

# Taylor Corporation

## HEALTH PLAN NOTICES

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### IMPORTANT NOTICE

**This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Taylor Corporation About Your Prescription Drug Coverage and Medicare."**

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [Surest.Care/Taylor](#), Surest mobile app or call Surest Member Services at 1-866-683-6440. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [Healthcare.gov/sbc-glossary/](#) or call 1-866-487-2365 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                      | Why This Matters                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | \$0                                                                                                                                                          | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive Care</u> .                                                                                                                                | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="#">Healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                                                                      |
| Are there other <u>deductibles</u> for specific services?           | No                                                                                                                                                           | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | For <u>network providers</u> :<br>\$6,600 individual / \$13,200 family<br><br>For <u>out-of-network providers</u> :<br>\$13,200 individual / \$26,400 family | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.<br><br>If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                              |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.                                                             | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="#">Surest.Care/Taylor</a> or call 1-866-683-6440 for a list of <u>network providers</u> .                                                  | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No                                                                                                                                                           | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event                                   | Services You May Need                                                                                                                             | What You Will Pay                                                                                                                   |                                                                                                                                    | Limitations, Exceptions, & Other Important Information*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                        |                                                                                                                                                   | In-Network Provider<br>(You will pay the least)                                                                                     | Out-of-Network Provider<br>(You will pay the most)                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness                                                                                                  | \$35 - \$140 <u>copay</u> /visit                                                                                                    | \$215 <u>copay</u> /visit                                                                                                          | <p>Certain procedures performed in the office may have a higher office visit <u>copay</u>. <u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p>*Cost share applies to any other Telehealth service based on <u>provider</u> type. If you receive services in addition to office visit, additional <u>copays</u> may apply.</p> <p>You may have to pay for services that are not <u>preventive</u>. Ask your <u>provider</u> if the services needed are <u>preventive</u>. Then check what your <u>plan</u> will pay for.</p> |
|                                                        | <u>Specialist</u> visit                                                                                                                           | \$35 - \$140 <u>copay</u> /visit                                                                                                    | \$215 <u>copay</u> /visit                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                        | <u>Preventive care/screening/immunization</u>                                                                                                     | No charge                                                                                                                           | \$215 <u>copay</u> /visit                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| If you have a test                                     | <b><u>Routine diagnostic test</u></b> (e.g., x-ray, blood work)<br><b><u>Non-routine diagnostic test</u></b> (e.g., sleep study, genetic testing) | <b><u>Routine diagnostic test</u></b> : No charge<br><b><u>Non-routine diagnostic test</u></b> : \$30 - \$1,500 <u>copay</u> /visit | <b><u>Routine diagnostic test</u></b> : No charge<br><b><u>Non-routine diagnostic test</u></b> : Up to \$2,850 <u>copay</u> /visit | <p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for certain Non-routine <u>diagnostic tests</u> or there may be no coverage.</p>                                                                                                                                                                                                                                                                                                                                               |
|                                                        | Imaging (CT/PET scans, MRIs)                                                                                                                      | \$200 - \$1,900 <u>copay</u> /visit                                                                                                 | Up to \$5,850 <u>copay</u> /visit                                                                                                  | <p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for certain imaging tests or there may be no coverage.</p>                                                                                                                                                                                                                                                                                                                                                                     |

\*For more information about limitations and exceptions, see the plan or policy document at [Surest.Care/Taylor](#).

| Common Medical Event                                                                                                                                                                          | Services You May Need         | What You Will Pay                               |                                                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|-------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                               |                               | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most)                                    |                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="https://www.caremark.com">Caremark.com</a> . | <b>Generic</b>                | <b>30-Day Supply</b><br>\$10 <u>copay</u>       | <b>30-Day Supply</b><br>\$20 <u>copay</u>                                             | Certain Tier 1 drugs are available with no charge, including prescribed generic contraceptives and tobacco cessation medications.<br><br>To learn more about drug tiers and about <u>copays</u> for specific drugs, visit <a href="https://www.caremark.com">Caremark.com</a> website.<br><br><u>Prior authorization</u> is required for certain drugs or there may be no coverage. |
|                                                                                                                                                                                               |                               | <b>90-Day Supply</b><br>\$25 <u>copay</u>       | <b>90-Day Supply</b><br>Not covered                                                   |                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                               | <b>Preferred Brand</b>        | <b>30-Day Supply</b><br>\$90 <u>copay</u>       | <b>30-Day Supply</b><br>\$180 <u>copay</u>                                            |                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                               |                               | <b>90-Day Supply</b><br>\$225 <u>copay</u>      | <b>90-Day Supply</b><br>Not covered                                                   |                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                               | <b>Non-Preferred Brand</b>    | <b>30-Day Supply</b><br>\$160 <u>copay</u>      | <b>30-Day Supply</b><br>\$320 <u>copay</u>                                            |                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                               |                               | <b>90-Day Supply</b><br>\$400 <u>copay</u>      | <b>90-Day Supply</b><br>Not covered                                                   |                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                               | <b><u>Specialty drugs</u></b> | <b>30-Day Supply</b><br>\$480 <u>copay</u>      | <b>30-Day Supply</b><br>\$960 <u>copay</u><br><br><b>90-Day Supply</b><br>Not covered | <u>Prior authorization</u> is required for certain <u>specialty drugs</u> or there may be no coverage.                                                                                                                                                                                                                                                                              |

| Common Medical Event                    | Services You May Need                          | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information*                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------|------------------------------------------------|-------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                             |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center) | \$70 - \$4,500 <u>copay</u> /visit              | Up to \$11,000 <u>copay</u> /visit                 | <p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned copays within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for certain outpatient surgery or there may be no coverage.</p>                                     |
|                                         | Physician/surgeon fees                         | No charge                                       | No charge                                          |                                                                                                                                                                                                                                                                                                                                                                             |
| If you need immediate medical attention | <u>Emergency room care</u>                     | \$850 <u>copay</u> /visit                       | \$850 <u>copay</u> /visit                          | <p><u>Copay</u> is waived if admitted within 24 hours. <u>Out-of-network emergency room care visit copay</u> applies to the <u>in-network out-of-pocket limit</u>.</p>                                                                                                                                                                                                      |
|                                         | <u>Emergency medical transportation</u>        | \$600 <u>copay</u> /transport                   | \$600 <u>copay</u> /transport                      | <p><u>Prior authorization</u> is required for non-emergency medical transportation or there may be no coverage. <u>Out-of-network emergency medical transportation copay</u> applies to the in-network <u>out-of-pocket limit</u>.</p>                                                                                                                                      |
|                                         | <u>Urgent care</u>                             | \$90 <u>copay</u> /visit                        | \$200 <u>copay</u> /visit                          | None                                                                                                                                                                                                                                                                                                                                                                        |
| If you have a hospital stay             | Facility fee (e.g., hospital room)             | \$700 - \$4,500 <u>copay</u> /stay              | Up to \$11,000 <u>copay</u> /stay                  | <p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for non-emergency facility admissions and inpatient surgery or there may be no coverage.</p> |
|                                         | Physician/surgeon fees                         | No charge                                       | No charge                                          |                                                                                                                                                                                                                                                                                                                                                                             |

\*For more information about limitations and exceptions, see the plan or policy document at [Surest.Care/Taylor](https://www.surestcare.com/taylor).

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                   |                                                                                                      | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-Network Provider<br>(You will pay the least)                                                     | Out-of-Network Provider<br>(You will pay the most)                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | <b>Home/Office:</b> \$35 <u>copay/visit</u><br><b>Outpatient Facility:</b> \$190 <u>copay/visit</u> | <b>Home/Office:</b> \$215 <u>copay/visit</u><br><b>Outpatient Facility:</b> \$570 <u>copay/visit</u> | Certain procedures/services in the outpatient setting may have a lower <u>copay</u> .<br><u>Prior authorization</u> is required for certain outpatient services or there may be no coverage.                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Inpatient services                        | \$3,500 <u>copay/stay</u>                                                                           | \$10,500 <u>copay/stay</u>                                                                           | Certain procedures/services in the inpatient setting may have a lower <u>copay</u> .<br><u>Prior authorization</u> is required for certain inpatient services or there may be no coverage.                                                                                                                                                                                                                                                                                                                   |
| If you are pregnant                                                       | Office visits                             | No charge                                                                                           | No charge                                                                                            | <u>Cost sharing</u> does not apply to <u>preventive services</u> with <u>network providers</u> .<br>Depending on the type of service, a <u>copay</u> may apply.                                                                                                                                                                                                                                                                                                                                              |
|                                                                           | Childbirth/delivery professional services | No charge                                                                                           | No charge                                                                                            | One <u>copay</u> for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother.                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                           | Childbirth/delivery facility services     | \$1,850 - \$3,500 <u>copay/stay</u>                                                                 | \$10,500 <u>copay/stay</u>                                                                           | <u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.<br><u>Cost sharing</u> does not apply to certain <u>preventive services</u> .<br><u>Prior authorization</u> is required for inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or there may be no coverage. |

| Common Medical Event                                           | Services You May Need            | What You Will Pay                                                                     |                                                                                         | Limitations, Exceptions, & Other Important Information*                                                                                                                                                                                                |
|----------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                  | In-Network Provider (You will pay the least)                                          | Out-of-Network Provider (You will pay the most)                                         |                                                                                                                                                                                                                                                        |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | \$80 <u>copay</u> /visit                                                              | \$240 <u>copay</u> /visit                                                               | 120 visit limit - combination of <u>network providers</u> and <u>out-of-network providers</u> per person per <u>plan</u> year.<br><u>Prior authorization</u> is required for certain <u>home health care</u> services or there may be no coverage.     |
|                                                                | <u>Rehabilitation services</u>   | \$20 - \$190 <u>copay</u> /visit                                                      | Up to \$360 <u>copay</u> /visit                                                         | No visit limit for occupational therapy<br>No visit limit for physical therapy<br>No visit limit for speech therapy<br>Visit limits are a combination of <u>network providers</u> and <u>out-of-network providers</u> per person per <u>plan</u> year. |
|                                                                | <u>Habilitation services</u>     | \$20 - \$190 <u>copay</u> /visit                                                      | Up to \$360 <u>copay</u> /visit                                                         | <u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.                          |
|                                                                | <u>Skilled nursing care</u>      | \$2,750 <u>copay</u> /stay                                                            | \$8,250 <u>copay</u> /stay                                                              | 120 day limit per person per <u>plan</u> year.<br><u>Prior authorization</u> is required or there may be no coverage.                                                                                                                                  |
|                                                                | <u>Durable medical equipment</u> | \$0 - \$1,000 <u>copay</u> /equipment based on <u>DME</u> tier                        | Up to \$2,000 <u>copay</u> /equipment based on <u>DME</u> tier                          | <u>Prior authorization</u> is required for certain <u>DME</u> or there may be no coverage.                                                                                                                                                             |
|                                                                | <u>Hospice services</u>          | <b>Home:</b> \$80 <u>copay</u> /visit<br><b>Inpatient:</b> \$3,500 <u>copay</u> /stay | <b>Home:</b> \$240 <u>copay</u> /visit<br><b>Inpatient:</b> \$10,500 <u>copay</u> /stay | None                                                                                                                                                                                                                                                   |
| If your child needs dental or eye care                         | Children's eye exam              | No charge                                                                             | Not covered                                                                             | None                                                                                                                                                                                                                                                   |
|                                                                | Children's glasses               | Not covered                                                                           | Not covered                                                                             | None                                                                                                                                                                                                                                                   |
|                                                                | Children's dental check-up       | Not covered                                                                           | Not covered                                                                             | None                                                                                                                                                                                                                                                   |

\*For more information about limitations and exceptions, see the plan or policy document at [Surest.Care/Taylor](#).

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

- |                       |                                                      |                            |
|-----------------------|------------------------------------------------------|----------------------------|
| • Cosmetic surgery    | • Long term care                                     | • Private duty nursing     |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) |
|                       |                                                      | • Weight loss programs     |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |                                                         |                                      |                                              |
|---------------------------------------------------------|--------------------------------------|----------------------------------------------|
| • Acupuncture (20 visit limit per person per plan year) | • Chiropractic care (No visit limit) | • Infertility treatment (Limitations apply)  |
| • Bariatric surgery                                     | • Hearing aids (limitations apply)   | • Routine foot care (for certain conditions) |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform). You may also contact Surest Member Services at 1-866-683-6440. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [HealthCare.gov](http://HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Surest Member Services at 1-866-683-6440, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al [1-866-633-2446].

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [1-866-633-2446].

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [1-866-633-2446].

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf [1-866-633-2446] uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-866-633-2446].

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni [1-866-633-2446].

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye [1-866-633-2446].

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang [1-866-633-2446].

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                                        |                 | Managing Joe's Type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)                                                                                                                                                                        |                 | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                                                    |                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| ■ The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                                                                                  | \$0             | ■ The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                                               | \$0             | ■ The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                                                    | \$0             |
| ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                                                                  | \$35 - \$140    | ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                               | \$35 - \$140    | ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                                    | \$25 - \$140    |
| ■ Hospital (facility) <u>copayment</u>                                                                                                                                                                                                                                                                         | \$700 - \$4,500 | ■ Hospital (facility) <u>copayment</u>                                                                                                                                                                                                                                      | \$700 - \$4,500 | ■ Hospital (facility) <u>copayment</u>                                                                                                                                                                                                                                           | \$700 - \$4,500 |
| ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                                                     | \$0             | ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                  | \$0             | ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                       | \$0             |
| This EXAMPLE event includes services like:<br><u>Specialist</u> office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br><u>Diagnostic tests</u> ( <i>ultrasounds and blood work</i> )<br><u>Specialist</u> visit ( <i>anesthesia</i> ) |                 | This EXAMPLE event includes services like:<br><u>Primary care physician</u> office visits ( <i>including disease education</i> )<br><u>Diagnostic tests</u> ( <i>blood work</i> )<br><u>Prescription drugs</u><br><u>Durable medical equipment</u> ( <i>glucose meter</i> ) |                 | This EXAMPLE event includes services like:<br><u>Emergency room care</u> ( <i>including medical supplies</i> )<br><u>Diagnostic tests</u> ( <i>x-ray</i> )<br><u>Durable medical equipment</u> ( <i>crutches</i> )<br><u>Rehabilitation services</u> ( <i>physical therapy</i> ) |                 |
| Total Example Cost                                                                                                                                                                                                                                                                                             | \$12,700        | Total Example Cost                                                                                                                                                                                                                                                          | \$5,600         | Total Example Cost                                                                                                                                                                                                                                                               | \$2,800         |
| In this example, Peg would pay:                                                                                                                                                                                                                                                                                |                 | In this example, Joe would pay:                                                                                                                                                                                                                                             |                 | In this example, Mia would pay:                                                                                                                                                                                                                                                  |                 |
| Cost sharing                                                                                                                                                                                                                                                                                                   |                 | Cost sharing                                                                                                                                                                                                                                                                |                 | Cost sharing                                                                                                                                                                                                                                                                     |                 |
| <u>Deductibles</u>                                                                                                                                                                                                                                                                                             | \$0             | <u>Deductibles</u>                                                                                                                                                                                                                                                          | \$0             | <u>Deductibles</u>                                                                                                                                                                                                                                                               | \$0             |
| <u>Copayments</u>                                                                                                                                                                                                                                                                                              | \$1,900         | <u>Copayments</u>                                                                                                                                                                                                                                                           | \$2,100         | <u>Copayments</u>                                                                                                                                                                                                                                                                | \$1,800         |
| <u>Coinsurance</u>                                                                                                                                                                                                                                                                                             | \$0             | <u>Coinsurance</u>                                                                                                                                                                                                                                                          | \$0             | <u>Coinsurance</u>                                                                                                                                                                                                                                                               | \$0             |
| What isn't covered                                                                                                                                                                                                                                                                                             |                 | What isn't covered                                                                                                                                                                                                                                                          |                 | What isn't covered                                                                                                                                                                                                                                                               |                 |
| Limits or exclusions                                                                                                                                                                                                                                                                                           | \$60            | Limits or exclusions                                                                                                                                                                                                                                                        | \$20            | Limits or exclusions                                                                                                                                                                                                                                                             | \$0             |
| The total Peg would pay is                                                                                                                                                                                                                                                                                     | \$1,960         | The total Joe would pay is                                                                                                                                                                                                                                                  | \$2,120         | The total Mia would pay is                                                                                                                                                                                                                                                       | \$1,800         |

The plan would be responsible for the other costs of these EXAMPLE covered services.

