



SCOTT



2026 Employee Benefits Guide

Salary Employees

This guide includes only highlights of the benefit plans. While we have tried to be as accurate as possible in developing this information, the official plan documents govern in all cases. If you would like a copy of the official plan documents, please contact the HR department.

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QUESTIONS?

For more information, visit the Benefits Portal on Paylocity.

If you have any questions about your benefits, please contact the Human Resources department.

Enrollment Guide

Plan Year

Benefits are administered on a calendar year that will begin January 1, 2026 and run through December 31, 2026.

Who is Eligible to Elect Benefits?

Current Employees and New Hires

- During Open Enrollment, all current, full-time employees, working at least 30 hours a week or more, can make changes to their benefits
- Full-time new hire coverage is effective the 1st of the month following the 30-day waiting period

Dependents

- Legally Married Spouse*
- Natural born or adopted child
- Child for which you have court appointed custody or mandated through court order

How to Enroll

Open Enrollment for the new plan year starts on **December 1st and ends on December 10th**. All employees are required to make their enrollment selections in the **Paylocity system by December 10th, 2025** unless told otherwise.



Making Changes During the Year

Your elections will be in effect until December 31, 2026 unless you experience a status change defined by the IRS such as:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child or other qualified dependent
- Change in employment status or change in coverage under another employer-sponsored plan

NOTE: Enrollment changes must be made within 30 days of the status change.

**Common law – Only spouses meeting the State's definition of "married" may be added to the health plan unless you were in this substantiated arrangement prior to 7-24-19 since these arrangements are grandfathered and only if they do not have the opportunity for other coverage. Member's may be asked to provide proof of their marriage that is in alignment with the State of SC's statute as well as any other form of required documentation required of spouses.*

Linktree

This site is your one-stop for all things employee benefits! If you need any plan documents or need direct access to member portals, scan the QR code below!

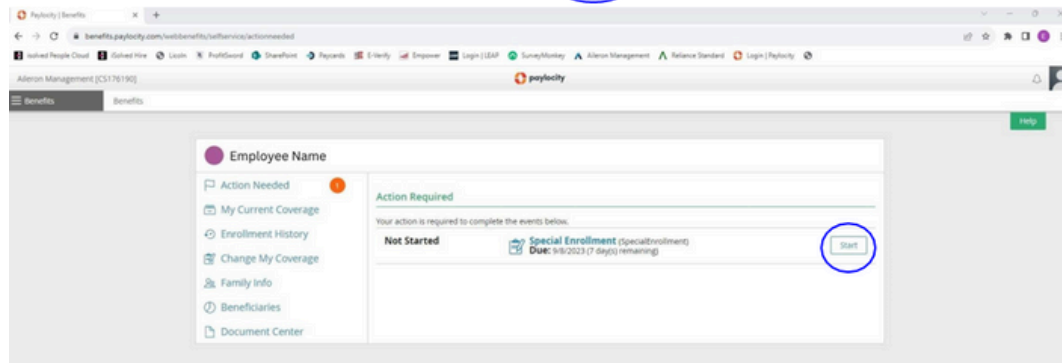
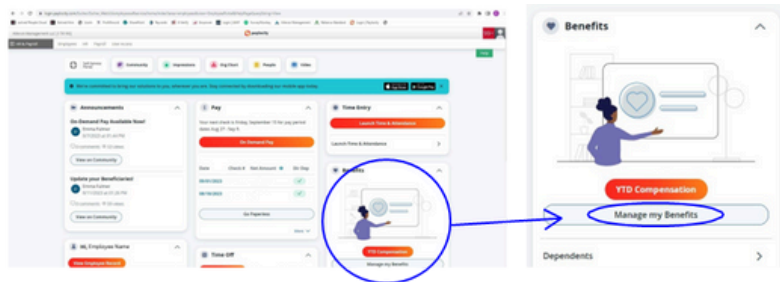


Paylocity Open Enrollment Instructions

Paylocity

Step 1

Log into Paylocity by going to access.paylocity.com. Then click on **Manage My Benefits**.

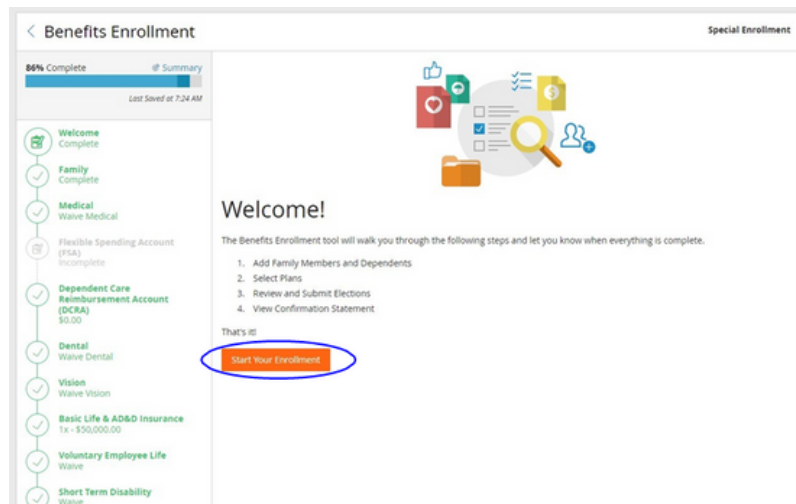


Step 2

Click **Start**.

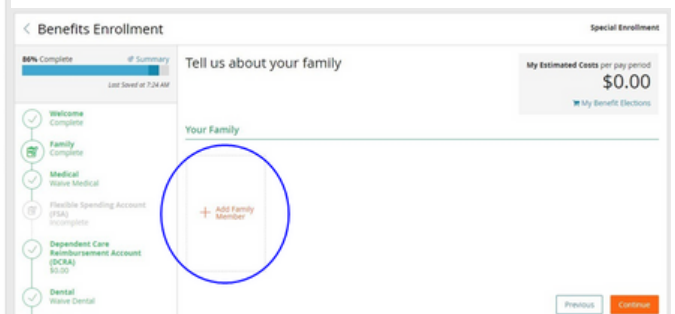
Step 3

Click **Start Your Enrollment**. It will take you through the process of either electing or waiving each benefit.



Step 4

If you plan to elect insurance that will cover any of your family members, add them here.



