2025
Benefit Guide
HTC America, Inc.

Welcome to your 2025 Benefits!

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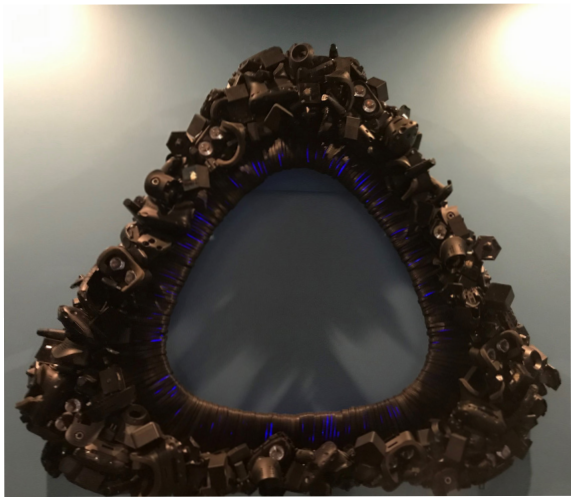
HTC Benefits 2025:

- Review your elections and make any changes for 2025 in ADP Workforce Now. See page 4 for more information.
- All benefit resources are available on the HTC Benefit Hub and mobile app.
- You must make pretax elections on the Navia website to elect coverage for FSA (Flexible Spending Accounts) for Medical and Dependent Care to participate for 2025.



If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 31 for more details.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/ Benefits Department.

Open Enrollment and Enrollment Instructions

Every year HTC evaluates the benefits that we offer to our employees. We are pleased to continue to offer a comprehensive benefit package.

It remains HTC's goal to provide healthcare and insurance resources that enable our employees and their families to enjoy fulfilling, active lives.

HTC continuously strives to provide benefit programs that enable us to remain the employer of choice, attracting and retaining top-tier talent.

These programs are designed not only to meet employee needs, but also the needs of your dependents.

This 2025 Benefit Guide provides a summary of all benefit programs. Because enrollment in benefit plans is critical, individual employees should carefully review the information provided.

If you have questions about your current benefits or need assistance understanding your options you a resource. A Gallagher Benefit Advocate can be reached toll-free, Monday-Friday from 6 am to 6 pm PST at 833.580.5861 or via email at bac.htcamerica@ajg.com.

New Hires – Enrollment Instructions

If you are a new hire enrolling in current year benefits, or you are experiencing a life status change event during (or after) open enrollment, you must make your current year election and your next year's election separately. Do not hesitate to contact Human Resources if you have any questions.

2025 Updates

- Slight increase to the HSA Deductible (Employee only increase from $1,600 to $1,650. Family increase from $3,200 to $3,300) to match IRS HDHP Minimum Deductible requirements.
- HTC is also increasing the HSA contributions to accomodate the increased deductibles above in the HDHP Plan.
- The Health Savings Account (HSA) & Flexible Spending Accounts (FSA) contribution maximums have increased for 2025.
- Plan highlights and additional online resources are available on the HTC Benefit Hub at https://c2mb.ajg.com/htc/home
- New Pet Insurance carrier with ASPCA, as there will be no new enrollments on the Trupanion plan moving forward

Current Employees – Enrollment Instructions

- All employees are required to make active elections for 2025. Enrollment for 2025 is an active enrollment and all employees must make elections for both medical benefits with Aetna and pre-tax FSA/HSA elections with Navia.
- Please review your benefits on the ADP Workforce Now platform. Even if you are not making changes to your current plan elections for the new year, you must log in to review and re-elect coverage for 2025.
- To see your elections for your 2024 year coverage, download a copy of your Benefit Statements (Your Benefits > Click Download > Enrollment Summary).
- Please confirm beneficiary and dependent data is up to date.
- Please review the 2025 coverage rates for supplemental benefits. We encourage all employees to review their coverage elections and confirm acceptance for 2025.
- Only current Trupanion elections will remain in effect for 2025. Please log into the Trupanion website to remove pets for the upcoming year.
- If you would like to newly enroll in pet insurance, you can do so with ASPCA. Enrollment is processed directly on their portal or via phone. This benefit will not be handled through payroll deductions.
- All employees should make their pretax elections for FSA, HSA and Commuter Benefits for the new year.
- FSA Medical and FSA Dependent Care elections will be made in ADP.
- HSA elections will be made using ADP Workforce.
- If you would like to participate in the Navia Commuter Benefit, you will need to elect your benefit in the Navia employee portal directly. Employer subsidies are only available for employees residing in California and are able to put pre-tax dollars aside for the use of this benefit. You may begin making elections after December 1, 2024, for benefits to begin on January 1, 2025. Members that are currently enrolled will still have access to the Navia employee portal year round to make monthly elections.

Enrolling through ADP

To review your current benefit elections and make updates to coverage for 2024, log into ADP Workforce Now at online.adp.com. If you are logging in for the first time, you will need to register as a first time user with one of two options:

- Use the registration code: **htcamerica-payroll**
- Use the "find me" option with ADP and confirm your personal information

An Open Enrollment pop-up message will appear after logging in, until you have completed your enrollment. Once continuing forward, you will indicate your tobacco status, view benefit enrollments, and compare plans. Follow the instructions in ADP Workforce Now throughout enrollment. After making your elections, be sure to take a moment to review your dependent and beneficiary information, especially when they are included in coverage. Once your benefit elections are ready for submission, it is recommended to review and download a copy for reference. If you have any questions on the enrollment process and general site navigation, contact MyLifeAdvisor@adp.com or call 855.547.8508, available from 5:00 am to 8:30 pm PT.

ASPCA (www.aspcapetinsurance.com/HTC) and GoNavia (www.naviabenefits.com) products require enrollment outside of ADP Workforce Now. To elect coverage for your furry family members or waive participation in this benefit for the 2025 plan year, log into ASPCA's website at www.aspcapetinsurance.com/HTC. If no changes are needed, your current enrollments with Trupanion coverage will roll over, however, this product will not permit new elections for 2025 and has been replaced by ASPCA Pet Health Insurance as a carrier for new enrollments in 2025.

To update current pet insurance elections, please call Trupanion at 855-861-2415. For new pet insurance enrollment, please visit ASPCA Pet Health Insurance. HTC's priority enrollment code is: **EB24HTC**

For monthly GO Navia parking and transit benefit elections made throughout the year, visit www.naviabenefits.com. For employees in California, FSA commuter benefits require you to re-enroll for coverage in 2025, even if you are not making any changes. Please note during enrollment that an employer subsidy was reinstated for 2024. To see your elections for your 2024 year coverage, download a copy of your Benefit Statements (Your Benefits > Click Download > Enrollment Summary).

You must re-enroll in the FSA for coverage in 2025, even if you are not making any changes. Please visit GoNavia (www.naviabenefits.com) to ren-enroll. You can also update HSA elections for 2025, and open an HSA account if you are enrolling in the HDHP medical plan for the first time.

Further instructions on enrollment are available on the Benefit Hub website at https://c2mb.ajg.com/htc/home.

Please review your current plan elections and costs for the 2025 plan year carefully. Updates may be made through the ADP Workforce Now, the Navia web portal for GoNavia commuter benefits, and the ASPCA portal for pet insurance benefits. You have until the end of the enrollment period to make updates. Once the enrollment period has ended, your elections will be final until the next enrollment period or until you have a qualifying life event. Contact your benefit administrator at Americas_Benefits@htc.com if you have any questions.

Portal Support

Have Questions? Need Help?

