To Our Flock!

onvo

Employee Benefits Guide

Questions? Contact HR@tryonvo.com

HEALTH BENEFITS

Note: *This PDF is interactive. You may click any title on the navigation bar above to jump to a desired page throughout the guide.*

DIRECTORY

For any questions or concerns you may have regarding your 2024-2025 Employee Benefits, please contact The Graham Company Service Line or your Onvo HR Department.

Before you reach out to the Graham Company Service Line, please have the following information ready: dependents' names, birth dates, social security numbers, addresses, and phone numbers.

For claims assistance, you can contact the insurance carrier. You will need your ID number or Social Security number, date of service and provider name.

Benefit/Carrier	Policy/ Group #	Contact Information
Medical Highmark BCBS	TBD	(800) 241-5704 *www.highmarkbcbs.com*
Health Savings Account Highmark BCBS	-	(800) 241-5704 *www.highmarkbcbs.com*
Dental and Vision Guardian	004821 07	(888) 482-7342 *www.guardianlife.com*
TransDI Disability, **Accident , Critical Illness**, **Hospital Indemnity**, **Universal Life Benefit** Transamerica (NEW!)	TBD	888-763-7474 https://www.transamerica.com
Human Resources Onvo	-	Ruby Penny (570) 291-4260 rpenny@tryonvo.com
Graham Company Concierge Line	-	1-888-842-1488 benefitsassist@grahamco.com www.grahamco.com

WELCOME

To Your Employee Benefits

We believe our employees are our greatest asset, and we are committed to ensuring their health and general well-being. We are pleased to offer a comprehensive array of quality benefits to protect your health, your family, and your way of life. This brochure was designed to answer some of the basic questions you may have about your benefits. Please read it carefully along with any supplemental materials you receive. Please go to employeenavigator.com. We provide multiple benefits for eligible employees including: Major Medical Insurance, Dental Insurance, Vision Insurance, 401(k) Savings Plan, Employee Discounts, Holidays, Life Insurance, Personal Time (PTO), Short Term Disability, and Vacation.
Below you will find a quick summary of the benefits we offer:

Medical Insurance

Onvo offers three Medical Plans

- BlueCare Custom PPO $3,000 deductible
- PPOBlue HDHP $4,000 deductible
- PPOBlue HDHP $6,000 deductible

Paid Time Off (PTO)

As part of Onvo, you will also have the benefit of receiving

- Personal Time
- Vacation
- Holidays

Dental and Vision Insurance

Dental coverage includes preventive, basic, and major care. Vision coverage includes exams, lenses, and frames.

AT&T & Highmark Discounts

Save up to 18% on Qualified AT&T Plans if you enroll in the AT&T Signature Program! Highmark offers additional discounts on gym memberships, fitness footwear, stress reduction classes, and more!

Direct Deposit & iPay

Direct Deposit allows you to save time and have your paycheck deposited straight into your bank account

iPay will let you see pay stubs, W2, tax info, 401(K) info, and PTO balances at your fingertips!

Retirement & Tax-Advantaged Plans

401(K)- Onvo matches dollar per dollar up to 4%. Onvo also offers those enrolled in HDHPs the option to enroll in a Health Savings Account (HSA)

WHAT'S NEW FOR 11/1/2024 – 10/31/2025

- **Medical.** There will be plan design changes to all three plan options. Employee premiums will increase. Everyone will receive a new ID card, regardless of whether you change plans.
- **HSA.** Employer contributions will remain the same.
- **Dental and Vision.** No changes to plan designs. Employee premiums will decrease.
- **Worksite Benefits**. The insurance carrier for these benefits will be changing to Transamerica. Coverages and costs will be changing slightly.

ELIGIBILITY

Onvo encourages the health and financial well-being of its employees by providing access to quality and affordable healthcare. Eligible employees have access to Onvo's comprehensive Benefit Program. Please note that any time during the plan year, Onvo may conduct audit requesting supporting documentation on all eligible dependents.

Please make sure to review this Benefit Guide in detail to learn more about these options.

EMPLOYEE ELIGIBILITY

Employees who work a minimum of 30 hours per week and are at least 18 years of age are eligible to enroll in the benefits described in this guide. New Hires have a waiting period of first of the month following 60 days from date of hire.

Once your enrollment is completed, you may not make any changes to your elections unless you have a Qualifying Life Event or your hours worked per week drop below the minimum.

DEPENDENT ELIGIBILITY

You may also cover your eligible dependents, including:

- Legal Spouse (Same Sex included), common law, domestic partners.
- Your eligible children up to age 26 for medical, dental and vision coverage.
- "Children" are defined as your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

QUALIFYING LIFE EVENTS

If you experience a Qualifying Life Event (for instance: getting married or having a baby), please contact HR; **proof of the Qualifying Life Event** must be submitted **to your HR within 30 days** in order to **change current benefit election**.

- A change in the number of dependents (birth, adoption, death, guardianship);
- A change in marital status (marriage, divorce, death, legal separation);
- A dependent's loss of eligibility (attainment of limiting age or change in student status);
- A change in associate's, spouse's, or dependents' work hours;
- A termination or commencement of employment of associate's spouse or eligible dependent with coverage;
- Other events as the administrator determines to be permitted or any other applicable guidelines issued by the Internal Revenue Service.