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [Surest.Care/Taylor](#), Surest mobile app or call Surest Member Services at 1-866-683-6440. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at [Healthcare.gov/sbc-glossary/](#) or call 1-866-487-2365 to request a copy.

| Important Questions                                                 | Answers                                                                                                                            | Why This Matters                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | \$0                                                                                                                                | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive Care</u> .                                                                                                      | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="#">Healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                                                                      |
| Are there other <u>deductibles</u> for specific services?           | No                                                                                                                                 | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | For <u>network providers</u> :<br>\$9,000 individual / \$18,000 family<br><br>For <u>out-of-network providers</u> :<br>Not covered | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.<br><br>If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                              |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance billing</u> charges and health care this <u>plan</u> doesn't cover.                                   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="#">Surest.Care/Taylor</a> or call 1-866-683-6440 for a list of <u>network providers</u> .                        | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No                                                                                                                                 | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

| Common Medical Event                                   | Services You May Need                                                                                                                             | What You Will Pay                                                                                                                   |                                                                                                                | Limitations, Exceptions, & Other Important Information*                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|--------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                        |                                                                                                                                                   | In-Network Provider<br>(You will pay the least)                                                                                     | Out-of-Network Provider<br>(You will pay the most)                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness                                                                                                  | \$55 - \$175 <u>copay</u> /visit                                                                                                    | Not covered                                                                                                    | <p>Certain procedures performed in the office may have a higher office visit <u>copay</u>. <u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p>*Cost share applies to any other Telehealth service based on <u>provider</u> type. If you receive services in addition to office visit, additional <u>copays</u> may apply.</p> <p>You may have to pay for services that are not <u>preventive</u>. Ask your <u>provider</u> if the services needed are <u>preventive</u>. Then check what your <u>plan</u> will pay for.</p> |
|                                                        | <u>Specialist</u> visit                                                                                                                           | \$55 - \$175 <u>copay</u> /visit                                                                                                    | Not covered                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|                                                        | <u>Preventive care/screening/immunization</u>                                                                                                     | No charge                                                                                                                           | Not covered                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| If you have a test                                     | <b><u>Routine diagnostic test</u></b> (e.g., x-ray, blood work)<br><b><u>Non-routine diagnostic test</u></b> (e.g., sleep study, genetic testing) | <b><u>Routine diagnostic test</u></b> : No charge<br><b><u>Non-routine diagnostic test</u></b> : \$40 - \$1,350 <u>copay</u> /visit | <b><u>Routine diagnostic test</u></b> : Not covered<br><b><u>Non-routine diagnostic test</u></b> : Not covered | <p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for certain Non-routine <u>diagnostic tests</u> or there may be no coverage.</p>                                                                                                                                                                                                                                                                                                                                               |
|                                                        | Imaging (CT/PET scans, MRIs)                                                                                                                      | \$250 - \$2,400 <u>copay</u> /visit                                                                                                 | Not covered                                                                                                    | <p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for certain imaging tests or there may be no coverage.</p>                                                                                                                                                                                                                                                                                                                                                                     |

\*For more information about limitations and exceptions, see the plan or policy document at [Surest.Care/Taylor](#).

| Common Medical Event                                                                                                                                                                   | Services You May Need         | What You Will Pay                                                                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                        |                               | In-Network Provider<br>(You will pay the least)                                              | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you need drugs to treat your illness or condition</b><br>More information about prescription drug coverage is available at <a href="https://www.caremark.com">Caremark.com</a> . | <b>Generic</b>                | <b>30-Day Supply</b><br>\$20 <u>copay</u><br><br><b>90-Day Supply</b><br>\$50 <u>copay</u>   | Not covered                                        | Certain Tier 1 drugs are available with no charge, including prescribed generic contraceptives and tobacco cessation medications.<br><br>To learn more about drug tiers and about <u>copays</u> for specific drugs, visit <a href="https://www.caremark.com">Caremark.com</a> website.<br><br>Prior authorization is required for certain drugs or there may be no coverage. |
|                                                                                                                                                                                        | <b>Preferred Brand</b>        | <b>30-Day Supply</b><br>\$100 <u>copay</u><br><br><b>90-Day Supply</b><br>\$250 <u>copay</u> | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                        | <b>Non-Preferred Brand</b>    | <b>30-Day Supply</b><br>\$250 <u>copay</u><br><br><b>90-Day Supply</b><br>\$625 <u>copay</u> | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                        | <b><u>Specialty drugs</u></b> | <b>30-Day Supply</b><br>\$750 <u>copay</u>                                                   | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                              |

| Common Medical Event                    | Services You May Need                          | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information*                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------|------------------------------------------------|-------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                             |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center) | \$80 - \$7,500 <u>copay</u> /visit              | Not covered                                        | <p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned copays within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for certain outpatient surgery or there may be no coverage.</p>                                     |
|                                         | Physician/surgeon fees                         | No charge                                       | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                             |
| If you need immediate medical attention | <u>Emergency room care</u>                     | \$1,200 <u>copay</u> /visit                     | \$1,200 <u>copay</u> /visit                        | <p><u>Copay</u> is waived if admitted within 24 hours. <u>Out-of-network emergency room care visit copay</u> applies to the <u>in-network out-of-pocket limit</u>.</p>                                                                                                                                                                                                      |
|                                         | <u>Emergency medical transportation</u>        | \$700 <u>copay</u> /transport                   | \$700 <u>copay</u> /transport                      | <p><u>Prior authorization</u> is required for non-emergency medical transportation or there may be no coverage. <u>Out-of-network emergency medical transportation copay</u> applies to the in-network <u>out-of-pocket limit</u>.</p>                                                                                                                                      |
|                                         | <u>Urgent care</u>                             | \$110 <u>copay</u> /visit                       | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                        |
| If you have a hospital stay             | Facility fee (e.g., hospital room)             | \$700 - \$7,500 <u>copay</u> /stay              | Not covered                                        | <p><u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.</p> <p><u>Prior authorization</u> is required for non-emergency facility admissions and inpatient surgery or there may be no coverage.</p> |
|                                         | Physician/surgeon fees                         | No charge                                       | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                             |

\*For more information about limitations and exceptions, see the plan or policy document at [Surest.Care/Taylor](https://www.surestcare.com/taylor).

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                     |                                                                                                | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-Network Provider<br>(You will pay the least)                                                       | Out-of-Network Provider<br>(You will pay the most)                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | <b>Home/Office:</b> \$55 <u>copay</u> /visit<br><b>Outpatient Facility:</b> \$200 <u>copay</u> /visit | <b>Home/Office:</b> Not covered <u>copay</u> /visit<br><b>Outpatient Facility:</b> Not covered | Certain procedures/services in the outpatient setting may have a lower <u>copay</u> .<br><u>Prior authorization</u> is required for certain outpatient services or there may be no coverage.                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Inpatient services                        | \$5,500 <u>copay</u> /stay                                                                            | Not covered                                                                                    | Certain procedures/services in the inpatient setting may have a lower <u>copay</u> .<br><u>Prior authorization</u> is required for certain inpatient services or there may be no coverage.                                                                                                                                                                                                                                                                                                                   |
| If you are pregnant                                                       | Office visits                             | No charge                                                                                             | Not covered                                                                                    | <u>Cost sharing</u> does not apply to <u>preventive services</u> with <u>network providers</u> .<br>Depending on the type of service, a <u>copay</u> may apply.                                                                                                                                                                                                                                                                                                                                              |
|                                                                           | Childbirth/delivery professional services | No charge                                                                                             | Not covered                                                                                    | One <u>copay</u> for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother.                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                           | Childbirth/delivery facility services     | \$3,700 - \$5,800 <u>copay</u> /stay                                                                  | Not covered                                                                                    | <u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.<br><u>Cost sharing</u> does not apply to certain <u>preventive services</u> .<br><u>Prior authorization</u> is required for inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or there may be no coverage. |

| Common Medical Event                                           | Services You May Need            | What You Will Pay                                                                     |                                                 | Limitations, Exceptions, & Other Important Information*                                                                                                                                                                                                |
|----------------------------------------------------------------|----------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                  | In-Network Provider (You will pay the least)                                          | Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                                                                        |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | \$90 <u>copay</u> /visit                                                              | Not covered                                     | 120 visit limit - combination of <u>network providers</u> and <u>out-of-network providers</u> per person per <u>plan</u> year.<br><u>Prior authorization</u> is required for certain <u>home health care</u> services or there may be no coverage.     |
|                                                                | <u>Rehabilitation services</u>   | \$30 - \$210 <u>copay</u> /visit                                                      | Not covered                                     | No visit limit for occupational therapy<br>No visit limit for physical therapy<br>No visit limit for speech therapy<br>Visit limits are a combination of <u>network providers</u> and <u>out-of-network providers</u> per person per <u>plan</u> year. |
|                                                                | <u>Habilitation services</u>     | \$30 - \$210 <u>copay</u> /visit                                                      | Not covered                                     | <u>Copays</u> are listed as a range. <u>Providers</u> are assigned <u>copays</u> within the range based on treatment outcomes and cost information that identifies <u>network providers</u> that provide cost-efficient care.                          |
|                                                                | <u>Skilled nursing care</u>      | \$4,000 <u>copay</u> /stay                                                            | Not covered                                     | 120 day limit per person per <u>plan</u> year.<br><u>Prior authorization</u> is required or there may be no coverage.                                                                                                                                  |
|                                                                | <u>Durable medical equipment</u> | \$0 - \$1,000 <u>copay</u> /equipment based on <u>DME</u> tier                        | Not covered                                     | <u>Prior authorization</u> is required for certain <u>DME</u> or there may be no coverage.                                                                                                                                                             |
|                                                                | <u>Hospice services</u>          | <b>Home:</b> \$90 <u>copay</u> /visit<br><b>Inpatient:</b> \$5,500 <u>copay</u> /stay | Not covered                                     | None                                                                                                                                                                                                                                                   |
| If your child needs dental or eye care                         | Children's eye exam              | No charge                                                                             | Not covered                                     | None                                                                                                                                                                                                                                                   |
|                                                                | Children's glasses               | Not covered                                                                           | Not covered                                     | None                                                                                                                                                                                                                                                   |
|                                                                | Children's dental check-up       | Not covered                                                                           | Not covered                                     | None                                                                                                                                                                                                                                                   |

\*For more information about limitations and exceptions, see the plan or policy document at [Surest.Care/Taylor](#).

## Excluded Services & Other Covered Services:

### Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

- |                       |                                                      |                            |
|-----------------------|------------------------------------------------------|----------------------------|
| • Cosmetic surgery    | • Long term care                                     | • Private duty nursing     |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine eye care (Adult) |
|                       |                                                      | • Weight loss programs     |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |                                                         |                                      |                                              |
|---------------------------------------------------------|--------------------------------------|----------------------------------------------|
| • Acupuncture (20 visit limit per person per plan year) | • Chiropractic care (NO visit limit) | • Infertility treatment (Limitations apply)  |
| • Bariatric surgery                                     | • Hearing aids (limitations apply)   | • Routine foot care (for certain conditions) |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform). You may also contact Surest Member Services at 1-866-683-6440. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [HealthCare.gov](http://HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Surest Member Services at 1-866-683-6440, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al [1-866-633-2446].

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [1-866-633-2446].

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [1-866-633-2446].

Pennsylvania Dutch (Deitsch): Fer Hilf griegie in Deitsch, ruf [1-866-633-2446] uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [1-866-633-2446].

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni [1-866-633-2446].

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye [1-866-633-2446].

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang [1-866-633-2446].

