2026 Employee Benefits Guide

PAFFORD
EMERGENCY MEDICAL SERVICES

Table of Contents

3 Welcome

5 Eligibility

6 Provider Services

8 Medical Plan Options

9 Health Savings Account (HSA)

10 Dental Benefits

11 Vision Benefits

12 Employee Assistance Program (EAP)

13 Life / AD&D

14 Voluntary Short-Term Disability (STD)

15 Voluntary Long-Term Disability (LTD)

16 Voluntary Group Accident

17 Voluntary Group Critical Illness

18 Voluntary Group Hospital Indemnity

19 Additional Benefits Through The Hartford

20 Additional Benefits Through Voya

21 bSwift Enrollment & Benefits Platform

24 Key Contacts

25 Benefit Terms

Important Notice

Pafford Emergency Medical Services has made every attempt to ensure the accuracy of the information described in this enrollment guide. This guide is not an official plan document and does not provide a complete description of your benefit plans. Any discrepancy between this guide and the insurance contracts, summary plan descriptions (SPDs) or any other legal documents that govern the plans of benefits described in this enrollment guide will be resolved according to those documents. Pafford Emergency Medical Services reserves the right to amend or discontinue the benefits described in this enrollment guide in the future, as well as change how eligible employees and Pafford Emergency Medical Services share plan costs at any time. This enrollment guide creates neither an employment agreement of any kind nor a guarantee of continued employment with Pafford Emergency Medical Services.

This enrollment guide updates the Pafford Emergency Medical Services' current summary plan description (SPD) for significant benefits information and changes. This guide constitutes a summary of material modifications (SMM) to the SPD, and the Company intends that this guide satisfies its disclosure obligations under 29 CFR § 2520.104b-3.

Welcome

OPEN ENROLLMENT is from November 30th to December 15th

At Pafford Emergency Medical Services, we truly value the dedication that goes into your work every day. We're proud of our talented employees and understand that our success is because of you. That's why as a Pafford Emergency Medical Services employee, you have access to a quality, comprehensive benefits package that offers flexibility and security for you and your family.

2026 Health Plan Changes

Benefits for Domestic Partners

- Pafford will no longer offer health plan coverage for domestic partners or their children. This decision follows a comprehensive review of our benefits program to ensure alignment with industry standards and regulatory requirements. We understand this change may impact some employees and their families. Our Benefits team is here to support you through this transition and answer any questions you may have.
- If you currently have a domestic partner or child(ren) of a domestic partner enrolled in the health plan, please note that their coverage will end on December 31, 2025. You will need to secure alternative coverage for them effective January 1, 2026.

Enhanced Medical Plan Designs: The Bronze Copay Plan and Electrum Plan have been enhanced. There is now a lower out of pocket maximum for both plans as well as a lower deductible for the Bronze Copay Plan.

Bronze Plan In-Network deductible ***decreased*** (individual/family): $6,350 / $12,700 to $5,000 / $10,000
Bronze Plan Out-of-Network deductible ***decreased*** *(individual/family)*: $12,700 / $25,400 to $10,000 / $20,000
Bronze Plan In-Network OOP ***decreased*** *(individual/family)*: $6,900 / $13,800 to $5,500 / $11,000
Bronze Plan Out-of-Network OOP ***decreased*** *(individual/family)*: $13,800 / $27,600 to $11,000 / $22,000
Electrum Plan: In-Network OOP ***decreased*** *(individual/family)*: $6,000 / $12,000 to $5,000 / $10,000

IRS mandated deductible increase for the UHC Silver HSA plan from $1,650/$3,300 to $1,700/$3,400.

Health Savings Account (HSA)

- The HSA contribution maximum will increase from $4,300 individual and $8,550 for family to $4,400 individual and $8,750 for family.

Equitable plans are being replaced

- Life, STD and LTD coverage will transition to The Hartford.
- Accident, Critical Illness, and Hospital Indemnity coverage will transition to Voya.
- If you currently have an Equitable policy, your current elections will roll over to the new carriers for 2026 except for Critical Illness. You must log in to update or enroll in Critical Illness benefits. Even if you had the benefit in 2025. With the carrier change comes a change in premium. For most plans, the premium is a reduction. However, we recommend you log in to confirm your coverage.

Employee Assistance Program (EAP) Name Change and network expansion: Name change from LifeWorks to TELUSHealth. Please note new contact information on page 12.

NEW Value Adds for 2026:

- **The Hartford added benefits:** Travel Assistance and Identity Theft Support Services, Bereavement Services, Funeral Planning and Will Prep.
- **Voya added benefits:** Wellness Benefit and Travel Assistance.

See the following page for additional instructions for open enrollment.

Welcome

OPEN ENROLLMENT is from November 30th to December 15th

2026 Open Enrollment

Starting November 30th, you will have the opportunity to make changes to your health care coverage that will become effective on January 1, 2026. **All benefit elections must be made by December 15th.**

This is a semi- passive enrollment. If you don't enroll in benefits, you may default to the same or comparable coverage that you elected last year. However, there are a few exceptions:

- Your Critical Illness elections won't be automatically rolled over. New elections need to be made.
    - Current plans include $5,000 and $15,000 for the employee and $2,500 and $7,500 for the spouse and child(ren). 2026 plans offer $10,000, $20,000 and $30,000 benefit for employee and $5,000, $10,000 and $15,000 for spouse and child(ren).
- You won't be automatically enrolled in the HSA – you need to make an election to participate each year.

You must participate in Open Enrollment if you wish to do any of the following:

- Make changes to your medical, dental, or vision coverage for the upcoming plan year
- Contribute to a Health Savings Account (HSA) if you are enrolled in the Silver HSA Medical Plan
- Make changes to your income protection benefits
    - Please update your beneficiary for your Life and Disability Insurance plans

Review this guide to choose which benefits are right for you. If after reading this guide you need more information, please contact the Pafford Benefits Team.

Enrolling in Benefits

AS A NEW HIRE 1

You can enroll in benefits effective the first of the month following 30 days of employment. If you miss this initial enrollment window, your next opportunity to enroll will be the annual open enrollment period.

DURING OPEN ENROLLMENT 2

You can make changes to your benefits each year during the annual open enrollment period (normally held in November) for benefits effective January 1–December 31 of the following year.

QUALIFYING LIFE EVENTS 3

Your 2026 elections will remain in effect throughout the plan year unless you experience a change in status that affects eligibility for benefits or another qualifying life event (in accordance with IRS rules). You must request an election change within 30 days and may need to provide supporting documentation (such as a marriage license or birth certificate).

ELIGIBILITY & CHANGE IN STATUS

As a full-time employee (working a minimum of 30 hours per week) you and your eligible dependents can participate in Pafford Emergency Medical Services benefits. Eligible dependents include:

- Your spouse
- Child(ren) up to age 26
- Child(ren) of any age if you support the child and he or she is incapable of self-support due to disability

When You Are Hired

You are eligible to enroll in benefits the first of the month following 30 days after your hire date. Your benefit elections will stay in effect until you request a change in coverage during the next annual open enrollment period or can a qualifying change in status.

Annual Open Enrollment

During the annual open enrollment period each year you can make changes to your healthcare benefit elections for the upcoming plan year. These elections will be effective for the upcoming plan year until you request a change in coverage during the next annual open enrollment period or because of a change in status.

Qualifying Life Event / Change in Status

You may not change benefit elections for you or your dependents until the next annual open enrollment period. However, certain changes are allowed during the year if you experience a qualifying “change in status” life event. Qualifying life events must be made within 30 days of the event.

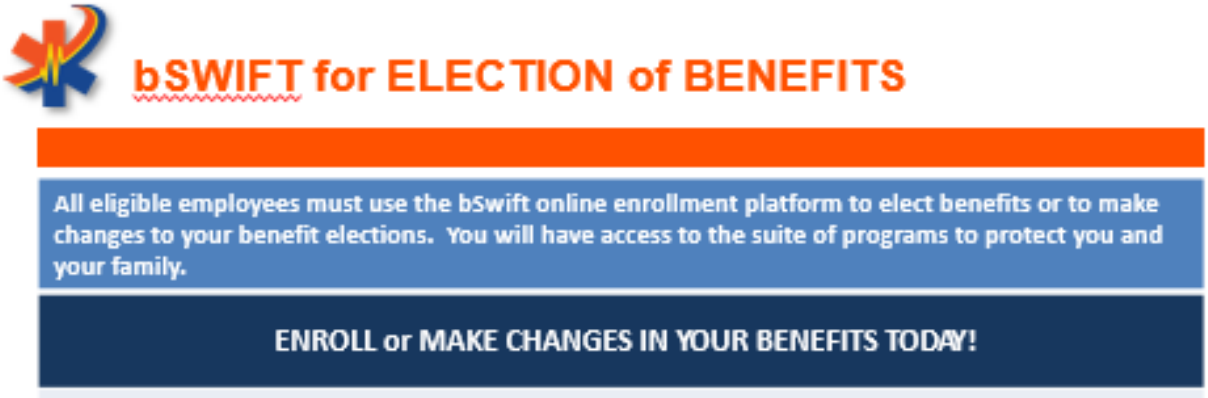
What is a qualifying life event?

A qualifying change in status event allows employees to change their participation election outside of the annual Open Enrollment timeframe. Examples of a qualifying family status change include:

- Marriage, legal separation or divorce
- Birth or adoption of a child, foster child
- Death of a covered person
- Involuntary loss of other health insurance coverage (examples are layoff, termination, disability, unpaid leave of absence, reduction in hours worked)

PROOF OF DEPENDENT ELIGIBILITY

You may be required to provide proof of eligibility for your dependents. Note that attempting to enroll an ineligible dependent could lead to disciplinary action and possible termination of employment. If your dependent becomes ineligible for coverage during the year, you must contact the HR Department within 30 days. Failure to provide notification may lead to disciplinary action and possible termination of employment.



See page 21 for your bSwift access information.

PROVIDER SERVICES

UMR A UnitedHealthcare Company

The UMR Benefits Website provides valuable information regarding your medical and HSA coverage. It enables you to access online claims and the Customer Care portal whenever you need it. You can review your benefits, check the status of a claim, sign up to receive electronic Explanation of Benefits, or request a replacement ID card, among other things. Visit your UMR Benefits Website at www.umr.com.

ACCESSING TELEMEDICINE CARE

relyMD
Previously MYidealDOCTOR

Provides you with 24/7/365 on-demand access to health consultants for counseling, diagnosing and prescribing via interactive audio or video for common and acute illnesses. RelyMD (formerly MYidealDoctor) is easy-to-use, secure, private, and affordable. Call 855-879-4332, download the mobile app or sign into your patient portal at www.relyMD.com.

PROACTIVE CARE MANAGEMENT (PCM)

PCM is a group of doctors, nurses and other professionals providing important services to improve care quality at no extra cost. They will be available to assist all members who seek their assistance and may reach out to engage members that have critical care needs.

PCM offers a great service through review, second opinions and another set of eyes to ensure you are getting quality proper care! This is only a recommendation service. Ultimately you and your doctors make the decisions and are in control of your medical treatment. To contact PCM, please call 877-455-0709 or email PCMadvocates@epicbrokers.com

PROVIDER SERVICES

PHARMACY

LIVINITI formerly Southern Scripts

Liviniti (formerly know as Southern Scripts) manages our pharmacy benefits. For questions and more information about your pharmacy drug benefit, please call Liviniti at 800-710-9341 or visit www.liviniti.com.

If you are a nicotine user, there are nicotine cessation programs available to help you quit. Contact Human Resources for more information.

RX COMPASS

RxCompass Powered by southernscripts

RxCompass is a drug management solution that provides significant savings on specialty and high-cost medications. The RxCompass program guides you through various drug savings pathways to maximize savings. In most instances, you will have a zero out-of-pocket cost.

Your RxCompass Navigator will engage with you based on the most appropriate pathway below. Your Care Navigator will provide immediate and ongoing support to ensure that you are never without therapy and have little to no out-of-pocket cost.

