¹ Available to employees enrolled in a Cigna HealthcareSM medical plan and their children in household up to age 18.

Offered by Cigna Health and Life Insurance Company

FAQ



Frequently Asked Questions



What is Pet Insurance?

Pet Insurance is for paw-rents seeking a financial safety net for accidents or illnesses that their pets might experience in the future.



What Age is the Best Age to Insure My Pet?

We advise all paw-rents to insure their pets at a young age. You can enroll your pet in a plan from Spot as soon as they're 8 weeks old.



What is a Pre-Existing Condition?

A pre-existing condition is any injury or illness which occurs or shows symptoms before coverage starts or during a waiting period.

How Do Plans from Spot Work?

Once you have your custom pet insurance policy and have paid your premium on a monthly or annual schedule, you can carry on as usual.

When you need to visit the vet for a covered condition, you can submit a claim for reimbursement of the eligible expenses.

Deductibles

Your annual deductible amount applies during each policy period. You must satisfy your annual deductible before your reimbursements start.

Payouts

Once your deductible is met, you will be reimbursed for eligible expenses according to the reimbursement percentage you select.



Fetch Your Free Quote, Today!

<https://spotpet.link/caresynergy>





Your Payday, Reimagined

UKG Wallet has partnered with your employer to bring you a digital wallet built for every day life.



💰 Decide when and how you get paid

Earned Wage Access (EWA) gets you paid before payday. Work your shift, and we'll make a portion of that money available, giving you more control over when and how you want to use it. The funds you access simply get deducted from your next paycheck. No gimmicks, no hoops—just your money, in your hands.

- Transfer real-time to UKG Visa® Card* (FREE)*
- Transfer real-time to non-UKG cards (\$2.99)
- Transfer to your bank in 1-3 business days (FREE)
- Pick up cash at Walmart (\$2.99)
- Apply towards an Uber ride (FREE)
- Schedule bill payments (FREE)
- Load to Amazon Cash (FREE)

💰 Build better financial habits

Get access to free financial planning tools and exclusive discounts. With UKG Wallet, you can know what's safe to spend and save, bringing you one step closer to reaching your goals.

- Financial Counseling
- Financial Learning
- Saving Tools
- Exclusive discounts

Access these and more in the UKG Wallet App²

WWW.UKG.COM

Scan the QR code to download the app!³



Additional Benefits

Wellness

Care Synergy cares about you and your continued health. For the January 1, 2026 plan year, Care Synergy will continue to have a \$50.00 surcharge for tobacco-users who are enrolled in the Care Synergy Cigna medical plans. You can avoid the surcharge by attesting that you are tobacco-free, or by completing a tobacco cessation program through the Cigna Quit Today Program.

Cigna Quit Today Program

Team members enrolled in the Cigna medical insurance can access the "Cigna Quit Today" program via phone or online. You can access the program online by logging onto MyCigna.com and clicking on the "My Health" tab at the top of the screen. Click on the "Health Dashboard" tab, and scroll down to the bottom of the page to Cigna's "Health Programs and Resources" section. Click the Left or Right scroll arrows to get to the "Leave Tobacco Behind for Good" option, then click on the "Quit Today" link.

Additional Smoke-Free Resources

If you are not currently enrolled in the Cigna medical plan, we still want to help you become tobacco free. Below are some free resources to help you reach your goal of becoming tobacco free in 2026!

Smokefree: <https://www.smokefree.gov> or 1-800-QUIT-NOW

There are text programs, daily challenges, applications with tips and the ability to monitor progress, live chat, and quit plans.

Colorado Quit Line: <https://www.coquitline.org> or 1-800-784-8669

Coaches available 365 days per year online, or via the telephone from 5 a.m. to 11 p.m. The website includes a guide on Preparing to Quit and other resources and tools.

This program was put in place to enhance the health and productivity of our Team Members. Team members that complete the 6-month program through Cigna or any of the additional free resource providers will receive premium savings on medical insurance for 2026 (if enrolled in the Cigna medical plan).



Take a moment for yourself with the **Calm App** — free for Team Members.

Recharge, reduce stress, and sleep better so you can bring your best self to work and beyond. You can use Calm to manage stress, prevent burnout, and maintain emotional well-being amid demanding work environments. Its guided meditations and relaxation tools help them recharge, focus, and provide better care for your patients.

Discover peace, better sleep, and a happier mind with the Calm App

Meditate Anywhere

- Guided sessions for beginners to experts. Reduce stress and anxiety in minutes.

Sleep Better

- Drift off with relaxing music, Sleep Stories narrated by soothing voices, and nature sounds.

Focus & Relax

- Background music and soundscapes designed to boost productivity or help you unwind.