Paylocity Open Enrollment Instructions

Paylocity

Step 5

Check the plan you want to elect or if you would like to waive the benefit, check the waive box. There are links to informational documents on the benefit screens. See highlighted area. Make these elections for the rest of the benefits.

Step 6

After you have made your elections, you will need to elect a beneficiary (or multiple), for your company-paid benefits. **You need to do this even if you have waived all other benefits.**

To add a beneficiary, click **Add Beneficiary**. To edit an existing beneficiary, click the **pencil icon**.

Step 7

Once you add your beneficiary(s), you will need to assign your primary beneficiary(s) a percentage. This needs to add up to 100%. You can also have a secondary beneficiary(s) if you would like. This percentage also needs to add up to 100%.

Step 9

Once you have reviewed your enrollment, don't forget to click **Submit**.



Step 8

View your enrollment summary to make sure you've elected everything you want and your total estimated costs per pay period fits your budget.



Exciting changes to your medical plan in 2026!



Effective January 1, 2026, your medical benefits will be administered by Cigna. While enhancements have been made to improve your coverage, every effort has been taken to minimize disruption. To help you prepare for these upcoming changes, we've provided helpful resources below. If you have any questions or need support, please don't hesitate to contact HR.

[NEW Network: Cigna OAP](#)

Cigna OAP provides access to a nationwide network of healthcare providers, giving you flexibility and choice no matter where you live or travel.

Search for an in-network provider by scanning the QR code and choose the **Cigna OAP network**.



You can also find an in-network provider by visiting member.gravie.com.

[NEW Prescription Drug Formulary: Express Scripts](#)

The Cigna OAP network partners with Express Scripts pharmacy benefits services to administer the pharmacy formulary. You can search your prescriptions by scanning the QR code or visiting the link below. Select your medical plan to compare prices and find retail pharmacies.



www.express-scripts.com/frontend/commercial-open-enrollment/gravie



LOWER deductible on the HSA plan!

Annual employee deductible reduced from \$7,500 to \$6,350!



Medical Benefits

Cigna OAP Network



Aileron offers a medical plan that not only covers essential health benefits but also assists in discounted treatments for chronic conditions, emergency treatments and more.

Medical Plan Costs (per pay period, semi-monthly)			
	Plan 1	Plan 2	Plan 3
Employee Only	\$117.00	\$90.00	\$135.00
Employee + Spouse	\$470.00	\$250.00	\$530.00
Employee + Child(ren)	\$280.00	\$195.00	\$320.00
Employee + Family	\$750.00	\$500.00	\$850.00

Finding a provider:

Find an in-network provider by visiting: member.gravie.com. The plan utilizes the Cigna OAP network.

	Plan 1	Plan 2	Plan 3
Benefits Overview	PPO Plan	HSA Plan	Comfort Fit
Deductible Employee / Family	\$5,000 / \$10,000 Embedded	\$6,350 / \$12,700 Embedded	N/A
Maximum Out-of-Pocket Employee / Family	\$7,900 / \$15,800	\$6,350 / \$12,700	\$9,200 / \$18,400
Coinsurance (You Pay)	20%	0%	N/A
Office Visits			
Primary Care Physician	\$30 copay	Deductible then 0%	No Cost
Specialist	\$50 copay	Deductible then 0%	No Cost
Adult & Child Preventive	No Cost	No Cost	No Cost
Urgent Care	\$75 copay	Deductible then 0%	No Cost
Chiropractic	Deductible then 20%	Deductible then 0%	No Cost
Telemedicine - Teladoc	No cost	Deductible then 0%	No Cost
Labs, X-Rays & Diagnostics			
Free Standing Facility	Deductible then 20%	Deductible then 0%	No Cost after MOOP
Hospital	Deductible then 20%	Deductible then 0%	No Cost after MOOP
Hospital Services			
Emergency Room	\$500 copay	Deductible then 0%	\$950 copay
Inpatient Hospitalization	Deductible then 20%	Deductible then 0%	No Cost after MOOP
Outpatient Services	Deductible then 20%	Deductible then 0%	No Cost after MOOP
Mental Health & Substance Abuse			
Inpatient/Outpatient	Deductible then 20%	Deductible then 0%	No Cost after MOOP
Office Visit	\$30 copay	Deductible then 0%	No Cost

The above chart is a brief overview and not an exhaustive list of your medical benefits. Please see your plan document for full details or see HR.

Pharmacy Benefits

Details at a Glance

Express Scripts

By EVERNORTH



Pharmacy benefits are administered through Express Scripts and includes copays for retail (30 day) and mail order (90 day) prescription fills.

	Plan 1	Plan 2	Plan 3
Pharmacy	PPO Plan	HSA Plan	Comfort Fit
Deductible	Combined with Medical	Combined with Medical	N/A
Retail (30 day Supply)			
Tier 1 - Generic	\$10	Deductible, then 0%	No Cost
Tier 2 - Preferred Brand Name	\$50	Deductible, then 0%	\$75
Tier 3 - Non-Preferred Brand Name	\$100	Deductible, then 0%	\$100
Tier 4 - Non-Formulary	Max Out of Pocket	Max Out of Pocket	Max Out of Pocket
Mail Order (90 day Supply)			
Tier 1 - Generic	\$20	Deductible, then 0%	No Cost
Tier 2 - Preferred Brand Name	\$100	Deductible, then 0%	\$150
Tier 3 - Non-Preferred Brand Name	\$200	Deductible, then 0%	\$200
Tier 4 - Non-Formulary	Max Out of Pocket	Max Out of Pocket	Max out of Pocket
Specialty*			
SaveOn Copay Assist	No Cost	Not Eligible	No Cost
Other Specialty	Deductible, then 20%	Deductible, then 0%	No Cost after MOOP

***Effective January 1, 2026 some Specialty medications will be eligible for the SaveOn Copay Assistance Program.**

With this program, your cost sharing will be 30% of the drug cost if you opt out of the SaveOn Copay Assistance. These expenses will not apply toward the plan Out of Pocket. Please note that HSA Plans are not able to participate in the SaveOn program.

- ACA Mandated Preventive drugs are covered at 100%.
- Additional cost sharing may apply for brand-name prescriptions when a generic equivalent is available.
- Certain drugs may require prior authorization or be subject to quantity limits.
- Specialty drugs must be filled at the designated Specialty Pharmacy (Accredo).