RxCompass PATIENT ASSISTANCE PROGRAMS | Variable copay | TeleSaverR | INTLMail | Specialty Brand

(833) 652-8379 **myrxcompass.com/contact** **myrxcompass.com**

MEDICAL PLAN OPTIONS & CONTRIBUTIONS

Key Features	UHC Electrum PPO Plan		UHC Silver HSA Plan		UHC Bronze Copay Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Calendar Year Deductible						
Individual / Family	$2,500 / $5,000	$5,000/$10,000	$1,700 / $3,400	$2,900 / $5,800	$5,000 / $10,000	$10,000 / $20,000
Out-of-Pocket Maximum						
Individual / Family (includes deductible)	$5,000 / $10,000	$10,000 / $20,000	$3,700 / $7,400	$7,400 / $14,700	$5,500 / $11,000	$11,000 / $22,000
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Coinsurance (portion you pay)	30%	50%	20%	40%	40% after Ded	60% after Ded
Physician Services						
Office Visit (PCP/ Specialist)	$30 / $40	50% after Ded	20% after Ded	40% after Ded	$30 /$40	60% after Ded
Preventive Care	No charge	50% after Ded	No charge	40% after Ded	No charge	60% after Ded
Telemedicine (RelyMD)	$10	n/a	20% after Ded	n/a	$10	n/a
Lab and X-Ray Services	30% after Ded	50% after Ded	20% after Ded	40% after Ded	40% after Ded	60% after Ded
Hospital Services						
Inpatient (per admission)	30% after Ded	50% after Ded	20% after Ded	40% after Ded	40% after Ded	60% after Ded
Emergency Treatment						
Urgent Care	$40	50% after Ded	20% after Ded	40% after Ded	40% after Ded	60% after Ded
Emergency Room Copay	$300 + 30% after Ded		20% after Ded		40% after Ded	
Retail Prescriptions (up to a 30-day supply)						
Generic	$15	Not covered	20% after Ded	Not covered	$15	Not covered
Preferred	$30	Not covered	20% after Ded	Not covered	$30	Not covered
Non-Preferred	$50	Not covered	20% after Ded	Not covered	$60	Not covered
Specialty	30%	Not covered	20% after Ded	Not covered	30% up to $500	Not covered
Mail-Order Prescriptions (up to a 90-day supply and30 days for Specialty)						
Generic	$45	Not covered	20% after Ded	Not covered	$45	Not covered
Preferred	$90	Not covered	20% after Ded	Not covered	$90	Not covered
Non-Preferred	$150	Not covered	20% after Ded	Not covered	$180	Not covered
Specialty	30%	Not covered	20% after Ded	Not covered	30% up to $500	Not covered

If you enroll in medical coverage, you will automatically be enrolled in dental, vision and life insurance. The values below indicate how much you're responsible for contributing towards coverage from each paycheck.

PREMIUMS – BUNDLED MEDICAL, DENTAL & VISION

NON-NICOTINE

Benefit	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
UHC Medical Electrum PPO	$106.65	$395.45	$364.68	$526.60
UHC Silver HSA Plan	$88.63	$301.84	$300.96	$409.93
UHC Bronze Copay Plan	$43.51	$187.28	$184.84	$333.63

NICOTINE (INCLUDES CIGARETTES, TOBACCO & VAPING)

Benefit	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
UHC Medical Electrum PPO	$129.73	$418.53	$387.76	$549.68
UHC Silver HSA Plan	$111.71	$324.92	$324.04	$433.01
UHC Bronze Copay Plan	$66.59	$210.36	$207.92	$356.71

HEALTH SAVINGS ACCOUNT (HSA)

If you're enrolling in the UHC Silver HSA medical plan, you are eligible to open a Health Savings Account (HSA) to pay for expenses on a pre-tax basis, such as eligible medical, dental and/or vision expenses.

ELIGIBILITY REQUIREMENTS

- ***Must be enrolled in the UHC Silver HSA medical plan***
- Must not be enrolled in Medicare, Tricare or VA Benefits (in the past 3 months)
- Must not be enrolled in other non-qualified medical coverage through another carrier or another family member
- You and your Spouse cannot be contributing to or participating in a general-purpose FSA through an employer

ADVANTAGES OF AN HSA

- **It's flexible:** Use your HSA now or save it for later. You decide when to save and when to spend. You can even save for health care expenses after you retire.
- **No use it or lose it rule:** The money in your HSA belongs to you. It rolls over each year, and you can take it with you if you ever leave the company.
- **Triple tax-advantaged:** (Applies to federal and most state taxes.)[1]
    - Pay no taxes on money you contribute.
    - Pay no taxes on interest you earn.
    - Pay no taxes when you withdraw money.
- **Invest your account:** Once your account balance reaches a certain amount, you can choose to invest it in a variety of investments.

Each year, the IRS sets limits on how much you can contribute to an HSA. Maximum employee contributions for 2026 are as follows:

- **$4,400 for an individual**
- **$8,750 for an employee and dependents**
- **$1,000 catch up contribution for anyone over the age of 55**

Important: HSAs involve very complex rules, including limitations on eligibility, contributions and expense reimbursement. Federal and state tax penalties may be assessed upon you if these requirements are not met. For more information, contact UMR at 800-826-9781. You should talk to a tax advisor about your personal circumstances with respect to the HSA rules. Another helpful resource is IRS Publication 969 (https://www.irs.gov/publications/p969/ar02.html).

[1] Certain states do not treat HSA contributions or distribution as tax-free (e.g., Alabama, California, New Jersey). Consult your tax advisor to understand how HSA participation may impact you and your family members from a tax perspective.

DENTAL BENEFITS

You and your dependents have access to dental coverage through Delta Dental. The plan pays benefits for both in-network and out-of-network services. However, you will receive maximum value from your dental benefits when you choose an in-network Delta Dental PPO provider. You will receive value when choosing a Delta Premier in-network provider but not as much compared to selecting a PPO dentist. If you go to a provider that is not a Delta Dental provider, you may have higher out-of-pocket costs. To search for an in-network provider visit deltadentalins.com and search in your area with the Delta Dental Find a Dentist tool.

DENTAL PLAN SUMMARY

Key Features	Delta Dental		
	Delta PPO Network	Delta Premier Network	Out-of-Network
Network	*PPO Contracted Fees (best value)*	*Premier Contracted Fees*	*90th Percentile*
Annual Maximum Benefit (waived for diagnostic & preventive services)	$2,000/Individual	$2,000/Individual	$2,000/Individual
Individual/Family Deductible (waived for diagnostic & preventive services)	$50/$150	$50/$150	$50/$150
Diagnostic & Preventive Services (Exams, X-Rays, Prophylaxis, Fluoride, Space Maintainers, Sealants)	100%	100%	100%
Basic Services (Stainless Steel Crowns, Endodontics, Periodontics Surgical, Periodontics Non-Surgical)	80%	80%	80%
Major Services (Major Restorative, Prosthodontics Removable, Prosthodontics Fixed)	50%	50%	50%

CONTRIBUTIONS – BUNDLED DENTAL

If you enroll in medical, you have the option of enrolling in dental coverage at no cost.

NICOTINE & NON-NICOTINE (INCLUDES CIGARETTES, TOBACCO & VAPING)				
Benefit	**Employee Only**	**Employee + Spouse**	**Employee + Children**	**Employee + Family**
Dental PPO Plan	$0.00	$0.00	$0.00	$0.00

CONTRIBUTIONS – UNBUNDLED DENTAL

If you waive medical, you have the option of enrolling in dental coverage separately. The values below indicate how much you're responsible for contributing towards coverage from each paycheck.

NICOTINE & NON-NICOTINE (INCLUDES CIGARETTES, TOBACCO & VAPING)				
Benefit	**Employee Only**	**Employee + Spouse**	**Employee + Children**	**Employee + Family**
Dental PPO Plan	$15.23	$30.26	$27.24	$45.79

VISION BENEFITS

You and your dependents have access to vision coverage through VSP. The plan pays benefits for both in-network and out-of-network services. However, you will receive maximum value from your vision benefits when you choose in-network providers. If you see a network provider, you will pay copays for most services. If you receive care outside the network, you will need to pay the full cost and file a claim to be reimbursed for a portion of the costs.

VISION PLAN SUMMARY

Key Features	UMR with Vision Service Plan (VSP) Vision Network	
	Copay	Frequency
	In-Network	
Exam	$10	Once every 12 months
Lenses	$25	Once every 12 months
Frame Allowance	$130 after a $25 eyewear copay Costco: $70 allowance after a $25 eyewear copay	Once every 24 months
Contact Lenses (instead of eye glasses)	Elective: $130 allowance Necessary: Covered in full after a $25 eyewear copay	Once every 12 months
Contact Lenses Fitting and Evaluation	Covered in full after a $25 eyewear copay	Once every 12 months

CONTRIBUTIONS – BUNDLED VISION

If you enroll in medical, you have the option of enrolling in vision coverage at no cost.

NICOTINE & NON-NICOTINE (INCLUDES CIGARETTES, TOBACCO & VAPING)				
Benefit	**Employee Only**	**Employee + Spouse**	**Employee + Children**	**Employee + Family**
Vision PPO Plan	$0.00	$0.00	$0.00	$0.00

CONTRIBUTIONS – UNBUNDLED VISION

If you waive medical, you have the option of enrolling in vision coverage separately. The values below indicate how much you're responsible for contributing towards coverage from each paycheck.

NICOTINE & NON-NICOTINE (INCLUDES CIGARETTES, TOBACCO & VAPING)				
Benefit	**Employee Only**	**Employee + Spouse**	**Employee + Children**	**Employee + Family**
Vision PPO Plan	$4.03	$7.91	$8.27	$12.31

EMPLOYEE ASSISTANCE PROGRAM (EAP)

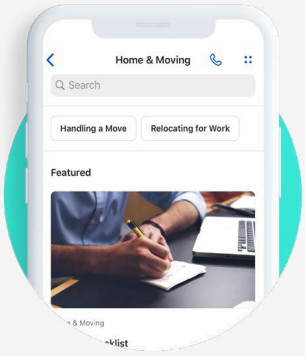
TELUS Health

How to use the Employee Assistance Program

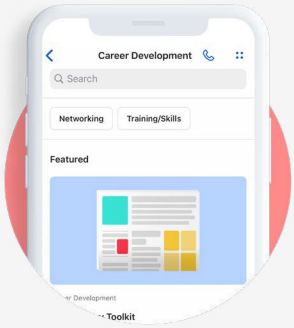
The Employee Assistance Program (EAP) is a confidential service provided by your employer that offers help with personal and work-related issues. Professionally trained advisors are available to help with family problems, marital concerns, financial and legal matters, stress, depression, elder care, physical health and other issues affecting your personal or work life.

The EAP is free and confidential. Advisors are available to help 24 hours a day, 7 days a week, 365 days a year. Below is information on how the EAP can help and how it works.

Life



Work



Personal/Family

The EAP encourages employees and those close to them to seek help early, before a minor problem becomes more serious. The EAP is designed to address short-term issues and to identify resources and referrals for emergency and long-term issues. When in doubt, contact the EAP for help or support.

Call your EAP toll-free, any time, 24/7, 365 days a year: 888-851-7032

Call us

If you're using the TELUSHealth mobile app, you can call us with one tap from your smartphone.

Provide your name

and employer's name to an advisor. Your information will be kept confidential.

Share your concerns

with a professional advisor for expert advice, strategies, and next steps.

Arrange with the advisor

about how, when, and where you want to be contacted if follow-up is required.

Your advisor will ask for your employer's name (or other sponsoring organization's name) so we can confirm the type of service available to you, along with other important health insurance and benefits information.

THE HARTFORD LIFE/AD&D BENEFITS

In addition to health benefits, Pafford Emergency Medical Services offers eligible employees income protection benefits through The Hartford. These benefits are intended to provide financial assistance for you and your beneficiaries in the event of disability, accident, or death.

Pafford Emergency Medical Services offers the following benefits through The Hartford:

- Basic Life and Accidental Death & Dismemberment (AD&D) Insurance
- Supplemental Life and Accidental Death & Dismemberment (AD&D) Insurance

THE HARTFORD - BASIC LIFE / AD&D

Pafford Emergency Medical Services provides you with Basic Life and AD&D insurance in the amount of $40,000 at no cost to you. If your death is the result of an accident, you will receive an additional Accidental Death & Dismemberment (AD&D) benefit. If you lose a limb or your eyesight as the result of an accident, the AD&D plan will pay a percentage of your AD&D benefit amount.

THE HARTFORD - SUPPLEMENTAL LIFE / AD&D

You have the option to supplement your company-paid coverage by purchasing additional Life and AD&D insurance for yourself, your spouse and your children. You are required to purchase coverage for yourself to enroll your family members.

- Employee supplemental life and AD&D insurance coverage: $10,000 increments up to $300,000.
    - Guarantee issue: $250,000
- Spouse supplemental life and AD&D insurance coverage: Increments of $5,000, up to $150,000.
    - Spouse coverage cannot exceed 50% of employee supplemental life coverage. Guarantee issue: $25,000
- Child supplemental life and AD&D insurance coverage:
    - Live birth to 15 days: $500
    - 15 days to 26 years (if a student): Increments of $1,000 to a maximum of $10,000

The values below indicate how much you're responsible for contributing towards coverage per pay period.

Age of Employee (Spouse rate will be based on Employee age)	Life/AD&D Amount per $1,000
Under 25	$0.037
25-29	$0.037
30-34	$0.051
35-39	$0.060
40-44	$0.083
45-49	$0.125
50-54	$0.194
55-59	$0.351
60-64	$0.406
65-69	$0.586
70 +	$1.334
AD&D coverage	$0.018
Child LIFE	$0.092

Please note: *Evidence of insurability may be required if you enroll after your initial eligibility period or if you elect amounts over the policy's Guarantee Issue amount.*

HARTFORD VOLUNTARY SHORT-TERM DISABILITY (STD)

VOLUNTARY SHORT-TERM DISABILITY (STD)

Pafford Emergency Medical Service offers Short-Term Disability (STD) insurance through The Hartford.

STD coverage replaces a portion of your income if you are unable to work due to an illness, pregnancy, or non-work-related injury. Benefits begin after one day for an accident and after seven days for sickness and continue for 13 weeks or until you are certified to return to work, whichever is sooner.

This plan provides you 60% of your weekly earnings to a maximum of $1,000 per week if you are unable to work due to illness or injury.

The values below indicate how much you're responsible for contributing towards coverage per pay period.