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby<br>(9 months of in-network pre-natal care and a hospital delivery)                                                                                                                                                                                                                        |                 | Managing Joe's Type 2 Diabetes<br>(a year of routine in-network care of a well-controlled condition)                                                                                                                                                                        |                 | Mia's Simple Fracture<br>(in-network emergency room visit and follow up care)                                                                                                                                                                                                    |                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| ■ The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                                                                                  | \$0             | ■ The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                                               | \$0             | ■ The <u>plan's</u> overall <u>deductible</u>                                                                                                                                                                                                                                    | \$0             |
| ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                                                                  | \$55 - \$175    | ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                               | \$55 - \$175    | ■ <u>Specialist copayment</u>                                                                                                                                                                                                                                                    | \$55 - \$175    |
| ■ Hospital (facility) <u>copayment</u>                                                                                                                                                                                                                                                                         | \$700 - \$7,500 | ■ Hospital (facility) <u>copayment</u>                                                                                                                                                                                                                                      | \$700 - \$7,500 | ■ Hospital (facility) <u>copayment</u>                                                                                                                                                                                                                                           | \$700 - \$7,500 |
| ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                                                     | \$0             | ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                  | \$0             | ■ Other <u>coinsurance</u>                                                                                                                                                                                                                                                       | \$0             |
| This EXAMPLE event includes services like:<br><u>Specialist</u> office visits ( <i>prenatal care</i> )<br>Childbirth/Delivery Professional Services<br>Childbirth/Delivery Facility Services<br><u>Diagnostic tests</u> ( <i>ultrasounds and blood work</i> )<br><u>Specialist</u> visit ( <i>anesthesia</i> ) |                 | This EXAMPLE event includes services like:<br><u>Primary care physician</u> office visits ( <i>including disease education</i> )<br><u>Diagnostic tests</u> ( <i>blood work</i> )<br><u>Prescription drugs</u><br><u>Durable medical equipment</u> ( <i>glucose meter</i> ) |                 | This EXAMPLE event includes services like:<br><u>Emergency room care</u> ( <i>including medical supplies</i> )<br><u>Diagnostic tests</u> ( <i>x-ray</i> )<br><u>Durable medical equipment</u> ( <i>crutches</i> )<br><u>Rehabilitation services</u> ( <i>physical therapy</i> ) |                 |
| Total Example Cost                                                                                                                                                                                                                                                                                             | \$12,700        | Total Example Cost                                                                                                                                                                                                                                                          | \$5,600         | Total Example Cost                                                                                                                                                                                                                                                               | \$2,800         |
| In this example, Peg would pay:                                                                                                                                                                                                                                                                                |                 | In this example, Joe would pay:                                                                                                                                                                                                                                             |                 | In this example, Mia would pay:                                                                                                                                                                                                                                                  |                 |
| Cost sharing                                                                                                                                                                                                                                                                                                   |                 | Cost sharing                                                                                                                                                                                                                                                                |                 | Cost sharing                                                                                                                                                                                                                                                                     |                 |
| <u>Deductibles</u>                                                                                                                                                                                                                                                                                             | \$0             | <u>Deductibles</u>                                                                                                                                                                                                                                                          | \$0             | <u>Deductibles</u>                                                                                                                                                                                                                                                               | \$0             |
| <u>Copayments</u>                                                                                                                                                                                                                                                                                              | \$3,800         | <u>Copayments</u>                                                                                                                                                                                                                                                           | \$2,600         | <u>Copayments</u>                                                                                                                                                                                                                                                                | \$1,700         |
| <u>Coinsurance</u>                                                                                                                                                                                                                                                                                             | \$0             | <u>Coinsurance</u>                                                                                                                                                                                                                                                          | \$0             | <u>Coinsurance</u>                                                                                                                                                                                                                                                               | \$0             |
| What isn't covered                                                                                                                                                                                                                                                                                             |                 | What isn't covered                                                                                                                                                                                                                                                          |                 | What isn't covered                                                                                                                                                                                                                                                               |                 |
| Limits or exclusions                                                                                                                                                                                                                                                                                           | \$60            | Limits or exclusions                                                                                                                                                                                                                                                        | \$20            | Limits or exclusions                                                                                                                                                                                                                                                             | \$0             |
| The total Peg would pay is                                                                                                                                                                                                                                                                                     | \$3,860         | The total Joe would pay is                                                                                                                                                                                                                                                  | \$2,620         | The total Mia would pay is                                                                                                                                                                                                                                                       | \$1,700         |

The plan would be responsible for the other costs of these EXAMPLE covered services.



## HSA Plus Plan



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit <https://employees.taylor.com> or call 1-877-252-9861. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-877-252-9861 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                                | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | <u>Network</u> : \$3,400 Individual / \$6,800 Family<br><u>Non-Network</u> : \$6,000 Individual / \$12,000 Family per calendar year.                                   | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                  |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive Care</u> are covered before you meet your <u>deductible</u> .                                                                                       | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> |
| Are there other <u>deductibles</u> for specific services?           | No, there are no other <u>deductibles</u> .                                                                                                                            | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                      |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | <u>Network provider</u> : \$6,800 Individual / \$13,600 Family. <u>Out-of-network providers</u> : \$12,700 Individual / \$25,400 Family per calendar year              | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                        |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>prior authorization</u> for services. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .                                                                                                                                                                                                                                                                                                                                                                                                                           |

| Important Questions                                        | Answers                                                                                                                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Will you pay less if you use a <b>network provider</b> ?   | Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-888-507-9379 for a list of <b>network providers</b> . | This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services. |
| Do you need a <b>referral</b> to see a <b>specialist</b> ? | No                                                                                                                        | You can see the <b>specialist</b> you choose without a <b>referral</b> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event                                          | Services You May Need                            | What You Will Pay                                   |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                   |
|---------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | <b>Network Provider</b><br>(You will pay the least) | <b>Out-of-Network Provider</b><br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                          |
| If you visit a health care <b>provider's</b> office or clinic | Primary care visit to treat an injury or illness | 20% <b>coinsurance</b>                              | 20% <b>coinsurance</b>                                    | Virtual visit - In- <b>network</b> 20% <b>coinsurance</b> after <b>deductible</b> by a Designated Virtual <b>Network Provider</b> . No virtual visit coverage for out-of- <b>network</b> . If you receive services in addition to office visit, additional copays, <b>deductibles</b> , or <b>coinsurance</b> may apply. |
|                                                               | <b>Specialist</b> visit                          | 20% <b>coinsurance</b>                              | 20% <b>coinsurance</b>                                    | If you receive services in addition to office visit, additional copays, <b>deductibles</b> , or <b>coinsurance</b> may apply.                                                                                                                                                                                            |
|                                                               | <b>Preventive care/screening/immunization</b>    | No charge                                           | 20% <b>coinsurance</b>                                    | You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for.                                                                                                                                  |
| If you have a test                                            | <b>Diagnostic test</b> (x-ray, blood work)       | 20% <b>coinsurance</b>                              | 20% <b>coinsurance</b>                                    | <b>Prior Authorization</b> required out-of- <b>network</b> for Sleep Studies.                                                                                                                                                                                                                                            |
|                                                               | Imaging (CT/PET scans, MRIs)                     | 20% <b>coinsurance</b>                              | 20% <b>coinsurance</b>                                    | None                                                                                                                                                                                                                                                                                                                     |

| Common Medical Event                                                                                                                                                                                  | Services You May Need                          | What You Will Pay                                                                                                                   |                                                                                                                                     | Limitations, Exceptions, & Other Important Information                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                       |                                                | <u>Network Provider</u><br>(You will pay the least)                                                                                 | <u>Out-of-Network Provider</u><br>(You will pay the most)                                                                           |                                                                                                                                                            |
| <b>If you need drugs to treat your illness or condition</b><br><b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com">www.caremark.com</a></b> | Generic Drugs (Tier 1)                         | \$10 <u>copay</u> /retail<br>\$25 <u>copay</u> /90 day retail                                                                       | \$10 <u>copay</u> /retail<br>\$25 <u>copay</u> /90 day retail                                                                       | Participant pays full price for prescription drugs up to the deductible. No coverage for mail service pharmacy drugs from <u>out-of-network</u> providers. |
|                                                                                                                                                                                                       | Preferred brand drugs (Tier 2)                 | 20% <u>coinsurance</u> /retail;<br>\$40 minimum \$80 maximum<br>20% <u>coinsurance</u> /90 day retail; \$100 minimum \$200 maximum  | 20% <u>coinsurance</u> /retail;<br>\$40 minimum \$80 maximum<br>20% <u>coinsurance</u> /90 day retail; \$100 minimum \$200 maximum  |                                                                                                                                                            |
|                                                                                                                                                                                                       | Non-preferred brand drugs (Tier 3)             | 50% <u>coinsurance</u> /retail;<br>\$60 minimum \$120 maximum<br>50% <u>coinsurance</u> /90 day retail; \$150 minimum \$300 maximum | 50% <u>coinsurance</u> /retail;<br>\$60 minimum \$120 maximum<br>50% <u>coinsurance</u> /90 day retail; \$150 minimum \$300 maximum |                                                                                                                                                            |
|                                                                                                                                                                                                       | <u>Specialty drugs</u> (Tier 4)                | 20% <u>coinsurance</u> \$75 minimum \$150 maximum                                                                                   | 20% <u>coinsurance</u> \$75 minimum \$150 maximum                                                                                   |                                                                                                                                                            |
| <b>If you have outpatient surgery</b>                                                                                                                                                                 | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>                                                                                                              | 20% <u>coinsurance</u>                                                                                                              | <u>Prior Authorization</u> required for out-of-network.                                                                                                    |
|                                                                                                                                                                                                       | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                                                                                              | 20% <u>coinsurance</u>                                                                                                              | None                                                                                                                                                       |
| <b>If you need immediate medical attention</b>                                                                                                                                                        | <u>Emergency room care</u>                     | 20% <u>coinsurance</u>                                                                                                              | 20% <u>coinsurance</u>                                                                                                              | None                                                                                                                                                       |
|                                                                                                                                                                                                       | <u>Emergency medical transportation</u>        | 20% <u>coinsurance</u>                                                                                                              | 20% <u>coinsurance</u>                                                                                                              | None                                                                                                                                                       |
|                                                                                                                                                                                                       | <u>Urgent care</u>                             | 20% <u>coinsurance</u>                                                                                                              | 20% <u>coinsurance</u>                                                                                                              | None                                                                                                                                                       |
| <b>If you have a hospital stay</b>                                                                                                                                                                    | Facility fee (e.g., hospital room)             | 20% <u>coinsurance</u>                                                                                                              | 20% <u>coinsurance</u>                                                                                                              | <u>Prior Authorization</u> required out-of-network.                                                                                                        |
|                                                                                                                                                                                                       | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                                                                                              | 20% <u>coinsurance</u>                                                                                                              | None                                                                                                                                                       |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                   |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | <u>Prior Authorization</u> required for certain services out-of- <u>network</u> .                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                  | Inpatient services                        | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | <u>Prior Authorization</u> required out-of- <u>network</u> for inpatient facility.                                                                                                                                                                                                                                                                                                                                                        |
| <b>If you are pregnant</b>                                                       | Office visits                             | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | <u>Prior Authorization</u> required out-of- <u>network</u> for inpatient stays that exceed normal 48 hours for natural delivery or 96 hours for cesarean.<br><u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on type of service, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound) |
|                                                                                  | Childbirth/delivery professional services | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                  | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>If you need help recovering or have other special health needs</b>            | <u>Home health care</u>                   | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | Limited to 120 visits per calendar year. <u>Prior Authorization</u> required out-of- <u>network</u> for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN).                                                                                                                                                                                                                                                      |
|                                                                                  | <u>Rehabilitation services</u>            | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                  | <u>Habilitation services</u>              | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                                  | <u>Skilled nursing care</u>               | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | Limited to 120 days per calendar year. <u>Prior Authorization</u> required out-of- <u>network</u> .                                                                                                                                                                                                                                                                                                                                       |
|                                                                                  | <u>Durable medical equipment</u>          | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | <u>Prior Authorization</u> required out-of- <u>network</u> for DME over \$1,000.                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                  | <u>Hospice services</u>                   | 20% <u>coinsurance</u>                              | 20% <u>coinsurance</u>                                    | <u>Prior Authorization</u> required out-of- <u>network</u> before admission for an inpatient stay in a hospice facility.                                                                                                                                                                                                                                                                                                                  |

| Common Medical Event                   | Services You May Need      | What You Will Pay                                   |                                                           | Limitations, Exceptions, & Other Important Information   |
|----------------------------------------|----------------------------|-----------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------|
|                                        |                            | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                          |
| If your child needs dental or eye care | Children's eye exam        | No Charge                                           | Not covered                                               | Child Routine vision exam is not covered out-of-network. |
|                                        | Children's glasses         | Not covered                                         | Not covered                                               | Child glasses are not covered.                           |
|                                        | Children's dental check-up | Not covered                                         | Not covered                                               | Child dental check-up is not covered.                    |

#### Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) |                                                                                                                                                            |                                                                                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Adult routine vision exam (i.e. refraction)</li> <li>Cosmetic Surgery</li> <li>Dental Care (Adult)</li> </ul>                   | <ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)                                    |                                                                                                                                                            |                                                                                                   |
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric Surgery</li> </ul>                                                                               | <ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Hearing aids</li> </ul>                                                                  | <ul style="list-style-type: none"> <li>Infertility treatment</li> </ul>                           |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov/](http://www.HealthCare.gov/) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-888-507-9379 or visit [www.myuhc.com](http://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**Does this plan provide Minimum Essential Coverage? Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-507-9379.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-507-9379.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwíijigo holne' 1-888-507-9379.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-888-507-9379 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-507-9379.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-507-9379.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-507-9379.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, á'gang 1-888-507-9379.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                          |         |
|------------------------------------------|---------|
| ■ The <u>plan's</u> overall deductible   | \$3,400 |
| ■ <u>Specialist coinsurance</u>          | 20%     |
| ■ Hospital (facility) <u>coinsurance</u> | 20%     |
| ■ Other <u>coinsurance</u>               | 20%     |

This EXAMPLE event includes services like:

Specialist office visits (*pre-natal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

|                    |          |
|--------------------|----------|
| Total Example Cost | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:

| <u>Cost Sharing</u>        |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$3,400 |
| <u>Copayments</u>          | \$10    |
| <u>Coinsurance</u>         | \$1,800 |
| <u>What isn't covered</u>  |         |
| Limits or exclusions       | \$60    |
| The total Peg would pay is | \$5,270 |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                          |         |
|------------------------------------------|---------|
| ■ The <u>plan's</u> overall deductible   | \$3,400 |
| ■ <u>Specialist coinsurance</u>          | 20%     |
| ■ Hospital (facility) <u>coinsurance</u> | 20%     |
| ■ Other <u>coinsurance</u>               | 20%     |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:

| <u>Cost Sharing</u>        |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$3,400 |
| <u>Copayments</u>          | \$200   |
| <u>Coinsurance</u>         | \$300   |
| <u>What isn't covered</u>  |         |
| Limits or exclusions       | \$20    |
| The total Joe would pay is | \$3,920 |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                          |         |
|------------------------------------------|---------|
| ■ The <u>plan's</u> overall deductible   | \$3,400 |
| ■ <u>Specialist coinsurance</u>          | 20%     |
| ■ Hospital (facility) <u>coinsurance</u> | 20%     |
| ■ Other <u>coinsurance</u>               | 20%     |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

| <u>Cost Sharing</u>        |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$2,800 |
| <u>Copayments</u>          | \$0     |
| <u>Coinsurance</u>         | \$0     |
| <u>What isn't covered</u>  |         |
| Limits or exclusions       | \$0     |
| The total Mia would pay is | \$2,800 |