Contact Americas_Payroll@HTC.com / 206.548.2202 for questions regarding:

Time Off | Time and Attendance | Payroll

For general site navigation, contact

ADP MyLife Advisors

Phone: 855.547.8508

E-Mail: MyLife Advisors@adp.com

Hours: 5:00 am to 8:30 pm PST

Benefits At A Glance – Medical

Plan Benefit	
Medical Option 1: Aetna High Deductible Health Plan Health Savings Account Open Choice Network Group #: 193793 www.aetna.com	**Medical Option 2:** Aetna Preferred Provider Plan PPO Open Choice Network Group #: 193793 www.aetna.com
Benefit Details at a Glance* (In-Network)	
Annual Deductible: Employee $1,650, Family Aggregate $3,300 **Maximum Out-of-Pocket:** Employee $4,000, Family Aggregate $8,000 **HTC Monthly Contribution to HSA (if elected):** Employee $95.83, Family $191.67 **Preventive Care:** Covered in Full; Most Other Services Covered at 80% after deductible **Your Prescription Cost:** Generic $15, Formulary $30, Non-Formulary $60	**Annual Deductible:** Employee $750, Family $1,500 **Maximum Out-of-Pocket:** Employee $4,000, Family $8,000 **Copays**: Office Visits – $25, ER – $250, Mental Health – $25 **Preventive Care**: Covered in Full, Most Other Services Covered at $25 copay, but some services are subject to deductible and coinsurance **Your Prescription Cost:** Generic $15, Formulary $35, Non-Formulary $60
Your Monthly Cost	
Employee Only: $0 Employee & Spouse: $146.35 Employee & Children: $99.18 Employee & Family: $248.62	Employee Only: $25 Employee & Spouse: $222.14 Employee & Children: $155.47 Employee & Family: $345.90

*For specific details about our benefits please refer to the applicable carrier's booklet

Benefits At A Glance

Plan Benefit	Benefit Details at a Glance*	Your Monthly Cost
Dental: Delta Dental of WA Preferred Provider Group #: 09416 www.deltadentalwa.com	**Maximum Annual Benefit:** $2,000 per person **Annual Deductible PPO Plan:** $50/individual, $150/family (In-Network) **Preventive:** Covered In Full, Restorative: Covered at 80% **Major:** Covered at 50% **Orthodontia:** Covered at 50% up to $1,500 maximum	Employee and Dependent(s) Cost: Included in medical plan above
Vision: Vision Service Plan (VSP) VSP Signature Network Group #: 30023495 www.vsp.com	**Annual Eye Exam (Basic):** $10 copay, **Frames:** $25 copay, then up to $150 allowance w/ 20% discount over $150 allowance **Lenses:** Covered in Full **Contact Lenses:** Up to $60 copay (fitting and exam) and up to $150 allowance	Employee and Dependent(s) Cost: Included in medical plan above
Long-Term Disability: Prudential www.prudential.com	**Long-Term:** 60% of earnings up to $10,000 per month, 180-day waiting period, to age 65 (SSNRA)	No Cost to Employee
Life and AD&D: Prudential www.prudential.com	**Life Insurance Coverage:** 2x Annual Earnings to $300,000 max **AD&D Coverage:** 2x Annual Earnings to $300,000 max	No Cost to Employee
Flexible Spending Account (FSA): Navia Benefit Solutions www.naviabenefits.com	Pre-tax funds to be spent on Health Care and/or Dependent Care. You may carry over up to $660 in unused Healthcare FSA election from one year to the next. Healthcare FSA election for the upcoming year is required to permit carryover. Unused amounts in your Dependent Care FSA cannot be carried over and will be forfeited. **Health Care Option:** Up to $3,300 **Dependent Care Option:** Up to $5,000	Employee contribution (HTC pays administrative fees)
Health Savings Account (HSA): Navia Benefit Solutions www.naviabenefits.com	Tax advantaged account you can use to pay for current and future healthcare expenses **EE only contribution limit:** $4,300 **Family contribution limit:** $8,550	Employee contribution (HTC pays administrative fees)
GoNavia Commuter Benefit Navia Benefit Solutions www.naviabenefits.com	A commuter benefit that enables you to pay for work related commuting expenses with pre-tax dollars. **Transit:** up to $325 per month **Parking:** up to $325 per month	Employee contribution (HTC pays administrative fees)
Voluntary Insurance: **Gallagher** vChoice	Optional Voluntary Life, AD&D Insurance, Critical Illness Insurance, Accident, Legal, Identity Theft and Pet Insurance.	Employee cost varies by selection
Employee Assistance Program: ComPsych www.guidanceresources.com	Confidential counseling, assessment and referral services for employees and their families.	No Cost to Employee
Travel Assistance: IMGlobal 855.847.2194 or 317.927.6828 www.imglobal.com	Worldwide emergency travel assistance provided by IMGlobal, through Prudential, for personal or business travel.	No Cost to Employee
401(k) Retirement Plan: Northwest Plan Services (NWPS) www.yourplanaccess.net/nwps	Traditional and Roth Retirement account options. HTC company match is up to 4% of annual federal compensation limit.	No Cost to Employee
Retirement Planning Advice: RBC 866.416.9716 www.rbcwealthmanagement.com	RBC advises the HTC Retirement Plan Committee on our overall investment strategy as well as what funds to invest within the plan. They offer individual advice at no charge to HTC employees.	No Cost to Employee

*For specific details about our benefits please refer to the applicable carrier's booklet

Contact Information

If you have specific questions about an HTC benefit plan, please contact your Gallagher Benefits Advocate at 833.580.5861 or if you would prefer, you can contact the carriers directly.

Benefit	Administrator	Phone	Website and Network
Benefits Portal	To access the HTC Benefit Hub: https://c2mb.ajg.com/htc/home		
Medical / Rx PPO / HDHP	Aetna	877.204.9186	www.aetna.com **Provider Network:** Open Choice Network
Informed Health Nurse Line	Aetna	800.556.1555	www.aetna.com
Dental PPO	Delta Dental of Washington	800.554.1907	www.deltadentalwa.com
Vision (Eye Exam and Hardware)	VSP	800.877.7195	www.vsp.com **Provider Network:** Signature Network
HSA	Navia Benefit Solutions	800.669.3539	www.naviabenefits.com
Flexible Spending Accounts (FSA)			
GoNavia Commuter Program			
Life and Disability	Prudential	Life: 800.524.0542 Disability: 800.842.1718	www.prudential.com
Voluntary Benefits	Gallagher vChoice	425.201.9082	
Pet Insurance	ASPCA	866.204.6764	www.aspcapetinsurance.com/HTC Priority code: EB24HTC
Pet Insurance	Trupanion (Not available for new enrollments)	855.235.3134	www.Trupanion.com
Employee Assistance Program (EAP)	ComPsych	800.311.4327	www.guidanceresources.com **Company Web ID:** GEN311
Travel Assistance	IMGlobal	855.847.2194 or 317.927.6828	www.imglobal.com Email: assist@imglobal.com
401(k)	NWPS	877.690.5410, option 7	www.yourplanaccess.net/nwps
401(k) Financial Advisors	RBC	866.416.9716	www.rbcwealthmanagement.com
HTC Human Resources	For additional questions you may email Human Resources at Americas_Benefits@htc.com		

Questions on Benefits?

Benefit Advocate Center

Gallagher Benefit Services, Inc. serves as a consultant and service provider in support of HTC employees' health and welfare benefits.