Age of Employee	Amount per $10 of Weekly Covered Benefit
Under 30	0.3287
30-34	0.3646
35-39	0.2769
40-44	0.2446
45-49	0.2862
50-54	0.3287
55-59	0.4431
60-64	0.5492
65+	0.5497

Example of How To Calculate Your STD Premium (Assumes an employee age 42 making $40,000 annually)
Employee annual salary: $40,000
Employee weekly salary ($40,000/52 weeks) = $769.23
Short Term Disability income replacement % = 60% of weekly benefit
Employee rate (per pay period) $10 of weekly covered benefit (Age 42) = $0.245
Calculation:
Weekly salary ($769.23) x benefit % (60%) = $461.54 is the weekly benefit (income replacement amount)
($461.54/$10 of benefit) x rate ($0.245) = $11.30 per pay period
($11.30 x 26 pay periods)/12 months = $24.50 per month
The maximum weekly benefit is capped at $1,000 per week

HARTFORD VOLUNTARY LONG-TERM DISABILITY (LTD)

VOLUNTARY LONG-TERM DISABILITY (LTD)

Pafford Emergency Medical Service offers Long Term Disability (LTD) insurance through The Hartford.

You can elect to enroll into the Voluntary LTD plan. The LTD Plan coverage replaces a portion of your income if you are unable to work due to an illness, pregnancy, or a non-work-related injury. Benefits begin after 90 days and may continue for up to Social Security Normal Retirement Age.

This plan provides you 60% of your monthly covered payroll to a maximum of $6,000 per month if you are unable to work due to illness or injury.

The values below indicate how much you're responsible for contributing towards coverage per pay period.

Age of Employee	Amount per $100 of Benefit
Under 30	$0.150
30-34	$0.208
35-39	$0.357
40-44	$0.482
45-49	$0.669
50-54	$1.001
55-59	$1.080
60-64	$1.151
65+	$1.263

Example Of How To Calculate Your LTD Premium (Assumes an employee age 42 making $40,000 annually)
Employee annual salary: $40,000
Employee monthly salary ($40,000/12 months) = $3,333.33
Long Term Disability income replacement % = 60% of monthly benefit
Employee per pay period rate per $100 of benefit (Age 42) = $0.482
Calculation:
Monthly salary ($3,333.33) x benefit % (60%) = $2,000 is the monthly benefit (income replacement amount)
($2,000/$100 of benefit) x per pay period rate ($0.48) = $9.60 per pay period
($9.60 x 26 pay periods) / 12 months = $20.80 per month
The maximum monthly benefit is capped at $6,000 per month

VOYA VOLUNTARY BENEFITS

VOLUNTARY GROUP ACCIDENT

Accident Insurance pays you benefits for specific injuries and events resulting from a covered accident while on or off-job. The amount of benefit depends on the type of injury and care received. It's an affordable way for employees to make sure they can keep their financial lives moving in the right direction.

Coverage is available to fulltime active employees working 30 hours per week, your spouse, and your children up to age 26 if employee coverage is elected.

The benefits exhibit below is a snapshot of the benefits available to you under the Accident policy. Please refer to the policy documents for a complete list of covered benefits.

Emergency Care	Benefit	Surgical	Benefit
Air Ambulance	$2,000	Knee Cartilage Repair	$800
Blood, Plasma, Platelets	$600	Ruptured Disk Repair	$800
Emergency Dental Work (Crown)	$350	Surgery (open abdominal, thoracic)	$1,500
Emergency Room Treatment	$300	Tendon, Ligament, Rotator Cuff tear (1)	$825
Specific Injury	**Benefit**	**Hospital**	**Benefit**
Burns (2nd degree, at least 36% of total body surface)	$1,250	Critical Care Unit Admission	$1,500
Burns (3rd degree, at least 2% but less than 4% of total body surface)	$7,500	Hospital Admission	$1,500
Concussion	$300	Rehabilitation Facility Confinement (per day up to 90 days)	$200/day
Skin Grafts	50% of burn benefit	Daily Hospital Confinement (up to 365 days)	$300/day
Fractures Non-Surgical/Surgical	**Benefit**	**Dislocations Non-Surgical/Surgical**	**Benefit**
Ankle, Heel, Foot, and Kneecap	$1,800 / $3,600	Collarbone or bones of the hand	$1,100 / $2,200
Leg	$2,500 / $5,000	Hip Joint	$3,850 / $7,700
Pelvis (except coccyx)	$3,200 / $6,400	Ankle or bones of the foot (other than toes)	$1,500 / $3,000
Hip (except joint)	$3,000 / $6,000	Shoulder	$1,600 / $3,200
Eye Injury (surgery)	**$350**	**Major Diagnostic Exams**	**$275**

Wellness Benefit

Employee	$75
Spouse	$75
Child	100% of employee's Wellness Benefit amount, maximum waived

The values below indicate how much you're responsible for contributing towards coverage per pay period.

Benefit	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Accident	$3.28	$6.44	$6.92	$10.08

VOYA VOLUNTARY BENEFITS

VOLUNTARY GROUP CRITICAL ILLNESS

Medical insurance alone can't stop a major diagnosis from draining finances. Copays, deductibles, alternative treatments — these unexpected expenses add up quickly. Critical Illness insurance provides an affordable option for easing the financial burden that can come with a serious illness. Under this plan, children are covered automatically at no extra cost.

Coverage is available to fulltime active employees working 30 hours per week, your spouse, and your children up to age 26 if employee coverage is elected.

The benefits exhibit below is a snapshot of the benefits available to you under the Critical Illness policy. Please refer to the policy documents for a complete list of covered benefits.

Covered Critical Illnesses
Cancer
Carcinoma In Situ -25%
Heart attack
Sudden cardiac arrest
Major organ transplant (includes Major Organ Failure)
End Stage Renal (Kidney Failure)
Coronary Artery Bypass – 25%
Stroke
Coma
Paralysis
Loss of sight, hearing, or speech
Infectious Disease -25%
Severe Burns

Employee	Benefit
Coverage Amount	Choice of $10,000, $20,000, or $30,000
Guarantee Issue	Same as coverage selected
Spouse	**Benefit**
Coverage Amount	50% of the employee benefit
Guarantee Issue	Same as coverage selected
Child	**Benefit**
Coverage Amount	50% of the employee benefit
Guarantee Issue	Same as coverage selected

Wellness Benefit Rider: Voluntary Wellness Benefit Rider Form #: RL-CI4-WELL2-20

Employee	$75
Spouse	$75
Child	100% of employee's Wellness Benefit amount, maximum waived

The values below indicate how much you're responsible for contributing towards coverage per pay period.

Age Band	Non-Tobacco per $1,000 of Coverage	Tobacco per $1,000 of Coverage
<30	$0.18	$0.194
30-39	$0.26	$0.32
40 - 49	$0.50	$0.75
50 - 59	$0.97	$1.78
60 - 69	$1.70	$3.61
70 +	$3.28	$6.79
Children	Included in Employee rate	

The values above are not combined for employee and spouse. The rates above are for employee or spouse individually.

VOYA VOLUNTARY BENEFITS

VOLUNTARY HOSPITAL INDEMNITY

A trip to the hospital can be costly — and most people are surprised to learn that they are responsible for a good portion of the bill. Hospital Indemnity insurance provides a direct benefit in the event of a hospitalization, regardless of treatment costs or other insurance coverage. It's an affordable way to protect yourself from rising health care costs.

The voluntary hospital indemnity plan pays a daily benefit if you have a covered stay in hospital or critical care unit. The benefit amount is determined based on the type of facility and number of days you stay. Coverage is available to fulltime active employees working 30 hours per week, your spouse, and your children up to age 26 if employee coverage is elected.

The benefits exhibit below is a snapshot of the benefits available to you under the Hospital Indemnity policy. Please refer to the policy documents for a complete list of covered benefits.

The dependent benefit is 100% of the employee amount(s).

Covered Benefits	Benefit
Hospital Confinement Benefit	$200/Day
Number of Covered Days per Hospital Confinement	365 Days
Hospital Admission (once per confinement)	$1,000/Calendar year
Critical Care Unit (CCU) Confinement	$200/Day
Number of Covered Days per CCU Confinement	60 Days per year beginning on day 2
Observation Unit Daily Benefits	$250/Day up to a max of 1 day per calendar year
Annual Wellness Screening	$75

The values below indicate how much you're responsible for contributing towards coverage per pay period.

Benefit	Employee Only	Employee + Spouse	Employee + Children	Employee + Family
Hospital Indemnity	$6.89	$13.77	$14.81	$21.69

ADDITIONAL BENEFITS THROUGH THE HARTFORD

EMPLOYEE ASSISTANCE PROGRAM (EAP)
ABILITY ASSIST COUNSELING SERVICES WITH HEALTHCHAMPION

Ability Assist Counseling Services offers 24/7 access to master's level clinicians. Includes three face-to-face visits per occurrence per year for emotional concerns and unlimited phone conversations for financial, legal and work-life concerns.
HealthChampion offers health care navigation support if you've become disabled or are diagnosed with a critical illness. You'll receive guidance on care options, helpful resources and help with timely and fair resolution of issues.

Call toll-free: **800-96-HELPS (800)-964-3577**
To register visit: www.guidanceresources.com
Use Company Code: **HLF902** Use Company Name: **ABILI**
Select: "Ability Assist Program" to create your own confidential username and password.

TRAVEL ASSISTANCE AND IDENTITY THEFT SERVICES

Travel Assistance is available when traveling more than 100 miles from home for 90 days or less. Services include:

- Medical assistance, including worldwide medical referrals, emergency transports, replacement of medical devices and corrective lenses.
- Pre trip information, lost luggage/document assistance and legal referrals.

Identity Theft Support Services provide 24/7/365 assistance including education on how to prevent theft and guidance on what to do if a theft occurs.

Travel Assistance via phone: U.S. and Canada: **800-243-6108** (toll free) Outside U.S.: **202-828-5885**
Or email: **assist@Imglobal.com**

WILL PREP SERVICES

Protect your family's future by creating a will. Provides will preparations services alongside step-by-step guidance.

Register online at: join.empathy.com/hartfordcare
Once you register, access these services by calling: **229-544-2332**

BEREAVEMENT AND FUNERAL PLANNING SERVICES

Grief support services, Estate and Probate services, after-loss support, and access to online content designed to assist with the grieving process.

To access these services:
Visit: **empathy.com/partner/Hartford**
Register: **join.empathy.com/hartfordcare**
Via Digital App, use Access Code: **EMP-HART**
Contact **Hartford@empathy.com**
For questions call: **270-681-1364**

On-demand assistance finding a funeral home, arranging all details, negotiating costs and creating step-by-step checklists.
Register online at: **join.empathy.com/hartfordcare**
Once you register, access these services by calling: **229-544-2332**

ADDITIONAL BENEFITS THROUGH VOYA

WELLNESS BENEFIT

The Wellness Benefit is included with your Supplemental Health Insurance coverage. It provides an annual benefit payment after you complete a covered health screening test, even if you didn't have out-of-pocket costs for the health screening test.

- Routine exams (Physicals – Adult, dental, eye)
- Mammography
- Colonoscopy
- Well child/preventative exams ages 1 – 18
- Biometric screenings
- Electrocardiogram (EKG)
- Blood testing (ex. Triglyceride, HDL, LDL, fasting glucose, HbA1c)
- Pap smear or thin prep pap test
- Serum cholesterol test for HDL & LDL levels
- Immunizations
- Cancer screenings (ex. CA 15-3, CA 125, CEA, PSA)
- Chest x-ray
- Mental health assessments
- Bone density screening
- Breast ultrasound, sonogram, MRI
- Tests for sexually transmitted infections (STIs)
- Covid test

Accident Insurance	Critical Illness	Hospital Confinement Indemnity Insurance
For yourself & for your covered spouse: $75 For each covered child*: $75	For yourself & for your covered spouse: $75 For each covered child*: $75	For yourself & for your covered spouse: $75 For each covered child*: $75

*Maximum amount for all children may apply

If you have questions about the Wellness Benefit claim process, call 1-877-236-7564.

VOYA TRAVEL ASSISTANCE

Group Name: Pafford Emergency Medical Services. Inc.
Group Number: 753891

Voya Travel Assistance offers you enhanced security for your leisure and business trips when traveling 100 miles or more from your primary residency or in another country, for trips 180 days or less. You and your dependents will have access to the Voya Travel Assistance customer service center or access to the services provided on the website 24 hours a day, 365 days a year – from anywhere in the world.

Benefits

- Emergency Medical Transportation Services: Dispatch of a physician, repatriation of remains, return of travel companion
- Medical Assistance Services: Replacement of medical devices, prescription transfer & shipping
- Travel Assistance Services: Emergency cash transfer, Legal referrals, pet housing & return, lost document assistance
- Security Assistance Services: Emergency political evacuation/repatriation, natural disaster evacuation

Voya Travel Assistance

Contact Voya Travel Assistance 24 hours a day, 365 days a year.
From anywhere in the world:+1 (317) 659-5841
Email: assist@imglobal.com

Visit Online and Register: imglobal.com/member
- Select "Create an account"
- Enter referral code: VOYATRAVEL
- Click "continue" to enter your personal information, email address, and create your password.