ENROLLMENT INSTRUCTIONS

HOW TO ENROLL

*This year's open enrollment is **ACTIVE**, meaning that any of your elections from the 2023 – 2024 Plan Year will not automatically be carried over to the 2024 – 2025 Plan Year.* **Open Enrollment will take place from September 25th through October 13th.**

If you wish to make changes to your previous benefits, add new ones, or waive coverage, you must sign into the Employee Navigator Portal. *Again, even if you do not plan to enroll in any of Onvo's benefit offerings, you must sign in to Employee Navigator and waive coverage.*

ELECTING BENEFITS THROUGH EMPLOYEE NAVIGATOR

1. If you already have an Employee Navigator Account, log in through: https://www.employeenavigator.com/benefits/account/login. If you need to register for the first time, you may access Employee Navigator by visiting: https://www.employeenavigator.com/benefits/Account/Register
2. If a new user, select "Register as a new user" and enter the company code: Onvo
3. You will be directed to enter your First Name, Last Name, SSN, and Date of Birth
4. Select " Let's Begin" to complete your required tasks. Complete any onboarding tasks before enrolling in your benefits. Once you've completed your tasks select "Start Enrollment".
5. After clicking Start Enrollment, you'll need to complete some personal & dependent information before moving to your benefit elections.
6. To enroll dependents in a benefit, click the checkbox next to the dependent's name under Who am I enrolling? Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click Select Plan underneath the plan cost.
7. Click Save & Continue at the bottom of each screen to save your elections.
8. If you do not want a benefit, click Don't want this benefit? at the bottom of the screen and select a reason from the drop-down menu.
9. Review the benefits you selected on the enrollment summary page to make sure they are correct then click Sign & Agree to complete your *enrollment.*

BENEFITS EFFECTIVE DATE

Generally, you cannot make any changes to your benefits during the year, unless you experience a Qualifying Life Event (QLE).

- New Hires: New Hires have a waiting period of first of the month following 60 days from date of hire.
- Current Employees: Any changes you make during the annual open enrollment period will become effective on January 1.

The benefits plan year is November 1, 2024 to October 31, 2025.

If you have questions about logging in or registering through Employee Navigator, please reach out to Onvo HR. If you have any benefits-related questions, please reach out to the Graham Company Service Line at 1-888-842-1488 or benefitsassist@grahamco.com, staffed Monday - Friday from 9 AM - 5 PM.

MEDICAL

Highmark BCBS

The medical program, administered by Highmark BlueCross BlueShield provides the framework for your health and well-being. In order to better meet the varying needs of our employees, Onvo is offering three medical plans described below. All plans will utilize a nationwide network – **PPO Blue Network**. See www.highmarkbcbs.com or call (800) 241-5704 for a list of network providers. If you need drugs to treat your illness or condition more information about prescription drug coverage is available online at www.highmarkbcbs.com.

	PPO $3,000		HDHP $4,000		HDHP $6,000	
Benefit Highlights	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible Individual / Family	$3,000 / $6,000	$12,000 / $24,000	$4,000 / $8,000*	$12,000 / $24,000	$6,000 / $12,000	$12,000 / $24,000
Coinsurance	100%	80%	80%*	70%	70%*	50%*
Maximum Out of Pocket Individual / Family	$6,000 / $12,000*	$15,000 / $30,000	$10,000 / $20,000*	$15,000 / $30,000	$12,000 / $24,000*	$24,000 / $48,000*
Office Visits Preventive Care Primary Care Specialist Urgent Care Telemedicine Services	Covered 100% $25 copay $50 copay $75 copay $20 copay	80% after ded. 80% after ded. 80% after ded. 80% after ded. Not covered	Covered 100% $25 copay after ded.* $50 copay after ded.* $75 copay after ded.* $20 copay after ded.	70% after ded. 70% after ded. 70% after ded. 70% after ded. Not covered	70% after ded.	50% after ded.*
Inpatient Hospital	100% after ded.	80% after ded.	80% after ded.*	70% after ded.	70% after ded.	50% after ded.*
Outpatient Surgery	100% after ded.	80% after ded.	80% after ded.*	70% after ded.	70% after ded.	50% after ded.*
Advanced Imaging MRI, CAT, PET scan, etc.	100% after ded.	80% after ded.	$50 copay after ded.*	70% after ded.	70% after ded.	50% after ded.*
Emergency Room Visit	$300 copay (waived if admitted)		$300 copay (waived if admitted)*		70% after ded.*	
Prescription Drugs *Retail (31 day)* Tier 1 Tier 2 Tier 3 Tier 4 *Mail (90-day)*	$10 copay $35 copay $60 copay $60 copay 2x Retail	Not Covered	$20 copay* $40 copay* $60 copay* $60 copay* 2x Retail	Not Covered	70% after ded.*	Not Covered

** Indicates plan changes*
Please Note: The plans listed above are only a summary of coverages for full details please see SBCs.

Deductible - The amount of money you must pay each year to cover eligible medical expenses before your insurance policy starts paying.
Out of Pocket Max - The most money you will pay during a year for coverage including deductibles, copays, and coinsurance).
Coinsurance - The amount you pay to share the cost of covered services after your deductible has been paid. The coinsurance rate is usually a percentage.

Premiums	PPO $3,000		HDHP $4,000		HDHP $6,000	
	Weekly	**Bi-Weekly**	**Weekly**	**Bi-Weekly**	**Weekly**	**Bi-Weekly**
Employee	$76.66	$153.32	$50.53	$101.07	$24.30	$48.60
Employee + Spouse	$171.18	$342.36	$147.86	$295.72	$123.58	$247.16
Employee + Child	$120.13	$240.25	$103.76	$207.52	$86.72	$173.44
Employee + Children	$170.95	$341.90	$147.66	$295.32	$123.41	$246.83
Family	$216.26	$432.52	$186.80	$373.59	$156.12	$312.24

HEALTH SAVINGS ACCOUNT

Highmark BCBS

A Health Savings Account (HSA) works with a High Deductible Health Plan (HDHP), and lets you set aside a portion of your paycheck, before taxes, into an account to help you pay for qualified medical expenses that aren't covered by your plan. It can also help you plan for future medical expenses.