Comfort Fit Medical Plan

Health Benefits

Comfort is the first of its kind health plan that eliminates cost barriers and provides value to all participants, promoting better long-term health and improved customer satisfaction. Comfort provides 100% coverage on most common healthcare services at a cost comparable to tradition group health plans.

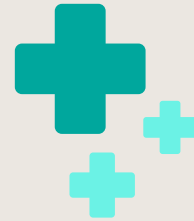
No hidden costs. No surprise bills.

No Cost Services:

- Preventive Care
- Primary Care
- Specialist Visit
- Urgent Care Visit
- Labs & imaging
- Generic Prescriptions
- Online Care
- Mental Health Care

Other Services:

- Emergency Room: [\\$950 copay](#)
- Brand Name Prescriptions: [\\$75 copay](#)
- Non-Preferred Brand Name Prescriptions: [\\$100 copay](#)
- Specialty Prescriptions: [No cost after out-of-pocket maximum](#)
- Hospital Surgery/Procedure: [No cost after out-of-pocket maximum](#)



Taylor hurts his ankle on a run. He visits the doctor for a check-up and x-ray.

Comfort Fit Cost: \$0
Traditional Plan Cost: \$450



Which Type of Plan is Right for You?

	PPO Plan	HDHP with HSA Plan	Comfort Fit Plan
Cost-Share	PPO plans are primarily driven by set copayments and lower deductibles to be met for certain services. These plans require a higher premium cost to account for the lower out-of-pocket costs.	HDHP/HSA plans are primarily driven by a higher deductible and lower premium costs. You will need to meet a deductible first, before the discount coinsurance cost for services kicks in.	The Comfort Fit plan eliminates copayments and deductibles. You will pay a higher premium up front in exchange for no cost services on most common healthcare services.
Out-of-Pocket Expenses	The employee only pays copays for certain office visits and prescription costs. For other services and procedures, you will be responsible for meeting the deductible and then paying the coinsurance up to your out-of-pocket expenses.	You will need to satisfy your deductible before the plan begins to pay. Because coinsurance is paid 100% by the plan, once you reach your deductible, you have also reached your Maximum Out of Pocket for the year.	There is no annual deductible. The plan pays 100% for most office visits, labs, and generic medications. For other services, the plan will pay after you meet your Maximum Out of Pocket for the year.
Eligibility for Health Savings Account (HSA)	No	Yes - Current 2026 yearly maximum for individual plans is \$4,400 and \$8,750 for family plans.	No
Preventive Care	All eligible in-network preventive care services are covered at no cost to you.	All eligible in-network preventive care services are covered at no cost to you.	All eligible in-network preventive care services are covered at no cost to you.
Primary Care and Specialist Office Visits	You will pay a copay at the time of your appointment of \$30 for a Primary Care Provider and \$50 for a Specialist Provider.	You will "most of the time" owe nothing at time of service. Your provider will bill the insurance company and then you will receive BOTH an invoice from the provider and an Explanation of Benefits (EOB) statement that should match what the provider is asking you to pay.	You will owe nothing for a Primary Care or Specialist office visit.
Emergency Room / Urgent Care Visits	You will pay a copay of \$500 for emergency room visits and \$75 for urgent care visits. If you are admitted, then you will have additional costs based on meeting your deductible and coinsurance.	You will be billed for both your emergency room and urgent care visit AFTER the visit. These visit costs will count towards meeting your deductible, then your coinsurance will apply.	Urgent care visits are covered at no cost to you. You will pay a \$750 copay for an emergency room visit. If you are admitted, then you will have additional costs based in meeting your maximum out of pocket.



Telemedicine

TELADOC



With Teladoc, you have access to primary care doctors anytime, anywhere.

If you are enrolled in any of the company medical plans, through Teladoc you can access doctors by phone or video 24/7, from wherever you are.

Teladoc Benefits

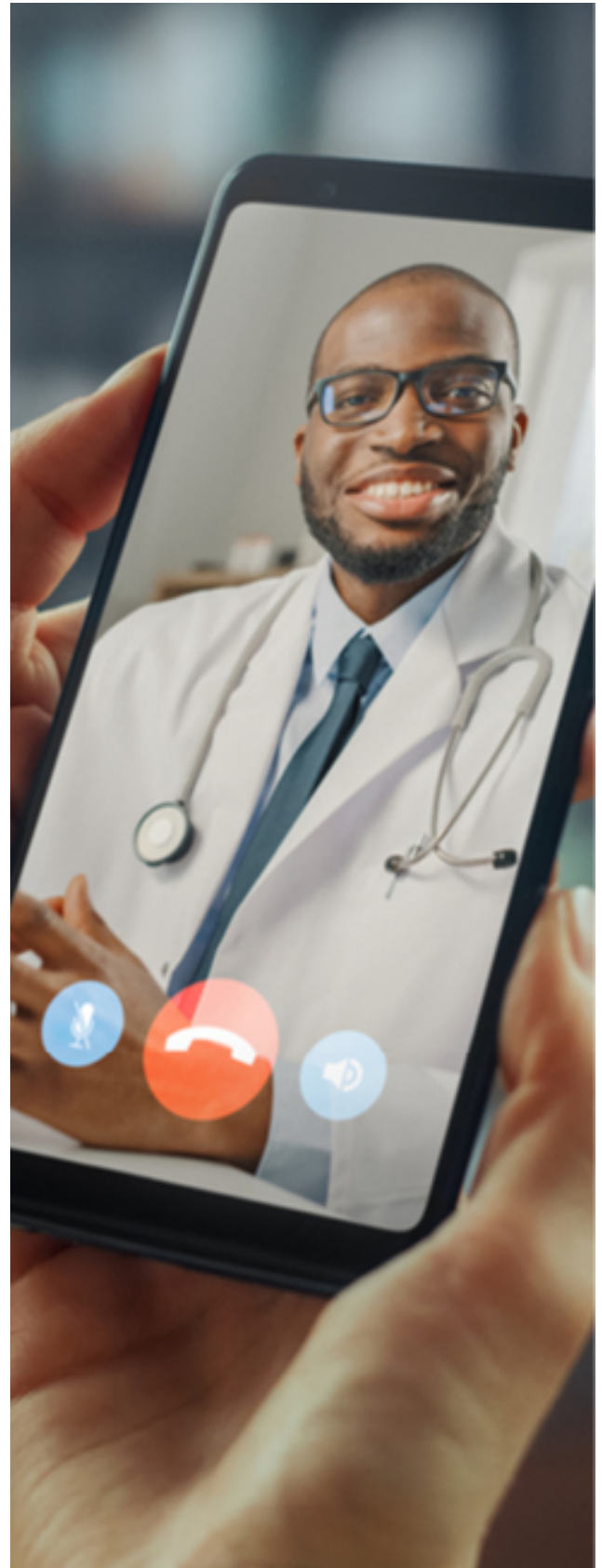
- You can talk to a doctor from wherever you are—day or night.
- Skip the trip to the ER or urgent care.
- \$0 copay for PPO and Comfort Fit plans

What can be treated with Teladoc?