## HSA



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit <https://employees.taylor.com> or call 1-877-252-9861. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-877-252-9861 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                                | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | <u>Network</u> : \$6,600 Individual / \$13,200 Family<br><u>Non-Network</u> : \$12,700 Individual / \$25,400 Family per calendar year.                                 | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                  |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive Care</u> are covered before you meet your <u>deductible</u> .                                                                                       | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> |
| Are there other <u>deductibles</u> for specific services?           | No, there are no other <u>deductibles</u> .                                                                                                                            | You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this <u>plan</u> covers.                                                                                                                                                                                                                                                                                                                                                      |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | <u>Network provider</u> : \$6,600 Individual / \$13,200 Family. <u>Out-of-network providers</u> : \$12,700 Individual / \$25,400 Family per calendar year              | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                        |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance-billing</u> charges, health care this <u>plan</u> doesn't cover, penalties for failure to obtain <u>prior authorization</u> for services. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> .                                                                                                                                                                                                                                                                                                                                                                                                                           |

| Important Questions                                        | Answers                                                                                                                   | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Will you pay less if you use a <b>network provider</b> ?   | Yes. See <a href="http://www.myuhc.com">www.myuhc.com</a> or call 1-888-507-9379 for a list of <b>network providers</b> . | This <b>plan</b> uses a <b>provider network</b> . You will pay less if you use a <b>provider</b> in the <b>plan's network</b> . You will pay the most if you use an <b>out-of-network provider</b> , and you might receive a bill from a <b>provider</b> for the difference between the <b>provider's</b> charge and what your <b>plan</b> pays ( <b>balance billing</b> ). Be aware, your <b>network provider</b> might use an <b>out-of-network provider</b> for some services (such as lab work). Check with your <b>provider</b> before you get services. |
| Do you need a <b>referral</b> to see a <b>specialist</b> ? | No                                                                                                                        | You can see the <b>specialist</b> you choose without a <b>referral</b> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event                                          | Services You May Need                            | What You Will Pay                                   |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                            |
|---------------------------------------------------------------|--------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | <b>Network Provider</b><br>(You will pay the least) | <b>Out-of-Network Provider</b><br>(You will pay the most) |                                                                                                                                                                                                                                                                   |
| If you visit a health care <b>provider's</b> office or clinic | Primary care visit to treat an injury or illness | 0% <b>coinsurance</b>                               | 0% <b>coinsurance</b>                                     | Virtual visit - In- <b>network</b> 20% <b>coinsurance</b> after <b>deductible</b> by a Designated Virtual <b>Network Provider</b> . If you receive services in addition to office visit, additional copays, <b>deductibles</b> , or <b>coinsurance</b> may apply. |
|                                                               | <b>Specialist</b> visit                          | 0% <b>coinsurance</b>                               | 0% <b>coinsurance</b>                                     | If you receive services in addition to office visit, additional copays, <b>deductibles</b> , or <b>coinsurance</b> may apply.                                                                                                                                     |
|                                                               | <b>Preventive care/screening/immunization</b>    | No charge                                           | 0% <b>coinsurance</b>                                     | You may have to pay for services that aren't <b>preventive</b> . Ask your <b>provider</b> if the services needed are <b>preventive</b> . Then check what your <b>plan</b> will pay for.                                                                           |
| If you have a test                                            | <b>Diagnostic test</b> (x-ray, blood work)       | 0% <b>coinsurance</b>                               | 0% <b>coinsurance</b>                                     | <b>Prior Authorization</b> required out-of- <b>network</b> for Sleep Studies.                                                                                                                                                                                     |
|                                                               | Imaging (CT/PET scans, MRIs)                     | 0% <b>coinsurance</b>                               | 0% <b>coinsurance</b>                                     | None.                                                                                                                                                                                                                                                             |

| Common Medical Event                                                                                                                                                                                  | Services You May Need                          | What You Will Pay                                                     |                                                                       | Limitations, Exceptions, & Other Important Information                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                       |                                                | <u>Network Provider</u><br>(You will pay the least)                   | <u>Out-of-Network Provider</u><br>(You will pay the most)             |                                                                                                                                                       |
| <b>If you need drugs to treat your illness or condition</b><br><b>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com">www.caremark.com</a></b> | Generic Drugs (Tier 1)                         | 0% <u>Coinsurance</u> /retail<br>Mail Order: 0% <u>Coinsurance</u>    | 0% <u>Coinsurance</u> /retail<br>0% <u>Coinsurance</u> /90 day retail | Participant pays full price for prescriptions up to the deductible. No coverage for mail service pharmacy drugs from <u>out-of-network</u> providers. |
|                                                                                                                                                                                                       | Preferred brand drugs (Tier 2)                 | 0% <u>Coinsurance</u> /retail<br>0% <u>Coinsurance</u> /90 day retail | 0% <u>Coinsurance</u> /retail<br>0% <u>Coinsurance</u> /90 day retail |                                                                                                                                                       |
|                                                                                                                                                                                                       | Non-preferred brand drugs (Tier 3)             | 0% <u>Coinsurance</u> /retail<br>0% <u>Coinsurance</u> /90 day retail | 0% <u>Coinsurance</u> /retail<br>0% <u>Coinsurance</u> /90 day retail |                                                                                                                                                       |
|                                                                                                                                                                                                       | <u>Specialty drugs</u> (Tier 4)                | 0% <u>Coinsurance</u>                                                 | Not covered                                                           |                                                                                                                                                       |
| <b>If you have outpatient surgery</b>                                                                                                                                                                 | Facility fee (e.g., ambulatory surgery center) | 0% <u>coinsurance</u>                                                 | 0% <u>coinsurance</u>                                                 | <u>Prior Authorization</u> required for out-of-network.                                                                                               |
|                                                                                                                                                                                                       | Physician/surgeon fees                         | 0% <u>coinsurance</u>                                                 | 0% <u>coinsurance</u>                                                 | None.                                                                                                                                                 |
| <b>If you need immediate medical attention</b>                                                                                                                                                        | <u>Emergency room care</u>                     | 0% <u>coinsurance</u>                                                 | 0% <u>coinsurance</u>                                                 | None.                                                                                                                                                 |
|                                                                                                                                                                                                       | <u>Emergency medical transportation</u>        | 0% <u>coinsurance</u>                                                 | 0% <u>coinsurance</u>                                                 | None                                                                                                                                                  |
|                                                                                                                                                                                                       | <u>Urgent care</u>                             | 0% <u>coinsurance</u>                                                 | 0% <u>coinsurance</u>                                                 | None                                                                                                                                                  |
| <b>If you have a hospital stay</b>                                                                                                                                                                    | Facility fee (e.g., hospital room)             | 0% <u>coinsurance</u>                                                 | 0% <u>coinsurance</u>                                                 | <u>Prior Authorization</u> required out-of-network.                                                                                                   |
|                                                                                                                                                                                                       | Physician/surgeon fees                         | 0% <u>coinsurance</u>                                                 | 0% <u>coinsurance</u>                                                 | None                                                                                                                                                  |
| <b>If you need mental health, behavioral health, or substance abuse services</b>                                                                                                                      | Outpatient services                            | 0% <u>coinsurance</u>                                                 | 0% <u>coinsurance</u>                                                 | <u>Prior Authorization</u> required out-of-network for certain services.                                                                              |
|                                                                                                                                                                                                       | Inpatient services                             | 0% <u>coinsurance</u>                                                 | 0% <u>coinsurance</u>                                                 | <u>Prior Authorization</u> required out-of-network for inpatient facility.                                                                            |
| <b>If you are pregnant</b>                                                                                                                                                                            | Office visits                                  | 0% <u>coinsurance</u>                                                 | 0% <u>coinsurance</u>                                                 |                                                                                                                                                       |
|                                                                                                                                                                                                       | Childbirth/delivery professional services      | 0% <u>coinsurance</u>                                                 | 0% <u>coinsurance</u>                                                 |                                                                                                                                                       |

| Common Medical Event                                           | Services You May Need                 | What You Will Pay                                   |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                             |
|----------------------------------------------------------------|---------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                       | <u>Network Provider</u><br>(You will pay the least) | <u>Out-of-Network Provider</u><br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                | Childbirth/delivery facility services | 0% <u>coinsurance</u>                               | 0% <u>coinsurance</u>                                     | <u>Prior Authorization</u> required out-of- <u>network</u> for inpatient stays that exceed 48 hours for natural delivery or 96 hours for cesarean. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of service, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC. (i.e., ultrasound). |
| If you need help recovering or have other special health needs | <u>Home health care</u>               | 0% <u>coinsurance</u>                               | 0% <u>coinsurance</u>                                     | Limited to 120 visits per calendar year. <u>Prior Authorization</u> required out-of- <u>network</u> for <u>Home Health Care</u> for certain services (skilled nursing by RN or LPN).                                                                                                                                                                                                                                               |
|                                                                | <u>Rehabilitation services</u>        | 0% <u>coinsurance</u>                               | 0% <u>coinsurance</u>                                     | None.                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                | <u>Habilitation services</u>          | 0% <u>coinsurance</u>                               | 0% <u>coinsurance</u>                                     | None.                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                | <u>Skilled nursing care</u>           | 0% <u>coinsurance</u>                               | 0% <u>coinsurance</u>                                     | Limited to 120 days per calendar year. <u>Prior Authorization</u> required out-of- <u>network</u> .                                                                                                                                                                                                                                                                                                                                |
|                                                                | <u>Durable medical equipment</u>      | 0% <u>coinsurance</u>                               | 0% <u>coinsurance</u>                                     | <u>Prior Authorization</u> required out-of- <u>network</u> for DME over \$1,000.                                                                                                                                                                                                                                                                                                                                                   |
|                                                                | <u>Hospice services</u>               | 0% <u>coinsurance</u>                               | 0% <u>coinsurance</u>                                     | <u>Prior Authorization</u> required out-of- <u>network</u> before admission for an inpatient stay in a hospice facility.                                                                                                                                                                                                                                                                                                           |
| If your child needs dental or eye care                         | Children's eye exam                   | No Charge                                           | Not covered                                               | Child Routine vision exam is not covered out-of-network                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                | Children's glasses                    | Not covered                                         | Not covered                                               | Child glasses are not covered.                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                | Children's dental check-up            | Not covered                                         | Not covered                                               | Child dental check-up is not covered.                                                                                                                                                                                                                                                                                                                                                                                              |

### Excluded Services & Other Covered Services:

#### Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- |                                                                                                                                                        |                                                                                                                                                              |                                                                                                    |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Adult routine vision exam (i.e. refraction)</li><li>• Cosmetic Surgery</li><li>• Dental Care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li></ul> | <ul style="list-style-type: none"><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------|

#### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- |                                                                                           |                                                                                            |                                                                         |
|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery</li></ul> | <ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Hearing aids</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment</li></ul> |
|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/healthreform>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov/](http://www.HealthCare.gov/) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-888-507-9379 or visit [www.myuhc.com](http://www.myuhc.com) or the Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-507-9379.

Traditional Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-507-9379.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiiijigo holne' 1-888-507-9379.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 1-888-507-9379 uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-507-9379.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-888-507-9379.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-888-507-9379.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, â'gang 1-888-507-9379.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                          |         |
|------------------------------------------|---------|
| ■ The <u>plan's</u> overall deductible   | \$6,600 |
| ■ <u>Specialist coinsurance</u>          | 0%      |
| ■ Hospital (facility) <u>coinsurance</u> | 0%      |
| ■ Other <u>coinsurance</u>               | 0%      |

This EXAMPLE event includes services like:

Specialist office visits (*pre-natal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

|                    |          |
|--------------------|----------|
| Total Example Cost | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:

| <u>Cost Sharing</u>        |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$6,600 |
| <u>Copayments</u>          | \$0     |
| <u>Coinsurance</u>         | \$0     |
| <u>What isn't covered</u>  |         |
| Limits or exclusions       | \$60    |
| The total Peg would pay is | \$6,660 |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                          |         |
|------------------------------------------|---------|
| ■ The <u>plan's</u> overall deductible   | \$6,600 |
| ■ <u>Specialist coinsurance</u>          | 0%      |
| ■ Hospital (facility) <u>coinsurance</u> | 0%      |
| ■ Other <u>coinsurance</u>               | 0%      |

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:

| <u>Cost Sharing</u>        |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$5,400 |
| <u>Copayments</u>          | \$0     |
| <u>Coinsurance</u>         | \$0     |
| <u>What isn't covered</u>  |         |
| Limits or exclusions       | \$20    |
| The total Joe would pay is | \$5,420 |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                          |         |
|------------------------------------------|---------|
| ■ The <u>plan's</u> overall deductible   | \$6,600 |
| ■ <u>Specialist coinsurance</u>          | 0%      |
| ■ Hospital (facility) <u>coinsurance</u> | 0%      |
| ■ Other <u>coinsurance</u>               | 0%      |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                    |         |
|--------------------|---------|
| Total Example Cost | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

| <u>Cost Sharing</u>        |         |
|----------------------------|---------|
| <u>Deductibles</u>         | \$2,800 |
| <u>Copayments</u>          | \$0     |
| <u>Coinsurance</u>         | \$0     |
| <u>What isn't covered</u>  |         |
| Limits or exclusions       | \$0     |
| The total Mia would pay is | \$2,800 |



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see <https://kp.org/plandocuments> or call 1-800-278-3296 (TTY: 711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-278-3296 (TTY: 711) to request a copy.

| Important Questions                                                             | Answers                                                                                                                                 | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$0                                                                                                                                     | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Not Applicable.                                                                                                                         | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                       |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                     | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$4,000 Individual / \$8,000 Family                                                                                                     | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2.     | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-278-3296 (TTY: 711) for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes, but you may self-refer to certain <a href="#">specialists</a> .                                                                    | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                      |