Note: *HSA funds can roll over from year to year! An actively at-work employee who is older than 65 may not enroll in an HSA unless they have waived Medicare.*

How does an HSA work?

In 2024, you can deposit up to $4,150 for yourself or up to $8,300 for your family, into your HSA. In 2025, you can deposit up to $4,300 for yourself or up to $8,550 for family coverage. For those 55 and older, $1,000 catch-up (additional) contributions can be made to their HSA. This limit is set by the IRS. You can use money in your HSA to *pay for insurance deductibles and medical care/supplies like dentistry, ophthalmology, and prescription drugs*. When you enroll, an account will be created for you. You'll be given access to a secure, easy-to-use web portal where you can track your account balance and submit requests for reimbursements.

In addition, you'll be issued an HSA Benefits Card you can use at point-of-sale to pay for qualified medical expenses. You can request reimbursement distributions online at www.highmarkbcbs.com or call (800) 241 5704. Payment will be made based on your available funds. Distributions can be made payable to you or a provider. Contributions above the yearly limit are called excess contributions and could be subject to a six percent excise tax. For more details, please view: www.irs.gov

HSA Eligibility

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

- You are enrolled in a High Deductible Health Plan (HDHP);
- You are not covered by your spouse or domestic partner's non-HDHP health plan;
- You are not eligible to be claimed as a dependent on someone else's tax return;
- You are not enrolled in Medicare or TRICARE; and
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care (service-related care will not be taken into consideration).

IRS HSA Contribution Limits	2024	2025
Individual	$4,150	$4,300
Individual (age 55+)	$5,150	$5,300
Family	$8,300	$8,550
Family (age 55+)	$9,300	$9,550

Triple Tax Savings!

You can take advantage of 'triple tax savings' when you open an HSA with Highmark BCBS. That's because...

- Your contributions are pre-tax (or tax deductible);
- Your account balance grows tax-free; and
- Withdrawals for qualified medical expenses are also tax-free.

DENTAL

Guardian

Guardian gives you the freedom to choose whether you would like to visit a participating dentist or an out-of-network dentist. There are considerable cost savings when using a dentist who is in network. The following is a brief summary of the major plan provisions.

Network: PPO: DentalGuard Preferred
See www.guardianlife.com or call **(888) 482-7342** for a list of network providers.

Benefit Highlights	Low Plan		Buy Up Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible *Individual / Family*	*Waived for Preventive* $50 / $150	*Waived for Preventive* $50 / $150	*Waived for Preventive* $50 / $150	*Waived for Preventive* $50 / $150
Annual Maximum Benefit	$1,000	$1,000	$1,500	$1,500
Diagnostic & Preventive Services *Cleaning, Flouride Treatments, Oral Exams, X-Rays, Sealants (per tooth)*	100%	100%	100%	100%
Basic *General Anesthesia, Fillings, Scaling & Root Planing (per quadrant), Simple Extractions*	80%	80%	90%	90%
Major *Dentures Single Crowns*	50%	50%	60%	60%

Please Note: The benefits listed above are only a summary of coverages for full details please see SBCs.

Premiums	Low Plan		Buy-Up Plan	
	Weekly	Bi-Weekly	Weekly	Bi-Weekly
Employee	$4.85	$9.69	$7.79	$15.58
Employee + Spouse	$10.54	$21.08	$16.95	$33.90
Employee + Child(ren)	$12.69	$25.37	$20.40	$40.80
Family	$18.37	$36.74	$29.54	$59.08

VISION

Guardian

Guardian is pleased to present to you vision benefits designed to give you and your covered family members the care, value, and service to help maintain good vision and overall health.

Network: Davis Vision*
See www.guardianlife.com or call **(888) 482-7342** for a list of network providers.

**Significant out-of-pocket savings available with your Full Feature plan by visiting one of Davis Vision's network locations including retail centers such as Costco®, Wal-Mart®, JCPenney®, Sears®, Target®, Sam's Club®, Pearle®, Visionworks®, and Visionworks Online®.*

Benefit Highlights	Vision Plan	
	In-Network Member Cost	Out-of-Network Member Cost
Copay	$25	$25
Exams	$25	Up to $50
Lenses *Single Vision* *Lined Bifcoal* *Lined Trifocal* *Lenticular*	Covered in full (after copay)	Up to $48 Up to $67 Up to $86 Up to $126
Contact Lenses* *Medically Necessary Contact Lens* *Conventional Contact Lens* *Disposable*	Covered in full 85% of balance over $135 85% of balance over $135	Up to $210 Up to $105 Up to $105
Frames	80% of balance over $135	Up to $48
Evaluation and Fitting	75% of professional fee	Included in Elective Contact Lens allowance
LASIK or PRK Vision Correction	Up to 25% off the usual charge	No discounts
Service Frequency *Exams / Lenses / Frames / Materials*	1x every: 12 months / 12 months / 24 months / 12 months	

**Contact lenses are in lieu of eyeglasses and frames*

Please Note: The benefits listed above are only a summary of coverages for full details please see SBCs.

Employee Premiums		
Coverage Tier	**Weekly**	**Bi-Weekly**
Employee	$1.40	$2.79
Employee + Spouse	$2.35	$4.70
Employee + Child(ren)	$2.40	$4.79
Family	$3.79	$7.59

TRANSDI PLUS

SHORT TERM DISABILITY INCOME INSURANCE

Transamerica (NEW!)