- Cold & flu symptoms
- Allergies & Sinus problems
- Asthma
- Acne
- Pink eye
- Ear infection
- Respiratory infection
- And more!

Feel better when you need to!

Call **1.800.TELADOC (835.2362)**, visit **Teladoc.com**, or download the mobile app to get started.



Virtual MSK Therapy

Sword Health



Musculoskeletal (MSK) disorders are the #1 issue in healthcare today, affecting 50% of people in the United States. Gravie health plan members have access to industry-leading virtual treatment for MSK conditions at no additional cost.

With Sword, Gravie members have a powerful tool to overcome MSK pain with a clinical-grade digital solution that outperforms traditional, in-person care. Combining personalized care from licensed physical therapists with innovative, sensor-based technology, Sword delivers treatment wherever and whenever it's convenient for you.

The clinically validated program works for all major MSK issues at any point in your journey: prevention, acute conditions, chronic pain, and post-surgical recovery.

Joints covered include:

- Neck
- Shoulder
- Elbow
- Low back
- Hip
- Wrist/hand
- Ankle

Digital Physical Therapy Changes Lives

On average, Sword patients experience less pain, avoid surgery, reduce medication use, reduce depression and anxiety, and improve productivity.

62% reduction in pain

60% reduction surgery intent

52% reduction in anxiety

53% reduction in depression

42% increase in productivity

49% reduction in medication and opioid use

Sign up by logging into your Gravie Account or through the Gravie mobile app.



Health Savings Accounts (HSA)

Discovery Benefits

What is an HSA?

A Health Savings Account (HSA) is a tax-advantaged savings account that can be used for your health, dental and vision expenses. Money comes out of each paycheck (pre-tax) and is deposited into your account for future use on qualified healthcare expenses.

Key Advantages of this Plan

- Triple Tax Savings
 - Funds are contributed pretax.
 - Any investment earnings are tax free.
 - Withdrawals are pre-tax as long as funds are used for qualified healthcare expenses.
- Portability
 - The account is yours even if you are no longer employed with Aileron.
- Savings
 - There is no time limit for using your HSA funds and there is no maximum account balance.

Contributions

Aileron will contribute the following amount to your HSA:

- Employee Only Coverage: \$600 Annually
- Employee + Spouse/Child(ren): \$900 Annually
- Family Coverage: \$1,200 Annually

The maximum contribution limits for 2026 are:

- Employee Only Coverage: \$4,400
- Family Coverage: \$8,750

The maximum contribution limits include the amount that Aileron contributes to your account. ****If you or your spouse are age 55 or older, you may contribute an additional \$1,000.**



www.DiscoveryBenefits.com

Eligibility

To be eligible for contributions into your HSA account you:

- **Must be enrolled in the HDHP Medical Plan**
- Cannot be claiming Social Security
- Cannot be claimed as a dependent on someone else's taxes
- Cannot have other health coverage such as Medicare, Tricare, a spouse's medical or pharmacy plan, or a Healthcare Flexible Spending Account (FSA).

Examples of Qualified Healthcare Expenses

- Deductible, coinsurance and copays
- Prescription drugs
- Dental services including orthodontia
- Vision services such as contacts and glasses
- Visit <https://www.irs.gov/publications/p502> for a full list of qualified expenses.

DID YOU KNOW?

You can use your HSA funds for qualified healthcare expenses for your spouse and children even they are not covered on your medical plan.



HSA Contribution Schedule

Health savings accounts (HSAs) are a great way to save money and budget for qualified health expenses. HSAs are tax-advantaged savings accounts that accompany high deductible health plans (HDHPs). [HSA benefits will be through Discovery Benefits](#). Based on the time of year that you enroll, your maximum contribution will be prorated. Please see the chart below:

Enrollment Month	Employee Only	Ailon Contributions	Total Amount Eligible to Contribute	Employee + Spouse or Child(ren)	Ailon Contributions	Total Amount Eligible to Contribute	Family	Ailon Contributions	Total Amount Eligible to Contribute
January	\$3,800.00	\$600.00	\$4,400.00	\$7,850.00	\$900.00	\$8,750.00	\$7,550.00	\$1,200.00	\$8,750.00
February	\$3,483.36	\$550.00	\$4,033.36	\$7,195.84	\$825.00	\$8,020.84	\$6,920.84	\$1,100.00	\$8,020.84
March	\$3,166.69	\$500.00	\$3,666.69	\$6,541.67	\$750.00	\$7,291.67	\$6,291.67	\$1,000.00	\$7,291.67
April	\$2,850.00	\$450.00	\$3,300.00	\$5,887.50	\$675.00	\$6,562.50	\$5,662.50	\$900.00	\$6,562.50
May	\$2,533.35	\$400.00	\$2,933.35	\$5,233.35	\$600.00	\$5,833.35	\$5,033.35	\$800.00	\$5,833.35
June	\$2,216.68	\$350.00	\$2,566.68	\$4,579.18	\$525.00	\$5,104.18	\$4,404.18	\$700.00	\$5,104.18
July	\$1,900.00	\$300.00	\$2,200.00	\$3,925.00	\$450.00	\$4,375.00	\$3,775.00	\$600.00	\$4,375.00
August	\$1,583.34	\$250.00	\$1,833.34	\$3,270.84	\$375.00	\$3,645.84	\$3,145.84	\$500.00	\$3,645.84
September	\$1,266.67	\$200.00	\$1,466.67	\$2,616.67	\$300.00	\$2,916.67	\$2,516.67	\$400.00	\$2,916.67
October	\$950.00	\$150.00	\$1,100.00	\$1,962.50	\$225.00	\$2,187.50	\$1,887.50	\$300.00	\$2,187.50
November	\$633.33	\$100.00	\$733.33	\$1,308.33	\$150.00	\$1,458.33	\$1,255.33	\$200.00	\$1,458.33
December	\$316.67	\$50.00	\$366.67	\$654.17	\$75.00	\$729.17	\$629.17	\$100.00	\$729.17

For associates participating in the HDHP, Ailon will contribute to your HSA account on a monthly basis. Please see the annual contribution amount in the chart below. Additionally, if you are age 55 or older, you may make an additional “catch-up” contribution of \$1,000. You may change your contribution amount at any time throughout the year if you don’t exceed the annual maximum.