They can help with the following:

- Answer Benefits Questions
- Assist with Claim Issues
- Resolve Prescription / Pharmacy Concerns
- Explain What the Insurance Has Paid
- Eligibility Issues
- ID Cards

Please contact your Benefit Advocate at: 425.201.9082

Email: bac.htcamerica@ajg.com
Monday through Friday:
6:00 am to 6:00 pm PST, 7:00 am to 7:00 pm MT, 8:00 am to 8:00 pm CST,
9:00 am to 9:00 pm EST

HTC Benefit Hub – Online Access

You can now access all your benefit information online anytime, anywhere.

To access our HTC Benefit Hub go to: https://c2mb.ajg.com/htc/home

Here is what you can expect to find:

- Insurance and HR Forms
- Detailed Benefit Summaries
- New-Hire Orientation Materials
- Benefit Advocate Contact Information
- WebEx Presentations and Tutorials

Mobile Access

With our mobile benefits site, you have access to information you need when you need it—at the doctor's or dentist's office, at home with your spouse, or anytime you want to find information easily! HTC's mobile site offers you the opportunity to review plan details right from your cell.

Plan Cost

HTC is pleased to continue funding 100% of the premiums for employees enrolled on the Aetna High Deductible Health Plan. Employees enrolled on the Aetna PPO plan have a $25 cost share. HTC will continue to cover a large percentage of the cost of dependent coverage on both plans. **HTC pays 100% of the cost for dental and vision**.

Premium Costs

Employee contributions towards premiums for medical, dental and vision are deducted from your scheduled payroll as a cafeteria 125 payroll deduction. These pretax deductions are exempt from Federal Income and FICA taxes.

Premiums for domestic partner coverage are taken out of your paycheck on an after tax basis. Your payroll deduction and the amount that HTC contributes towards your domestic partner coverage is taxable and is referred to as "imputed income."

2025 Employee Cost per Month:

Monthly Premiums	Employee Pays (Monthly)	
	Aetna: High Deductible Health Plan	Aetna: PPO Plan
Employee Only	$0.00	$25.00
Employee + Spouse / Domestic Partner	$146.35	$222.14
Employee + Child(ren)	$99.18	$155.47
Employee + Family	$248.62	$345.90

2025 HTC Cost per Month:

Monthly Premiums	Employer Pays (Monthly)	
	Aetna: High Deductible Health Plan	Aetna: PPO Plan
Employee Only	$915.97	$1,025.34
Employee + Spouse / Domestic Partner	$1,900.74	$2,127.26
Employee + Child(ren)	$1,544.21	$1,723.01
Employee + Family	$2,529.10	$2,834.89

Eligibility

DID YOU KNOW

All regular full-time employees scheduled to work 30 or more hours each week are eligible for coverage under HTC's employee benefit plans. Most benefit coverages will begin on the first day of the month following your date of hire.

Who Is Eligible?

If you are a new hire, you must complete your enrollment and submit any required dependent documentation (if applicable) to Human Resources within 31 days of hire, but you are encouraged to complete enrollment as soon as possible to ensure that benefits will be effective on the date of eligibility.

You may enroll your eligible dependents for HTC's medical, dental, vision and voluntary plans. Eligible dependents include:

- Your legal spouse
- Your domestic partner*
- Your children up to age 26
- Any overage dependent child who is incapable of self-support because of a physical or mental disability and meets carrier requirements for coverage

*Domestic partners may be of the same or opposite sex and may only enroll if they meet all the guidelines of the domestic partner affidavit. These guidelines are:

- Resides with the employee in the same permanent residence
- Is the employee's sole domestic partner
- Is at least 18 years of age
- Is not a blood relative any closer than would prohibit legal marriage in the state in which the employee legally resides
- Are jointly responsible for basic living expenses including the cost of basic food, shelter and any other expenses of a domestic partner. They need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the cost
- Are not married to anyone else
- Were mentally competent to consent to contract when the domestic partnership began
- Are each other's sole domestic partner

Making Changes To Your Benefits

Employees are allowed an opportunity to adjust their benefit elections once a year during annual HTC open enrollment period. Your elections will be effective for a full calendar year (from January 1st - December 31st) unless you have a "qualified life event" or terminate employment. Because many of your benefits are available on a pre-tax basis, the IRS requires you to have a qualified life event in order to make changes to your benefit elections during the year. See the next page for examples.

Eligibility

DID YOU KNOW

You may be able to change your benefit elections if you or your eligible family members gain or lose benefits coverage as a result of a qualified life event, provided the change in your benefit election is consistent with the life event.

Qualified Life Events

You may be able to change your benefit elections if you or your eligible family members experience a qualified life event, provided the change in your benefit election is consistent with the life event. The change must be in accordance with IRS Section 125 requirements. You will have 30 days in which to make changes to your benefits and provide Human Resources with the required documentation.

Event	Medical, Dental and Vision	Flexible Spending Accounts (FSA)	Voluntary Life	Voluntary AD&D
Marriage	May enroll newly eligible spouse or you may drop coverage if enrolling in spouse's plan (additional documentation required if dropping plans)	Healthcare and Dependent Care FSA: May enroll, increase, decrease or cease election	May enroll, increase, decrease or cease coverage	May enroll, increase, decrease or cease coverage
Gain Dependent Birth / Adoption Foster Child	May enroll or increase coverage for newly-eligible dependent	May enroll or increase election	No change	No change
Spouse Gains Employment	May drop or decrease coverage for self and dependents who become eligible for, and elect coverage under, spouse's plan	May enroll, increase or decrease election	May increase or decrease coverage	No change
Spouse Loses Employment	May enroll self, spouse or dependents who lose eligibility under spouse's prior plan	May enroll or increase election	May increase or decrease coverage	May increase or decrease coverage
Loss of Spouse	May drop election only for spouse. May elect for self or dependents who lose eligibility under spouse's plan	May decrease election	May enroll, increase, decrease or cease coverage	May drop election only for spouse

Medical Benefits

DID YOU KNOW

To locate a provider, visit: **Aetna.com**, select "find a doctor" and choose the Open Choice network

ALL EMPLOYEES have the choice between two Medical plans:

High Deductible and Aetna PPO

Health Plans: Open Choice Network

Health insurance companies contract with doctors and hospitals to create a network of providers. These providers become "contracted providers" and are considered "in-network." These network doctors and hospitals charge a contracted fee for their services. When you choose to see these "contracted providers," the amount you pay out of your pocket is typically lower.

HTC's High Deductible and PPO Health Plans offer a wide choice of providers. You can elect to use a provider in the Open Choice Network, or any other "out-of-network" provider for your health care services. You do not need a referral for specialist care, nor are you required to choose a primary care physician to coordinate your care.

It is your responsibility as a plan participant to verify that your providers are participating in the network. You can view in-network providers on Aetna's website, by calling Aetna customer service, or by asking your doctor directly. Rather than asking your doctor, "Do you take my insurance?," be sure to ask, "Can you confirm if you are a participating provider in the network associated with my insurance plan?." Many providers who are not participating in the network may still take your insurance and process it as an out-of-network claim, so be sure to specifically confirm that they are a participating provider.

How To Find An In-Network Provider

Aetna has over 8,000 participating locations; many are open seven days a week, with no appointments necessary. By visiting an Aetna location, your costs will typically be less. Look up the nearest urgent care center or walk-in clinic on aetna.com and select "Find a doctor" to use the directory. You can also look up in-network providers using the mobile app, more detail on page 14.

The Aetna Concierge also can help to answer questions about your benefits, clarifying diagnosis, find in-network doctors, schedule appointments and help you to learn more about your coverage or plan for an upcoming treatment. Call the number on your Aetna member ID card or visit Aetna.com and log in to your member website.

- Customer Service: 877.204.9186

Summary of Benefits and Coverage (SBC)

As an employee of HTC, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

HTC offers you a choice of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about health coverage options in a standard format, to help you compare across options. The SBCs are available on the web at the HTC Benefit Hub: https://c2mb.ajg.com/htc/home.