Transamerica's TransDi Short Term Disability Income Insurance provides income replacement benefits of up to 60% of your salary in the unfortunate event you are unable to work due to injury or illness.This covers injuries and illnesses from off-the-job.

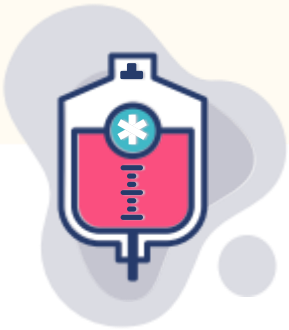
Benefit Highlights	Plan
Monthly Benefit	60% of your Monthly Salary to a Maximum Monthly Benefit of $3,000
Elimination Period *Accident / Sickness*	7 days / 7 days
Benefit Period	3 months
Pre-Existing Conditions	Benefits for pre-existing conditions will not be payable until after the insured has been insured continuously for 12 months. Pre-existing condition means a sickness or physical condition for which the insured had treatment, incurred expense, took medication, or received a diagnosis or advice from a physician during the 12-month period prior to the effective date of insurance. It also includes any condition that manifests itself in a way that would cause a reasonable, prudent person to seek medical advice, diagnosis, care, or treatment.
Additional Provisions	Accelerated Benefit for Terminal Illness Rider Waiver of Premium Provision Partial Disability Benefit

Please Note: The benefits listed above are only a summary of coverages for full details please see SBCs.

Please refer to Employee Navigator for the full list of rates.

Why is Disability coverage so valuable?

- **It's flexible.** You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.
- **Disability Insurance allows you to receive a percentage of your lost earnings if you suffer a covered disability and are unable to work.**



ACCIDENT

Transamerica (NEW!)

You do everything you can to keep your family safe, but accidents do happen. It's comforting to know you have help to manage the medical costs associated with accidental injuries, both on and off the job. Transamerica's Accident insurance pays a scheduled cash benefit upon diagnosis of covered accident injuries.

Benefit Highlights	Plan
Sports Package	Benefits are 25% higher when accident is due to organized sports. No lifetime maximum.
Accidental Death (AD) *Other than Automobile or Common Carrier*	$25,000
Fractures	$750 - $2,700
Dislocations	$225 - $2,400
Burns	$500 - $12,500
Ambulance *Ground / Air*	$375 / $1,125
Concussion/Traumatic Brain Injury	$250
Coma	$25,000
Paralysis	$12,500 - $25,000
Laceration	$62.50 - $625
Urgent Care/Initial Dr. Visit	$50 - $100

Benefit Highlights	Plan (Continued)
Surgery *Exploratory / Major*	$500 / $2,500
Hospital Admission	$1,500
ICU Care Admission	$3,000
Hospital Confinement *Per day, up to 365 days*	$225
ICU Confinement *Per day, up to 15 days*	$450
Rehab Confinement *Per day, up to 30 days*	$225
X-Ray	$50 (max 3 per accident)
Medical Diagnostic Imaging *CT, MRI, etc.*	$100
Therapy *Up to 10 per accident*	$50
Prosthetics	$1,000 - $2,000
Blood, Plasma, Platelets	$500

Please Note: The benefits listed above are only a summary of coverages for full details please see SBCs.

Why is this coverage so valuable?

- It can help you with out-of-pocket costs that your medical plan doesn't cover, like copays and deductibles
- Coverage is guaranteed without answering health questions
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly.

Employee Premiums		
Coverage Tier	**Weekly**	**Bi-Weekly**
Employee	$1.59	$3.18
Employee + Spouse	$2.72	$5.45
Employee + Child(ren)	$3.90	$7.80
Family	$5.03	$10.07

CRITICAL ILLNESS

Transamerica (NEW!)

Transamerica's Critical Illness insurance pays a lump-sum cash benefit upon diagnosis of a covered Critical Illness to help ease your financial and emotional worries. You can use the benefit any way you wish, such as for treatment, bills, or child care. The Critical Illness policy will pay a ***$50 wellness benefit once per calendar year, per person.***

Benefit Highlights	Plan
Benefit Amount *Employee* *Spouse and Child (14 days – age 26)*	$5,000 to $30,000 in $5,000 increments $2,500 to $15,000 in $2,500 increments up to 50% of the employee's lump sum benefit
Guaranteed Issue (GI) *Employee* *Spouse* *Child (14 days – age 26)*	$25,000 $20,000 $20,000
Pre-Existing Conditions Limitations	N/A
Benefit Separation Period *First Occurrence* *Recurrent Benefit*	30 days 90 days
Benign Brain Tumor, Benign Spinal Cord Tumor, Invasive Cancer, Heart Attack, Quadriplegia, Paraplegia, Hemiplegia, Sensory Loss, Some Infectious Diseases, End Stage Renal Failure, Bone Marrow Transplant, Major Organ Transplant, Some Progressive Diseases (Parkinson's, MS, ALS, etc.), Severe Burns, Stroke, Invasive Coronary Disease	$500 - $12,500
Some Vascular Diseases, SAR-COV-2, Monoplegia, Coronary Artery Disease Requiring Bypass Grafts, Coronary Artery Dissease Requiring Angioplasty/Stent, Non-Invasive Cancer	10% - 25%
Childhood Diseases/Conditions	50% - 100%

Please Note: The benefits listed above are only a summary of coverages for full details please see SBCs.

Please refer to Employee Navigator for the full list of rates.

Why should I buy coverage now?

- No pre-existing condition limitation, benefit age reduction.
- Coverage is Guarantee Issue
- It's more affordable when you buy it through your employer.
- The cost is conveniently deducted
- from your paycheck.
- You can keep coverage if you leave the company or
- retire. You'll be billed at home.