Ailon Annual HSA Contribution		
Employee Only	Employee + Spouse or Child(ren)	Family
\$50 per month (\$600 Annual Max)	\$75 per month (\$900 Annual Max)	\$100 per month (\$1,200 Annual Max)

Flexible Spending Account

Healthcare and Dependent Care FSA

Aileron offers you the opportunity to defer pre-tax dollars into a Healthcare Flexible Spending Account (FSA) to pay for eligible medical, dental, and vision expenses and a Dependent Care Flexible Spending Account to pay for eligible childcare expenses.

Use It or Lose It

It is important to estimate as accurately as possible when making your FSA election because IRS regulations require that you must forfeit any money not used for expenses incurred by the end of the plan year.

Rollover

You may rollover up to \$680 in your Healthcare FSA from one plan year to the next.

Can I have an HSA and an FSA?

You cannot contribute to both a Health Care FSA and HSA during the same plan year.

During open enrollment, you can elect an FSA and determine how much you want to contribute in Paylocity. In order to make changes after open enrollment, you need to experience a qualifying event, such as:

- Change in marital status
- Birth or adoption
- Loss of a dependent (death)
- Change in employment status

Additional dependent care FSA qualifying event changes include:

- Change in daycare providers
- Child turning age 13
- Increase or decrease in the cost of qualifying day care expenses
- Judgement, decree or order requiring change in coverage



Healthcare FSA

Dependent Care FSA

Maximum Annual Election

\$3,400

Maximum Annual Election

\$7,500

Eligible Expenses

- Deductible, coinsurance and copays
- Prescription drugs
- Dental services including orthodontia
- Vision services such as contacts and glasses
- Visit <https://www.irs.gov/publications/p502> for a full list of qualified expenses.

Eligible Expenses

- Care of dependent children under age 13 by a day care center or before-school or after-school program.
- Care for a disabled spouse, parent or child if the individual lives with you and cannot care for themselves.
- Care must be provided to keep employee and spouse gainfully employed.

Dental Benefits

Guardian

In addition to protecting your smile, dental insurance helps pay for dental care and includes routine care, such as oral exams, cleanings and x-rays. Receiving dental care can protect you and your family from the high cost of dental disease and surgery. The chart below provides a brief overview of your benefits with [Guardian's Dental Network Access Plan](#).

To find an in-network provider:

- Visit guardiananytime.com
- Click "Find a Dental Provider"
- Choose the **PPO: DentalGuard Preferred** network
- Enter a provider's name, office name, or zip code
- Don't forget to ALWAYS check the in-network status of your providers in order to take full advantage of your benefit. Non-participating dentists are not required to file claims on your behalf or guarantee a discounted service

Benefit Description	In-Network	Out-of-Network
Deductible Individual/Family	\$50 / \$150	\$50 / \$150
Annual Benefit Maximum	\$1,000	\$1,000
Lifetime Ortho Maximum	\$1,000	\$1,000
Preventive & Diagnostics Exams/Cleanings (each twice in a contract year), Bitewing X-rays	100%, not subject to deductible	100%, not subject to deductible
Basic Services Fillings, Simple Extractions, Other X-rays	80%	80%
Major Services Endodontics, Periodontics, Implants, Crowns, Bridgework, Full and Partial Dentures	50%	50%
Orthodontia Benefits (children to age 19)	50%	50%
Rollover Amount		\$250*

*You are able to rollover an additional \$100 for in-network benefits



Dental Plan Costs (per pay period, semi-monthly)	
Employee Only	\$8.50
Employee + Spouse	\$17.00
Employee + Child(ren)	\$23.00
Employee + Family	\$34.00

Vision Benefits

Guardian

Having vision benefits can help you maintain your vision as well as detect various health problems. Our policy covers routine eye exams and other procedures and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses through **VSP**.

Benefit Description	In-Network	Out-of-Network
Copay Exams / Materials	\$10 / \$25	Varies
Frequency Vision Exam Lenses OR Contact Lenses Frames	12 months 12 months 24 months	12 months 12 months 24 months
Eye Exams	100% after copay	Up to \$39 benefit allowance
Lenses Standard Lenses - Single Vision Lined Bifocal Lenses Lined Trifocal Lenticular Lenses	100% after copay 100% after copay 100% after copay 100% after copay	up to \$23 reimbursement up to \$37 reimbursement up to \$49 reimbursement up to \$64 reimbursement
Frames	Up to \$130 covered, 20% off balance*	Up to \$46 benefit allowance
Contact Lenses All Other Elective Contact Lenses Medically Necessary	Up to \$130 benefit allowance 100% after copay	Up to \$100 benefit allowance Up to \$210 benefit allowance
LASIK Vision Correction	10 - 20% off VSP contracted laser centers**	

*See full benefit summary for details on participating provider

**5% off promotional price



To find a VSP in-network provider, visit vsp.com/eye-doctor:

- Search by Location, Office, or Doctor
- Click “Search” to display a list of providers near you

Vision Plan Costs (per pay period, semi-monthly)	
Employee Only	\$3.59
Employee + Spouse	\$6.80
Employee + Child(ren)	\$7.96
Employee + Family	\$11.21

Life and AD&D Benefits

Guardian

Basic Life and AD&D Insurance

Aileron provides full-time employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance. This benefit is **100% paid by Aileron**.

BASIC LIFE AND AD&D	
Benefit Amount	1x annual salary up to \$50,000
Guaranteed Issue	Full Benefit
Age Reduction Schedule	Benefit reduces to 65% at age 65, 40% at age 70, 25% at age 75 (benefits term at retirement)

Voluntary Life and AD&D Insurance

In addition to the basic life and AD&D insurance that Aileron purchases for you, you may want to purchase additional life and AD&D insurance. If you purchase voluntary life and AD&D insurance, the premium is **100% paid by you**.