If you prefer, you may also request a paper copy by emailing Americas_Benefits@htc.com.

ID Cards: All employees will receive a new benefit card for 2025 – this will arrive in the first quarter.

Medical Benefits

Benefit	Aetna High Deductible Health Plan Provider Network: Open Choice		Aetna PPO Plan Provider Network: Open Choice	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$1,650 Individual $3,300 Family*	$3,000 Individual $6,000 Family*	$750 Individual $1,500 Family	$1,500 Individual $3,000 Family
Annual Out-of-Pocket Maximum (Includes Deductible)	$4,000 Individual $8,000 Family Family embedded OOP max 2x individual	$8,000 Individual $16,000 Family Family embedded OOP max 2x individual	$4,000 Individual $8,000 Family	$9,000 Individual $18,000 Family
Office Visits: Primary and Specialty Care	20% after deductible	50% after deductible	$25 copay	50% after deductible
Preventive Care	Covered in Full	Not Covered	Covered in Full	Not covered
Inpatient Hospitalizations	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Emergency Room	20% after deductible		$250 copay, then 20% after deductible (copay waived in admitted)	
Urgent Care Facility	20% after deductible	50% after deductible	$25 copay	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Diagnostic Lab and X-Ray	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Inpatient Mental Health / Chemical Dependency	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Outpatient Mental Health / Chemical Dependency	20% after deductible	50% after deductible	$25 copay	50% after deductible
Durable Medical Equipment	20% after deductible	50% after deductible	20% after deductible	50% after deductible
Prescription Drugs	Retail: $15 Generic $30 Brand Name, Formulary $60 Brand Name, Non-Formulary after deductible	In-Network copay, then 40% after deductible	Retail: $15 Generic $35 Brand Name, Formulary $60 Brand Name, Non-Formulary	In-Network copay, then 40%
	Mail Order: 2x retail cost	Not Covered	Mail Order: 2x retail cost	Not Covered
Telehealth	20% after deductible	50% after deductible	$25 copay	50% after deductible

*Family deductible is aggregate.

Aetna.com and Online Tools

Aetna.com Secure Member Website

Aetna.com is your secure member website. It's where you go to:

- Find doctors, pharmacies and hospitals
- Make sure your doctor is in-network before you go
- Look for a new doctor near your home or work
- Print a temporary ID card, or order a new ID card
- Look up a claim to check status
- Check to see what your doctor billed, how much your health benefits and insurance plan paid, and what you have to pay
- Find out how claims work

Use any mobile phone with web access to log in to www.aetna.com and try some great tools. Or if you have a smartphone, check out the Aetna app! You can:

- View a mobile ID card which you can email to your doctor
- Check your benefits coverage
- Find a doctor
- Check what your plan covers
- Check your claims
- 24-hour Nurseline
- See how much you've paid so far and how much you have left to pay

Aetna's Virtual Telehealth Resources

Informed Health Nurse Line*

Informed Health Line is a health and well-being concierge service in which members are connected with a single point who guides them to helpful health information and resources – 24 hours a day, seven days a week.

Available services:
• Speak directly with Registered Nurses or master's level specialists or Nurse Chat online
• Other Assistance Programs

Informed Health Line call 1.800.556.1555 or visit www.aetna.com

*Always call 911 or your local emergency number if you are having a medical emergency. NurseLine gives general information, but does not diagnose or prescribe. NurseLine cannot advise you about what is covered by your plan

Nurses are accessible by phone 24/7

800.556.1555

CVS Health Virtual Primary Care

From wellness visits to quick care, we've got you covered. Easily schedule a virtual care appointment from anywhere. You can use CVS Health Virtual Primary Care™ in addition to your traditional network of providers. Access is included in your medical plan, made available through Aetna®, a CVS Health® company because **healthier happens together™**.

Schedule a virtual primary care visit quickly and easily. You get to choose your provider and enjoy flexible appointments that work with your busy lifestyle.

- Access 24/7 quick care for minor illnesses and injuries via laptop or phone
- Schedule mental health counseling 7 days a week including evenings, by appointment
- Book a new patient visit within days with your selected provider

Some visits cost as low as zero dollars. Members enrolled in qualified high-deductible health plans must meet their deductible before receiving covered non-preventive services at no cost-share.

Get started today

Visit: CVS.com/virtual-care

Finding Providers and Prior Authorizations – Aetna

Questions?

Call customer service at the number on the back of your Aetna member ID card or you can call your Gallagher Benefit Advocate at 833.580.5861.

How To Find An In-Network Provider

Aetna has over 8,000 participating locations; many are open seven days a week, with no appointments necessary. By visiting an Aetna location, your costs will typically be less. Look up the nearest urgent care center or walk-in clinic on aetna.com and select "Find a doctor" to use the directory. You can also look up in-network providers using the mobile app, more detail on page 14.

Aetna customer service can help to answer questions about your benefits, clarifying diagnosis, find in-network doctors, schedule appointments and help you to learn more about your coverage or plan for an upcoming treatment. Call the number on your Aetna member ID card or visit Aetna.com and log in to your member website.

- Log on to www.aetna.com
- Continue as a guest and enter required fields.
- Select "Aetna Standard Plans"
- Then select "Open Choice® PPO"
- Select what kind of provider you need – Medical Doctors & Specialists, Parmacys, Urgent Care, etc.
- Your provider listing will include specific providers currently accepting your Aetna Health Plan. You must call and check with the provider before scheduling your appointment or receiving services to confirm if they are still participating in Aetna's network.
- Customer Service: 877.204.9186

Reminder: Contact your provider's office to confirm coverage for services is In-Network.

Download the Aetna App from Google Play or the App Store. Look up contracted providers, view your benefits, manage prescriptions, and access your electronic benefit card!

Prior Authorizations

Did you know that many services and procedures may require approval from Aetna before they are provided to you? This is called a Prior Authorization, and it helps you:

- Find out if you're covered by your benefits before you have your scheduled procedure
- Save money and avoid extra costs
- Get an estimate of your out-of-pocket costs before you go to the doctor
- Avoid unnecessary services

You should always ask your healthcare provider about requesting a Prior Authorization before you schedule a service or procedure.

Examples of Services that Require Prior Authorization:

- Planned admission into hospitals or skilled nursing facilities
- Non-emergency ground or air ambulance transport
- Advanced imaging, such as MRIs and CT scans
- Transplant and donor services
- Some planned outpatient procedures
- Some injectable medications you get in a healthcare provider's office
- Reconstructive surgery
- Home medical equipment costing $500 or more

What Happens if Your Doctor Doesn't Request a Prior Authorization

If your doctor gives you a service that requires a Prior Authorization without requesting one, you may have to pay extra costs. You may have to pay either:

- The full cost of your service, or
- A share of the cost of the service plus up to an additional $1,500

To avoid extra costs always ask your healthcare provider to request a Prior Authorization before you have a planned medical service.

Health Savings Account (HSA) Information

DID YOU KNOW

If you elect the Aetna HDP medical plan with Health Savings Account, HTC will contribute $1,000 (Individual) / $2,000 (Family) into your HSA. This amount is broken down into per pay period deposits. You must open your HSA account with Navia in order to receive the employer contribution.

Health Savings Account (HSA)

Employees electing the High Deductible Health Plan (HDHP) will be given the opportunity to open a Health Savings Account with Navia. HTC will deposit contributions and maintain banking fees for all active employees enrolled in the HDHP. New enrollees must remeber to visit www.naviabenefits.com to open an HSA account in order to receive the employer deposit.