Childhood Diseases/Conditions

Cerebral Palsy, Cleft Lip, Palate, Cystic Fibrosis, Down Syndrome;

HOSPITAL INDEMNITY

HOSPITAL SELECT II

Transamerica (NEW!)

Transmerica's Hospital Select II plan can complement your health insurance to help you pay for the costs associated with a hospital stay. It can also provide funds that can be used to help pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, copays, and deductibles.

This plan also allows you to continue coverage in the event that your employment ends or when the policy is terminated and not being replaced.

Benefit Highlights	Plan
Hospital Admission *1 time per calendar year*	$1,500
Hospital Confinement *31 days per confinement*	$100
Intensive Care Unit (ICU) Admission *1 time per calendar year*	$3,000
Intensive Care Unit (ICU) Confinement *31 days per confinement*	$100

Please Note: The benefits listed above are only a summary of coverages for full details please see SBCs.

Why should I buy coverage now?

- No pre-existing condition limitation, no benefit age reduction.
- Coverage is Guarantee Issue.

Employee Premiums		
Coverage Tier	**Weekly**	**Bi-Weekly**
Employee	$3.32	$6.64
Employee + Spouse	$7.03	$14.06
Employee + Child(ren)	$4.87	$9.74
Family	$7.96	$15.91

This plan may be helpful if you are starting a family and anticipate birthing in an **inpatient** setting (please note that this plan does not cover inpatient hospitalizations for the pregnancy of dependent children i.e. the pregnancy of your child if covered by your Family plan). It may also be helpful if you anticipate having a surgery conducted in an **inpatient** setting where you will be **fully admitted** overnight.

UNIVERSAL LIFE

Transamerica (NEW!)

Transamerica's Universal Life Insurance is a type of permanent life insurance that can cover you for the duration of your life, as long as premiums are paid.

This plan also includes an Accelerated Death Benefit for Chronic Condition Rider that can be used if diagnosed with a chronic condition to pay for any expenses you may have, such as costs for an assisted living facility, family caregivers, or household bills, and doesn't require institutionalization or that the chronic condition be permanent.

Benefit Highlights	Plan
Employee *increments of* *Guaranteed Issue (GI)* *Minimum Benefit* *Maximum Benefit*	 $5,000 $150,000 $25,000 $500,000
Spouse/Domestic Partner *In increments of* *Guaranteed Issue (GI)* *Minimum Benefit* *Maximum Benefit* *Max % of Employee Election*	 $5,000 $35,000 $5,000 $100,000 100%
Child (14 days old – age 26) *In increments of* *Guaranteed Issue (GI)* *Minimum Benefit* *Maximum Benefit* *Max % of Employee Election*	 $10,000 $20,000 $10,000 $20,000 100%

Please Note: The benefits listed above are only a summary of coverages for full details please see SBCs.

Please refer to Employee Navigator for the full list of rates.

Why should I purchase life insurance?

- Cover burial and final expenses
- Help replace lost wages or income of a wage earner
- Transfer wealth or leave an inheritance

$7,000 - $10,000
Is the cost of the average funeral in the U.S.

$7,200
Family caregivers spend per year on out-of-pocket costs

YOUR 401(K)

Our 401(k) plan offers immediate vesting of company-matched funds and numerous investment options from which to choose. To be eligible, you must be employed by Onvo for at least 90 days. Once you have reached 3 months of employment, you can enroll in the 401(k) plan any month afterwards. When you become eligible, an email including the plan number and passcode you need will be sent to the address on file for you to enroll. This plan is available to all associates, including casual and temporary associates, who are at least 21.

To enroll or learn more, please go to: www.mykplan.com/enroll/learnmore

How Does the 401(k) Work?

The 401(k) Plan will allow you to accumulate a percentage of your earnings for retirement. The company will match your contribution dollar for dollar up to 4% of your earnings.

What if you can't afford to put away 4% of your earnings?

That's ok! You decide what percent you would like to contribute. You can start with an amount you are more comfortable with. With this plan YOU are in control.

- You decide where your money is invested.
- You have the freedom to make changes.

You will be 100% vested in the plan from your first day, which means any money accumulated belongs to you!

Let's Use an Example:

If you earn $300 in a week and you chose to contribute 4% of your earnings to your 401(k) plan, that would be $12 you put into your retirement savings. The company will match your $12 with another $12. So, in one week you only spent $12 towards your retirement, but you now have $24 in your retirement savings! Easy as that!

DIRECT DEPOSIT

At Onvo, you also have the choice of receiving your paychecks as a direct deposit to your bank account. Save yourself the time of going to the bank and waiting in line to deposit or cash your check, and be paid effortlessly through direct deposit. It's easy to set up. Direct deposit also ensures that employees will be paid even if they are not present to receive their paycheck at work. For further information, log on to your iPay account, or contact your direct supervisor

IPAY DEPOSIT

iPay is a great way to see all of your pay stubs, W2 and tax information, 401(k) information, and your PTO balances, all right at your fingertips! You can also change or edit your direct deposits without a hassle.
All you need to do is:

- Go to: https://ipay.adp.com
- Register by clicking find me

Do you find that you are always on the go, and not at a computer as often? No need to worry, iPay also has a mobile app for both the App Store and Google Play Store. Just search and download:

ADP Mobile Solutions

Available instantly without having to wait. It's that easy!