You can purchase coverage for yourself, your spouse and children. You must purchase coverage on yourself in order to purchase dependent coverage. If you elect an amount above the guaranteed issue, you will be required to complete an evidence of insurability form (answer medical questions) and the benefit will be subject to underwriting approval.

VOLUNTARY LIFE AND AD&D	
Employee Benefit	\$10,000 increments up to \$100,000 Guaranteed Issue Amount: \$100,000
Spouse Benefit	\$5,000 increments up to \$50,000 not to exceed 50% of the employee election amount. Guaranteed Issue Amount: \$25,000
Children Benefit	Age 14 days to 20 years (26 if full time student): \$10,000 Guaranteed Issue Amount: \$10,000
Age Reduction Schedule	Benefit reduces to 65% at age 65; 40% at age 70; 25% at age 75; 10% at age 80

Calculating Your Voluntary Life Rate (per pay period, semi-monthly)

Use the age banded rate chart below to calculate your semi-monthly premium based on the amount of coverage you wish to elect. Spouse rates are based on the employee age.

$$\frac{\text{Elected Amount}}{1,000} \times \text{Age Rate} = \text{Semi-Monthly Premium}$$

Age	<34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
Rate	\$0.051	\$0.069	\$0.105	\$0.159	\$0.285	\$0.435	\$0.483	\$0.873	\$1.749	\$4.430	\$9.845

Child premium is **\$0.90 semi-monthly per child**.

Disability Insurance

Guardian

Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness. Please note that you are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

At **Aileron**, we want to do everything we can to protect you and your family. **That's why Aileron pays for the full cost of long-term disability insurance, meaning that you owe nothing out of pocket.** Short-term disability is available for purchase via semi-monthly payroll deduction.

	Voluntary Short-Term Disability	Long-Term Disability
Benefit Amount	60% of weekly salary	60% of monthly salary
Maximum Benefit	\$1,000 per week	\$5,000 per month
Benefits Begin	On the 15th day	90 days
Benefit Duration	11 weeks	5 years or to age 70
Pre-existing Condition Limitation	3/12*	3/12

Age Bands	Rate per \$10 of weekly STD benefit
0-29	\$0.576
30-34	\$0.540
35-39	\$0.492
40-44	\$0.444
45-49	\$0.444
50-54	\$0.480
55-59	\$0.564
60+	\$0.672

***Please note**
 A Pre-Existing Condition is any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage,
 You will not receive a benefit if you meet these terms for the first 12 months of coverage.

How to Calculate Your Bi-Monthly (per pay check) STD Premium

$$\text{1} \quad \frac{\text{Annual Salary}}{\div 52 \text{ Weeks}} \times 0.60 \text{ Benefit} = \text{Benefit Amount*}$$

The maximum weekly benefit is \$1,000 which covers a weekly salary of \$1,666. If your salary exceeds \$86,666, use the \$1,000 max benefit as your Benefit Amount.

$$\text{2} \quad \frac{\text{Benefit Amount}}{\times} \frac{\text{Age Rate}}{\div \$10} = \text{Monthly Premium}$$

Divide the Total Monthly Premium by 2 to get your semi-monthly payroll deduction.

Employee Assistance Program (EAP)

ComPsych Guardian

Aileron offers all eligible employees an EAP administered through ComPsych Guardian.

The EAP offers comprehensive solutions to help you when faced with a personal crisis such as depression, anxiety, or substance use. **The EAP includes:**

Telephone or In-Person Counseling

You receive **three** free counseling sessions per year, per household member. Licensed and professional counselors listen and carefully evaluate your needs and offer short-term counseling focused on coping strategies. Professionals provide assistance for:

- Marital difficulties
- Substance abuse (alcohol & drugs)
- Parenting and family conflicts
- Grief counseling
- Stress & anger management
- Depression and emotional problems
- And much more!

Employees in need of long-term counseling and specialized care are referred to the appropriate treatment plans.

How does it work?

You can call ComPsych at 855-239-0743 to access telephone or in-person counseling and work-life services. If needed, you may be referred to ongoing treatment or specialty care. You can also visit www.guidanceresources.com.



Accident Insurance

Guardian

Accident Insurance coverage helps provide financial support if you or a covered family member experience a covered accident and/or unexpected medical stay and procedures. **Aileron** offers this plan on a voluntary enrollment basis with the benefit of having premiums taken out of your semi-monthly paycheck.

The costs associated with treatment can mount quickly. For covered accidental injuries, fixed benefits are paid directly to you regardless of any other coverage you may have and you can spend it any way you choose. Benefits are paid according to a fixed schedule that includes benefits for hospitalization, fractures and dislocations, emergency room visits, major diagnostic exams, physical therapy and more.

Common Accidents Covered*	Cash Payout Available
Wellness Benefit	\$50 per year per covered person
Emergency Room Services	\$200
Knee or Ankle Joint Injury	\$1,600
Urgent Care	\$100
Dislocation / Fracture	Up to \$6,000
Concussion	\$200
Laceration	Up to \$400
Family Lodging	Daily \$125 up to 30 Days
Accidental Death and Dismemberment	Employee: \$40,000 Spouse: \$12,500 Child: \$5,000

*Please see benefit summary for complete list of covered services and payout requirements.



Accident Costs (per pay period, semi-monthly)	
Employee Only	\$5.84
Employee + Spouse	\$9.57
Employee + Child(ren)	\$10.05
Employee + Family	\$13.78

Critical Illness

Guardian

Aileron offers voluntary **Critical Illness coverage**. Critical Illness insurance pays a fixed benefit if you are diagnosed with a covered illness after your coverage effective date.

This insurance can help cover out-of-pocket medical as well as non-medical expenses. This plan also pays a \$50 wellness screening benefit per person per year once you provide proof of an eligible health screening.

You can elect a maximum coverage amount of \$10,000 or \$20,000 for you and your spouse. Dependent children automatically receive a maximum benefit of 50% of the employee elected amount.

BENEFIT CATEGORY*	CONDITION	% of Max Benefit
Cancer and Benign Tumors	Invasive Cancer	100%
	Benign Brain and Spinal Tumor	100%
	BRCA1 or BRCA2 Mutation	30%
	Skin Cancer	\$250
Heart and Vascular	Heart Attack/Heart Failure	100%
	Stroke (Severe)	100%
	Coronary Artery Disease	50%
	Stroke (Moderate)	50%
	Pulmonary Embolism	30%
Neurological Disorders	Advanced Alzheimer's	100%
	ALS	100%
	Dementia	100%
	Multiple Sclerosis	100%
	Advanced Parkinson's	100%
Childhood Illnesses and Disorders	Autism Spectrum	100%
	Cerebral Palsy	100%
	Cleft Lip or Palate	100%
	Congenital Heart Defect	100%
	Type 1 Diabetes	100%

*To see a full list of covered benefits, please see the respective benefit plan documents located in Paylocity.