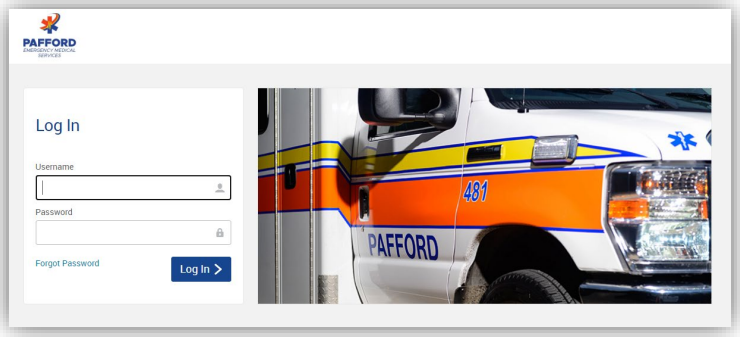
Enrolling in the Pafford Benefit Program for 2026

Benefit & Enrollment Website – bSwift Platform

bSwift Platform

1. Review Benefits
2. Elect or Make Changes to Benefits for 2026
3. You must access the system to elect benefits or make changes
4. You do need to enter the system to elect your HSA contributions for 2026
5. You do need to enter the system to elect your Critical Illness benefit amounts for 2026

Access the benefits enrollment platform by using the following web address: → **paffordla.bswift.com**



Log-in Information Using:

Username: First Initial of first name plus last name and last four of social security number
Password: The last four digits of your Social Security number

Example: John Smith = JSmith4444
Once you log in for the first time you will need to created a password

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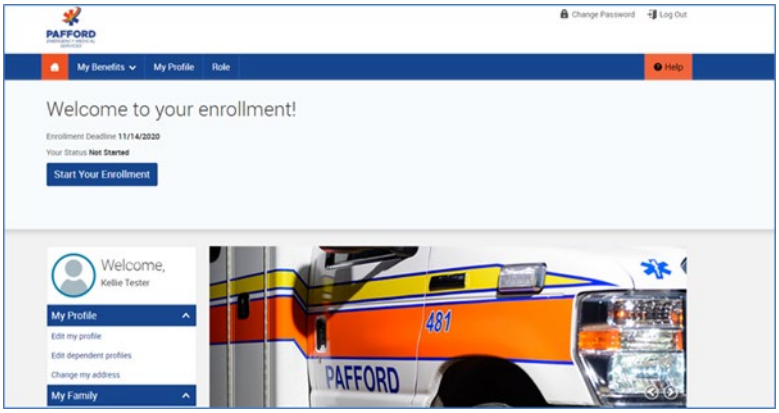
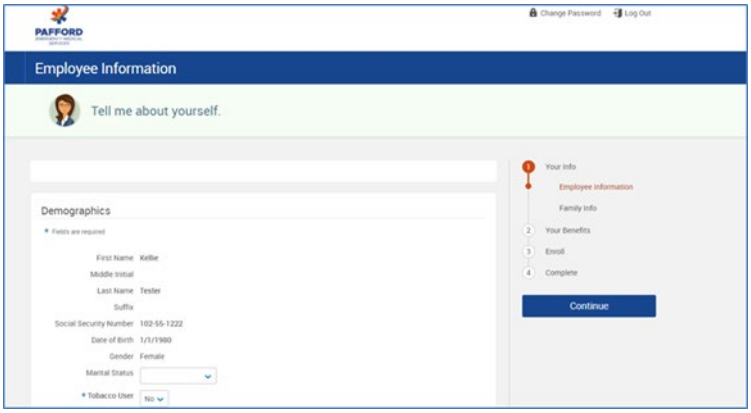
To begin your enrollment from the Home Page, click on the "**Start Your Enrollment**" button.



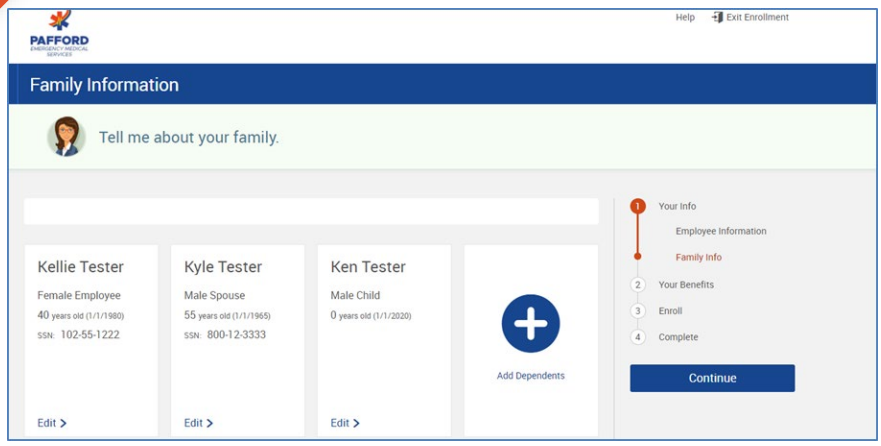


Verify Your Personal Information

Before beginning your enrollment, please verify the accuracy of your personal information (e.g. address, DOB, etc.) You will also be required to enter user Tobacco User status and you can enter a personal email and phone number.

When you are finished, please click "**I agree**" and "**Continue**."

Enrolling in the Pafford Benefit Program for 2026
Benefits & Enrollment Website – bSwift platform



Verify your Family Information

Please be sure to review your family member information and add any dependents you would like to cover under your benefits. If any existing family members have inaccurate or incomplete information, click on the "**Edit**" link and change the necessary information or to add a family member, click the "**Add Dependents**" link. If you add a dependent, please note that all fields with an asterisk (*) are required.

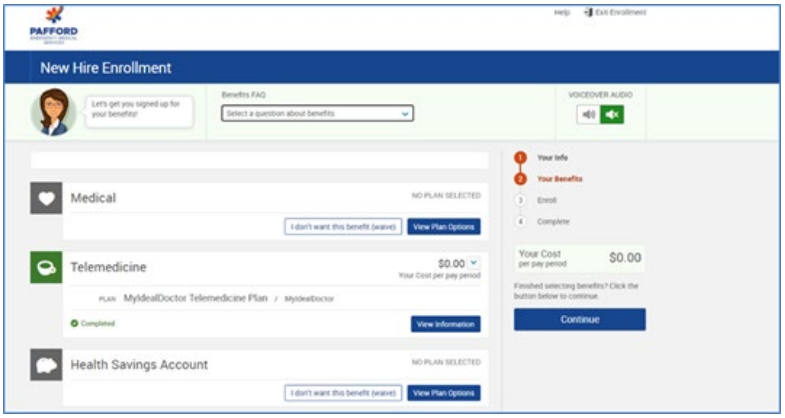
After verifying your personal and family information, click "**Save and Continue**" or "**Save and Add Another.**"

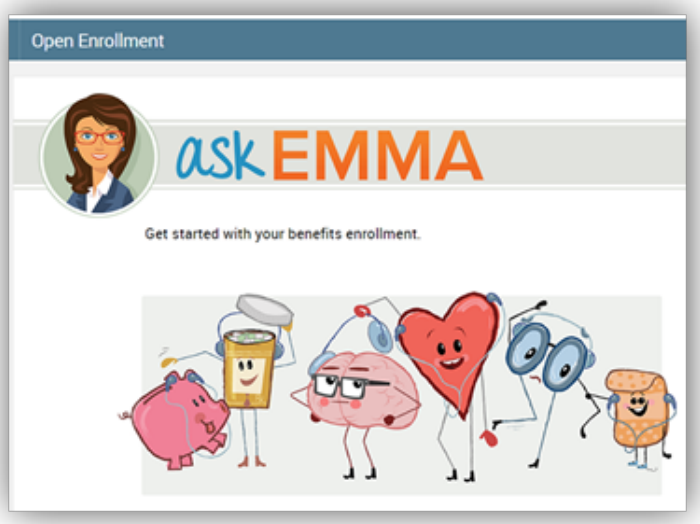
When all of your family information is accurate, please click **"Continue"** to proceed to your enrollment.

Selecting Your Benefits

All available benefits will be displayed on the screen. Please select whether you want to waive the plan, keep your current selection or select **"View Plan Options"** to review your options and make a new selection. When a benefit selection is complete, a green check mark will be displayed next to the plan type.

Please Note: Your enrollment selections are not considered complete until you check the "Save My Enrollment" button at the end of the enrollment and confirmation process.





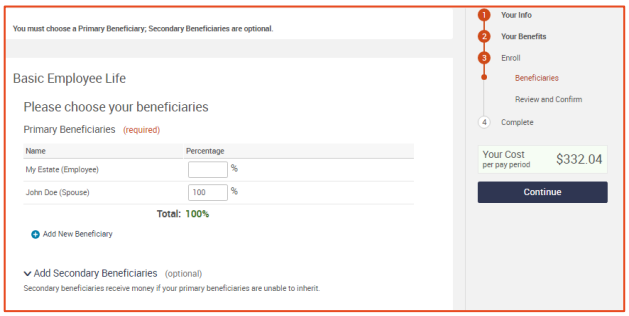
Meet ASK EMMA

1. Ask EMMA will guide you and help you decide which medical plan fits your needs.
2. Just answer her questions (your answers are confidential and will not be shared with your employer)
3. Ask Emma will demonstrate a plan comparison for you

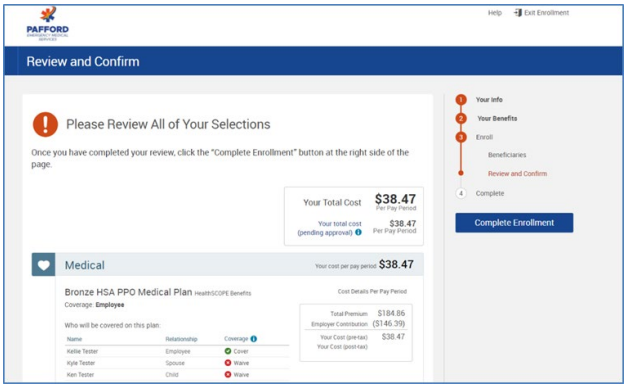
Enrolling in the Pafford Benefit Program for 2026

Benefits & Enrollment Website – bSwift platform

Remember to complete the Life insurance Beneficiary
You Must designate at least one beneficiary

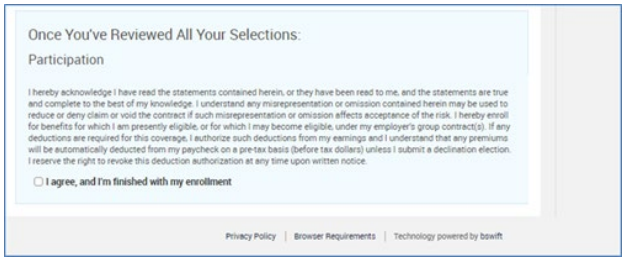


Review All Your Selections – You're Almost Finished!
Once you have made a selection for all plan types and have completed your beneficiary selections, you can click "Continue" to the review portion of your enrollment.

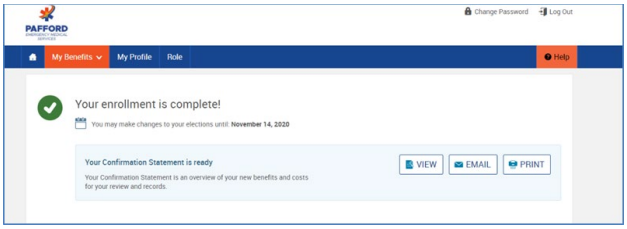


You will now be directed to the final review page. Carefully review all of your benefit elections and covered dependents. Note that you may change your elections by clicking the "**Edit Selection**" button for any of your plan selections. The dependents you wish to have included in your coverage will be listed. You may notice that some of your elections are pended due to approval by the insurance carrier

Once satisfied with your selection after careful review, please read through the participation agreement and select **"I agree, and I'm finished with my enrollment**" at the bottom to complete. Then, click the "**Complete Enrollment**" button to send your information to HR and complete your online enrollment.



Confirmation Statement
Click "View" to open your final confirmation statement.



To make changes, click on the "Edit Selection" button on the appropriate benefit to return to the benefit election screen. **Please Note: It is highly recommended that you save yourself a copy of your final confirmation statement.**

Updating your Selections
You may update your benefit selections at any time during the open enrollment period. If your window is still open, you may click the **"Change My Elections"** button in green on your home page to get back into your enrollment.