ATT&T DISCOUNTS

Onvo Employees can also receive a discount and save up to 18% on Qualified AT&T Plans; (excluding Unlimited Choice and Plus) if you enroll in the AT&T Signature Program. You can also save up to 25% on eligible products with the Accessory Discount.
Visit an AT&T Retail Store with proof of employment and reference: **FAN # 2733095**, or call **888-444-4410**

EMPLOYMENT LEVELS

Onvo employees are eligible to participate in benefit plans based on their job responsibilities and classification. Working 30 hours or more per week will automatically make you eligible for benefits. You may also enroll your eligible family members under certain plans you choose for yourself as well. To better assist and clarify each level, you will find that we have specified the level of employees, and the meaning of each level below. If you should have any questions or need clarification on which level you are, please contact your direct supervisor.

Salaried and hourly employees working in the corporate office and those classified as a General Manager or fuel driver

Employees classified as an Assistant Manager

Employees that are Maintenance

All other Full-Time employees

PAID TIME OFF (PTO)

Onvo offers a comprehensive and competitive benefits plan that comprises an important part of your total compensation package. These benefits are designed to provide you and your family with a wide range of features and options to support your health, work and life needs. All active, full-time employees regularly scheduled to work 30 hours or more per week are eligible to receive PTO based on their job responsibilities and classification. Part-time employees averaging less than 30 hours are not eligible to participate.

Vacation– Days may be taken following 90 days of employment. Vacation time is earned based on years of service an accrued beginning on hire date or position/promotion start date. Vacation days must receive approval from their direct supervisor.

Holidays– General Managers are required to schedule appropriately and work when needed during Holidays, and are allowed to substitute another day during the Holiday week. Holiday time must be used In the week of the Holiday or the week Immediately following.

Personal Time– Days are given after 90 days of employment. They cannot be combined with Vacation, and must be scheduled in advance as well as receive approval from their direct supervisor.

Note: All Personal Time and Vacation time in excess of 24 hours will reset on the anniversary date. Above benefits must be used in the benefit period and cannot be redeemed for monetary value if not used.

Vacation / Holidays / Personal Time	Annual Vacations Days Earned	Accural Hours Per Month	Paid Holidays	Personal Time
Level 1 1 to 5 Years of Service 6 to 9 Years of Service 10+ Years of Sevice	10 Days 15 Days 20 Days	6.66 Hours 10.00 Hours 13.36 Hours	Independence Day, Memorial Day, Labor Day, Thanksgiving, Christmas, New Year's Day	Following three (3) months of employement, employees will have two (2) days per year to be used as personal time.
Level 2 1 to 5 Years of Service 6 to 9 Years of Service 10+ Years of Sevice	5 Days 10 Days 15 Days	3.34 Hours 6.66 Hours 10.00 Hours	Independence Day, Memorial Day, Labor Day, Thanksgiving, Christmas, New Year's Day	Following three (3) months of employement, employees will have two (2) days per year to be used as personal time.
Level 3 1 to 5 Years of Service 6 to 9 Years of Service 10+ Years of Sevice	5 Days 10 Days 15 Days	3.34 Hours 6.66 Hours 10.00 Hours	Independence Day, Memorial Day, Labor Day, Thanksgiving, Christmas, New Year's Day	N/A
Level 4 1+ Years of Service	4 Days	2.66 Hours	N/A*	

**Level 4 and all employees who are not Level 1-3 who are scheduled and work on Christmas or Thanksgiving will be paid time and a half.*

GLOSSARY

Learning about key health terms is important, and we believe the Glossary below will help to assist you while reading through your benefits. Should you have any additional questions, please contact Human Resources at **(570) 291-4260**.

1. **Coinsurance–** A percentage of medical costs that you pay, usually after reaching your deductible. For example, if your medical bill for covered, in-network services is$100 and your coinsurance is 20%, your plan pays $80. It is in addition to any copays you may have. (Additional fees apply for out-of- network care.)

2. **Coordination of Benefits (COB)** – This applies when you have more than one (1) health care plan. It's about making sure the plans work together to pay benefits. One plan becomes your main plan. It pays your claims first. The other plan pays toward the remaining cost. It is important to respond to COB outreach from Highmark to avoid claim payment delays.

3. **Copay** – A fixed dollar amount that you pay for certain covered services. For example, you could have a copay of $20 for a doctor visit or $30 for a prescription drug.

4. **Deductible** – The amount you must pay each plan year before your plan begins to pay for covered care. Some plans may have services that do not require you to meet a deductible.

5. **Out-of-Pocket Costs**– Costs you pay personally when you get health services or prescriptions. These include deductibles, copays, and coinsurance for covered services.

6. **Out-of-Pocket Maximum** – This is the most you would pay in out-of-pocket cost throughout the plan year. Its inclusive of any medical and prescription cost made under the plan (deductible, copay, coinsurance). It does not include your payroll deducted premium contribution.

7. **Premium** – The dollar amount you pay for your health insurance or plan. You and/or your employer usually pay it monthly.

8. **Primary Care Provider (PCP)** – The heath care professional who provides most of your basic care. PCP can be a doctor who practices in family, general, internal or pediatric medicine or, a certified registered nurse practitioner.

9. **Specialist** – A doctor who limits his or her practice to a single branch of medicine or surgery.

FREQUENTLY ASKED Q&A

This document outlines important annual, required legal notices for Onvo If you have any questions about these notices, contact the Human Resources at **(570) 291-4260**.

GENERAL

If I want to decline coverage, must I still complete the enrollment process?
Yes. It is important that Human Resources has a record of your decision. Please keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a special qualifying event such as a marriage, divorce, birth or adoption of a child, or loss of other coverage.

Can I enroll my spouse or dependent on one plan and myself on another?
No. All covered dependents, including spouse, must be on the same plan as the employee.

Can I drop or change plans during the plan year?
Changes can only be made if there has been a qualifying event or personal life change. Examples include marriage, divorce, birth of a child, or change in employment status.