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event                                                                                                                                                                                     | Services You May Need                                  | What You Will Pay Plan Provider (You will pay the least)                                      | What You Will Pay Non-Plan Provider (You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                                                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                                   | Primary care visit to treat an injury or illness       | \$40 / visit                                                                                  | Not Covered                                                 | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                          | <a href="#">Specialist</a> visit                       | \$50 / visit                                                                                  | Not Covered                                                 | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                          | <a href="#">Preventive care/screening/immunization</a> | No Charge                                                                                     | Not Covered                                                 | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.                            |
| If you have a test                                                                                                                                                                                       | <a href="#">Diagnostic test</a> (x-ray, blood work)    | \$15 / encounter                                                                              | Not Covered                                                 | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                          | Imaging (CT/PET scans, MRI's)                          | 30% <a href="#">coinsurance</a> up to \$150 / procedure                                       | Not Covered                                                 | None                                                                                                                                                                                                                                                   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a> | Generic drugs (Tier 1)                                 | Retail: \$15 / <a href="#">prescription</a> ; Mail order: \$30 / <a href="#">prescription</a> | Not Covered                                                 | Up to a 30-day supply retail or 100-day supply mail order. Subject to <a href="#">formulary</a> guidelines. No Charge for Contraceptives.                                                                                                              |
|                                                                                                                                                                                                          | Preferred brand drugs (Tier 2)                         | Retail: \$40 / <a href="#">prescription</a> ; Mail order: \$80 / <a href="#">prescription</a> | Not Covered                                                 | Up to a 30-day supply retail or 100-day supply mail order. Subject to <a href="#">formulary</a> guidelines.                                                                                                                                            |
|                                                                                                                                                                                                          | Non-preferred brand drugs (Tier 2)                     | Retail: \$40 / <a href="#">prescription</a> ; Mail order: \$80 / <a href="#">prescription</a> | Not Covered                                                 | The <a href="#">cost sharing</a> for non-preferred brand drugs under this <a href="#">plan</a> aligns with the <a href="#">cost sharing</a> for preferred brand drugs (Tier 2), when approved through the <a href="#">formulary</a> exception process. |
|                                                                                                                                                                                                          | <a href="#">Specialty drugs</a> (Tier 4)               | 30% <a href="#">coinsurance</a> up to \$250 / <a href="#">prescription</a>                    | Not Covered                                                 | Up to a 30-day supply retail. Subject to <a href="#">formulary</a> guidelines.                                                                                                                                                                         |
| If you have outpatient surgery                                                                                                                                                                           | Facility fee (e.g., ambulatory surgery center)         | 30% <a href="#">coinsurance</a>                                                               | Not Covered                                                 | None                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                                          | Physician/surgeon fees                                 | 30% <a href="#">coinsurance</a>                                                               | Not Covered                                                 | None                                                                                                                                                                                                                                                   |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay Plan Provider<br>(You will pay the least)                                                                                                                                                                                 | What You Will Pay Non-Plan Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information                                                                                                                                                                                   |
|---------------------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 30% <a href="#">coinsurance</a>                                                                                                                                                                                                             | 30% <a href="#">coinsurance</a>                                | None                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Emergency medical transportation</a> | \$150 / trip                                                                                                                                                                                                                                | \$150 / trip                                                   | None                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Urgent care</a>                      | \$40 / visit                                                                                                                                                                                                                                | Not Covered                                                    | <a href="#">Non-Plan providers</a> covered when temporarily outside the service area: \$40 / visit.                                                                                                                                     |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 30% <a href="#">coinsurance</a>                                                                                                                                                                                                             | Not Covered                                                    | None                                                                                                                                                                                                                                    |
|                                                                           | Physician/surgeon fee                            | 30% <a href="#">coinsurance</a>                                                                                                                                                                                                             | Not Covered                                                    | None                                                                                                                                                                                                                                    |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Mental / Behavioral Health: \$40 / individual visit. 30% <a href="#">coinsurance</a> for other outpatient services; Substance Abuse: \$40 / individual visit. 30% <a href="#">coinsurance</a> up to \$5 / day for other outpatient services | Not Covered                                                    | Mental / Behavioral Health: \$20 / group visit, <a href="#">deductible</a> does not apply; Substance Abuse: \$5 / group visit, <a href="#">deductible</a> does not apply.                                                               |
|                                                                           | Inpatient services                               | 30% <a href="#">coinsurance</a>                                                                                                                                                                                                             | Not Covered                                                    | None                                                                                                                                                                                                                                    |
| If you are pregnant                                                       | Office visits                                    | No Charge                                                                                                                                                                                                                                   | Not covered                                                    | Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services        | 30% <a href="#">coinsurance</a>                                                                                                                                                                                                             | Not Covered                                                    | None                                                                                                                                                                                                                                    |
|                                                                           | Childbirth/delivery facility services            | 30% <a href="#">coinsurance</a>                                                                                                                                                                                                             | Not Covered                                                    | None                                                                                                                                                                                                                                    |

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay Plan Provider<br>(You will pay the least)              | What You Will Pay Non-Plan Provider<br>(You will pay the most) | Limitations, Exceptions & Other Important Information |
|-----------------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------|
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | No Charge                                                                | Not Covered                                                    | 3 visit limit / day, 100 visit limit / year.          |
|                                                                       | <a href="#">Rehabilitation services</a>   | Inpatient: 30% <a href="#">coinsurance</a> ;<br>Outpatient: \$40 / visit | Not Covered                                                    | None                                                  |
|                                                                       | <a href="#">Habilitation services</a>     | \$40 / visit                                                             | Not Covered                                                    | None                                                  |
|                                                                       | <a href="#">Skilled nursing care</a>      | No Charge                                                                | Not Covered                                                    | 100 day limit / benefit period.                       |
|                                                                       | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a>                                          | Not Covered                                                    | Requires prior authorization.                         |
|                                                                       | <a href="#">Hospice service</a>           | No Charge                                                                | Not Covered                                                    | None                                                  |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | No Charge for refractive exam                                            | Not Covered                                                    | None                                                  |
|                                                                       | Children's glasses                        | Not Covered                                                              | Not Covered                                                    | None                                                  |
|                                                                       | Children's dental check-up                | Not Covered                                                              | Not Covered                                                    | None                                                  |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                      |                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Children's glasses</li> <li>Cosmetic surgery</li> <li>Dental Care (Adult &amp; Child)</li> </ul>                                                           | <ul style="list-style-type: none"> <li>Hearing aids</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>   | <ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                      |                                                                                                                                                      |                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Acupuncture (20 visit limit / year combined with chiropractic)</li> <li>Bariatric surgery</li> </ul>                                                       | <ul style="list-style-type: none"> <li>Chiropractic care (20 visit limit / year combined with acupuncture)</li> <li>Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> </ul>                                                      |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

## Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

|                                                                                              |                                                                                                           |
|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------|
| Kaiser Permanente Member Services                                                            | 1-800-278-3296 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>     |
| Department of Labor's Employee Benefits Security Administration                              | 1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a> |
| Department of Health & Human Services, Center for Consumer Information & Insurance Oversight | 1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>                         |
| California Department of Insurance                                                           | 1-800-927-HELP (4357) or <a href="http://www.insurance.ca.gov">www.insurance.ca.gov</a>                   |
| California Department of Managed Healthcare                                                  | 1-888-466-2219 or <a href="http://www.dmhc.ca.gov">www.dmhc.ca.gov</a>                                    |

### Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-757-7585 (TTY: 711)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griege in Deutsch, ruf 1-800-278-3296 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-278-3296 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-278-3296 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-278-3296 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-800-278-3296 (TTY: 711)

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

|                                                                 |      |
|-----------------------------------------------------------------|------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$50 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%  |
| ■ Other (blood work) <a href="#">copayment</a>                  | \$15 |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                                        |                 |
|----------------------------------------|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <a href="#">Deductibles</a>            | \$0             |
| <a href="#">Copayments</a>             | \$100           |
| <a href="#">Coinsurance</a>            | \$2,500         |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$50            |
| <b>The total Peg would pay is</b>      | <b>\$2,650</b>  |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |      |
|-----------------------------------------------------------------|------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$50 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%  |
| ■ Other (blood work) <a href="#">copayment</a>                  | \$15 |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$0            |
| <a href="#">Copayments</a>             | \$900          |
| <a href="#">Coinsurance</a>            | \$300          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Joe would pay is</b>      | <b>\$1,200</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |      |
|-----------------------------------------------------------------|------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0  |
| ■ <a href="#">Specialist copayment</a>                          | \$50 |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%  |
| ■ Other (x-ray) <a href="#">copayment</a>                       | \$15 |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                                        |                |
|----------------------------------------|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <a href="#">Deductibles</a>            | \$0            |
| <a href="#">Copayments</a>             | \$400          |
| <a href="#">Coinsurance</a>            | \$300          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$700</b>   |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Nondiscrimination Notice

In this document, “we”, “us”, or “our” means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at [kp.org](https://www.kp.org).

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - ◆ Qualified sign language interpreters
  - ◆ Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - ◆ Qualified interpreters
  - ◆ Information written in other languages

If you need these services, call our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 hours a day, 7 days a week.
- All others: **1-800-464-4000 (TTY 711)**, 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

### How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at [kp.org](https://www.kp.org) or call Member Services and ask them to send you a form that you can send back.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at [kp.org/facilities](https://www.kp.org/facilities) for addresses)
- **Online:** Use the online form on our website at [kp.org](https://www.kp.org)

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

**Attn: Kaiser Permanente Civil Rights Coordinator**  
Member Relations Grievance Operations  
P.O. Box 939001  
San Diego CA 92193

**How to file a grievance with the California Department of Health Care Services Office of Civil Rights** *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY 711)
- **By mail:** Fill out a complaint form or send a letter to:

Office of Civil Rights  
Department of Health Care Services  
P.O. Box 997413, MS 0009  
Sacramento, CA 95899-7413

**California Department of Health Care Services Office of Civil Rights Complaint forms are available at:**  
[http://www.dhcs.ca.gov/Pages/Language\\_Access.aspx](http://www.dhcs.ca.gov/Pages/Language_Access.aspx)

- **Online:** Send an email to [CivilRights@dhcs.ca.gov](mailto:CivilRights@dhcs.ca.gov)

**How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights**

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office of Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY 711 or 1-800-537-7697)
- **By mail:** Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201

**U.S. Department of Health and Human Services Office for Civil Rights Complaint forms are available at:** <https://www.hhs.gov/ocr/office/file/index.html>

- **Online:** Visit the **Office of Civil Rights Complaint Portal** at: <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>

## Notice of Language Assistance

**English: ATTENTION.** Language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. to 8 p.m., 7 days a week
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 hours a day, 7 days a week
- All others: **1-800-464-4000 (TTY 711)**, 24 hours a day, 7 days a week

**Arabic: تنبيه.** المساعدة اللغوية متوفرة بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضاً طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل مع قسم خدمات الأعضاء لدينا للحصول على المساعدة. لا تعمل خدمات الأعضاء في العطلات الرئيسية.

- Medicare، بما في ذلك D-SNP على: **1-800-443-0815 (TTY 711)**، 8 صباحاً إلى 8 مساءً، 7 أيام في الأسبوع
- Medi-Cal: على **1-855-839-7613 (TTY 711)**، 24 ساعة في اليوم، 7 أيام في الأسبوع
- الآخرين جميعاً: **1-800-464-4000 (TTY 711)**، 24 ساعة في اليوم، 7 أيام في الأسبوع

**Armenian: ՈւՆԴԱՂՈՒԹՅՈՒՆ:** Լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափեր, ինչպիսիք են՝ բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք նաև դիմել օժանդակ աջակցության և սարքերի համար, որոնք անհրաժեշտ են մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման բաժին: Անդամների սպասարկման բաժինը փակ է հիմնական տոն օրերին:

- Medicare, ներառյալ D-SNP՝ **1-800-443-0815 (TTY 711)**, 8 a.m.-ից 8 p.m.-ը, շաբաթը 7 օր
- Medi-Cal՝ **1-855-839-7613 (TTY 711)**, օրը 24 ժամ, շաբաթը 7 օր
- Մյուս բոլորը՝ **1-800-464-4000 (TTY 711)**, օրը 24 ժամ, շաբաթը 7 օր

**Chinese: 请注意，**我们有免费语言协助。您可以要求我们提供口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式的文本，如盲文、音频或大字版。您还可以要求使用我们设施中的语言辅助工具和设备。请联系会员服务部以获取帮助。重要节假日期间会员服务不开放。

- Medicare, 包括 D-SNP : **1-800-443-0815 (TTY 711)**, 每周 7 天, 上午 8 点至晚上 8 点
- Medi-Cal : **1-855-839-7613 (TTY 711)**, 每周 7 天, 每天 24 小时
- 所有其他保险计划 : **1-800-757-7585 (TTY 711)**, 每周 7 天, 每天 24 小时

**Farsi:** توجه. امکان بهره‌مندی از مساعدت زبانی به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین را درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین می‌توانید امکانات و دستگاه‌های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با خدمات اعضای ما تماس بگیرید. خدمات اعضاء، در تعطیلات رسمی بسته است.

- Medicare, شامل D-SNP : با شماره **1-800-443-0815 (TTY 711)** از 8 صبح تا 8 عصر، در 7 روز هفته تماس بگیرید
- Medi-Cal: با شماره **1-855-839-7613 (TTY 711)**، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید
- همه موارد دیگر: با شماره **1-800-464-4000 (TTY 711)**، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید

**Hindi:** ध्यान दें। भाषा सहायता आपके लिए बिना किसी शुल्क के उपलब्ध है। आप दुभाषिया सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन लैंग्वेज के दुभाषिये भी शामिल हैं। आप सामग्रियों को अपनी भाषा या वैकल्पिक प्रारूप, जैसे कि ब्रेल, ऑडियो, या बड़े प्रिंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुविधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा विभाग को कॉल करें। सदस्य सेवा विभाग मुख्य छुट्टियों वाले दिन बंद रहता है।

- Medicare, जिसमें D-SNP शामिल है: **1-800-443-0815 (TTY 711)**, सुबह 8 बजे से रात 8 बजे तक, सप्ताह के 7 दिन
- Medi-Cal: **1-855-839-7613 (TTY 711)**, दिन के चौबीस घंटे, सप्ताह के 7 दिन
- बाकी सभी: **1-800-464-4000 (TTY 711)**, दिन के चौबीस घंटे, सप्ताह के 7 दिन

**Hmong:** FAJ SEEB. Muaj kev pab txhais lus pub dawb rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau ntawm peb cov chaw kuaj mob. Hu mus thov kev pab rau ntawm peb Lub Chaw Pab Tswv Cuab. Lub chaw pab tswv cuab kaw rau cov hnuv so uas tseem ceeb.