An HSA is a tax advantaged account you can use to pay for current and future healthcare expenses (even expenses during retirement). You may also contribute to your HSA account through pre-tax, payroll deductions. The maximum you can contribute is the difference between the 2025 statutory contribution limit based on your enrollment and HTC's annual contribution.

2025 CONTRIBUTION LIMITS (IRS)	
Employee Only	$4,300
Employee + Dependents	$8,550
HTC ANNUAL CONTRIBUTION AMOUNTS	
Employee Only	$1,150
Employee + Dependents	$2,300
Note: HTC contributions are broken down into equal per pay period amounts	
Maximum Employee Contributions for 2025	
Employee Only	$3,150
Employee + Dependents	$6,250

Employees 55 and older may also contribute an additional $1,000 "catch-up" contribution per calendar year.

For new hires during the plan year, HTC contributions will be pro-rated and will begin the pay period after your health coverage is in effect or you set up your account through Navia whichever occurs last.

Unlike the FSA, all monies deposited and not used will rollover from year to year. There is no "use it or lose it" penalty with an HSA, and the balance remains yours to use for qualified medical expenses or to save for future medical expenses.

How an HSA Works

Here is an example of how an HSA works: In 2024, John enrolled in the HDHP plan (employee only coverage) and opened the HTC HSA. During the 2025 plan year, he deposited the money he saved from lower premiums ($25) plus an additional $75, for a total of $100 each month. Additionally, he took advantage of the $1,150 contribution from HTC. At the end of 2025 he has a balance of $2,350 that will roll over into 2026.

In 2025, John plans to continue to contribute $100 per month. In 2025, John will receive his annual preventive exam which is covered at 100% and expects to have additional services of $1,000. He will pay for these expenses from his HSA. At the end of 2025, John will have $3,550 in his HSA. He can continue to roll this over and build his HSA account in future years. Once he reaches a minimum balance, he can also find additional investment opportunities on Navia.

Things to keep in mind about enrolling in an HSA

- You cannot be covered by any other non-HSA-eligible medical plan or medical insurance (such as your spouse's plan) except dental, vision, or long-term care.
- You cannot have any carry over FSA funds from the prior year. Any carryover FSA funds from the prior year will prevent you from being able to open an HSA in the upcoming year and will exclude you from receiving employer HSA contributions.
- You cannot be enrolled in Medicare.
- You must not have received Veterans Administration benefits (outside of medical treatment related to your service) in the last three months.
- You cannot be claimed as a dependent on another person's tax return.
- You cannot be participating in a Healthcare FSA, through yourself or a spouse. Through your spouse's employer, you could enroll in a Limited Purpose FSA and still be HSA-eligible – but a traditional Healthcare FSA will disqualify you.
- You cannot be enrolled in a general purpose Health Reimbursement Account (HRA).

Use HSA funds for alternative or preventive treatments like:

- LASIK Surgery

Health Savings Account (HSA) Information

DID YOU KNOW

All benefit eligible employees may choose to enroll in the HDHP; however, not all employees are eligible to enroll in the Health Savings Account (HSA).

Reminder: If a provider becomes out-of-network, you can set aside additional pre-tax funds in either FSA or HSA accounts to help cover shortfall.

QUALIFIED MEDICAL EXPENSES FOR YOUR HSA INCLUDE:
Routine Health Care: doctor's office visits, x-rays, lab work, prescriptions
Hospital Expenses: room and board, surgery, supplies
Dental Care: cleanings, fillings, crowns, x-rays
Vision Care: eye exams, eyeglasses, contacts, copays
Medical and Dental coinsurance (the part of the medical bill paid by you, not your health insurance)
Orthodontia
Medical Equipment (Some examples include wheelchairs, walkers, hospital beds and crutches)

- Hearing Aids
- Tobacco Cessation Programs
- Chiropractic Services
- Family Planning Procedures
- Over-the-Counter Drugs (NEW!)
- Menstrual Care Products (NEW!)
- Acupuncture

How do I know what are "qualified medical expenses?"

Unfortunately, we cannot provide a comprehensive list of "qualified medical expenses." A partial list is provided in IRS Pub 502 (https://www.irs.gov/pub/irs-pdf/p502.pdf). There have been thousands of cases involving the many nuances of what constitutes "medical care" for purposes of section 213(d) of the Internal Revenue Code. A determination of whether an expense is for "medical care" is based on all the relevant facts and circumstances. To be an expense for medical care, the expense has to be primarily for the prevention or alleviation of a physical or mental illness. The determination often hangs on the word "primarily."

Can I use my HSA to pay for medical services provided in other countries?

Yes, but you should always save your medical receipts to document your expenses, and have them on file when you file your taxes.

What happens if I don't use the money in the HSA for medical expenses?

If the money is used for anything other than qualified medical expenses, the expenditure will be subject to income tax. A 20% tax penalty will also apply in most circumstances. Consult your tax professional for additional guidance if you believe you've used your HSA funds incorrectly.

HSA Eligibility Guidelines

Guidelines are regulated by the IRS. During the enrollment process, Navia will ask four questions to confirm that you are eligible to open an account:

- Are you covered by an HDHP?
- Are you covered by another health plan that is not a HDHP? (This includes coverage under a spouse, a spouse's FSA, HTC's healthcare FSA, etc.)
- Are you enrolled in Medicare?
- Are you claimed as a dependent on someone else's taxes?

Questions regarding HSA eligibility can be directed to Navia's customer service by calling 800.669.3539. While Navia can provide some basic guidelines pertaining to HSA eligibility they cannot make plan recommendations. Employees may also want to speak with their tax advisors to determine whether an HSA is a good fit for their specific circumstances.

Who can use the HSA account

- You many enroll your domestic partner in HTC benefit plans and receive insurance coverage; however, domestic partner out-of-pocket expenses are generally not eligible for reimbursement through your HSA.
- While Dependent Children, who are not tax dependents, may be covered under HTC's health plan until age 26, HSA funds may only be used for Tax Dependents.
- Employees may receive tax-free reimbursement for expenses of his or her same-gender spouse through the HSA.

Dental Benefits

DID YOU KNOW

You may go to PPO, Premier, or any non-participating dentist. If your provider is non-participating your out-of-network dentist charges more than the maximum allowable fee, you will be responsible for the difference between the allowed amount and billed charges.

PPO Dental Program – Delta Dental of Washington			
	PPO Dentist	Premier Dentist	Non-Participating Dentists
Maximum Benefit	$2,000		
Annual Deductible	$50 per person, $150 per family		
Diagnostic / Preventive Exam / X-ray Cleaning Space Maintainers Sealants	Covered in full	Covered in full	Plan pays 100% of allowable*
Restorative / Basic Periodontics Endodontics Fillings Oral Surgery	20%	20% after deductible	20% after deductible
Major Crowns Bridges Dentures Implants	50%	50% after deductible	50% after deductible
Orthodontia	Plan pays 50%, $1,500 lifetime maximum, children and family		

Dental Provider Options

You may seek care from any licensed dentist; however, when you choose to receive services from a Delta Dental PPO dentist:

- Your out-of-pocket costs for covered services are usually lower since participating providers charge a contracted fee for their services;
- Your provider will file claims for reimbursement on your behalf;
- You will not need to pay charges above the maximum allowable fee. Delta Dental Premier® dentists have contracts with Delta Dental, but they are not part of the Delta Dental PPO network. A list of participating Delta Dental PPO providers is available online at www.deltadentalwa.com; click the "Patients" tab then click "Find a Dentist". Under helpful links, choose "Delta Dental PPO" network, enter your zip code and click "Search for a Dentist". You may also call 800.554.1907 and a Delta Dental representative will assist you.