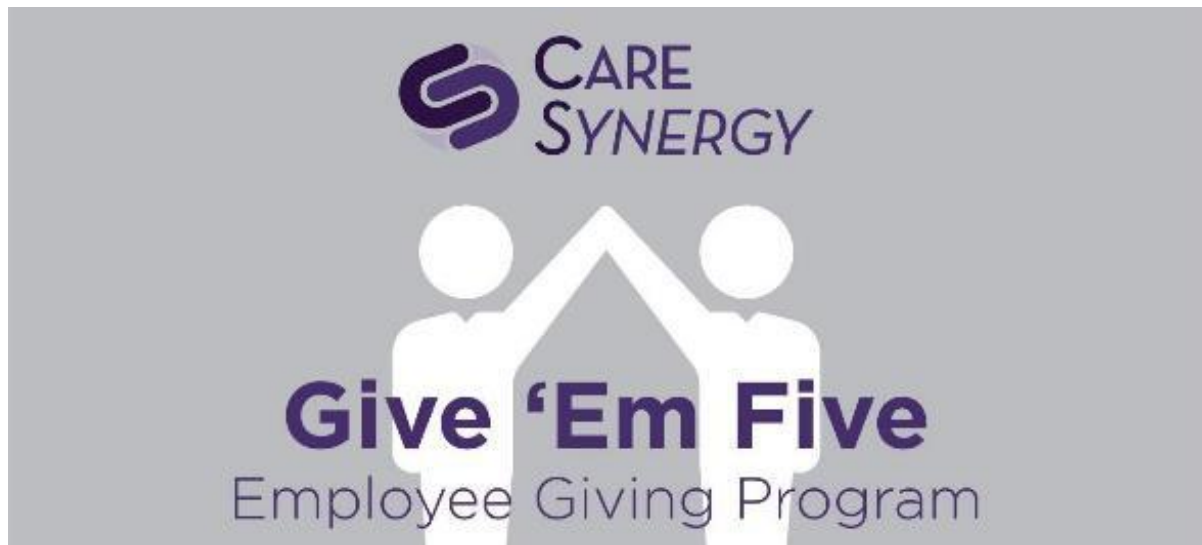
Daily Calm

- Start each day with a mindful moment, curated by meditation experts.

More information on this exciting new benefit will be available after the first of the year.



Give 'Em Five



As Care Synergy and Affiliates Team Members, not only are we committed to the Mission of each Affiliate, we are also deeply committed to our fellow coworkers.

"Give 'Em Five" is a program that allows team members to give to other Team Members in the event they have a personal financial emergency.

Details of the program include:

- Team members may contribute \$1, \$2, \$3, \$4, \$5 or any other amount per paycheck via payroll deduction to the employee emergency fund.
- It is completely confidential for both the donor and the requestor.
- This fund is to be used when there is a financial need and when other avenues for support have been exhausted.

If you would like to participate in the program, please see Human Resources for a payroll deduction form. Once the form is completed, submit to payroll. This is a voluntary program and your deduction amount can be changed at any time.

Please contact Human Resources to request an Emergency Relief Application.

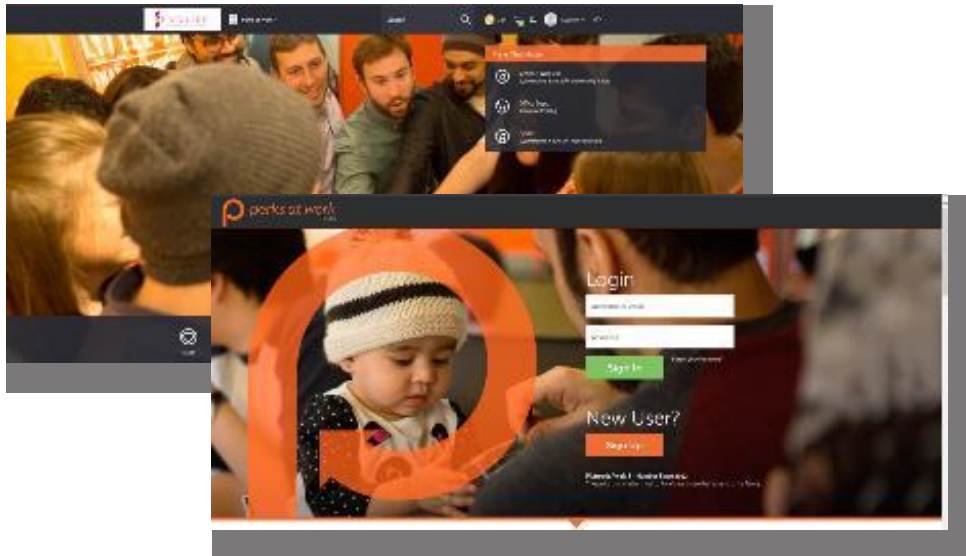
Intalere Marketplace is now Perks at Work



One-stop shopping and significant savings for employees on small- (food, utilities, etc.) to large-scale (computers, travel, etc.) purchases.