What is the difference between a calendar year and a contract year?
A plan on a calendar year runs from January 1 – December 31. Items like deductible, maximum out-of-pocket expense, etc. will reset every January 1. All Individual and Family plans are on a calendar year. A plan on a contract year (also called benefit year) runs for any 12-month period within the year. Items like deductible, maximum out-of-pocket expense, etc. will reset at the plan's renewal date.

What happens if I sign up for insurance but find later on in the year that I cannot afford the premiums?
If the reason for your change in affordability is due to a life-changing event such as the loss of a job, death of a spouse, or birth of a child, you would be eligible for special enrollment within 60 days of the event. If you do not enroll during this period, you will not be assured a health plan will cover you either through the Health Insurance Marketplace or in the private market. If you do not pay your premium, you could lose coverage and will not be able to enroll again until the next open enrollment period.

Benefit payments
For benefits received in the Network, you are responsible only for your co-payment, deductible and coinsurance amounts. Your provider will file the claim.

MEDICAL

Should I notify my pharmacy and physician of my benefits plan with Highmark BCBS?
Yes. On your next visit to the pharmacy or doctor, simply present your Highmark BCBS ID card. This will allow the provider to correctly bill Highmark BCBS Network for the services you have received. It's important to inform your physician of the requirement to utilize a Highmark BCBS Network facility as a medical plan participant.

YOUR PLAN RIGHTS

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

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS

OPTIONS AND YOUR HEALTH COVERAGE

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options.

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

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

Does Onvo Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

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

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by **Onvo,** then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after - tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit.

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

Open enrollment for health insurance coverage through the Marketplace generally begins November 1 for coverage starting as early as January the following year. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period when you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. You may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a temporary Marketplace Special Enrollment Period for certain individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. If you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

YOUR PLAN RIGHTS

What About Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in **Onvo's** group plan, you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in the employer's health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your HR representative. Additionally, the Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Onvo

This section contains information about any health coverage offered by **Onvo.** If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

If you are not eligible for health insurance coverage through you and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

EMPLOYER NAME ONVO

EMPLOYER EIN 23-2581761

EMPLOYER ADDRESS 2227 Scranton Carbondale Hwy, Scranton, PA 18508

WHO CAN WE CONTACT ABOUT EMPLOYEE HEALTH COVERAGE AT THIS JOB? Ruby Penny

PHONE NUMBER 570.291.4260 x 1003

1. Indexed annually; see this link for 2024.
2. An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

YOUR PLAN RIGHTS

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

1. As your employer, we offer a health plan to:
   - Some employees. Eligible employees are:

     ➤ *Full-time employees working 30+ hours per week.*

2. With respect to dependents:
   - We do offer coverage. Eligible dependents include:
     - Spouses
     - Domestic Partners
     - Dependent Children

- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

WOMEN'S RIGHTS AND CANCER ACT NOTICE

Special Rights Following Mastectomy. A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; Prostheses; and treatment of physical complications of mastectomy.

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.
Contact Highmark at 1 (800) 241-5704 for more information.

NEWBORNS AND MOTHER'S HEALTH PROTECTION ACT

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

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2009

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (GINA):

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

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA):

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

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries. For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets.

NOTICE OF PATIENT PROTECTIONS:

Onvo generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select primary care provider, and for a list of participating primary care providers, contact Highmark at 1 (800) 241-5704

For children, you may designate a pediatrician as the primary care provider for Onvo's Medical Plans.

You do not need prior authorization from Onvo or from any other person(including a primary care provider) in order to obtain access to obstetrical or gynecological care from health care professional in our network who specializes in obstetrics and gynecology. The health care professional, however, may be required to comply with certain procedure, including obtaining prior authorization for certain services, following a pre-approved treatment plan , or procedures for making referrals. For a listing of participating healthcare professionals who specialize in obstetrics or gynecology, contact Highmark at 1 (800) 241-5704

NOTICE REGARDING SPECIAL ENROLLMENT

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

LOSS OF OTHER COVERAGE

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

MARRIAGE, BIRTH OR ADOPTION

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, or placement for adoption.
Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days from the date of your marriage.

MEDICAID OR CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.
Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

FOR MORE INFORMATION OR ASSISTANCE

To request special enrollment or obtain more information, please contact:

NAME	Ruby Penny
ADDRESS	2227 Scranton Carbondale Hwy, Scranton, PA 18508
TELEPHONE	570.291.4260 x 1003

HIPAA PRIVACY NOTICE

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

PRIVACY OBLIGATIONS OF THE PLAN

The Plan is required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW THE PLAN MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following are the different ways the Plan may use and disclose your PHI:

- **For Treatment.** The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise emergency room physicians about the types of prescription drugs you currently take.
- **For Payment.** The plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.
- **To the Plan Sponsor.** The Plan may disclose your PHI to designated personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to designated HR personnel so that they can carry out related administrative functions. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other employee or department and (2) will not be used for any employment related actions and decisions or in connection with any other sponsored employee benefit plan.
- **To a Business Associate.** Certain services are provided to the Plan by third party administrators known as "business associates." For example, we may forward information about your health care treatment to our broker to assist with the claim processing. In doing so, we will disclose your PHI to the broker so he/she can perform their claim payment function. However, we will require its business associates to appropriately safeguard your health information.
- **Health-Related Benefits and Services.** The Plan may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.
- **Personal Representative Involved in Your Care.** The Plan may also advise a family member or close friend about your condition, your location (for example that you are in the hospital) or death.
- **As Required by Law.** The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

SPECIAL USE AND DISCLOSURE SITUATIONS

The Plan may also use or disclose your PHI under the following circumstances:

- **Lawsuits and Disputes.** The Plan may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful process.
- **Law Enforcement.** The Plan may release your PHI if asked to do so by a law enforcement official (for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime).
- **Workers' Compensation.** The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws.