*Allowable: Maximum allowable fees. You may be responsible for charges above allowable fees and billed by your provider for the balance.

Download the DeltaDental mobile app from Google play or the App Store

Vision Benefits

DID YOU KNOW

Choose a VSP "Signature" Network provider to receive in-network benefits. You will receive a higher benefit for visiting "in-network" providers and typically pay less in out-of-pocket costs.

Vision Benefit	Preferred Provider "Signature" Network	Participating Retail Chains	Non-Preferred Provider
Routine Eye Examination (once per calendar year)	$10 copay	$10 copay	$10 copay then reimbursed up to $50
Hardware	$25 copay toward lenses and frames		
Lenses (once per calendar year)	Preferred Lenses Covered in full, after copay	Preferred Lenses Covered in full, after copay	Reimbursed per allowance schedule, after copay*
Frames (once per calendar year)	Covered up to $150 retail after copay; 20% discount on amounts over allowance	Covered up to $80 at Costco and $150 at other participating retail chains after copay	Reimbursed up to $70 after copay
Contact Lenses, in lieu of lenses and frames (once per calendar year)	Covered up to $150 allowance, 15% discount, then up to a $60 copay (fitting and evaluation)	Covered up to $150 Contact lens exam is not covered and is a private transaction with participating retail chains	Reimbursed up to $105 allowance (for services and materials)

Vision Provider Options

*See benefit summary for full out-of-network.

You may seek care from any licensed provider. However, it is highly recommended that you choose to receive services from a VSP Network provider, your provider will file claims for reimbursement on your behalf.

A list of VSP Signature Network providers is available online at www.vsp.com or by calling 800.877.7195.

Please Note: VSP does not distribute benefit cards.

Participating Retail Chains

In addition to 2,300+ regional retail chain locations on the VSP Network, VSP Retail Chain Affiliate Partners adds more than 1,900 optical stores for your convenience. Some of these include:

- Costco® Optical
- Visionworks®
- Wisconsin Vision
- Heartland Vision
- RxOptical®
- Cohen's Fashion Optical
- Shopko® Eyecare Center

Please Note: While the Retail Chain may be in the Signature Network, the actual doctor / provider may not be. Before you seek services, you will want to confirm both the location and provider are in the VSP Signature Network.

Flexible Spending Accounts (FSA)

DID YOU KNOW

HTC offers you two flexible spending accounts (FSA): Traditional Health Care and Dependent Care that allow you to use pre-tax dollars to pay for eligible expenses.

Flexible Spending Accounts (FSA)

The pre-tax features of an FSA save you money by reducing your taxable income and allow you to pay for eligible health care and dependent care expenses with tax-free dollars

Navia Benefit Solutions provides an "Enrollment Kit" to help decide how much to contribute and explanations on the pros and cons of a FSA. It is highly recommended to review prior to making your elections.

Important Note: You will need to re-elect your FSA for 2025 as this is an active enrollment. Re-enrollment is not automatic. You must re-enroll every year to continue saving tax dollars through the FSA account.

Employees enrolling in the High Deductible Health Plan (HDHP) with HSA are not eligible to enroll in the Healthcare Flexible Spending Account. HDHP / HSA enrollees may participate in the Dependent Care Spending Account.

Please refer to www.naviabenefits.com for a list of all eligible expenses.

If you would like to participate in the Navia benefits, you will need to make your elections in ADP. For monthly elections made throughout the year, visit www.naviabenefits.com. You must reenroll in the FSA for coverage in 2025, even if you are not making any changes.

FSA commuter benefit elections will become available after December 1, 2024. Further instructions on enrollment are available on the Benefit Hub Website. You must reenroll in commuter benefits for coverage in 2025, even if you are not making any changes unless you select a recurring enrollment within the Navia platform.

Please Note: You may enroll your domestic partner in the HTC benefit plans and receive insurance coverage; however, domestic partners out-of-pocket expenses are generally not eligible for reimbursement through either the FSA or HSA.

Employees may receive tax-free reimbursement for expenses of his or her same-gender spouse through the FSA and HSA.

FSA Options

Health Care Spending Account

You may contribute up to $3,300 per plan year into the Health Care spending account (only available to employees choosing the PPO plan).

Dependent Care Spending Account

You may contribute up to $5,000 per plan year into the Dependent Care spending account (only the custodial parent may use the Dependent Care spending account).

FSA Section 125 Premium-Only Plan

This plan allows the employees' share of qualified health insurance premiums to be deducted from your paycheck on a pre-tax basis, unless otherwise requested.

Important IRS Rules for FSAs

- You cannot change or stop your contributions to the FSA during the year unless you have a qualifying change in status.
- Money cannot be transferred between FSA accounts.
- Unused Health Care FSA balances up to $660 will be rolled over to the subsequent plan year. The funds will be available after the run-out period (April 1). An election for 2025 Healthcare FSA is required and should be completed in ADP Workforce Now for 2025 FSA Healthcare Benefit Coverage. Any funds in excess of $660 will be forfeited. An FSA election for 2025 is required in order to access the rollover funds from 2025.
- The Dependent Care FSA has a 2.5 month grace period. You will have through 3/15 of the next calendar year to incur new expenses and utilize your 2024 Dependent Care FSA balance. Following the conclusion of the grace period, any remaining balance will be forfeited.

GoNavia Commuter Benefit

The GoNavia Commuter Program is a commuter benefit that enables you to pay for work related commuting expenses with pre-tax dollars. This means that participants don't pay income taxes on the money they set aside for their commuting expenses (subject to monthly limits):

- Transit expenses such as bus, ferry, subway, train passes and qualified vanpool expenses – up to $325 per month.
- Daily or monthly parking fees – up to $325 per month.

*Please note: the following items are not covered under the GoNavia Commuter Program:

- Tolls
- Parking fees at the airport or your home
- Gas
- Business trip costs
- Taxis
- Mileage

The GoNavia Commuter Program offers a flexible month-to-month enrollment so that you can sign up or drop out at virtually anytime and your funds can be rolled over from month-to-month or even year-to-year!

Just place your order on the Navia Benefit Solutions website by the 20th of each month to receive your order for the subsequent month. For example, to order commuter funds for the month of December, you must place your order by no later than November 20. Or, you can set up automatic recurring monthly reorders.

Upon enrollment, you will receive a Navia Benefits card loaded with your initial monthly funds to purchase work related commuter services at any merchant that accepts MasterCard™. Additional funds will be loaded each subsequent month as long as you remain enrolled. In the event your merchant does not accept the Navia Benefits card, you may be able to utilize the Pay Me Directly option.

Please note: If you are already a participant in the Flexible Spending Account(s), your funds will be loaded onto your existing Navia Benefits card.

This benefit is only available for CA employees

If you have any questions contact Navia at:

800.669.3530

Or visit:

www.naviabenefits.com

Life / AD&D and Disability Benefits

Prudential

DID YOU KNOW

HTC provides benefit eligible employees with Life insurance, Accidental Death & Dismemberment AD&D) insurance and Long-Term disability at no cost to you!

Group Life and AD&D Coverage

Administered by Prudential, life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by HTC. Accidental Death & Dismemberment (AD&D) insurance provides payment to you (or your beneficiaries) if you lose a limb or die in an accident.

HTC provides each eligible employee with Group Term Life and AD&D coverage equal to two times your annual earnings, subject to a maximum of $300,000. Benefits will reduce by 35% at age 65 and 50% at age 70. You are automatically enrolled and HTC pays the entire premium for eligible employees.