Intalere is pleased to provide you with Intalere Perks at Work, your one-stop shop for employee pricing. It leverages the purchasing power of all Intalere members and affiliates to help you save money on all of your large purchases (computers, travel, etc) as well as everyday purchases (food, utilities, etc.).

Once you register on Intalere Perks at Work, you will have access to 30,000 merchants and over 25 savings categories. Through Perks at Work, you can receive deep discounts on your favorite fashion brands including Gap, Nordstrom and Lands' End and also save on electronics, computers, vacations and more. You also can access Intalere Exclusives* — exclusive deals with significant savings!



Activating your account is easy!

1. Visit Intalere Perks at Work at <http://www.perksatwork.com>
2. Click on "Sign Up" under the New User section.
3. Complete the short registration process and hit "continue" to submit your information to be verified. If an error appears, you may need to hit "continue" a second time.

Note: Once you enter your email, the company information should populate automatically; however, you may be required to enter "Intalere" as your company name and "savings12" as your company code.
4. You will then receive a link via email to validate your account; now you have access to Intalere's Perks at Work!
5. Time to start shopping and start saving!



Learn More

Contact us today to learn more about Intalere's Perks at Work:

Intalere Customer Service
877-711-5600
info@intalere.com
www.intalere.com

Intalere Perks at Work Benefits

WOWPoints. You will be awarded WOWPoints* in addition to the deep discounts you receive using Intalere Perks at Work! WOWPoints are a virtual currency that you accumulate over time. They never expire and can be used at any time to make purchases directly on the site.

Family Membership. Your account comes with a family membership. Simply logon, click on My Account and choose Family Invitations to add family members to your account.

**Most Intalere Exclusives are not eligible for WOWPoints.*

SL-PERKSWK 040116

Service Rewards - Nectar



Program Highlights:

- **Anniversary Recognition:** Receive a message of gratitude each year through Nectar. For milestone anniversaries (1, 3, 5, 10, 15, 20, 25, and 30 years), you'll get a credit of \$50 for each year of service.
- **Rewards:** Accumulate points through recognition and redeem them for fantastic rewards, including company swag and Amazon items with free, expedited shipping.

This program not only acknowledges your service but also offers tangible rewards to show appreciation for your contributions.



Additional Information

Resources and Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information, contact Human Resources at CS-HR or 303-228-5647.

Medical & Dental

Provider Name:	Cigna
Group #:	3339544
Provider Phone Number:	(800) 244-6224
Provider Web Address:	www.mycigna.com
Cigna OneGuide Pre-enrollment Hotline	1-800-564-7642
Cigna OneGuide	1-800-Cigna-24

Prescription & Pharmacy

Provider Name:	Cigna
Provider Phone Number:	(800) 244-6224
Provider Web Address:	www.mycigna.com

Telemedecine

Provider Name:	Cigna MDLive
Provider Phone Number:	888-726-3171
Provider Web Address:	www.mycigna.com

Vision

Provider Name:	VSP
Group #:	30093607
Provider Phone Number:	(800) 877-7195
Provider Web Address:	www.vsp.com

Flexible Spending Accounts/Health Savings Accounts

Provider Name:	Employee Benefits Corporation (EBC)
Provider Phone Number:	800-346-2126
Provider Web Address:	www.ebcflex.com

Short-Term/Long-Term Disability

Provider Name:	SunLife
Group #:	955915
Provider Phone Number:	800-247-6875 Telephonic claims: 888-444-0239
Provider Web Address:	www.sunlife.com/account

Basic & Voluntary Life/AD&D Accident, Critical Illness & Hospital Indemnity

Provider Name:	SunLife
Group #:	955915
Provider Phone Number:	800-247-6875
Provider Web Address:	www.sunlife.com/account

Voluntary Long-term Care

Provider Name:	LTC Solutions, Inc.
Provider Phone Number:	877-286-2852
Provider Email:	LTCiBenefitsTeam@ltc-solutions.com

Legal & ID Theft Protection

Provider Name:	LegalShield
Provider Phone Number:	(800) 654-7757
Provider Web Address:	www.benefits.legalshield.com/caresynergy

Employee Assistance Programs

Provider Name:	CIGNA
Provider Phone Number:	(800) 926-2273
Provider Web Address:	www.cignabehavioral.com , www.mycigna.com
Provider Name:	GuidanceResources
Provider Phone Number:	877-595-5281
Provider Web Address:	Guidanceresources.com WebID: EAPBusiness

Decision Support

Provider Name:	Pasito Cigna OneGuide
Provider Web Address:	https://app.joinpasito.com/caresynergynetwork/login
Provider Name:	Cigna Pre-enrollment Hotline
Provider Phone Number:	800-564-7642