Age Bands	Semi-Monthly Premium per \$20,000 benefit	Semi-Monthly Premium per \$10,000 benefit
0-29	\$5.10	\$2.55
30-39	\$9.00	\$4.50
40-49	\$17.90	\$8.95
50-59	\$34.70	\$17.35
60-69	\$58.80	\$29.40
70+	\$100.20	\$50.10



Hospital Indemnity

Guardian

Hospital Indemnity insurance pays a fixed benefit if you have a hospital admission or stay after your coverage effective date.

Covered hospital benefits include hospital admissions for chronic care, observation, ICU and non-ICU, and newborn nursery care.

Key Advantages of this Plan

- Benefits are payable directly to you to be spent any way you choose. Benefits are paid per admission, per day, or a one time lump-sum.
- This plan pays in addition to any other coverage you may have.
- Coverage is fully portable - if you change jobs, you can take your coverage with you.

Benefits	Amounts
Hospital Admission	\$1,000 per admission to a max of 2 admissions per year, per insured
Hospital Confinement	\$100 per day to a max of 30 days per year, per insured
Hospital ICU Admission	\$1,000 per admission to a max of 2 admissions per year, per insured
Hospital ICU Confinement	\$200 per day to a max of 30 days per year, per insured
Treatments Covered	Sickness & injury
Pre-Existing Condition Limitation	3/12

Hospital Indemnity	Semi-Monthly Cost
Employee Only	\$7.25
Employee + Spouse	\$13.57
Employee + Child(ren)	\$11.67
Family	\$17.99



FAQs & Glossary



If I want to make changes, what must be completed?

Complete your online enrollment and capture all necessary changes.

Are vision care providers required to be in the network to obtain the annual routine visit?

To get the most out of your benefit, you should visit an in-network vision care provider for your annual routine visit. We do encourage you to shop around for lenses and frames.

What is the maximum age for a dependent to be on our health plan?

Coverage for dependent children will end on their 26th birthday.

How do I obtain a new ID card or additional cards for dependent children?

If you need a new ID card, please contact Human Resources.

Is there a pre-existing limitation on the plan?

The medical plan does not have a pre-existing limitation.

Are elections for medical and dental independent?

Yes. You can cover yourself & spouse on medical and just yourself on dental. You must be covered on a plan to elect coverage for you dependents.

Do we need a referral to see a specialist?

You do not need a referral to see a specialist, but we do encourage you to visit your primary care physician prior to seeing a specialist as they should stay abreast of any medical issues you may be experiencing.

If we visit our pediatrician after normal hours, is this considered a specialist visit?

That will be dependent on how the provider files the claim. Many times after hours clinics are considered urgent care.

Deductible

The amount you pay for applicable out-of-pocket covered health care services before your insurance plan starts to pay.

Coinsurance

The percentage of costs of a covered health care service shared between the insurance carrier and the insured after you pay your deductible.

Copayment

A fixed amount you pay for a covered health care service.

Prior Authorization

Certain services or procedures may require written permission or recommendation from a health care professional to validate medical necessity in order to be covered by your insurance.

Primary Care Physician

A physician, nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Specialist

A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical services. The UCR amount may be used to determine the allowed amount.

Preferred Provider

A provider who has a contract with your insurer or plan to provide services to you at a discount. Preferred providers will file claims on your behalf and will not balance bill.

Non-Preferred Provider

A provider who does not have a contract with your health insurer or plan to provide services to you. You will pay more to see a non-preferred provider and will have more administrative responsibilities.

Premium

The amount that must be paid for your insurance plan each month. This amount may be shared by you and your employer.

Key Contacts



HAVE QUESTIONS, PROBLEMS OR CONCERNS?

The following are your carrier numbers and websites should you need assistance understanding your benefits, claims, or other insurance-related information.

Carrier Contacts

Plan	Carrier	Contact Information
Medical	Gravie	1-800-501-2920 member.gravie.com
Medical Network	Cigna OAP	Go to member.gravie.com to see your in-network providers
Dental	Guardian	1-800-541-7846 guardiananytime.com
Vision	Guardian	1-866-569-9900 guardiananytime.com
Life and Disability	Guardian	Life/AD&D: 1-800-525-4542 Short Term Disability: 1-800-268.2525 Long Term Disability: 1-800-538-4583 guardiananytime.com
Employee Assistance Program (EAP)	ComPsych Guardian	855-239-0743 guidanceresources.com
Accident	Guardian	1-800-541-7846 guardiananytime.com
Critical Illness	Guardian	1-800-541-7846 guardiananytime.com
Hospital Indemnity	Guardian	1-800-541-7846 guardiananytime.com
Telemedicine	Teledoc	1-800-Teladoc www.teladoc.com
Marisa Middaugh	Human Resources	mmiddaugh@aileronmanagement.com

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfir/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/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</p>	<p>Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>
MONTANA – Medicaid	NEBRASKA – Medicaid
<p>Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov</p>	<p>Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178</p>

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
<p>Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900</p>	<p>Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov</p>
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
<p>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)</p>	<p>Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831</p>
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100</p>	<p>Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825</p>
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>	<p>Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075</p>
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
<p>Website: https://www.pa.gov/en/services/dhs/apply-for-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)</p>	<p>Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)</p>
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
<p>Website: https://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>Website: http://dss.sd.gov Phone: 1-888-828-0059</p>
TEXAS – Medicaid	UTAH – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493</p>	<p>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/</p>
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427</p>	<p>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</p>

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

General Notice of COBRA Rights

(For use by single-employer group health plans)

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

**Marisa Middaugh
100 W Washington St
Greenville, SC 29601**

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if 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 an 8-month special enrollment period¹ 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.

¹ <https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods>.