- Medicare, suav nrog D-SNP: **1-800-443-0815 (TTY 711)**, 8 teev sawv ntxov txog 8 teev tsaus ntuj, 7 hnuv hauv ib lub vij
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 teev hauv ib hnuv, 7 hnuv hauv ib lub vij
- Tag nrho lwm yam: **1-800-464-4000 (TTY 711)**, 24 teev hauv ib hnuv, 7 hnuv hauv ib lub vij

**Japanese:** ご注意。言語サポートは無料でご利用いただけます。あなたは手話通訳を含む通訳サービスを依頼できます。点字、大型活字、または録音音声など、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることができます。当社の施設では補助器具や機器の要請も承っております。支援が必要な方は、加入者サービス部門にお電話ください。加入者向けサービスは主要な休日では営業していません。

- D-SNP を含む Medicare: **1-800-443-0815 (TTY 711)**、午前 8 時から午後 8 時まで、年中無休
- Medi-Cal: **1-855-839-7613 (TTY 711)**、24 時間、年中無休
- その他全て: **1-800-464-4000 (TTY 711)**、24 時間、年中無休

**Khmer (Cambodian):** យកចិត្តទុកដាក់។ ជំនួយភាសាគឺមានដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាផងដែរ។ អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្នាម សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំ

ជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។ សូមទូរសព្ទទៅផ្នែកសេវាសមាជិករបស់យើងសម្រាប់ជំនួយ។ សេវាសមាជិកត្រូវបាន បិទនៅថ្ងៃឈប់សម្រាកសំខាន់ៗ។

- Medicare, រួមទាំង D-SNP: **1-800-443-0815 (TTY 711)** ពីម៉ោង 8 ព្រឹក ដល់ 8 យប់ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- Medi-Cal: **1-855-839-7613 (TTY 711)** 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍
- ផ្សេងៗទៀត: **1-800-464-4000 (TTY 711)** 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍

**Korean:** 안내 사항. 무료 언어 지원 제공. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 부서에 도움을 요청하시기 바랍니다. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

- Medicare(D-SNP 포함), 주 7일 오전 8시~오후 8시에 **1-800-443-0815 (TTY 711)** 번으로 문의
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 주 7일, 하루 24시간
- 기타: **1-800-464-4000 (TTY 711)**, 주 7일, 하루 24시간

**Laotian:** ໂປດຊາບ. ມີການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍບໍລິການນາຍພາສາ, ລວມທັງນາຍພາສາມື. ທ່ານສາມາດຊໍ້ໃຫ້ ແປເອກະສານນີ້ເປັນພາສາຂອງທ່ານ ຫຼື ຮູບແບບອື່ນເຊັ່ນອັກສອນນັ້ນ, ສຽງ, ຫຼື ການພິມຂະໜາດໃຫຍ່. ນອກຈາກນັ້ນທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍ ຟັງ ແລະ ອປະກອນການຊ່ວຍເຫຼືອໃນສະຖານທີ່ຂອງພວກເຮົາ. ໃຫ້ທ່ານພະແນກບໍລິການສະມາຊິກຂອງພວກເຮົາເພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ພະແນກບໍລິການ ສະມາຊິກແມ່ນປິດໃນວັນພັກທີ່ສໍາຄັນຕ່າງໆ.

- Medicare, ລວມທັງ D-SNP: **1-800-443-0815 (TTY 711)**, 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ, 7 ວັນຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ
- ອື່ນໆ: **1-800-464-4000 (TTY 711)**, 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ

**Mien:** CAU FIM JANGX LONGX OC. Ninh mbuo duqv liepc ziangx tengx faan waac bun meih muangx mv zuqc heuc meih ndorqv nyaanh cingv oc. Meih corc haiv tov taux ninh mbuo tengx lorz faan waac bun meih, caux longc buoz wuv faan waac bun muangx. Meih aengx haih tov taux ninh mbuo dorh nyungc horngh jaa dorngx faan benx meih nyei waac a'fai fiev bieqc da'nyeic diuc daan, fiev benx domh nzangc-pokc bun hlou, bungx waac-qiez bun uangx, a'fai aamx bieqc domh zeiv-linh. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Mborqv finx lorz taux yie mbuo dinc zangc domh gorn ziux goux baengc mienh nyei dorngx liouh tov heuc ninh mbuo tengx nzie weih. Ziux goux baengc mienh nyei gorn zangc se gec mv zoux gong yiem gingc nyei hnoi-nyieqc oc.

- Medicare, caux D-SNP: **1-800-443-0815 (TTY 711)**, yiem 8 dimv lungh ndorm taux 8 dimv lungh muonx, yietc norm leiz baaix zoux gong 7 hnoi
- Medi-Cal: **1-855-839-7613 (TTY 711)**, yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi
- Yietc zungv da'nyeic diuc jauv-louc: **1-800-464-4000 (TTY 711)**, yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi

**Navajo:** GIHA. Tséé' naalkáah sidá'ígíí éí doo t'ée' ííł'í' dah sidáa'ígíí. T'ée' góó t'í'í'ígíí éí tséé' naalkáah sidá'ígíí bikáa' dah sidaa'ígíí, t'á'ii bik'eh dah na'alka'ígíí. T'á'ii éí t'ée' góó t'í'í'ígíí bik'eh dah deidiyós, t'á'ii éí bi'ée' bik'eh dah na'alka'ígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'alka'ígíí bikáa' dah na'alka'ígíí t'áá'altso bik'eh dah deidiyós. Bi'ée' naalkáah sidá'ígíí bik'eh ha'a'aah. T'á'ii bik'eh dah na'alka'ígíí éí bik'eh dah naazhja'ígíí bik'eh dah na'alka'ígíí.

- Medicare, bikáa' dah deidiyós D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. góó 8 p.m., 7 jǐ t'áálá'í damóo
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 t'ohch'oolí t'áálá'í jǐ, 7 jǐ t'áálá'í damóo
- T'áa al'aa: **1-800-464-4000 (TTY 711)**, 24 t'ohch'oolí t'áálá'í jǐ, 7 jǐ t'áálá'í damóo

**Punjabi:** ਧਿਆਨ ਦਿਓ। ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗਵੇਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

- Medicare, ਜਿਸ ਵਿੱਚ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ: **1-800-443-0815 (TTY 711)**, ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- Medi-Cal: **1-855-839-7613 (TTY 711)**, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- ਬਾਕੀ ਸਾਰੇ: **1-800-464-4000 (TTY 711)**, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ

**Russian: ВНИМАНИЕ!** Для Вас доступны бесплатные услуги перевода. Вы можете запросить услуги устного перевода, в том числе услуги переводчика языка жестов. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников. Отдел обслуживания участников не работает в дни государственных праздников.

- Medicare, включая D-SNP: **1-800-443-0815 (TTY 711)**, без выходных с 8:00 до 20:00.
- Medi-Cal: **1-855-839-7613 (TTY 711)**, круглосуточно без выходных.
- Любые другие поставщики услуг: **1-800-464-4000 (TTY 711)**, круглосуточно без выходных.

**Spanish: ATENCIÓN.** Se ofrece ayuda en otros idiomas sin ningún costo para usted. Puede solicitar servicios de interpretación, incluyendo intérpretes de lengua de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

- Medicare, incluyendo D-SNP: **1-800-443-0815 (TTY 711)**, de 8 a. m. a 8 p. m., los 7 días de la semana.
- Medi-Cal: **1-855-839-7613 (TTY 711)**, las 24 horas del día, los 7 días de la semana.
- Todos los otros: **1-800-788-0616 (TTY 711)**, las 24 horas del día, los 7 días de la semana.

**Tagalog: PAUNAWA.** May magagamit na tulong sa wika nang wala kang babayaran. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro para sa tulong. Ang mga serbisyo sa miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815 (TTY 711)**, 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000 (TTY 711)**, 24 oras sa isang araw, 7 araw sa isang linggo

**Thai:** ส่งถึง มีบริการให้ความช่วยเหลือด้านภาษา แก่ท่านโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสาร เป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ ช่วยเหลือ และอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

- Medicare รวมถึง D-SNP: **1-800-443-0815 (TTY 711)** 8.00 น. ถึง 20.00 น. หรือ 7 วันต่อสัปดาห์
- Medi-Cal: **1-855-839-7613 (TTY 711)** ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์
- อื่นๆ ทั้งหมด: **1-800-464-4000 (TTY 711)** ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์

**Ukrainian:** УВАГА! Послуги перекладача надаються безкоштовно. Ви можете залишити запит на послуги усного перекладу, зокрема мовою жестів. Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Крім того, ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів. Відділ обслуговування клієнтів зачинений у державні свята.

- Medicare, зокрема D-SNP: **1-800-443-0815 (TTY 711)**, з 8:00 до 20:00, без вихідних.
- Medi-Cal: **1-855-839-7613 (TTY 711)**, цілодобово, без вихідних.
- Усі інші надавачі послуг: **1-800-464-4000 (TTY 711)**, цілодобово, без вихідних.

**Vietnamese:** LƯU Ý. Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Quý vị có thể yêu cầu dịch vụ thông dịch, bao gồm cả thông dịch viên ngôn ngữ ký hiệu. Quý vị có thể yêu cầu tài liệu được dịch sang ngôn ngữ của quý vị hay định dạng thay thế, chẳng hạn như chữ nổi braille, băng đĩa thu âm hay bản in khổ chữ lớn. Quý vị cũng có thể yêu cầu các phương tiện và thiết bị phụ trợ tại các cơ sở của chúng tôi. Gọi cho ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp. Ban dịch vụ hội viên không làm việc vào những ngày lễ lớn.

- Medicare, bao gồm cả D-SNP: **1-800-443-0815 (TTY 711)**, 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần.
- Medi-Cal: **1-855-839-7613 (TTY 711)**, 24 giờ trong ngày, 7 ngày trong tuần.
- Mọi chương trình khác: **1-800-464-4000 (TTY 711)**, 24 giờ trong ngày, 7 ngày trong tuần.

## **MEDICARE PART D CREDITABLE COVERAGE NOTICE**

### **IMPORTANT NOTICE FROM TAYLOR CORPORATION 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 Taylor Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Taylor Corporation has determined that the prescription drug coverage offered by the Taylor Corporation Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

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Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

#### **Enrolling in Medicare—General Rules**

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

#### **Late Enrollment and the Late Enrollment Penalty**

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

### **Special Enrollment Period Exceptions to the Late Enrollment Penalty**

There are “special enrollment periods” that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes “creditable” prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

### **Compare Coverage**

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. See the Taylor Corporation Plan’s summary plan description for a summary of the Plan’s prescription drug coverage. If you don’t have a copy, you can get one by contacting us at the telephone number or address listed below.

### **Coordinating Other Coverage With Medicare Part D**

Generally speaking, if you decide to join a Medicare drug plan while covered under the Taylor Corporation Plan due to your employment (or someone else’s employment, such as a spouse or parent), your coverage under the Taylor Corporation Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan’s summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Taylor Corporation prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan’s eligibility and enrollment rules. You should review the Plan’s summary plan description to determine if and when you are allowed to add coverage.

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

Contact the person listed below for further information, or call 507.386.5853. **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 Taylor Corporation changes. You also may request a copy.

### **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](http://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](http://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 whether or not you are required to pay a higher premium (a penalty).**

|                          |                                                 |
|--------------------------|-------------------------------------------------|
| Date:                    | January 1, 2026                                 |
| Name of Entity/Sender:   | Manager of Benefits                             |
| Contact—Position/Office: | Manager of Benefits                             |
| Address:                 | 1725 Roe Crest Drive<br>North Mankato, MN 56003 |
| Phone Number:            | 507.386.5853                                    |

**Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents’) right to coverage under the Plan is determined solely under the terms of the Plan.**

**HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY**  
**AND PROCEDURES**

**TAYLOR CORPORATION**  
**IMPORTANT NOTICE**  
**COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES**

|                                                                                                                                                                                     |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><b>THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE<br/>USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.<br/>PLEASE REVIEW IT CAREFULLY.</b></p> |
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This notice is provided to you on behalf of:

**Taylor Corporation Employee Health Care Plan**

For the remainder of this notice, Taylor Corporation is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.

- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities;
- When required for judicial or administrative proceedings;
- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if

he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other than the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or

at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline, provided that you are given a written statement of the reasons for the delay and the date by which the group health plan will complete its action on the request. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include

disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

**20. The Right to Receive a Paper Copy of This Notice Upon Request:** If you are receiving this Notice in an electronic format, then you have the right

to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 23).

**21. Changes in the Privacy Practice.** Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

**22. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services:** If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

**23. Person to Contact at the Group Health Plan for More Information:** If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

### **Privacy Official**

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

HIPPA Privacy Officer

### **Organized Health Care Arrangement Designation**

The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

The members of the Organized Health Care Arrangement are:

### **Effective Date**

The effective date of this notice is: January 1, 2026.

## **NOTICE OF SPECIAL ENROLLMENT RIGHTS**

### **TAYLOR CORPORATION EMPLOYEE HEALTH CARE PLAN**

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 later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within **60 days** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within **60 days** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Manager of Benefits  
507.386.5853

***\* This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

## GENERAL COBRA NOTICE

### 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 in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.**

**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. If you believe you are eligible for this extension, contact the Plan Administrator.

**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, Medicare, 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](http://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 period<sup>1</sup> to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

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

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

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

### **If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact 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](http://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](http://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**

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Manager of Benefits  
1725 Roe Crest Drive  
North Mankato, MN 56003  
507.386.5853

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<sup>1</sup> <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>

**NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION  
FOR PRE-AUTHORIZATION FOR OB/GYN CARE**

Taylor Corporation Employee Health Care 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. Until you make this designation, Taylor Corporation Employee Health Care Plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact 507.386.5853.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Taylor Corporation Employee Health Care 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 Taylor Corporation Employee Health Care Plan at:

Manager of Benefits  
507.386.5853

## **WOMEN'S HEALTH AND CANCER RIGHTS NOTICE**

Taylor Corporation Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Taylor Corporation Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, please refer to your or contact your Plan Administrator at:

Manager of Benefits  
507.386.5853

## **MICHELLE'S LAW NOTICE**

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Manager of Benefits, 507.386.5853.

## **NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS**

Taylor Corporation Wellness Program is a voluntary wellness program available to all employees and spouses enrolled in the medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in the Benefit Guide and Wellness Program Guide.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting [at](#) or [.](#)

The information from the Biometric Screening and the Health Risk Assessment will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as education, coaching, or additional testing. You also are encouraged to share your results or concerns with your own doctor.