KEY CONTACTS

For Questions About	Carrier	Phone Number	Website/Email
Medical	UHC / UMR	800-826-9781	www.umr.com
ProActive Care Management (PCM)	N/A	877-455-0709	PCMadvocates@epicbrokers.com
Prescription Drug	Liviniti	800-710-9341	www.liviniti.com
Health Savings Account (HSA)	UMR	800-357-6246	www.umr.com
Telemedicine	RelyMD	855-879-4332	www.relyMD.com
Dental	Delta Dental	800-521-2651	www.deltadentalins.com
Vision	VSP	800-877-7195	www.vsp.com
Employee Assistance Program (EAP)	TELUS Health	888-851-7032	one.telushealth.com
Employee Assistance Program (EAP)	Ability Assist	800-964-3577	www.guidanceresources.com
Life and AD&D Insurance	The Hartford	800-835-0385	www.thehartford.com
Short-Term Disability (STD)	The Hartford	800-835-0385	www.thehartford.com
Long-Term Disability (LTD)	The Hartford	800-835-0385	www.thehartford.com
Voluntary Group Accident	Voya	877-236-7564	www.voya.com
Voluntary Group Critical Illness	Voya	877-236-7564	www.voya.com
Voluntary Groups Hospital Indemnity	Voya	877-236-7564	www.voya.com
bSwift Benefits Platform	bSwift		Paffordla.bswift.com
Benefits Department	N/A	318-497-6007	penny@paffordems.com

BENEFIT TERMS

Coinsurance	The percentage you pay for the cost of covered health care services **after** you've met your deductible. For example, if the coinsurance under your plan is 30%, you would pay 30% of the cost of the service and your insurance would pay the remaining 70%.
Copayment (Copay)	A fixed amount (for example, $30) you pay for a covered health care service, usually when you receive the service (as specified by your plan).
Deductible	The amount you pay in a plan year before your health plan begins to pay benefits.
Explanation of Benefits (EOB)	A statement from the plan explaining what portion of a claim was paid.
Health Savings Account (HSA)	A bank account that lets you put money aside, tax-free, to save and pay for qualified health care expenses. The Internal Revenue Service (IRS) limits who can open and put money into an HSA.
Network	A group of doctors, hospitals, labs, and other providers that your health insurance contracts so you can make visits at a pre-negotiated (and often discounted) rate. To search for your Pafford Emergency Medical Services network call UMR at 800-826-9781 or go to www.umr.com.
Out-of-Pocket Maximum	The cap on your out-of-pocket costs for the plan year. Once you've reached this amount, your plan will cover 100% of your qualified medical expenses for the plan year.
Premium	The amount of money that's paid for your health insurance every month. Pafford Medical Service pays a portion of this amount, and you pay the rest.

PAFFORD
EMERGENCY MEDICAL SERVICES

PAFFORD EMERGENCY MEDICAL SERVICES, INC.: 7670-00-414690 003

BRONZE 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 www.umr.com or by calling 1-800-826-9781. 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.umr.com or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$5,000 person / $10,000 family In-network $10,000 person / $20,000 family Out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$5,500 person / $11,000 family In-network $11,000 person / $22,000 family Out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-826-9781 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

BRONZE PLAN

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 (You will pay the least)	Out-of-network (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	$30 Copay per visit; Deductible Waived	60% Coinsurance	None
	Specialist visit	$40 Copay per visit; Deductible Waived	60% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	60% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% Coinsurance	60% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	40% Coinsurance	60% Coinsurance	Preauthorization is required.

BRONZE PLAN

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.liviniti.com.	Generic drugs (Tier 1)	$15 Copay per prescription (retail); $30 Copay per prescription (31-60 day supply); $45 Copay per prescription (61-90 day supply) mail order	Not Covered	None
	Preferred brand drugs (Tier 2)	$30 Copay per prescription (retail); $60 Copay per prescription (31-60 day supply); $90 Copay per prescription (61-90 day supply) mail order	Not Covered	
	Non-preferred brand drugs (Tier 3)	$60 Copay per prescription (retail); $120 Copay per prescription (31-60 day supply); $180 Copay per prescription (61-90 day supply) mail order	Not Covered	
	Specialty drugs (Tier 4)	30% Copay up to a Maximum of $500 per prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% Coinsurance	60% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	40% Coinsurance	60% Coinsurance	
If you need immediate	Emergency room care	40% Coinsurance	40% Coinsurance	In-network deductible applies to Out-of-network benefits

BRONZE PLAN

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
medical attention	Emergency medical transportation	40% Coinsurance	40% Coinsurance	In-network deductible applies to Out-of-network benefits; Preauthorization is required for Non-emergent Air ambulance.
	Urgent care	40% Coinsurance	60% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% Coinsurance	60% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/surgeon fees	40% Coinsurance	60% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay per visit; Deductible Waived Office visits; 40% Coinsurance other outpatient services	60% Coinsurance	Preauthorization is required for Partial hospitalization.
	Inpatient services	40% Coinsurance	60% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
If you are pregnant	Office visits	No charge; Deductible Waived	60% Coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may

BRONZE PLAN

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Childbirth/delivery professional services	40% Coinsurance	60% Coinsurance	apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	40% Coinsurance	60% Coinsurance	
If you need help recovering or have other special health needs	Home health care	40% Coinsurance	60% Coinsurance	100 Maximum visits per calendar year
	Rehabilitation services	40% Coinsurance	60% Coinsurance	None
	Habilitation services	40% Coinsurance	60% Coinsurance	Habilitation services for Learning Disabilities are not covered
	Skilled nursing care	40% Coinsurance	60% Coinsurance	100 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Durable medical equipment	40% Coinsurance	60% Coinsurance	Preauthorization is required for DME in excess of $1,500 for rentals or purchases.
	Hospice service	40% Coinsurance	60% Coinsurance	None

BRONZE PLAN

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	No charge; Deductible Waived	1 Maximum exam per calendar year
	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 Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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 visits per calendar year
- Chiropractic care – 20 visits per calendar year
- Hearing aids – 1 per ear every 3 calendar years
- Routine eye care (Adult) – 1 exam per calendar year

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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. 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 or call 1-800-318-2596.

BRONZE PLAN

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 plan's overall deductible	$5,000
Specialist copayment	$40
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$5,570**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,000
Specialist copayment	$40
Hospital (facility) coinsurance	40%
Other coinsurance	40%

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:

Cost Sharing	
Deductibles	$100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist copayment	$40
Hospital (facility) coinsurance	40%
Other coinsurance	40%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,610**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-826-9781.

PAFFORD EMERGENCY MEDICAL SERVICES, INC.: 7670-00-414690 001 002 SILVER PLAN

Coverage for: Individual + Family | **Plan Type:** HDHP

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 www.umr.com or by calling 1-800-826-9781. 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.umr.com or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,700 person / $3,400 family In-network $2,900 person / $5,800 family Out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$3,700 person / $7,400 family In-network $7,400 person / $14,700 family Out-of-network $3,700 In-network / $7,400 Out-of-network Maximum amount that any one person will satisfy towards the annual family out-of-pocket	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-826-9781 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

SILVER PLAN

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 (You will pay the least)	Out-of-network (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	20% Coinsurance	40% Coinsurance	None
	Specialist visit	20% Coinsurance	40% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	40% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Preauthorization is required.

If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.liviniti.com.	Generic drugs (Tier 1)	20% Coinsurance	Not Covered	None
	Preferred brand drugs (Tier 2)	20% Coinsurance	Not Covered	
	Non-preferred brand drugs (Tier 3)	20% Coinsurance	Not Covered	
	Specialty drugs (Tier 4)	20% Coinsurance up to $500	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	In-network deductible applies to Out-of-network benefits; Preauthorization is required for Non-emergent Air ambulance.
	Urgent care	20% Coinsurance	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.

	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	20% Coinsurance	40% Coinsurance	Preauthorization is required for Partial hospitalization.
	Inpatient services	20% Coinsurance	40% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
If you are pregnant	Office visits	No charge; Deductible Waived	40% Coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	100 Maximum visits per calendar year
	Rehabilitation services	20% Coinsurance	40% Coinsurance	None
	Habilitation services	20% Coinsurance	40% Coinsurance	Habilitation services for Learning Disabilities are not covered

	Skilled nursing care	20% Coinsurance	40% Coinsurance	100 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Preauthorization is required for DME in excess of $1,500 for rentals or purchases.
	Hospice service	20% Coinsurance	40% Coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	No charge; Deductible Waived	1 Maximum exam per calendar year
	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 Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Chiropractic care – 20 visits per calendar year
- Hearing aids – 1 per ear every 3 calendar years
- Routine eye care (Adult) – 1 exam per calendar year

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 plan's overall deductible	$1,700
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,770**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,700
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	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:

Cost Sharing	
Deductibles	$1,100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$5,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,700
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,910**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-826-9781.

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

PAFFORD EMERGENCY MEDICAL SERVICES, INC.: 7670-00-414690 004

ELECTRUM 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 www.umr.com or by calling 1-800-826-9781. 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.umr.com or call 1-800-826-9781 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$2,500 person / $5,000 family In-network $5,000 person / $10,000 family Out-of-network	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out–of–pocket limit for this plan?	$5,000 person / $10,000 family In-network $10,000 person / $20,000 family Out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Penalties, premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.umr.com or call 1-800-826-9781 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

ELECTRUM PLAN

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 (You will pay the least)	Out-of-network (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	$30 Copay per visit; Deductible Waived	50% Coinsurance	None
	Specialist visit	$40 Copay per visit; Deductible Waived	50% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	50% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge; Deductible Waived Office setting; 30% Coinsurance Outpatient setting	50% Coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	50% Coinsurance	Preauthorization is required.

ELECTRUM PLAN

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.liviniti.com.	Generic drugs (Tier 1)	$15 Copay per prescription (retail); $30 Copay per prescription (31-60 day supply); $45 Copay per prescription (61-90 day supply) mail order	Not Covered	None
	Preferred brand drugs (Tier 2)	$30 Copay per prescription (retail); $60 Copay per prescription (31-60 day supply); $90 Copay per prescription (61-90 day supply) mail order	Not Covered	
	Non-preferred brand drugs (Tier 3)	$50 Copay per prescription (retail); $100 Copay per prescription (31-60 day supply); $150 Copay per prescription (61-90 day supply) mail order	Not Covered	
	Specialty drugs (Tier 4)	30% Copay up to a Maximum of $500 per prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	50% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	
If you need immediate	Emergency room care	$300 Copay per visit; 30% Coinsurance	$300 Copay per visit; 30% Coinsurance	In-network deductible applies to Out-of-network benefits; Copay may be waived if admitted

ELECTRUM PLAN

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
medical attention	Emergency medical transportation	30% Coinsurance	30% Coinsurance	In-network deductible applies to Out-of-network benefits; Preauthorization is required for Non-emergent Air ambulance.
	Urgent care	$40 Copay per visit; Deductible Waived	50% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	$30 Copay per visit; Deductible Waived Office visits; 30% Coinsurance other outpatient services	50% Coinsurance	Preauthorization is required for Partial hospitalization.
	Inpatient services	30% Coinsurance	50% Coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
If you are pregnant	Office visits	No charge; Deductible Waived	50% Coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, deductible, copayment or coinsurance may

ELECTRUM PLAN

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Childbirth/delivery professional services	30% Coinsurance	50% Coinsurance	apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	30% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	50% Coinsurance	100 Maximum visits per calendar year
	Rehabilitation services	30% Coinsurance	50% Coinsurance	None
	Habilitation services	30% Coinsurance	50% Coinsurance	Habilitation services for Learning Disabilities are not covered
	Skilled nursing care	30% Coinsurance	50% Coinsurance	100 Maximum days per calendar year; Preauthorization is required. If you don't get preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Durable medical equipment	30% Coinsurance	50% Coinsurance	Preauthorization is required for DME in excess of $1,500 for rentals or purchases.
	Hospice service	30% Coinsurance	50% Coinsurance	None

ELECTRUM PLAN

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge; Deductible Waived	No charge; Deductible Waived	1 Maximum exam per calendar year
	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 Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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 visits per calendar year
- Chiropractic care – 20 visits per calendar years
- Hearing aids – 1 per ear every 3 calendar years
- Routine eye care (Adult) – 1 exam per calendar year

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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. 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 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 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at: www.HealthCare.gov and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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 Standard? 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 1-800-826-9781.

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-826-9781.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-826-9781.

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf die do Nummer uff 1-800-826-9781.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-826-9781.

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-826-9781.

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-826-9781.

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 plan's overall deductible	$2,500
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$5,070**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,500
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$4,600**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,500
Specialist copayment	$40
Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,300
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,410**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.umr.com or call 1-800-826-9781.

RxCompass
Powered by southernscripts

Member Journey

You are always the center of everything the Care Navigator works for and towards.

Your RxCompass Navigator will engage with you based on the most appropriate pathway below. Your Care Navigator will provide immediate and ongoing support to ensure that you are never without therapy and have little to no out-of-pocket cost.