USES AND DISCLOSURES REQUIRING AUTHORIZATION

The plan is required to obtain plan participants' authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, to sell PHI, or to use or disclose PHI for any purpose not described in the notice. The Plan Administrator must obtain this authorization from the plan participant in writing. The plan participant my revoke this authorization anytime in writing by contacting the Plan Administrator at the address below:

2227 Scranton Carbondale Hwy, Scranton, PA 18508

HIPAA PRIVACY NOTICE (CONTINUED)

PROHIBITED USE OF PHI

The plan is prohibited from using PHI that is genetic information for underwriting purposes

YOUR RIGHTS REGARDING YOUR PHI

Your rights regarding PHI the Plan maintains about you are as follows:

- Right to Inspect and Copy. You have the right to inspect and copy PHI maintained by the Plan. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not included psychotherapy notes. To inspect and copy PHI maintained by the Plan, you must submit your request in writing to the Plan Administrator. The Plan may charge a fee for the cost of copying, mailing, or other costs associated with your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

- Right to Request Restrictions. You have the right to request a restriction on the health information the Plan uses or discloses about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan disclosed about you to someone who is involved in your care, like a family member or friend. (For example, you could ask that the Plan not use or disclose information about a surgery you had.) To request restrictions, you must make your request in writing to the Plan Administrator. You must advise us: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply. Note: The Plan is not required to agree to your request.

- Right to be Notified of a Breach. You have the right to receive notice if there has been a breach of your unsecured protected health information.

- Right to Amendments to Your PHI. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

We are not obligated to make all requested amendments but will give each request careful consideration. To be considered, your amendment request must be submitted in writing to the person listed below.

- Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures. Your request to for an accounting must be submitted in writing to the person listed below.

- Right to Request Confidential Communications. You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger.

- Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may write to the Plan Administrator to request a written copy of this notice at any time.

If you wish to make any of the above-listed requests, you may write to the Plan Administrator at the address listed below in the Contact Information section.

Changes to this Notice: The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will post a copy of the current notice on the Intranet.

Complaints: If you believe your privacy rights under this policy have been violated, you may file a written complaint with Human Resources at the address listed below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission occurred.

HIPAA PRIVACY NOTICE (CONTINUED)

Other Uses and Disclosures of Health Information: Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorize the Plan to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose your PHI for the reasons covered by your written authorization, however, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information:

If you have any questions about this notice, please contact:

RUBY PENNY, HUMAN RESOURCES DIRECTOR, 570.291.4260 x 1003, 2227 Scranton Carbondale Hwy, Scranton, PA 18508

Notice Effective Date: 9.1.2024

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

INTRODUCTION

You are receiving this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

Read this notice carefully to help understand your COBRA rights. Keep in mind that 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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice does not fully describe COBRA continuation coverage or other rights under the Plan. For additional and more complete 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 does not 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 known as 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 may be required to pay for COBRA continuation coverage.

EMPLOYEE If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

SPOUSE If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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. In the event your spouse, who is the employee, reduces or terminates your coverage under the Plan in anticipation of a divorce or legal separation that later occurs, the divorce or legal separation may be considered a qualifying event even though the coverage was reduced or terminated before the divorce or separation.

DEPENDENT CHILDREN Your dependent children (including any child born to or placed for adoption with you during the period of COBRA coverage who is properly enrolled in the Plan and any child of yours who is receiving benefits under the Plan pursuant to a qualified medical child support order) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- 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."

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS (CONTINUED)

RETIREE COVERAGE

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

WHEN IS COBRA 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;
- COMMENCEMENT OF A PROCEEDING IN BANKRUPTCY WITH RESPECT TO THE COMPANY;] 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: **[CONTACT NAME]**. The Plan procedures for this notice, including a description of any required information or documentation, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, you will lose your right to elect COBRA continuation coverage.

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives timely 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. If COBRA continuation coverage is not elected within the 60-day election period, a qualified beneficiary will lose the right to elect COBRA continuation coverage. COBRA continuation coverage is a temporary continuation of coverage.

- When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage may last for up to a total of **36 months.**
- When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of **18 months.** There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Also, when the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

DISABILITY EXTENSION

If you or anyone in your family covered under the Plan is determined by the Social Security Administration 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 total 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 continuation coverage. The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, there will be no disability extension of COBRA continuation coverage. The affected individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS (CONTINUED)

SECOND QUALIFYING EVENT EXTENSION

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 notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving COBRA continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B or both) or 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.

The Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice, can be found in the most recent Summary Plan Description or by contacting the Plan Administrator. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA?

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

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under 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.

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

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

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Onvo coverage will not be affected. Upon enrollment in a Medicare drug plan, you may continue the Onvo coverage, and the coverage will coordinate with Part D coverage according to the Medicare Secondary Payer Law. Please contact us for more information about what happens to your coverage if you decide to enroll in a Medicare Part D program.

If you do decide to join a Medicare drug plan and drop your current employer-sponsored coverage, you and your dependents will be able to get this coverage back at a future date, though you may need to wait until Onvo's next open enrollment period to resume coverage under the group plan.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

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

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

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Onvo changes. You also may request a copy of this notice at any time. For more information about his notice or your current prescription drug coverage, please contact Ruby Penny, the Human Resources Director at 570.291.4260 x 1003

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE…

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

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

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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 January 31, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

NOTES

2024 - 2025 EMPLOYEE BENEFITS GUIDE