### **Protections from Disclosure of Medical Information**

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Taylor Corporation may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) business associates of Lockton in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Manager of Benefits at 507.386.5853

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

| GEORGIA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | INDIANA – Medicaid                                                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>GA HIPP Website: <a href="https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp">https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp</a><br/> Phone: 678-564-1162, Press 1<br/> GA CHIPRA Website:<br/> <a href="https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra">https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra</a><br/> Phone: 678-564-1162, Press 2</p> | <p>Health Insurance Premium Payment Program<br/> All other Medicaid<br/> Website: <a href="https://www.in.gov/medicaid/">https://www.in.gov/medicaid/</a><br/> <a href="http://www.in.gov/fssa/dfr/">http://www.in.gov/fssa/dfr/</a><br/> Family and Social Services Administration<br/> Phone: 1-800-403-0864<br/> Member Services Phone: 1-800-457-4584</p> |
| IOWA – Medicaid and CHIP (Hawki)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | KANSAS – Medicaid                                                                                                                                                                                                                                                                                                                                             |
| <p>Medicaid Website:<br/> <a href="#">Iowa Medicaid   Health &amp; Human Services</a><br/> Medicaid Phone: 1-800-338-8366<br/> Hawki Website:<br/> <a href="#">Hawki - Healthy and Well Kids in Iowa   Health &amp; Human Services</a><br/> Hawki Phone: 1-800-257-8563<br/> HIPP Website: <a href="#">Health Insurance Premium Payment (HIPP)   Health &amp; Human Services (iowa.gov)</a><br/> HIPP Phone: 1-888-346-9562</p>                                                                                                                                          | <p>Website: <a href="https://www.kancare.ks.gov/">https://www.kancare.ks.gov/</a><br/> Phone: 1-800-792-4884<br/> HIPP Phone: 1-800-967-4660</p>                                                                                                                                                                                                              |
| KENTUCKY – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | LOUISIANA – Medicaid                                                                                                                                                                                                                                                                                                                                          |
| <p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br/> <a href="https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx">https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx</a><br/> Phone: 1-855-459-6328<br/> Email: <a href="mailto:KIHIPP.PROGRAM@ky.gov">KIHIPP.PROGRAM@ky.gov</a><br/> KCHIP Website: <a href="https://kynect.ky.gov">https://kynect.ky.gov</a><br/> Phone: 1-877-524-4718<br/> Kentucky Medicaid Website:<br/> <a href="https://chfs.ky.gov/agencies/dms">https://chfs.ky.gov/agencies/dms</a></p>      | <p>Website: <a href="http://www.medicicaid.la.gov">www.medicicaid.la.gov</a> or <a href="http://www.ldh.la.gov/lahipp">www.ldh.la.gov/lahipp</a><br/> Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>                                                                                                                                 |
| MAINE – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MASSACHUSETTS – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                             |
| <p>Enrollment Website:<br/> <a href="https://www.mymaineconnection.gov/benefits/s/?language=en_US">https://www.mymaineconnection.gov/benefits/s/?language=en_US</a><br/> Phone: 1-800-442-6003<br/> TTY: Maine relay 711<br/> Private Health Insurance Premium Webpage:<br/> <a href="https://www.maine.gov/dhhs/ofi/applications-forms">https://www.maine.gov/dhhs/ofi/applications-forms</a><br/> Phone: 1-800-977-6740<br/> TTY: Maine relay 711</p>                                                                                                                  | <p>Website: <a href="https://www.mass.gov/masshealth/pa">https://www.mass.gov/masshealth/pa</a><br/> Phone: 1-800-862-4840<br/> TTY: 711<br/> Email: <a href="mailto:masspremassistance@accenture.com">masspremassistance@accenture.com</a></p>                                                                                                               |
| MINNESOTA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | MISSOURI – Medicaid                                                                                                                                                                                                                                                                                                                                           |
| <p>Website:<br/> <a href="https://mn.gov/dhs/health-care-coverage/">https://mn.gov/dhs/health-care-coverage/</a><br/> Phone: 1-800-657-3672</p>                                                                                                                                                                                                                                                                                                                                                                                                                          | <p>Website:<br/> <a href="http://www.dss.mo.gov/mhd/participants/pages/hipp.htm">http://www.dss.mo.gov/mhd/participants/pages/hipp.htm</a><br/> Phone: 573-751-2005</p>                                                                                                                                                                                       |

| MONTANA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                   | NEBRASKA – Medicaid                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Website: <a href="http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP">http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP</a><br>Phone: 1-800-694-3084<br>Email: <a href="mailto:HSHIPPProgram@mt.gov">HSHIPPProgram@mt.gov</a>                                                                                                                                                                                                                       | Website: <a href="http://www.ACCESSNebraska.ne.gov">http://www.ACCESSNebraska.ne.gov</a><br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178                                                                                                                                                                                                                           |
| NEVADA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                    | NEW HAMPSHIRE – Medicaid                                                                                                                                                                                                                                                                                                                                                                    |
| Medicaid Website: <a href="http://dhcfp.nv.gov">http://dhcfp.nv.gov</a><br>Medicaid Phone: 1-800-992-0900                                                                                                                                                                                                                                                                                                                                            | Website: <a href="https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program">https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program</a><br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br>Email: <a href="mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov">DHHS.ThirdPartyLiabi@dhhs.nh.gov</a> |
| NEW JERSEY – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                       | NEW YORK – Medicaid                                                                                                                                                                                                                                                                                                                                                                         |
| Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a><br>Phone: 1-800-356-1561<br>CHIP Premium Assistance Phone: 609-631-2392<br>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a><br>CHIP Phone: 1-800-701-0710 (TTY: 711)                                                              | Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a><br>Phone: 1-800-541-2831                                                                                                                                                                                                                                             |
| NORTH CAROLINA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                            | NORTH DAKOTA – Medicaid                                                                                                                                                                                                                                                                                                                                                                     |
| Website: <a href="https://medicaid.ncdhhs.gov/">https://medicaid.ncdhhs.gov/</a><br>Phone: 919-855-4100                                                                                                                                                                                                                                                                                                                                              | Website: <a href="https://www.hhs.nd.gov/healthcare">https://www.hhs.nd.gov/healthcare</a><br>Phone: 1-844-854-4825                                                                                                                                                                                                                                                                         |
| OKLAHOMA – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                         | OREGON – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                  |
| Website: <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a><br>Phone: 1-888-365-3742                                                                                                                                                                                                                                                                                                                                          | Website: <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a><br>Phone: 1-800-699-9075                                                                                                                                                                                                                                                 |
| PENNSYLVANIA – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                     | RHODE ISLAND – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                            |
| Website: <a href="https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html">https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html</a><br>Phone: 1-800-692-7462<br>CHIP Website: <a href="http://Children's Health Insurance Program (CHIP) (pa.gov)">Children's Health Insurance Program (CHIP) (pa.gov)</a><br>CHIP Phone: 1-800-986-KIDS (5437) | Website: <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a><br>Phone: 1-855-697-4347, or<br>401-462-0311 (Direct RItE Share Line)                                                                                                                                                                                                                                              |
| SOUTH CAROLINA – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                            | SOUTH DAKOTA - Medicaid                                                                                                                                                                                                                                                                                                                                                                     |
| Website: <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a><br>Phone: 1-888-549-0820                                                                                                                                                                                                                                                                                                                                                        | Website: <a href="http://dss.sd.gov">http://dss.sd.gov</a><br>Phone: 1-888-828-0059                                                                                                                                                                                                                                                                                                         |

| TEXAS – Medicaid                                                                                                                                                     | UTAH – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Texas Health and Human Services</a><br>Phone: 1-800-440-0493                                  | Utah’s Premium Partnership for Health Insurance (UPP)<br>Website: <a href="https://medicaid.utah.gov/upp/">https://medicaid.utah.gov/upp/</a><br>Email: <a href="mailto:upp@utah.gov">upp@utah.gov</a><br>Phone: 1-888-222-2542<br>Adult Expansion Website:<br><a href="https://medicaid.utah.gov/expansion/">https://medicaid.utah.gov/expansion/</a><br>Utah Medicaid Buyout Program Website:<br><a href="https://medicaid.utah.gov/buyout-program/">https://medicaid.utah.gov/buyout-program/</a><br>CHIP Website: <a href="https://chip.utah.gov/">https://chip.utah.gov/</a> |
| VERMONT– Medicaid                                                                                                                                                    | VIRGINIA – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Website: <a href="#">Health Insurance Premium Payment (HIPP) Program   Department of Vermont Health Access</a><br>Phone: 1-800-250-8427                              | Website: <a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select">https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select</a><br><a href="https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs">https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs</a><br>Medicaid/CHIP Phone: 1-800-432-5924                                                                                                                                |
| WASHINGTON – Medicaid                                                                                                                                                | WEST VIRGINIA – Medicaid and CHIP                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| Website: <a href="https://www.hca.wa.gov/">https://www.hca.wa.gov/</a><br>Phone: 1-800-562-3022                                                                      | Website: <a href="https://dhhr.wv.gov/bms/">https://dhhr.wv.gov/bms/</a><br><a href="http://mywvhipp.com/">http://mywvhipp.com/</a><br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)                                                                                                                                                                                                                                                                                                                                                      |
| WISCONSIN – Medicaid and CHIP                                                                                                                                        | WYOMING – Medicaid                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Website:<br><a href="https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm">https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm</a><br>Phone: 1-800-362-3002 | Website:<br><a href="https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/">https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/</a><br>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](http://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](http://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](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

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

|                          |                               |
|--------------------------|-------------------------------|
| Employer Name:           | Taylor Corporation            |
| Employer State of Situs: | Minnesota                     |
| Name of Issuer:          | Surest                        |
| Plan Marketing Name:     | Surest Plan, Surest Plus Plan |
| Plan Year:               | 2025                          |

**Ten (10) Essential Health Benefit (EHB) Categories:**

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

**2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)**

| Item | EHB Benefit                                                                  | EHB Category       | Benchmark Page # Reference | Employer Plan Covered Benefit? |
|------|------------------------------------------------------------------------------|--------------------|----------------------------|--------------------------------|
| 1    | Accidental Injury -- Dental                                                  | Ambulatory         | Pgs. 10 & 17               | Yes                            |
| 2    | Allergy Injections and Testing                                               | Ambulatory         | Pg. 11                     | Yes                            |
| 3    | Bone anchored hearing aids                                                   | Ambulatory         | Pgs. 17 & 35               | Partially                      |
| 4    | Durable Medical Equipment                                                    | Ambulatory         | Pg. 13                     | Yes                            |
| 5    | Hospice                                                                      | Ambulatory         | Pg. 28                     | Yes                            |
| 6    | Infertility (Fertility) Treatment                                            | Ambulatory         | Pgs. 23 - 24               | Yes                            |
| 7    | Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                    | Ambulatory         | Pg. 21                     | Yes                            |
| 8    | Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services) | Ambulatory         | Pgs. 15 - 16               | Yes                            |
| 9    | Private-Duty Nursing                                                         | Ambulatory         | Pgs. 17 & 34               | No                             |
| 10   | Prosthetics/Orthotics                                                        | Ambulatory         | Pg. 13                     | Yes                            |
| 11   | Sterilization (vasectomy men)                                                | Ambulatory         | Pg. 10                     | Yes                            |
| 12   | Temporomandibular Joint Disorder (TMJ)                                       | Ambulatory         | Pgs. 13 & 24               | Yes                            |
| 13   | Emergency Room Services (Includes MH/SUD Emergency)                          | Emergency services | Pg. 7                      | Yes                            |
| 14   | Emergency Transportation/ Ambulance                                          | Emergency services | Pgs. 4 & 17                | Yes                            |
| 15   | Bariatric Surgery (Obesity)                                                  | Hospitalization    | Pg. 21                     | Partially                      |
| 16   | Breast Reconstruction After Mastectomy                                       | Hospitalization    | Pgs. 24 - 25               | Yes                            |
| 17   | Reconstructive Surgery                                                       | Hospitalization    | Pgs. 25 - 26, & 35         | Yes                            |
| 18   | Inpatient Hospital Services (e.g., Hospital Stay)                            | Hospitalization    | Pg. 15                     | Yes                            |
| 19   | Skilled Nursing Facility                                                     | Hospitalization    | Pg. 21                     | Yes                            |
| 20   | Transplants - Human Organ Transplants (including transportation & lodging)   | Hospitalization    | Pgs. 18 & 31               | Yes                            |

|    |                                                                               |                                                      |                                       |     |
|----|-------------------------------------------------------------------------------|------------------------------------------------------|---------------------------------------|-----|
| 21 | Diagnostic Services                                                           | Laboratory services                                  | Pgs. 6 & 12                           | Yes |
| 22 | Intranasal opioid reversal agent associated with opioid prescriptions         | MH/SUD                                               | Pg. 32                                | Yes |
| 23 | Mental (Behavioral) Health Treatment (Including Inpatient Treatment)          | MH/SUD                                               | Pgs. 8 -9, 21                         | Yes |
| 24 | Opioid Medically Assisted Treatment (MAT)                                     | MH/SUD                                               | Pg. 21                                | Yes |
| 25 | Substance Use Disorders (Including Inpatient Treatment)                       | MH/SUD                                               | Pgs. 9 & 21                           | Yes |
| 26 | Tele-Psychiatry                                                               | MH/SUD                                               | Pg. 11                                | Yes |
| 27 | Topical Anti-Inflammatory acute and chronic pain medication                   | MH/SUD                                               | Pg. 32                                | No  |
| 28 | Pediatric Dental Care                                                         | Pediatric Oral and Vision Care                       | See AllKids Pediatric Dental Document | No  |
| 29 | Pediatric Vision Coverage                                                     | Pediatric Oral and Vision Care                       | Pgs. 26 - 27                          | Yes |
| 30 | Maternity Service                                                             | Pregnancy, Maternity, and Newborn Care               | Pgs. 8 & 22                           | Yes |
| 31 | Outpatient Prescription Drugs                                                 | Prescription drugs                                   | Pgs. 29 - 34                          | Yes |
| 32 | Colorectal Cancer Examination and Screening                                   | Preventive and Wellness Services                     | Pgs. 12 & 16                          | Yes |
| 33 | Contraceptive/Birth Control Services                                          | Preventive and Wellness Services                     | Pgs. 13 & 16                          | Yes |
| 34 | Diabetes Self-Management Training and Education                               | Preventive and Wellness Services                     | Pgs. 11 & 35                          | Yes |
| 35 | Diabetic Supplies for Treatment of Diabetes                                   | Preventive and Wellness Services                     | Pgs. 31 - 32                          | Yes |
| 36 | Mammography - Screening                                                       | Preventive and Wellness Services                     | Pgs. 12, 15, & 24                     | Yes |
| 37 | Osteoporosis - Bone Mass Measurement                                          | Preventive and Wellness Services                     | Pgs. 12 & 16                          | Yes |
| 38 | Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test | Preventive and Wellness Services                     | Pg. 16                                | Yes |
| 39 | Preventive Care Services                                                      | Preventive and Wellness Services                     | Pg. 18                                | Yes |
| 40 | Sterilization (women)                                                         | Preventive and Wellness Services                     | Pgs. 10 & 19                          | Yes |
| 41 | Chiropractic & Osteopathic Manipulation                                       | Rehabilitative and Habilitative Services and Devices | Pgs. 12 - 13                          | Yes |
| 42 | Habilitative and Rehabilitative Services                                      | Rehabilitative and Habilitative Services and Devices | Pgs. 8, 9, 11, 12, 22, & 35           | Yes |

*Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.*

|                          |                         |
|--------------------------|-------------------------|
| Employer Name:           | Taylor Corporation      |
| Employer State of Situs: | Minnesota               |
| Name of Issuer:          | United Healthcare       |
| Plan Marketing Name:     | HSA Plan, HSA Plus Plan |
| Plan Year:               | 2025                    |

**Ten (10) Essential Health Benefit (EHB) Categories:**

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

**2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)**

| Item | EHB Benefit                                                                  | EHB Category       | Benchmark Page # Reference | Employer Plan Covered Benefit? |
|------|------------------------------------------------------------------------------|--------------------|----------------------------|--------------------------------|
| 1    | Accidental Injury -- Dental                                                  | Ambulatory         | Pgs. 10 & 17               | Yes                            |
| 2    | Allergy Injections and Testing                                               | Ambulatory         | Pg. 11                     | Yes                            |
| 3    | Bone anchored hearing aids                                                   | Ambulatory         | Pgs. 17 & 35               | Partially                      |
| 4    | Durable Medical Equipment                                                    | Ambulatory         | Pg. 13                     | Yes                            |
| 5    | Hospice                                                                      | Ambulatory         | Pg. 28                     | Yes                            |
| 6    | Infertility (Fertility) Treatment                                            | Ambulatory         | Pgs. 23 - 24               | Yes                            |
| 7    | Outpatient Facility Fee (e.g., Ambulatory Surgery Center)                    | Ambulatory         | Pg. 21                     | Yes                            |
| 8    | Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services) | Ambulatory         | Pgs. 15 - 16               | Yes                            |
| 9    | Private-Duty Nursing                                                         | Ambulatory         | Pgs. 17 & 34               | No                             |
| 10   | Prosthetics/Orthotics                                                        | Ambulatory         | Pg. 13                     | Yes                            |
| 11   | Sterilization (vasectomy men)                                                | Ambulatory         | Pg. 10                     | Yes                            |
| 12   | Temporomandibular Joint Disorder (TMJ)                                       | Ambulatory         | Pgs. 13 & 24               | Yes                            |
| 13   | Emergency Room Services (Includes MH/SUD Emergency)                          | Emergency services | Pg. 7                      | Yes                            |
| 14   | Emergency Transportation/ Ambulance                                          | Emergency services | Pgs. 4 & 17                | Yes                            |
| 15   | Bariatric Surgery (Obesity)                                                  | Hospitalization    | Pg. 21                     | Partially                      |
| 16   | Breast Reconstruction After Mastectomy                                       | Hospitalization    | Pgs. 24 - 25               | Yes                            |
| 17   | Reconstructive Surgery                                                       | Hospitalization    | Pgs. 25 - 26, & 35         | Yes                            |
| 18   | Inpatient Hospital Services (e.g., Hospital Stay)                            | Hospitalization    | Pg. 15                     | Yes                            |
| 19   | Skilled Nursing Facility                                                     | Hospitalization    | Pg. 21                     | Yes                            |
| 20   | Transplants - Human Organ Transplants (including transportation & lodging)   | Hospitalization    | Pgs. 18 & 31               | Yes                            |

|    |                                                                               |                                                      |                                       |     |
|----|-------------------------------------------------------------------------------|------------------------------------------------------|---------------------------------------|-----|
| 21 | Diagnostic Services                                                           | Laboratory services                                  | Pgs. 6 & 12                           | Yes |
| 22 | Intranasal opioid reversal agent associated with opioid prescriptions         | MH/SUD                                               | Pg. 32                                | Yes |
| 23 | Mental (Behavioral) Health Treatment (Including Inpatient Treatment)          | MH/SUD                                               | Pgs. 8 -9, 21                         | Yes |
| 24 | Opioid Medically Assisted Treatment (MAT)                                     | MH/SUD                                               | Pg. 21                                | Yes |
| 25 | Substance Use Disorders (Including Inpatient Treatment)                       | MH/SUD                                               | Pgs. 9 & 21                           | Yes |
| 26 | Tele-Psychiatry                                                               | MH/SUD                                               | Pg. 11                                | Yes |
| 27 | Topical Anti-Inflammatory acute and chronic pain medication                   | MH/SUD                                               | Pg. 32                                | No  |
| 28 | Pediatric Dental Care                                                         | Pediatric Oral and Vision Care                       | See AllKids Pediatric Dental Document | No  |
| 29 | Pediatric Vision Coverage                                                     | Pediatric Oral and Vision Care                       | Pgs. 26 - 27                          | Yes |
| 30 | Maternity Service                                                             | Pregnancy, Maternity, and Newborn Care               | Pgs. 8 & 22                           | Yes |
| 31 | Outpatient Prescription Drugs                                                 | Prescription drugs                                   | Pgs. 29 - 34                          | Yes |
| 32 | Colorectal Cancer Examination and Screening                                   | Preventive and Wellness Services                     | Pgs. 12 & 16                          | Yes |
| 33 | Contraceptive/Birth Control Services                                          | Preventive and Wellness Services                     | Pgs. 13 & 16                          | Yes |
| 34 | Diabetes Self-Management Training and Education                               | Preventive and Wellness Services                     | Pgs. 11 & 35                          | Yes |
| 35 | Diabetic Supplies for Treatment of Diabetes                                   | Preventive and Wellness Services                     | Pgs. 31 - 32                          | Yes |
| 36 | Mammography - Screening                                                       | Preventive and Wellness Services                     | Pgs. 12, 15, & 24                     | Yes |
| 37 | Osteoporosis - Bone Mass Measurement                                          | Preventive and Wellness Services                     | Pgs. 12 & 16                          | Yes |
| 38 | Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test | Preventive and Wellness Services                     | Pg. 16                                | Yes |
| 39 | Preventive Care Services                                                      | Preventive and Wellness Services                     | Pg. 18                                | Yes |
| 40 | Sterilization (women)                                                         | Preventive and Wellness Services                     | Pgs. 10 & 19                          | Yes |
| 41 | Chiropractic & Osteopathic Manipulation                                       | Rehabilitative and Habilitative Services and Devices | Pgs. 12 - 13                          | Yes |
| 42 | Habilitative and Rehabilitative Services                                      | Rehabilitative and Habilitative Services and Devices | Pgs. 8, 9, 11, 12, 22, & 35           | Yes |

*Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.*



# Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved  
OMB No. 1210-0149  
(expires 12-31-2026)

## 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%<sup>1</sup> 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.<sup>1,2</sup>

**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 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.

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

<sup>2</sup> 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.

## 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 through your employment, please check your health plan's summary plan description or contact

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The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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<br>Taylor Corporation                                                    |  | 4. Employer Identification Number (EIN)<br>41-0852411 |                      |
| 5. Employer address<br>1750 Roe Crest Drive                                               |  | 6. Employer phone number<br>507-386-5853              |                      |
| 7. City<br>North Mankato                                                                  |  | 8. State<br>MN                                        | 9. ZIP code<br>56003 |
| 10. Who can we contact about employee health coverage at this job?<br>Manager of Benefits |  |                                                       |                      |
| 11. Phone number (if different from above)                                                |  | 12. Email address                                     |                      |

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

## **SUMMARY ANNUAL REPORT**

### **For Taylor Corporation Flexible Benefit Plan**

This is a summary of the annual report of the Taylor Corporation Flexible Benefit Plan, EIN 41-0852411, Plan No. 501, for period 01/01/2024 through 12/31/2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Taylor Corporation has committed itself to pay certain self-insured claims incurred under the terms of the plan.

### **Insurance Information**

The plan has contracts with to pay claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2024 were \$0.

### **Your Rights To Additional Information**

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Taylor Corporation at 1725 Roe Crest Drive, North Mankato, MN, 56003 or by telephone at 507-625-2828.

You also have the legally protected right to examine the annual report at the main office of the plan (Taylor Corporation, 1725 Roe Crest Drive, North Mankato, MN, 56003) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Or you may access a copy on the DOL's web site [www.efast.dol.gov](http://www.efast.dol.gov).

### **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 less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email [DOL\\_PRA\\_PUBLIC@dol.gov](mailto:DOL_PRA_PUBLIC@dol.gov) and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)

## **SUMMARY ANNUAL REPORT**

### **For Taylor Corporation Self-insured Hospitalization Welfare Plan**

This is a summary of the annual report of the Taylor Corporation Self-insured Hospitalization Welfare Plan, EIN 41-0852411, Plan No. 503, for period 01/01/2024 through 12/31/2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Taylor Corporation has committed itself to pay certain self-insured Medical, Stop Loss, Dental, and WELLNESS claims incurred under the terms of the plan.

### **Insurance Information**

The plan has contracts with Kaiser Foundation Health Plan, Inc. to pay and Medical claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2024 were \$1,404,953.

### **Your Rights To Additional Information**

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Taylor Corporation at 1725 Roe Crest Drive, North Mankato, MN, 56003 or by telephone at 507-625-2828.

You also have the legally protected right to examine the annual report at the main office of the plan (Taylor Corporation, 1725 Roe Crest Drive, North Mankato, MN, 56003) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Or you may access a copy on the DOL's web site [www.efast.dol.gov](http://www.efast.dol.gov).

### **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 less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email [DOL\\_PRA\\_PUBLIC@dol.gov](mailto:DOL_PRA_PUBLIC@dol.gov) and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)

## **SUMMARY ANNUAL REPORT**

### **For Taylor Coproration Life, Accidental Death And Dismemberment Plan**

This is a summary of the annual report of the Taylor Coproration Life, Accidental Death And Dismemberment Plan, EIN 41-0852411, Plan No. 505, for period 01/01/2024 through 12/31/2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

### **Insurance Information**

The plan has contracts with Lincoln National Life Insurance Company to pay Life Insurance and Accidental Death and Dismemberment claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2024 were \$2,837,275.

### **Your Rights To Additional Information**

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Taylor Corporation at 1725 Roe Crest Drive, North Mankato, MN, 56003 or by telephone at 507-625-2828.

You also have the legally protected right to examine the annual report at the main office of the plan (Taylor Corporation, 1725 Roe Crest Drive, North Mankato, MN, 56003) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Or you may access a copy on the DOL's web site [www.efast.dol.gov](http://www.efast.dol.gov).

### **Paperwork Reduction Act Statement**

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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 less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email [DOL\\_PRA\\_PUBLIC@dol.gov](mailto:DOL_PRA_PUBLIC@dol.gov) and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)

## **SUMMARY ANNUAL REPORT**

### **For Taylor Corporation Long Term Disability Plan**

This is a summary of the annual report of the Taylor Corporation Long Term Disability Plan, EIN 41-0852411, Plan No. 506, for period 01/01/2024 through 12/31/2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

### **Insurance Information**

The plan has contracts with Lincoln National Life Insurance Company to pay Long-term Disability and Employee Assistance Program claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2024 were \$933,411.

### **Your Rights To Additional Information**

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Taylor Corporation at 1725 Roe Crest Drive, North Mankato, MN, 56003 or by telephone at 507-625-2828.

You also have the legally protected right to examine the annual report at the main office of the plan (Taylor Corporation, 1725 Roe Crest Drive, North Mankato, MN, 56003) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Or you may access a copy on the DOL's web site [www.efast.dol.gov](http://www.efast.dol.gov).

### **Paperwork Reduction Act Statement**

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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 less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email [DOL\\_PRA\\_PUBLIC@dol.gov](mailto:DOL_PRA_PUBLIC@dol.gov) and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)

## **SUMMARY ANNUAL REPORT**

### **For Taylor Corporation Vision Plan**

This is a summary of the annual report of the Taylor Corporation Vision Plan, EIN 41-0852411, Plan No. 504, for period 01/01/2024 through 12/31/2024. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

### **Insurance Information**

The plan has contracts with Vision Service Plan to pay Vision claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2024 were \$769,922.

### **Your Rights To Additional Information**

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of Taylor Corporation at 1725 Roe Crest Drive, North Mankato, MN, 56003 or by telephone at 507-625-2828.

You also have the legally protected right to examine the annual report at the main office of the plan (Taylor Corporation, 1725 Roe Crest Drive, North Mankato, MN, 56003) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Or you may access a copy on the DOL's web site [www.efast.dol.gov](http://www.efast.dol.gov).

### **Paperwork Reduction Act Statement**

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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 less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email [DOL\\_PRA\\_PUBLIC@dol.gov](mailto:DOL_PRA_PUBLIC@dol.gov) and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)

## **Summary Annual Report**

### **For Taylor Corporation 401(K) Plan**

This is a summary of the annual report Form 5500 Annual Return/Report of Employee Benefit Plan for Taylor Corporation 401(K) Plan, Employer Identification Number 41-0852411, Plan No. 002 for the period January 01, 2024 through December 31, 2024. The Form 5500 annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA). Your plan is a Single-Employer defined contribution plan, which include the following characteristic(s) of 401(k), 401(m), Automatic Enrollment, Default Investment Account, ERISA Section 404(c), Member of Controlled Group, Participant-Directed, Pre-Approved Pension Plan, Profit-Sharing.

#### **Basic Financial Statement**

Benefits under the plan are provided through insurance and through a trust fund. Plan expenses were \$112,528,645. These expenses included \$480,274 in administrative expenses and \$111,970,644 in benefits paid to participants and beneficiaries and \$77,727 in other expenses. A total of 10348 persons were participants in or beneficiaries of the plan at the end of the plan year, although not all of these persons had yet earned the right to receive benefits.

The value of plan assets, after subtracting liabilities of the plan, was \$910,320,803, as of December 31, 2024 compared to \$845,632,141 as of January 01, 2024. During the plan year, the plan experienced an increase in its net assets of \$64,688,662. This increase includes unrealized appreciation or depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. The plan had total income of \$182,362,629, including employer contributions of \$11,869,364, employee contributions of \$46,676,434, other contributions of \$4,587,978, gains of \$0, from the sale of assets, and earnings from investments of \$119,228,853.

#### **Your Rights To Additional Information**

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. financial information and information on payments to service providers;
2. insurance information, including sales commissions paid by insurance carriers;
3. information regarding any Common/Collective Trust, Pooled Separate Accounts, Master Trusts, or 103-12 Investment Entities;
4. an accountant's report;
5. assets held for investment;

To obtain a copy of the full annual report, or any part thereof, write or call Taylor Corporation, 1725 ROE CREST DRIVE , NORTH MANKATO, MN 560031807, 507-625-2828.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan Administrator, these two statements and accompanying notes will be included as part of that report.

You also have the legally protected right to examine the annual report at the main office of the plan at Taylor Corporation, 1725 ROE CREST DRIVE , NORTH MANKATO, MN 560031807, and at the U.S. Department of Labor in Washington, D.C. or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C.

20210. The annual report is also available online at the Department of Labor website [www.efast.dol.gov](http://www.efast.dol.gov).