RxCompass PATIENT ASSISTANCE PROGRAMS

- The Patient Assistance program guidelines are reviewed for your medication
- The application forms are sent to you for completion with support from your Care Navigator
- The Care Navigator forwards completed forms to your prescribing physician for finalization
- The finalized application is sent to the manufacturer
- If you are approved for Patient Assistance, your Care Navigator will initiate follow-up shipments
- If you are denied for Patient Assistance, your Care Navigator will navigate you through an alternate pathway to source your medication

---

Variable copay™

- If Variable Copay program is determined the best source of your medication, you will be referred to an Intake Specialist
- If you are not already enrolled in a copay savings program, the Intake Specialist will register you
- Upon enrollment, you will be transitioned to a Variable Copay Network Pharmacy to fill your medication

---

TeleSaverRx

Bolt-On Specialty Drug Savings Program

- If TeleSaverRx is determined to be the best source of your medication, you are navigated through the intake process which includes an annual Telehealth visit
- TeleSaverRx will obtain the prescription from your physician and contact you to set up delivery of your medication

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INTLMail | Specialty Brand

- If International Mail is determined to be the best source of your medication, you are advised:
  - **International Brand** –The International Mail team will contact you directly to enroll
  - **International Specialty** –The International Mail team will contact you directly to enroll. A copy of your passport or government ID may be required
- International Mail will obtain the prescription from your physician and contact you to set up delivery of your medication

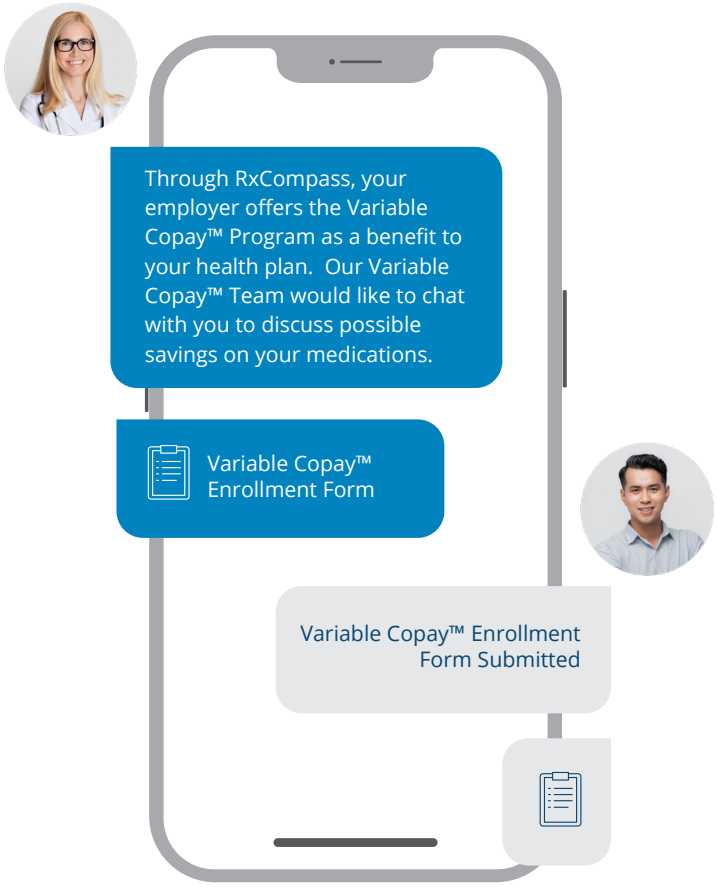
RxCompass

Care Navigation

Easily Connecting With Your Members

TEXT | EMAIL | CALL

RxCompass Patient Communication



RxCompass offers easy, secure, and instant communication for enrolled members.

The RxCompass Care Navigators can now connect with members via text message in real-time to deliver efficient communication that does not disrupt the member's daily life.

RxCompass has adopted technology which allows members to securely connect with us according to their preferences, whether it be ***text messages, phone calls, or emails.***

By utilizing the HIPAA compliant text messaging and emailing platform, members can:

- **Correspond with Care Navigators at their fingertips to learn more about reduced cost share on eligible medications**
- **Receive updates on the shipment and delivery of medication**
- **Receive applications or pertinent documents to be completed**

At RxCompass, the member is at the center of everything the Care Navigator works for and towards. With our member-centric approach, our goal is to make communication between members and Care Navigators secure and convenient.

Rx Compass

Powered by southernscripts

Frequently Asked Questions

What is RxCompass?

A Southern Scripts-owned and operated Overlay Program; RxCompass includes multiple program offerings with centralized contracting and billing:

- INTL Mail Brand
- INTL Mail Specialty
- TeleSaverRx 340B program
- Variable Copay
- Patient Assistance Program
- Site of Care – A program designed to achieve savings on the medical benefit

Geared-Up For A Smooth Integration

ONE Contract | **ONE** Care Navigation Team | **ONE** Member Experience | **ONE** Invoice | **ONE** Report Source

Do all drug savings pathways have to be implemented with RxCompass, or can clients opt out of select pathways?

Clients may choose to opt out of select pathways, such as INTL Mail; however, RxCompass recommends utilizing all pathways to achieve the greatest possible savings.

What are the advantages of RxCompass?

One of the biggest differentiators of RxCompass from other drug savings programs is that the program is vertically integrated with the PBM. This integration allows for seamlessness to clients via contracts, communication, reporting, and invoicing. By having the PBM services combined with alternative funding solutions under one roof, the client has a one-stop shop for their plan needs. The RxCompass program provides an enhanced member experience with our concierge approach, assuring all members will remain on an approved drug without a gap in the continuity of care. Most importantly, RxCompass will utilize all available drug savings pathways to generate the largest possible savings for the client.

Are any medications sourced internationally?

The RxCompass INTL Mail pathway sources medications internationally. In all instances, drugs are sourced through tier-one countries like Australia, Canada, England, and New Zealand.

What is a MERP, and is it required for the RxCompass program?

A Medical Expense Reimbursement Plan (MERP) is a turn-key administrative tool that provides increased protection as it relates to ACA and ERISA compliance, as well as provides:

- Consistency in claims processing
- Better employee experience
- Speeds up the processing time
- More protection for plan fiduciaries

For these reasons, the MERP is required for RxCompass.

Who will administer the MERP?

The TPA can administer the MERP; we can provide sample SPD language for the TPA to utilize if desired. Additionally, RxCompass has a recommended MERP administrator, Grenz Benefits, who can provide turnkey administration. If Grenz Benefits is the preferred option, RxCompass can facilitate an introduction. Grenz Benefits has an annual MERP administration fee.

How is billing facilitated?

A RxCompass invoice will be sent out once a month for the RxCompass administration fee.

Are medications eligible for rebates through RxCompass?

Within the RxCompass program, any fills through Variable Copay will be rebate eligible. Other drug-sourcing pathways, including INTL Mail, TeleSaver Rx, and PAP, are not rebate-eligible.

What if members have difficulty communicating during normal business hours?

RxCompass utilizes HIPAA-compliant text messaging technology, so we may communicate with members in a more convenient way. Text messaging allows members to respond at a time that is best for them.

What is the implementation timeline for RxCompass?

We ask that a 60-day notice be given to prepare for the implementation of RxCompass, allowing time for documentation to be completed and members to be informed of the program. It is important to note that all legal documents must be signed and completed no later than 15 days prior to the effective date. If signatures are not returned in a timely manner, implementation will be rescheduled for the following month.

What is the workflow/member experience?

- Prescription: Member is prescribed a RxCompass-eligible medication from their physician. RxCompass-eligible medications treat certain conditions, such as Enzyme Replacement, Psoriasis, Asthma, Rheumatoid arthritis, Crohn's Disease, and Diabetes. Typically, less than 10% of the membership is impacted by the RxCompass program.
- Retail Pharmacy: Member may experience a rejection for their Rx at the retail pharmacy for Prior Authorization or due to the medication being offered through RxCompass.
- Case Creation: The rejection at the pharmacy will generate a notification to the RxCompass Care Navigation Team, who will assess the situation prior to member engagement.
- Member Engagement: A Care Navigator will engage with the member via text or telephone and provide assistance so they may obtain the medication efficiently and as close to $0 OOP cost. If a member is on an HDHP, they will need to satisfy their deductible. During the initial communication, the Care Navigator will determine how much medication the member has on hand and can approve additional fills as necessary.
- Prescription Filled: The Care Navigator will monitor the prescription to ensure it is received.
- Continued Support: The Care Navigator will be available for continued support for ongoing fills. Members may contact the Care Navigation Team at (833) 652-8379 or carenavigator@myrxcompass.com

Is RxCompass Mandatory or Voluntary?

Utilization of various RxCompass pathways is voluntary. A drug exclusion list will be in place, causing the member to reject. Navigators will engage the member to discuss the best pathway. If a member does not want to utilize any available pathways, the member would be able to fill on the MERP.

What if a member declines all RxCompass drug-sourcing pathways?

RxCompass is committed to a member-centric approach, so we would continue to place overrides allowing the member to fill their medication at their retail pharmacy, as deemed clinically appropriate through our Prior Authorization process. In this scenario, RxCompass would work with the Account Executive to ensure the client or their representative is notified.

Does the Transition of Care (TOC) process apply to RxCompass?

- Yes, the normal Transition of Care process applies, contingent on receipt of appropriate data, as normal.
- Transition of Care overrides address the Prior Authorization only; Drugs will still reject on the primary plan to facilitate the transition to a lower-cost pathway.

When should a member expect to hear from RxCompass after receiving a rejection at the pharmacy?

A member of the RxCompass Care Team will engage with a member within 24-48 hours of the rejection at the pharmacy.

What are the RxCompass Call Center hours?

The hours of operation are Monday-Friday from 8 am-6 pm EST.

How do I contact RxCompass?
myrxcompass.com/contact
myrxcompass.com
Email: carenavigator@myrxcompass.com
Telephone: Toll-Free (833) 652-8379

Support when illness or injury stops work.

Short-term Disability Insurance

Pafford Medical Services, Inc.

Short-term Disability Insurance which we call Short-term Income Protection Benefits replace part of your income if you are unable to work for a short time due to an illness or injury to help cover your day-to-day living expenses, creating stability in an unstable time.

Short-term Income Protection Benefits.

Short-term Income Protection Benefits is coverage that you pay for and it can help provide financial support and stability if you are unable to work due to an illness or injury. You must be actively at work with your employer on the day your coverage takes effect.

Short-term Income Protection Benefits coverage options.

If you are an eligible employee, you can elect to receive a weekly cash benefit that replaces 60% of your Total Weekly Earnings, up to $1,000. Benefits begin as soon as 1 day from the date you are unable to work due to an injury and 8 days due to an illness and may pay up to 13 weeks.

Will you need to answer medical questions?

If you enroll during the scheduled enrollment period or within 31 days of becoming eligible, you won't need to answer medical questions. If you enroll later or during a family status change, you will need to answer medical questions.

The Hartford

Map your route to financial wellness.

Short-term Income Protection Benefits can help replace lost wages and ensure mortgage, rent or groceries are paid, providing a comforting source of income and support while you are unable to work.

Here's how you and your family can benefit from coverage if something happens to you:

Married with kids, lots of expenses

Helps replace income so your family can stay on track financially if you're unable to work.

Single parent, multiple responsibilities

Provides steady income to help support your children while you recover.

Dual income, no kids

Covers your share of the bills if you're temporarily out of work.

Growing children, aging parents

Supports your family and caregiving duties while you focus on healing.

Single and carefree

Covers rent, bills, and lifestyle costs so you don't have to rely on savings.

The Hartford

Disability Form Series includes GBD-1000 A (10/08), GBD-1200 (10/08), or state equivalent.

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Support when illness or injury stops work.

Long-term Disability Insurance

Pafford Medical Services, Inc.

Long-term Disability Insurance which we call Long-term Income Protection Benefits replace part of your income if you are unable to work for an extended time due to an illness or injury to help cover your day-to-day living expenses, creating stability in an unstable time.

Long-term Income Protection Benefits

Long-term Income Protection Benefits is coverage that you pay for and it can help provide financial support and stability if you are unable to work due to an illness or injury. You must be actively at work with your employer on the day your coverage takes effect.

Long-term Income Protection Benefits coverage options

If you are an eligible employee, you can elect to receive a monthly cash benefit that replaces 60% of your monthly pay, up to $6,000 per month. Benefits begin after 90 days of disability.

Will you need to answer medical questions?

If you enroll during the scheduled enrollment period or within 31 days of becoming eligible, you won't need to answer medical questions. If you enroll later or during a family status change, you will need to answer medical questions.

Map your route to financial wellness.

Long-term Income Protection Benefits can help replace lost wages and ensure mortgage, rent or groceries are paid, providing a comforting source of income and support while you are unable to work for an extended period of time.

The Hartford

Here's how you and your family can benefit from coverage if something happens to you:

Married with kids, lots of expenses

Helps replace income so your family can stay on track financially if you're unable to work.

Single parent, multiple responsibilities

Provides steady income to help support your children while you recover.

Dual income, no kids

Covers your share of the bills if you're temporarily out of work.

Growing children, aging parents

Supports your family and caregiving duties while you focus on healing.

Single and carefree

Covers rent, bills, and lifestyle costs so you don't have to rely on savings.

The Hartford

Disability Form Series includes GBD-1000 A (10/08), GBD-1200 (10/08), or state equivalent.

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Be there to help no matter what.

Life & Accidental Death & Dismemberment Insurance

Pafford Medical Services, Inc.

Group Life insurance provides a cash benefit to help with final planning and loss of future income at a lower cost, using a more simplified enrollment process than individual policies.

At The Hartford, our focus on empathy and compassion sets our claims process apart as a carrier that truly cares about its customers and their well-being.

Basic Life insurance coverage.

Your Company cares about your financial well-being and is offering all eligible employees with a Basic Life insurance benefit of $40,000 at no cost to you. You can choose to enhance your protection with a Supplemental Life insurance plan at an affordable group rate. You must be actively at work with your employer on the day your coverage takes effect.

Supplemental Life insurance coverage options.

For Yourself: Increments of $10,000 up to a maximum of $300,000

For Your Spouse : Increments of $5,000 up to a maximum of $150,000

For Your Child(ren): Increments of $1,000 up to a maximum of $10,000

If you are newly eligible and elect an amount over the Guaranteed Issue amount, you and your spouse will need to provide Evidence of Insurability (EOI). If you are enrolled in coverage, you may use this annual enrollment period to increase two additional levels for you and your spouse up to the Guaranteed Issue amount with no EOI required. If you enroll for the first time after your initial enrollment period, EOI will be required. If you enroll during a family status change, you will need to answer medical questions.