Disability Insurance

Administered by Prudential, disability benefits replace a portion of your income if you are unable to return to your job due to illness, injury, or disability. HTC pays 100% of disability premiums for eligible employees.

Benefit Amount – All Eligible Employees	
Group Life Insurance	2 times Annual Earnings*
Group AD&D Insurance	2 times Annual Earnings
Benefit Maximum	$300,000
Guaranteed Issue Amount	$300,000

Reductions in Life Insurance

Age 65	35% of the original amount
Age 70	50% of the original amount

*If insurance provided by HTC exceeds $50,000, the IRS requires that a small portion of the cost of this benefit be treated as taxable income.

Long-Term Disability Highlights	Benefit Coverage
Monthly Benefit Amount: The amount the benefit pays after the elimination period	Up to 60% of pre-disability earnings
Maximum Monthly Benefit: The monthly benefit limit throughout your total disability	$10,000
Elimination Period: The period of days of disability during which benefits are not payable	180 days
Maximum Duration of Benefits: The time period for which you may receive benefits	Social security normal retirement age

Please note that your disability benefits paid by Prudential may be offset or coordinate with any state disability plan you're eligible for. Contact Prudential for additional information specific to your state.

Beneficiary Designations

Prudential

What is a life insurance beneficiary?

A beneficiary is an individual or entity that will receive all or a portion of the life insurance proceeds that may become payable at the death of the covered person.

Who can be named as a beneficiary?

An employee may designate one or more individuals, including a minor, a trust, or even the employee's estate, as a beneficiary. Please note that in some states, your spouse is required to sign off on a primary beneficiary designation for a person other than themselves.

If more than one beneficiary is identified, the employee should designate the percentage share of the insurance proceeds to be assigned to each beneficiary. If no distribution percentage is specified, the insurance proceeds will be divided equally.

What is the difference between a primary and contingent beneficiary?

A primary beneficiary is the individual, group of individuals, entity, or entities entitled to receive the insurance proceeds that are payable at the time of the death of a covered person.

A contingent or secondary beneficiary is the individual, group of individuals, entity, or entities entitled to receive the insurance proceeds that are payable at the time of the death of a covered person if none of the primary beneficiaries survive the covered person.

Can more than one beneficiary be named? If so, how are proceeds divided?

Yes, the employee may designate multiple primary and contingent beneficiaries. The insurance proceeds will be divided equally, unless the employee indicates how much of the insurance proceeds each beneficiary should receive. The employee can divide the insurance proceeds based upon dollar amount, as long as the total equals the full amount of the insurance proceeds. The employee can also divide the insurance proceeds based upon percentage, or fraction, as long as the total equals 100%.

Can an employee list a minor as a beneficiary?

If a beneficiary is a minor at the time the insurance proceeds are payable, the proceeds will be disbursed in one of the following ways:

1. To the legal guardian of the minor beneficiary's financial assets;
2. To an adult responsible for the well-being of the minor beneficiary if permitted under any applicable Uniform Transfer to Minor Act; or
3. The insurance proceeds will be held by Prudential until the minor beneficiary is of legal age (based upon state law) to receive the payment.

When can an employee change his or her beneficiary?

Generally, an employee may change his or her beneficiary at any time. The employee is not generally required to notify the current beneficiary. The employee may choose to change a beneficiary based on life circumstances, including marriage, divorce, or the birth of a child.

If you have any questions regarding your designated beneficiaries, please contact your **Gallagher Benefit Advocates** at 833.580.5861.

vChoice

Supplemental Coverages

Voluntary Employee Life Insurance (Unum)

- You may elect 1-5 times your base salary to a maximum of $500,000. Guaranteed issue amount is $210,000.

Voluntary Spouse Life Insurance (Unum)

- You may elect .5-2.5 times employees salary up to 50% of employee election. Guaranteed Issue is$105,000.

Voluntary Child Life (Unum)

- You may purchase a $10,000 life insurance policy on all eligible children for one low monthly premium, provided that you have elected supplemental life insurance coverage for yourself. For dependents birth to 6 months of age, you may purchase $1,000.
- Please note: Dependent Coverage: Insurance coverage is not allowed if that dependent is totally disabled on the date that insurance would otherwise be effective. This means you may not enroll or increase coverage if your dependent meets the definition of "Totally Disabled."
- If your eligible dependent is totally disabled, your dependent's coverage will begin on the first of the month following the date your eligible dependent no longer is totally disabled. This provision does not apply to a newborn child while dependent insurance is in effect.
- "Totally disabled" means that, as a result of an injury, a sickness or a disorder, your dependent is confined in a hospital or similar institution; is unable to perform two or more activities of daily living (ADLs) because of a physical or mental incapacity resulting from an injury or a sickness; is cognitively impaired; or has a life threatening condition.

Voluntary Accidental Death & Dismemberment (Standard)

- Benefit eligible employees may purchase coverage in multiples of $100,000 up to $500,000 (not to exceed 10 times your annual earnings), for spouse/domestic partners in multiples of $50,000 up to $500,000 (not to exceed 100% of EE), and $10,000 for children.

Voluntary Accident (Standard)

- Accident insurance can help protect against financial hardships resulting from emergency room treatment, hospital admissions and physical therapy expenses as a result of a non-work related accident.

Voluntary Legal (MetLife Legal)

- MetLife Legal Plan services provides you with telephone and office consultations for a number of legal matters such as: will preparation, adoption, money matters, real estate, vehicle and driving and civil law.

Voluntary Identity Theft (Allstate Identity Theft Protection)

- Identity theft protection is offered through Allstate Identity Theft Protection, Inc. Features include identity monitoring, credit reporting, internet surveillance, digital identity, wallet replacement feature, restoring identity theft, identity theft insurance and solicitation reduction. You may elect coverage for you and your family based on your specific needs.

Please Note: If you are electing an amount above the Guaranteed Issue you must complete the Evidence of Insurability form. If you or your family wishes to enroll more than 31 days after you become eligible, you must wait until the next open enrollment. Guaranteed Issue coverage will not be available to you at that time and you must complete an Evidence of Insurability form. For current participants: Please be aware that if you are declined due to adverse health for any amounts above the Guaranteed Issue, you will be locked at Guaranteed Issue regardless of any future salary changes.

Please enroll in vChoice benefits through ADP Workforce Now. We encourage all employees to review their coverage elections and confirm acceptance for 2025.

Enroll or update your Pet Insurance elections through the Trupanion website at **www.trupanion.com**.

Voluntary Pet Insurance

With an accident & illness plan provided by the ASPCA Pet Health Insurance program, you have help choosing the care you want when your pet is hurt or sick. You can take comfort in knowing they have coverage.

Simple to Use
Just pay your vet bill, submit claims, and get reimbursed for eligibile expenses! You're free to visit any licensed vet, specialist, or emergency clinic in the US or Canada, and you can choose to receive reimbursement by direct deposit or mail.

Exam Fees, Diagnostics, and Treatments for Covered Conditions

- Accidents
- Hereditary Conditions
- Dental Disease
- Illnesses
- Behavioral Issues
- Cancer

Customizable Options
Annual Limit - from $3,000 to unlimited
Remibursement Percentage - 90%, 80%, or 70% of your eligible vet bill
Annual Deductible - select $100, $250, or $500
You'll only need to satisfy it once per 12-month policy period.

Add Preventive Care Coverage
Get reimbursed scheduled amounts for things that protect your pet from getting sick, like vaccines, dental cleanings, and screenings for a little more per month.

Select Accident-Only Coverage
If you're just looking to have some cushion when your pet gets hurt, you can choose coverage that only includes coverage for accidents.