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

Keep your Plan informed of address changes

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

Plan contact information

2026 Plan Year
Marisa Middaugh
100 W Washington St
Greenville, SC 29601

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (“GINA”) protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

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

Health Insurance Exchange Notice

For Employers Who Offer a Health Plan to Some or All Employees

New Health Insurance Marketplace Coverage 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 ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.¹²

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if

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

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact:

Marisa Middaugh
100 W Washington St
Greenville, SC 29601

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 Your Employer

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

3. Employer name Aileron Management	4. Employer Identification Number (EIN) 83-1169497	
5. Employer address 100 W Washington St	6. Employer phone number 8645903369	
7. City Greenville	8. State SC	9. ZIP code 29601
10. Who can we contact about employee health coverage at this job? Marisa Middaugh		
11. Phone number 8645903369	12. Email address	

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

- As your employer, we offer a health plan to:
 - Some employees. Eligible employees are: full-time employees
 - With respect to dependents:
 - We do offer coverage. Eligible dependents are: legally married spouse and children up to age 26
 - 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.

Note: 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.

Medicare Part D Creditable Coverage Notice

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

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Aileron Management coverage will not be affected.

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month

that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information call Marisa Middaugh at 8645903369. 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 Aileron Management changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 11/4/2025

Name of Entity/Sender: Aileron Management

Contact--Position/Office: Marisa Middaugh, HR Director

Address: 100 W Washington St Greenville, SC 29601

Phone Number: 8645903369

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at 8645903369.

Michelle's Law Notice

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

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

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

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

To obtain additional information, please contact:

Marisa Middaugh
100 W Washington St
Greenville, SC 29601

Newborns' and Mothers' Health Protection Act Notice

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).

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain [out-of-pocket costs](#), like a [copayment](#), [coinsurance](#), or [deductible](#). You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

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

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

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

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

If you think you've been wrongly billed, contact the No Surprises Help Desk, operated by the U.S. Department of Health and Human Services, at 1-800-985-3059.

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

Notice of Privacy Practices

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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of *the Aileron Management's Gravie Medical Plans* (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information (PHI) is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to:

- a. Your past, present, or future physical or mental health or condition;
- b. The provision of health care to you; or
- c. The past, present, or future payment for the provision of health care to you.

I. Contact Information

If you have any questions about this Notice or about our privacy practices, and for any correspondence or requests related to the contents of this Notice, please contact Marisa Middaugh, 864-999-2306, 100 W Washington St, Ste 300, Greenville, SC 29601.

II. Effective Date

This Notice is effective 02/09/2026

III. Our Responsibilities

We are required by law to:

- a. maintain the privacy of your PHI;
- b. provide you with certain rights with respect to your PHI;
- c. provide you with a copy of this Notice of our legal duties and privacy practices with respect to your PHI; and
- d. follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your PHI that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices.

IV. How We May Use and Disclose Your PHI

Under the law, we may use or disclose your PHI under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your PHI. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories. Note that we will use and disclose PHI as described below unless otherwise prohibited or restricted by applicable state or other law, and that information can lose its protected status as PHI once re-disclosed by a recipient.

For Treatment. When and as appropriate, we may use or disclose medical information about you to facilitate medical treatment or services by health care providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about you with physicians who are treating you.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations. We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Substance Use Disorder (SUD) Treatment Information. Some of your health information may be part of a SUD patient record and subject to additional protections under federal law (42 CFR Part 2) governing confidentiality of SUD patient records.

If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the SUD patient record for purposes of treatment, payment or health care operations, we may use and disclose your SUD patient record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your SUD patient record through specific

consent you provide to us or another third party, we will use and disclose your SUD patient record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your SUD patient record, or testimony that describes the information contained in your SUD patient record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

Treatment Alternatives or Health-Related Benefits and Services. We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

As Required by Law. We will disclose your PHI when required to do so by federal, state, or local law. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the plan, we may disclose PHI to certain employees of the Employer. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

V. Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your PHI without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, we may release your PHI after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military. If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your PHI for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your PHI for public health activities. These activities generally include the following:

- a. to prevent or control disease, injury, or disability;
- b. to report births and deaths;
- c. to report child abuse or neglect;
- d. to report reactions to medications or problems with products;
- e. to notify people of recalls of products they may be using;
- f. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- g. to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. We may disclose your PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement. We may disclose your PHI if asked to do so by a law-enforcement official.

- a. in response to a court order, subpoena, warrant, summons, or similar process;
- b. to identify or locate a suspect, fugitive, material witness, or missing person;
- c. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- d. about a death that we believe may be the result of criminal conduct; and
- e. about criminal conduct.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law-enforcement official, we may disclose your PHI to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. We may disclose your PHI to researchers when:

- a. The individual identifiers have been removed; or
- b. When an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

VI. Required Disclosures

The following is a description of disclosures of your PHI we are required to make.

Government Audits. We are required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You. When you request, we are required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

VII. Other Disclosures

Personal Representatives. We will disclose your PHI to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- a. You have been, or may be, subject to domestic violence, abuse, or neglect by such person; or
- b. Treating such person as your personal representative could endanger you; and
- c. In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your PHI not described above will only be made with your written authorization. For example, in general and subject to specific conditions, we will not use or disclose your psychiatric notes; we will not use or disclose your PHI for marketing; and we will not sell your PHI, unless you give us a written authorization. You may revoke written authorizations at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

VIII. Your Rights

You have the following rights with respect to your PHI:

Right to Inspect and Copy. You have the right to inspect and copy certain PHI that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your PHI, you must submit your request in writing. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- a. is not part of the medical information kept by or for the Plan;
- b. was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

- c. is not part of the information that you would be permitted to inspect and copy; or
- d. is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your PHI that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured PHI.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

IX. Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the person listed in the Contact Information section of this Notice. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

Lumelight is not a law firm and cannot dispense legal advice. Anything contained in this communication is not and should not be construed as legal advice. If you need legal advice, please contact your legal counsel.

Notice of Special Enrollment Rights

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

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.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact:

Marisa Middaugh

100 W Washington St

Greenville, SC 29601

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

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

B. Reemployment Rights

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

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

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

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
 - Initial employment;
 - Reemployment;
 - Retention in employment;
 - Promotion; or
 - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not 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.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at <http://www.dol.gov/vets>. An interactive online USERRA Advisor can be viewed at <http://www.dol.gov/elaws/userra.htm>.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: <http://www.dol.gov/vets/programs/userra/poster.htm>. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: \$5000 deductible (in-network) and 80% coinsurance (in-network) and \$10000 deductible (out-of-network) and 50% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at 8645903369.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 8645903369 for more information.



The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the guide and actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about the guide, please contact HR.

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