For Yourself: Up to $250,000

For Your Spouse : Up to $25,000

Basic Accidental Death & Dismemberment (AD&D) insurance

Your Company also offers a Basic AD&D benefit of $40,000 at no cost to you.

The Hartford

Supplemental Accidental Death & Dismemberment (AD&D)[1] insurance.

For Yourself: Increments of $10,000 up to a maximum of $300,000

For Your Spouse : Increments of $5,000 up to a maximum of $150,000

For Your Child(ren): Increments of $1,000 up to a maximum of $10,000

Supplemental AD&D will automatically equal Supplemental Life insurance.

Help ease your loved ones financial burden.

By providing your beneficiaries a lump sum in the event of your death, Life and AD&D benefits can help replace lost income and ensure mortgage or college loans are paid, while covering funeral costs and other final expenses. By planning now, you can help ensure that, whatever the future holds, your loved ones will have a comforting source of income and support.

Here's how you and your family can benefit from coverage if something happens to you:

Married with kids, lots of expenses

Help your family afford the same lifestyle they have today.

Single parent, multiple responsibilities

Help take care of your children financially.

Dual income, no kids

Help your spouse maintain the same standard of living as you have today.

Growing children, aging parents

Help protect your kids' financial futures and take care of elderly parents.

Single and carefree

Help make sure those student loans and car payment aren't a burden to anyone.

The Hartford

Life Form Series includes GBD-1000 A (10/08), GBD-1100 (10/08), or state equivalent. Life Form Series includes GBD-1000, GBD-1100, or state equivalent. Accident Form Series includes GBD-1000, GBD-1300, GBD-3300, GBD-3500, or state equivalent.

[1] Not available in all states.

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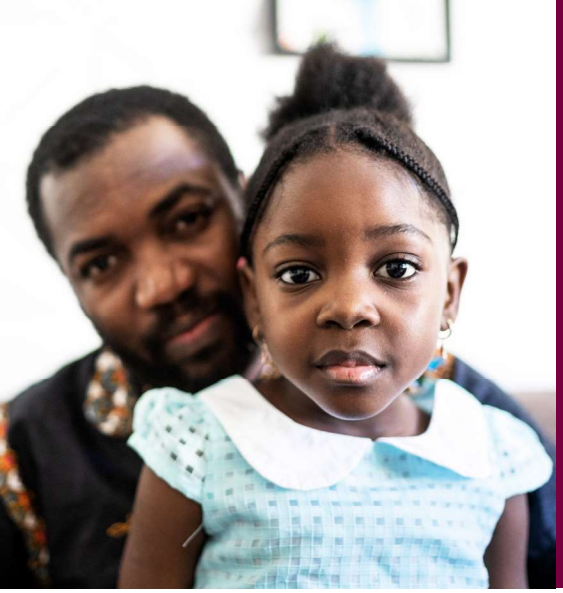

If your family ever needs a hand, we're ready.

Additional services from The Hartford

Our Life and Disability insurance can help protect the financial future of your loved ones. Your coverage includes valuable services that can help you and your family.

Your loved ones can benefit from services that go beyond the benefit.

You're taking steps to take care of the people who depend on you. In addition to taking care of financial concerns, your Life and Disability insurance comes with access to a suite of services to support your loved ones through every step of life's most difficult moments.

Services for Life insurance include:

Funeral Planning[1]

Our Funeral Planning Services offers a suite of online tools to help guide you through key decisions. It allows for pre-planning and entails a step-by-step checklist, an expert care team, will preparation and burial arrangements.

Register online at: join.empathy.com/hartfordcare

Once you register, access these services by calling: **229-544-2332**

Will Prep[1]

Whether you have a few assets or many, help protect your family's future by creating a will. Our online will preparation service is backed by online support from licensed attorneys. Just follow the instructions to create a will that's customized and legally binding.

Register online at: join.empathy.com/hartfordcare

Once you register, access these services by calling: **229-544-2332**

Bereavement

Bereavement Services[1] provide a personalized bereavement solution built to help families deal with the many challenges that loss can bring. Empathy provides high-quality, complimentary, on-demand support for every Group Life beneficiary anticipating or dealing with loss, so that they and their families have everything they need during this difficult time.

This includes grief support services, estate and probate services, helpful planning tools, digital app, document storage, after-loss support, and access to online content designed to assist with the grieving process.

To access these services:

Visit: empathy.com/partner/hartford

Register: join.empathy.com/hartfordcare

Via Digital App, use Access Code: **EMP-HART**

Contact: hartford@empathy.com

For questions, call: **270-681-1364**

The Hartford

Services for Life and Disability insurance include:

Travel Assistance with Identity Theft Support Services[2]

Travel Assistance is available when traveling more than 100 miles from home and for 90 days or less. Services include but are not limited to:

- Medical assistance, including worldwide medical referrals, medical monitoring, prescription transfer, replacement of medical devices and corrective lenses.
- Emergency transports, medical repatriations and evacuations and repatriations of mortal remains.
- Pre-trip information, lost luggage/document assistance and legal referrals.

Identity Theft Support Services[3] provide 24/7/365 assistance including education on how to prevent theft and guidance on what to do if a theft occurs.

Caseworkers help review credit information, and if a theft has occurred, will notify major credit bureaus, assist with completing an identity theft affidavit, help with replacing credit/debit cards and more.

Ability Assist® Counseling Services with HealthChampion® Health Care Navigation[2,4]

Ability Assist Counseling Services offers 24/7 access to master's level clinicians. Includes three face-to-face visits per occurrence per year for emotional concerns and unlimited phone consultations for financial, legal and work-life concerns.

HealthChampion offers health care navigation support if you've become disabled or are diagnosed with a critical illness. You'll receive guidance on care options, helpful resources and help with timely and fair resolution of issues.

What do I do first?

In the event of a life-threatening emergency, call local emergency authorities first for immediate assistance.

Then, contact Travel Assistance via phone:

U.S. and Canada: **800-243-6108** (toll-free)

Outside U.S.: **202-828-5885**

Or email: **assist@imglobal.com**

Ability Assist® and HealthChampion®

Call toll-free: **800-96-HELPS (800-964-3577)**

To register, visit:
www.guidanceresources.com

Use Company Code: **HLF902**

Use Company Name: **ABILI**

Select: "Ability Assist Program" to create your own confidential username and password.

Save contact info for future use.
Photograph with a mobile device.

Visit TheHartford.com/employeebenefits

The Hartford

[1] Bereavement Services, Funeral Planning Services and Will Prep Services are provided through The Hartford by Empathy. Empathy is not affiliated with The Hartford and is not a provider of insurance services. The Hartford is not responsible and assumes no liability for the goods and services described in this material and reserves the right to discontinue any of these services at any time. Services may vary and may not be available in all states. Visit www.TheHartford.com/employee-benefits/beyond-insurance for more information.

[2] Services are offered through vendors which are not affiliated with The Hartford and these services are not insurance. The Hartford is not responsible and assumes no liability for the goods and services described in this material and reserves the right to discontinue any of these services at any time. Services may vary and may not be available in all states.[2a] Visit www.TheHartford.com/employee-benefits/beyond-insurance for more information.

[2a] Value Added Services are not available for Disability Products in Washington.

[3] Identity Theft Support Services are not available in NY and WA.

[4] HealthChampion® specialists are available during business hours only. Inquiries outside this time frame can request a callback the next day or schedule an appointment.

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How to file a claim for benefits

Group Policy Name:

Pafford Emergency Medical Services, Inc.

Group Policy Number:

753891

Accident Insurance*
Critical Illness Insurance*
Hospital Confinement Indemnity Insurance*
Wellness Benefit**

**The Wellness Benefit is an annual benefit included as part of your insurance coverage.

Contact your employer if you are unsure of which coverage(s) you may be enrolled in. See the certificate of coverage and any applicable riders for a complete list of covered conditions, along with complete provisions, exclusions and limitations.

Easily submit your claims online

Step 1: Visit https://presents.voya.com/EBRC/paffordems and click on *Start A Claim*

Step 2: Complete the questionnaire

This generates a custom claim form package for you.
If you are enrolled in and filing a claim under any of the Supplemental Health coverages* on the left, your claims experience can be completed online. Follow the prompts on the Claims Center to file your claim.

Wellness Benefit claims can also be filed by submitting your claim at the end of the questionnaire.

Step 3: Download your claim form package, if applicable

Step 4: Complete the form package and gather supporting documents, if applicable

Step 5: Submit your claim

Using your preferred submission method, submit your completed and signed forms, as well as any supporting documents.

Return to **voya.com/claims** and click on Step 2, “Submit Your Forms” to upload your documents securely.

To mail or fax your submission, see the top of your custom claims form package.

Step 6: Monitor your claim’s status

You can monitor your claim’s status any time by entering the claim number on the Online Claims Center at **voya.com/claims**. If your claim is approved, your benefit will be paid within 10 business days of the approval.

For a complete description of your available benefits, conditions on benefit determination, exclusions and limitations, see your certificate(s) of insurance and any riders.

For Supplemental Health coverages* claims, call 1-877-236-7564.

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Wellness Benefit

What is the Wellness Benefit?

The Wellness Benefit is included with your Supplemental Health Insurance coverage. It provides an annual benefit payment after you complete a covered health screening test, even if you didn't have out-of-pocket costs for the health screening test.

How can the Wellness Benefit help?

Receiving regular health screenings is felt to help with detecting serious illnesses early and exercising preventative care. The Wellness Benefit encourages you to get regular health screenings by providing a benefit payment for health screenings, which can be used to help pay for the cost of the test or however you like.

Who qualifies for the Wellness Benefit?

By completing a health screening test, you, your spouse, and/or your children may be eligible if enrolled in Supplemental Health Insurance coverages. Below are some examples of covered health screening tests.

- Routine exams (Physicals – Adult, dental, eye)
- Mammography
- Colonoscopy
- Well child/preventative exams ages 1 – 18
- Biometric screenings
- Electrocardiogram (EKG)
- Blood testing (ex. Triglyceride, HDL, LDL, fasting glucose, HbA1c)
- Pap smear or thin prep pap test
- Serum cholesterol test for HDL & LDL levels
- Immunizations
- Cancer screenings (ex. CA 15-3, CA 125, CEA, PSA)
- Chest x-ray
- Mental health assessments
- Bone density screening
- Breast ultrasound, sonogram, MRI
- Tests for sexually transmitted infections (STIs)
- Covid test

How much is the Wellness Benefit?

Your employer's policies specify the benefit amount payable for each person who completes a covered health screening test for the listed Supplemental Health coverages below. Please note, you may only receive one benefit payment annually per coverage, even if multiple health screening tests are completed. If you have multiple Supplemental Health coverages, the same health screening test can be used to qualify for benefit payments under all applicable coverages.

Accident Insurance	Hospital Confinement Indemnity Insurance	Critical Illness
For yourself & for your covered spouse: $75	For yourself & for your covered spouse: $75	For yourself & for your covered spouse: $75
For each covered child*: $75	For each covered child*: $75	For each covered child*: $75

* Maximum amount for all children may apply

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

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Getting your Wellness Benefit is easy

You can access the Wellness Benefit automatically included in your Supplemental Health coverages by following the short steps below.

Step 1: Complete a health screening test

You, your covered spouse and/or your covered children complete a health screening test.

Step 2: Start your claim

Visit the your Employee Benefits Resource Center (EBRC) at https://presents.voya.com/EBRC/paffordems. You can also scan the QR code to file your claim. You'll want to have the following details ready to submit your claim:

Group Name: Pafford Emergency Medical Services, Inc.
Group Policy Number: 753891

Scan to file a claim

Step 3: Submit your claim

Complete the questions regarding the health screening test, electronically sign and submit your claim. You will immediately receive a **confirmation number** letting you know the claim submission was successful. Once the claim is set up, you will receive an email with a **claim number**.

Step 4: Check status

To check your claim's status in real-time, visit voya.com/claims and enter your **claim number**. When your claim is approved, you will receive a benefit payment for each covered individual for whom an eligible claim was filed.

If you have any questions about the claim process, call **1-877-236-7564**.

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Security when you travel

Voya Travel Assistance

Group Name: Pafford Emergency Medical Services, Inc.
Group Number: 753891

We live in a highly connected world where frequent domestic and international travel is the norm

Voya Travel Assistance offers you enhanced security for your leisure and business trips when traveling 100 miles or more from your primary residency or in another country, for trips 180 days or less. You and your dependents will have access to the Voya Travel Assistance customer service center or access to the services provided on the website 24 hours a day, 365 days a year – from anywhere in the world. Voya Travel Assistance services are provided by International Medical Group, Inc. (IMG), Indianapolis, IN.