Please contact ASPCA for rates and enrollment.

To enroll or ask questions call:
866-204-6764
Use Priority Code: **EB24HTC**
Or visit:
www.aspcapetinsurance.com/HTC

Employee Assistance Program and Travel Assistance

DID YOU KNOW

HTC offers an Employee Assistance Program and Travel Assistance Program to all Employees!

Employee Assistance Program (EAP)

HTC offers a confidential counseling, assessment and referral service to you and your family members. When you call ComPsych you will be talking to an expert who's been trained to offer confidential advice and practical solutions. ComPsych Online is also a great way to find the information you need whenever you have a question. Key features of this program include:

- Trained counselors via telephone for assistance with issues including:
  - Depression, stress or grief
  - Marital and parenting problems
  - Alcohol and substance abuse
  - Conflict resolution or work conflicts
- Referrals for sessions with a nearby counselor; up to 3 visits, per issue, per year.
- Child care referral service
- Legal resource and referral service
- Financial counseling resource
- Online self-assessment and self-help programs

From coping with changes in your life to dealing with family issues, you can turn to ComPsych for information, ideas and support. Whatever is happening in your life they can help. This program is available 24 hours a day, 7 days a week. Language Assistance is also available.

Contact Information

Call 800.311.4327. You can also visit their website at www.guidanceresources.com using Company Web ID: GEN311.

Travel Assistance

Provided through HTC's partnership with Prudential, employees have access to a worldwide emergency travel assistance program provided by IMGlobal. Whether you are traveling for business or personal reasons, this worldwide emergency travel assistance program goes with you when you travel to a foreign country or domestically, away from home. Help is just a phone call away – day or night –- if you, your spouse or your dependent children need immediate assistance anywhere in the world.

Contact Information

Call 855.847.2194 or 317.927.6828 anytime, or email assist@imglobal.com. You can also visit their website at www.imglobal.com.

Prudential

For more information about IMGlobal's worldwide emergency travel assistance, contact them at: **855.847.2194** or **317.927.6828**

Email: **assist@imglobal.com**

401(k) Plan

Our plan is designed to help you prepare for retirement. Once you are enrolled, your contributions are automatically deducted from your paycheck. You can save a little at a time and leave it until you retire. The sooner you start saving, the greater the possibility of reaching your savings goals.

Matching Contribution

HTC wants to help you meet your financial goals with this plan. HTC offers both traditional and Roth 401(k) options, up to 4% company-matching contributions, and access to our financial advisors. Once you have met the eligibility requirements set forth by the HTC 401(k) retirement plan, if you do not make a deferral elections on the NWPS website prior to the first payroll processed after you become eligible, HTC will automatically withhold 4% of your compensation from your pay each payroll period and contribute that amount to the Plan as a salary deferral. The automatic enrollment provisions apply to newly eligible participants and Rehires. The automatic contribution will be effective as soon as administratively feasible, approximately 30 days following the date of hire. No later than the third pay date. For any pay periods you are not deferring contributions into the 401(k) plan, you will not be eligible to receive an employer matching contribution to your 401(k) plan.

- Log on to NWPS Plan Administrators: www.yourplanaccess.net/nwps
- Your username is your social security (XXX-XX-XXXX) number and your password is the last 4 digits (ex. 1234) of your social security number.
- For log in issues or password resets call NWPS customer service at 877.690.5410, option 7.

From there, you will be able to do everything from setting your contribution rate and investment allocations to monitoring your rate of return and viewing your quarterly statements.

Financial Advisors

To aid employees with their 401(k) investments, HTC has partnered with RBC to be our retirement plan advisors. If you are ever in need of financial advice as it relates to your portfolio, please do not hesitate to contact them at 866.416.9716.

DID YOU KNOW

In 2025, you may contribute up to $23,500 annually into your 401(k). If you are age 50 or over, you may also make an additional catch-up contribution of $7,500 annually.

Important Notices

As an employer, we are required to provide our employees with legal information surrounding their benefits. If you have questions on any of the following notices, please contact your Benefit Advocates at 833.580.5861 or via email at bac.htcamerica@ajg.com and they would be happy to assist you.

Patient Protection Disclosure Notice

HTC's group health plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 510.903.5999 or Americas_Benefits@htc.com.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from the group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator at 510.903.5999 or Americas_Benefits@htc.com.

Preventive Care

Certain preventive care services must be provided by non-grandfathered group health plans without member cost-sharing (such as deductibles or copays) when these services are provided by a network provider. Please refer to your insurance company for more information. Contact information is listed in the back of this Guide.

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide medical and surgical coverage for mastectomies also provide coverage for reconstructive surgery following such mastectomies in a manner determined in consultation with the attending physician and the patient.

Coverage must include:

- All stages of reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedema.

Organ Transplant

There is no pre-existing condition limitations for this health plan. Organ and bone marrow transplants have a $7,500 travel and lodging maximum. Please see your plan contract booklet for further details.

Statement of ERISA Rights

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

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

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

You should be provided a certificate of creditable coverage, free of charge, from your health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

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

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

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement, or your rights under ERISA, or if you need assistance or information regarding your rights under HIPAA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20220. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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 towards 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).

You may also be able to enroll yourself or your dependents in the future if you or your dependents lose health coverage under Medicaid or your state Children's Health Insurance Program, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 60 days after that coverage ends or after you become eligible for premium assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Human Resources Department. Refer to your benefit booklet for details.

Summary Plan Descriptions

This booklet gives you an overview of the main features of your benefit plans. The plans are administered according to legal plan documents and insurance contracts. Although we've tried to summarize the provisions of these legal documents clearly and accurately, if any information presented here conflicts with the legal documents, the legal documents will govern.

For more detailed information on the plans and your legal rights under the plans, be sure to read the summary plan descriptions or request a copy of the plan documents.

Non-Network Costs

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. Contact your claims payer or insurer for more information. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language.

COBRA

Federal COBRA is a U.S. law that applies to employers who employ 20 or more individuals and sponsor a group health plan. Under Federal COBRA you may be eligible to continue your same group health insurance for up to 18 months if your job ends or your hours are reduced. You are responsible for COBRA premium payments.

HIPAA Notice of Privacy Practices Reminder

HIPAA requires HTC to notify its employees that a privacy notice is available and is posted on the benefits portal. Please visit the HTC Benefit Hub, www.c2mb.ajg.com/htc/home for a copy of HTC's Privacy Notice or contact the plan administrator at 510.903.5999 or Americas_Benefits@htc.com.

Notice of Creditable Coverage

Important Notice from HTC 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 HTC 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. HTC has determined that the prescription drug coverage offered by the HTC Benefit 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 through 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 HTC coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current HTC coverage, be aware that you and your dependents may not be able to get this coverage back by enrolling back into the HTC benefit plan during the open enrollment period under the HTC benefit plan.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with HTC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage. Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through HTC changes. You also may request a copy of this notice at any time.

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 1-800-MEDICARE (800-633-4227). TTY users should call 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 800-772-1213 (TTY 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:	January 1, 2025
Name of Entity/Sender:	HTC America, Inc.
Contact-Position:	Human Resources
Address:	1625 Shattuck Ave, Suite 300 Berkeley, CA 94709
Phone Number:	206.548.2202

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 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 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, 2024. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Fax: 916.440.5676| Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884 | HIPP Phone: 800.766.9012
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 | TTY: 617.886.8102
MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739

MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 | Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075

PENNSYLVANIA – Medicaid and CHIP
https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/en/famis-select https://www.coverva.org/hipp/ Medicaid and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 1/31/2026)

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

DCN23BGHTC