Perks At Work

Provider Name:	Intalere Perks at Work
Provider Phone Number:	877-711-5600
Provider Web Address:	info@intalere.com www.intalere.com

Service Rewards

Provider Name:	Nectar
Service Contact:	support@nectarhr.com
Provider Web Address:	https://app.nectarhr.com/login

403(b)

Provider Name:	Principal
Provider Phone Number:	Text 'ENROLL' to 78259
Provider Web Address:	www.principal.com/Welcome



NOTICES

Medicare Part D Prescription Drug Creditability/Non-creditability

When you or a family member becomes eligible for Part D (Medicare’s prescription drug benefit), it is important to understand when to enroll in Part D. You can wait as long as you maintain “creditable” coverage (i.e., coverage which on average expects to pay at least as well as Part D expects to pay on average). But if you do not have creditable coverage, you need to enroll in Part D at the earliest opportunity to avoid future penalties.

Below are highlights to note:

A continuous break in creditable coverage of 63 or more days will trigger a late enrollment penalty payable for life.

The longer you go without creditable coverage, the higher the penalty. For the rest of your life, you would be charged an additional 1% of Part D base premium for each month you are late.

When creditable coverage ends, a special enrollment period of two (2) months may be provided to enroll in Part D (but note that this is only available when normal coverage ends, not when retiree or COBRA coverage ends).

The Part D annual open enrollment occurs each year from October 15th through December 7th for coverage to begin January 1st.

The information below indicates whether prescription drug coverage under our plan is creditable.

Creditable Coverage
LocalPlus/OAP HDHP LocalPlus/OAP PPO

Anyone needing to learn more about Medicare should contact a Medicare-approved counselor in their state at <https://www.shiphelp.org>.

REMEMBER: If you have creditable coverage through our plan, keep this Notice as proof. 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 you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

DATE: October 07, 2025

NAME OF ENTITY/SENDER: Care Synergy

CONTACT – POSITION/OFFICE: Crystal O’Brien – Vice President HR

ADDRESS: 8289 E. Lowry Blvd
Denver, CO 80230

PHONE NUMBER: 303-228-5647

Notice: Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance, 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 stopped contributing towards the other coverage). However, you must request enrollment within 30 days after you 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. To request special enrollment or obtain more information, see the contact information at the end of these notices.

A special enrollment right also arises for employees and their dependents who lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid or who are eligible to receive premium assistance under those programs. The employee or dependent must request enrollment within 60 days of the loss of coverage or the determination of eligibility for premium assistance.

Notice: HIPAA Notice of Privacy Practice

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. It also describes how your protected health information may be used or disclosed to carry out treatment, payment or healthcare operation or for any purposes that are permitted or required by law.

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 • 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 • 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 action

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 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, and we may say “no” if it would affect your care.
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 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 on page 9. - 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 (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. - We will not retaliate against you for filing a complaint.

YOUR CHOICES	For certain health information, you can tell us your choices about what to 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 <i>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.</i>
In these cases, we <i>never</i> 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.
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.
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.

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: [Your Rights Under HIPAA | HHS.gov](#).

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 partner 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.

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: [Your Rights Under HIPAA | HHS.gov](#).

Notice: Consolidated Omnibus Budget Reconciliation Act (COBRA)

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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

Your hours of employment are reduced, or

Your employment ends for any reason other than your gross misconduct.

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

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

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

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

When is COBRA Continuation Coverage Available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the contact person shown at the end of these notices.

How is COBRA Continuation Coverage Provided?

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

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

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

Disability Extension of 18-Month Period of COBRA Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

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

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I Enroll in Medicare Instead of COBRA Continuation Coverage After My Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

The month after your employment ends; or

The month after group health plan coverage based on current employment ends.

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

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

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Notice: Women's Health and Cancer Rights Act (WHCRA)

Did 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 reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema)? For more information, see the contact information at the end of these notices.

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 March 17, 2026. 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.flmedicaidtplecovery.com/flmedicaidtplecovery.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) 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	KANSAS – Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspreassistance@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
MONTANA – Medicaid Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov	NEBRASKA – Medicaid Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	NEW HAMPSHIRE – Medicaid 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 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
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)	RHODE ISLAND – Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RlTe Share Line)
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	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPPP) 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 (HIPPP) 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 March 17, 2026, 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.

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 and posted electronically.

For more information, contact:

DATE:	October 07, 2025
NAME OF ENTITY/SENDER:	Care Synergy
CONTACT – POSITION/OFFICE:	Crystal O’Brien – Vice President HR
ADDRESS:	8289 E. Lowry Blvd Denver, CO 80230
PHONE NUMBER:	303-780-4600

Effective Date of this Notice: January 1, 2026