Emergency Medical Transport Services

- Dispatch of a Physician
- Emergency Medical Evacuation
- Medical Repatriation
- Return of Dependent Children
- Return of Travel Companion
- Vehicle Return Services
- Visit of a Family Member or Friend
- Repatriation of Remains

Medical Assistance Services

- Convalescence Arrangements
- Outpatient & Inpatient Care
- Interpretation Services
- Medical Monitoring
- Medical & Dental Referrals
- Prescription Transfer & Shipping
- Replacement of Medical Devices

Travel Assistance Services

- Emergency Cash Transfer
- Consulate and Embassy Location
- ID Theft Assistance
- Legal Referrals
- Lost Luggage and/or Document Assistance
- Pet Housing and Return
- Pre-Trip Informational Services
- Urgent Message Relay

Security Assistance Services

- Emergency Political Evacuation/Repatriation
- Location Intelligence App
- Natural Disaster Evacuation

Voya Travel Assistance services are provided by International Medical Group, Inc. (IMG), Indianapolis, IN. All services are governed by the terms and conditions outlined in the contract between IMG and ReliaStar Life Insurance Company, a subsidiary of Voya Financial, Inc. Provisions and availability may vary by state.

ReliaStar Life Insurance Company (Minneapolis, MN),
a member of the Voya® family of companies

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If you need emergency or pre-trip services…

…use the contact information on the reverse and identify yourself as an eligible participant in the Voya Travel Assistance program.

You will be asked to provide some additional information in order to confirm your eligibility under this program. Once your eligibility has been verified, Voya Travel Assistance will arrange and provide the emergency transportation services previously described.

Please note: Services are only eligible for payment through Voya Travel Assistance if Voya Travel Assistance was contacted at the time of service and arranged for the service. If costs are incurred for other services, you are responsible for those costs or reimbursement of those costs if initially paid by Voya Travel Assistance; Voya Travel Assistance will ask for your credit card and debit your account for the required amount.

Voya Travel Assistance

Contact Voya Travel Assistance 24 hours a day, 365 days a year for: Emergency Medical Transport, Medical Assistance, Travel Assistance, and Security Assistance Services.

From anywhere in the world: +1 (317) 659-5841
Email: assist@imglobal.com

Visit Online and Register: imglobal.com/member

- ☑ Select "Create an account"
- ☑ Enter referral code: VOYATRAVEL
- ☑ Click "continue" to enter your personal information, email address, and create your password.

Access Voya Travel Assistance on the go

Be supported on the go with Voya Travel Assistance by downloading the IMG mobile app from the Apple App Store and Android Google Play Store.

How it works

At any time before or during a trip, you may contact Voya Travel Assistance for assistance services. It is recommended that you keep a copy of this summary with your travel documents. Use the wallet card to have convenient access to the numbers that you need.

App Store® is a trademark of Apple Inc. Android is a trademark of Google LLC.

Exclusions and limitations

Travelers are eligible when traveling 100 miles or more from their primary residence or in another country, for trips 180 days or less.

Voya Travel Assistance shall not be responsible for any claim, damage, loss, costs, liability, or expense which arises as a result of Voya Travel Assistance's inability to contact the Group Policyholder's authorized Contact for any reason beyond Voya Travel Assistance's control or as a result of the failure and/or refusal of the Group Policyholder to authorize services proposed by Voya Travel Assistance.

Medical Transport Service

All transportations must be coordinated by Voya Travel Assistance in order to be eligible. IMG will not be responsible for medical transportations that are not coordinated by Voya Travel Assistance Services are not available to the traveler for sickness, injuries, or losses resulting from:

- Normal childbirth, normal pregnancy (except complications of pregnancy), or voluntary induced abortion
- Traveling for the purposes of securing medical treatment
- A member's mental or nervous condition, unless hospitalized
- Active participation in war and/or terrorism
- Traveling against the advice of a physician

Security Assistance Services

All emergency medical transport, political, natural disaster, or security evacuation services will be coordinated by IMG. Services listed in this brochure are only valid if IMG remains a client of ReliaStar Life Insurance Company, a subsidiary of Voya Financial, Inc.

Evacuation services are provided to the nearest safe location and then to covered member's resident country, if needed.

Level 4 Restriction: Services will be denied if the Member's destination country is at a Level 4 Travel Advisory (other than for COVID) on the US State Department website at the time of your Scheduled Departure Date to travel there.

Voya Travel Assistance will not be responsible for political or natural disaster evacuations that are not coordinated and provided by Voya Travel Assistance or its security partner.

Voya Travel Assistance is not responsible for any medical expenses incurred by travelers under this quote.

Services are not available to the extent they would expose Voya Travel Assistance or any of its insurers to any sanction, prohibition or restriction under U.N. resolutions or the trade or economic sanctions, laws, or regulations of the E.U., U.K., or U.S.A. All services are governed by the terms and conditions outlined in the contract between IMG and ReliaStar Life Insurance Company, a subsidiary of Voya Financial, Inc.

Voya Travel Assistance services are provided by International Medical Group, Inc. (IMG), Indianapolis, IN. All services are governed by the terms and conditions outlined in the contract between IMG and ReliaStar Life Insurance Company, a subsidiary of Voya Financial, Inc. Provisions and availability may vary by state.

ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies.

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Notice of Privacy Practices

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

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

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

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

a. Your past, present, or future physical or mental health or condition;

b. The provision of health care to you; or

c. The past, present, or future payment for the provision of health care to you.

I. Contact Information

If you have any questions about this Notice or about our privacy practices, and for any correspondence or requests related to the contents of this Notice, please contact *Pafford Benefits Department at penny@paffordems.com*

II. Effective Date

This Notice is effective *February 1, 2026.*

III. Our Responsibilities

We are required by law to:

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

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

IV. How We May Use and Disclose Your PHI

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

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

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

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

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

If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a “Part 2 Program”) through a general consent you provide to the Part 2 Program to use and disclose the SUD patient record for purposes of treatment, payment or health care operations, we may use and disclose your SUD patient record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your SUD patient record through specific consent you provide to us or another third party, we will use and disclose your SUD patient record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your SUD patient record, or testimony that describes the information contained in your SUD patient record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, transmit, use, and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a Business

Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

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

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

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

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

V. Special Situations

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

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

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

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

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

a. to prevent or control disease, injury, or disability;

b. to report births and deaths;

c. to report child abuse or neglect;

d. to report reactions to medications or problems with products;

e. to notify people of recalls of products they may be using;

f. to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

g. to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

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

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

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

a. in response to a court order, subpoena, warrant, summons, or similar process;

b. to identify or locate a suspect, fugitive, material witness, or missing person;

c. about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;

d. about a death that we believe may be the result of criminal conduct; and

e. about criminal conduct.

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

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

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

Research. We may disclose your PHI to researchers when:

a. The individual identifiers have been removed; or

b. When an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information and approves the research.

VI. Required Disclosures

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

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

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

VII. Other Disclosures

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

a. You have been, or may be, subject to domestic violence, abuse, or neglect by such person; or

b. Treating such person as your personal representative could endanger you; and

c. In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

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

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

VIII. Your Rights

You have the following rights with respect to your PHI:

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

To inspect and copy your PHI, you must submit your request in writing. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.
We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request.
Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.
To request an amendment, your request must be made in writing. In addition, you must provide a reason that supports your request.
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a. is not part of the medical information kept by or for the Plan;

b. was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

c. is not part of the information that you would be permitted to inspect and copy; or

d. is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.
Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your PHI. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.
To request this list or accounting of disclosures, you must submit your request in writing. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
Right to Request Restrictions. You have the right to request a restriction or limitation on your PHI that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your PHI that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.
Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.
We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

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

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

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

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

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

IX. Complaints

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

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

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

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

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

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

Pafford Emergency Medical Services Health Plan Notices

2026 Plan Year

Included in This Packet:

- Medicare Notice of Creditable Coverage
- Patient Protection Notice
- Notice of Special Enrollment Rights
- Newborns' and Mothers' Health Protection Act Notice
- Women's Health and Cancer Rights Act Notice
- Notice of HIPAA Privacy Practices

PAFFORD
EMERGENCY MEDICAL SERVICES

Health Plan Notices

Important Notice About
Your Prescription Drug Coverage and Medicare

Notice of Creditable Coverage

This Notice applies only if you and/or your dependent(s) are enrolled in a Pafford Emergency Medical Services medical plan and you are eligible for Medicare. If this does not apply to you, you may ignore this notice.

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

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

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

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

When Can You Join A Medicare Drug Plan?

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

Health Plan Notices

What Happens To Your Employer Coverage If You Decide to Join A Medicare Drug Plan?

Your health plan coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will be eligible to receive all of your current health and prescription drug benefits. If you do decide to join a Medicare drug plan and drop your employer coverage, be aware that you and your dependents will be eligible to receive health and prescription drug benefits in the future.

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

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

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

Health Plan Notices

For More Information About This Notice Or Your Employer Prescription Drug Coverage…

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

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For More Information about Medicare prescription drug coverage:

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

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

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

Penny Dunn
Benefits Coordinator
Pafford EMS, Inc
PO Box 1981
Ruston, LA 71273

318-497-6007

Health Plan Notices

Patient Protection Notice

Your health plan may require or allow for the designation of a primary care provider. If so, 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, including a pediatrician, as the primary care provider. Until you make this designation, the health plan may designate one for you.

You do not need prior authorization from the health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.

For information on how to select a primary care provider, a list of participating primary care providers, or a list of health care professionals who specialize in obstetrics or gynecology, contact your health plan.

Notice of HIPAA Special Enrollment Rights

If an eligible employee declines enrollment in a group health plan for the employee or the employee's spouse or dependents because of other health insurance or group health plan coverage, the eligible employee may be able to enroll him/herself and eligible dependents in this plan if eligibility is lost for the other coverage (or because the employer stops contributing toward this other coverage). However, the eligible employee must request enrollment within 30 days after the other coverage ends (or after the employer ceases contributions for the coverage).

In addition, if an eligible employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents, provided that the eligible employee requests enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Furthermore, eligible employees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after becoming ineligible for coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan or being determined to be eligible for financial assistance under a Medicaid, CHIP, or state plan with respect to coverage under the plan.

To request special enrollment or obtain more information, contact your health plan.

Health Plan Notices

Newborns' and Mothers' Health Protection Act Notice

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

Women's Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact your health plan.

Notice of HIPAA Privacy Practices

Health Plan Notices

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

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Pafford Emergency Medical Services Health Plan (the "Plan") sponsored Pafford Emergency Medical Services (“Plan Sponsor”) and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and subsequent amending regulations (“HIPAA Privacy Rule”). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. We are required to provide this HIPAA Privacy Notice to you pursuant to HIPAA.

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

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

If you have any questions about this Notice or about our privacy practices, please contact the individual listed at the end of this notice.

Our Responsibilities

Pafford Emergency Medical Services is required by law to:

- Maintain the privacy of your protected health information;
- Provide you with certain rights with respect to your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your Protected health information; and
- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised HIPAA Privacy Notice electronically or by first class mail to the last known address on file.

How We May Use and Disclose Your Protected Health Information

Health Plan Notices

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

For Payment. We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. We may share or discuss your PHI with your family members or others involved in your care or payment for your care, unless you object in writing and provide the objection to the Plan's HIPAA contact listed at the end of this Notice. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments. In any of these cases, we will disclose only the information necessary to resolve the issue at hand.

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

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

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services,

Health Plan Notices

Business Associates will receive, create, maintain, transmit, use, and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, pharmacy benefit management, or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

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

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

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

Special Situations

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

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

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

Health Plan Notices

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

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

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

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

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

Law Enforcement. We may disclose your protected health information if asked to do so by a law-enforcement official:

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

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

Health Plan Notices

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

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

Research. We may disclose your protected health information to researchers when:

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

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

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

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

Other Disclosures

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

- you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
- treating such person as your personal representative could endanger you; and
- in the exercise of professional judgment, it is not in your best interest to treat the

person as your personal representative.

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

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

Your Rights

You have the following rights with respect to your protected health information:

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

To inspect and copy your protected health information, you must submit your request in writing to the individual listed at the end of this Notice. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the individual listed at the end of this Notice.

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

request an amendment, your request must be made in writing and submitted to the individual listed at the end of this Notice. You must provide a reason that supports your request.

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

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

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

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

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

***Right to Request Restrictions*.** You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health

care provider involved has been paid in full by you or another person. To request restrictions, you must send your request in writing the individual listed at the end of this notice.
In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing the individual listed at the end of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

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

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

To obtain a paper copy of this notice, contact the individual listed at the end of this notice.

Complaints

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

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

HIPAA Contact

Penny Dunn
Benefits Coordinator
Pafford EMS, Inc
PO Box 1981
Ruston, LA 71273
318-497-6007

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%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

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.

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

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

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 Penny Dunn Penny@paffordems.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Pafford Emergency Medical Services, Inc.		4. Employer Identification Number (EIN) 72-1451789
5. Employer address 2100 Floyd Park Drive, Suite 1		6. Employer phone number 318-497-6007
7. City Ruston	8. State LA	9. ZIP code 71270
10. Who can we contact about employee health coverage at this job? Penny Dunn		
11. Phone number (if different from above)	12. Email address penny@paffordems.com	

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

- As your employer, we offer a health plan to:

  All employees. Eligible employees are:

  [x] All full-time equivalent employees working an average of 30 hours or more per week or an average of 130 hours in a month.

  [ ] Some employees. Eligible employees are:

- With respect to dependents:

  [x] We do offer coverage. Eligible dependents are:

  Spouses and eligible dependent children

  [ ] We do not offer coverage.

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

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)