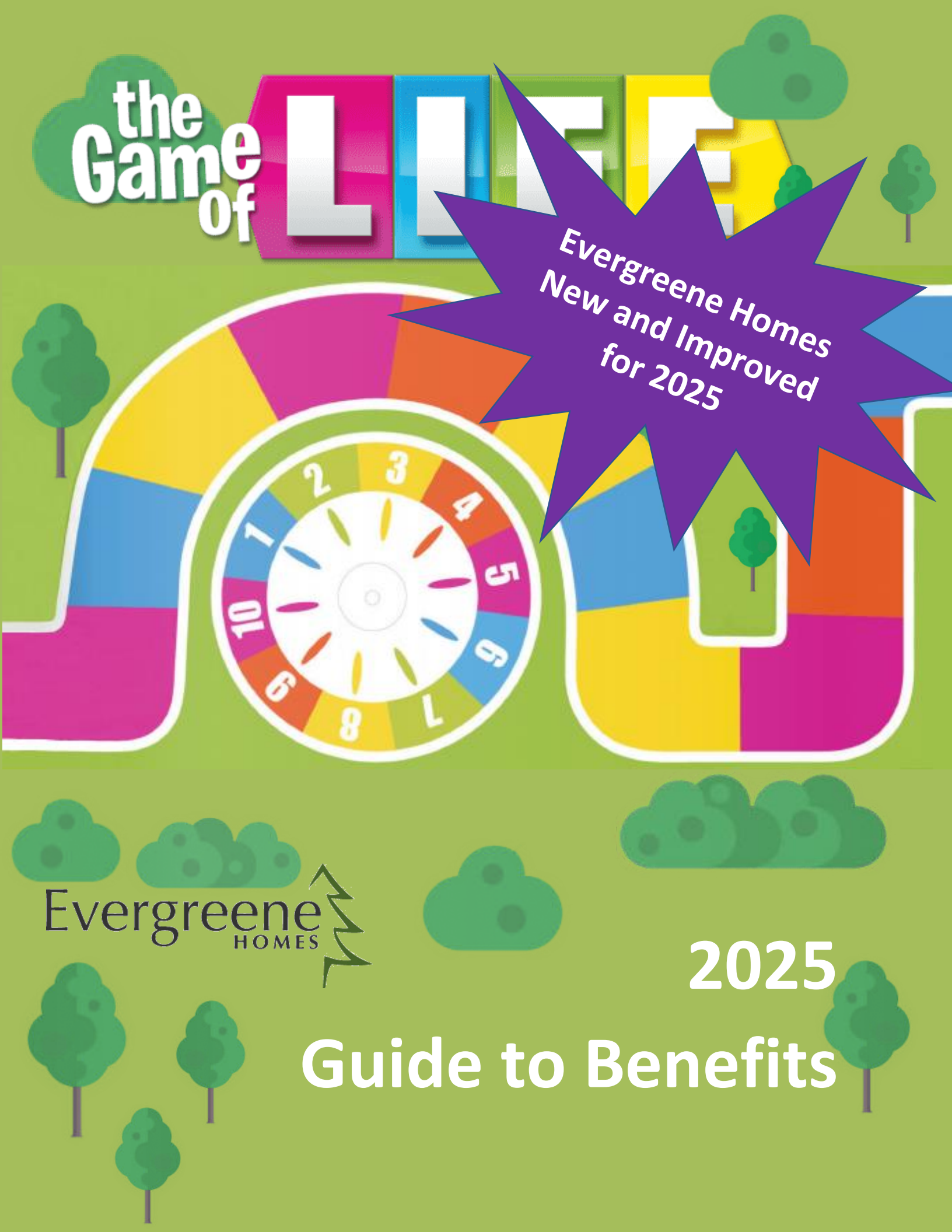
the Game of LIFE
Evergreene Homes
New and Improved
for 2025
Evergreene
HOMES
2025
Guide to Benefits

Game Rules

Carefully review your healthcare enrollment options.

Choose the plan and benefit options that best suits you and your family.

Log into Employee Navigator for Online Enrollment.

Complete your enrollment before the deadline.

Make good health care choices all year long.

Take advantage of your $0 Copay preventative healthcare visits.

Manage your healthcare dollars responsibly and improve your quality of life.

Create and manage Benefits via your Online ID.

Employee Navigator is available 24 / 7 for benefit review.

Immediately Notify Human Resources of any Qualifying Event.

Spin the Wheel!

At Evergreene Homes, we value each one of our employees.

We are excited to share these benefits with you and your family and are honored to play a role in your family's health and well-being.

Evergreene Homes offers benefit options for the well-being of our employees and their families. Recognizing that the benefits package comprises not only a major part of your total compensation, but also an important personal benefit. It is the goal of Evergreene Homes to provide a comprehensive yet cost effective benefits package.

This document is designed to help you better understand the benefits provided by Evergreene Homes and to help you evaluate which options are best for you and your family. If you have questions about any of the benefits mentioned in this guide, please don't hesitate to reach out to Keith Jones.

Thank you for all that you do to change the game!

Table of Contents

Contact Information:

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Keith Jones
703.667.7869
KJones@EvergreeneHomes.Com

Medical
United HealthCare AllSavers
1.800.291.2634

Telehealth / Healthiest You
1.866.703.1250
https://Member.HealthiestYou.Com/Login

Life
Principal
800.245.152

Dental
Principal
800.247.4695

Vision
Principal / VSP Vision
800.877.7195

Disability
Principal
800.245.152

Accident & Critical Illness
Principal

Travel Assistance
888.647.2611
Principal.Com/Travel Assistance

Will Preparation
AragWill.Com/Principal
800.546.3718

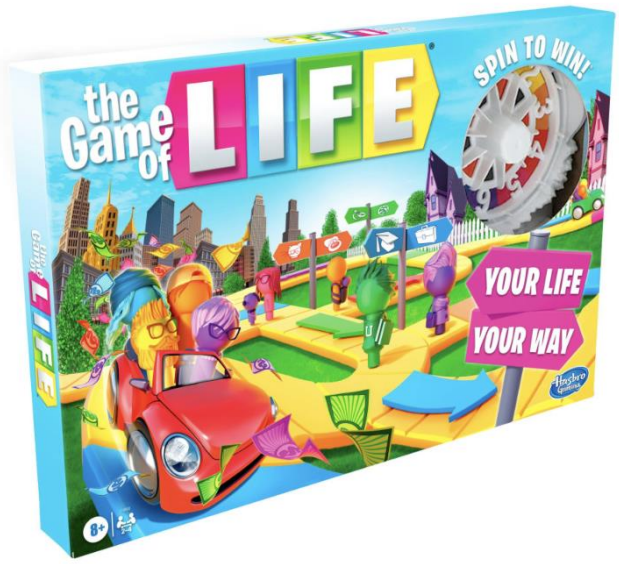
EAP / Employee Assistance Program
Member.MagellanHealthcare.Com
800.450.1327

Pet Insurance
ASPCA Pet Health Insurance
www.ASPCAPetInsurance.Com/Evergreene
Priority Code: EB22Evergreene

Broker – **Summit Insurance Services**
Tracy Teague – Account Manager:
Email:
TTeague@HilbGroup.com
Phone (571) 918-1087

401k
Lincoln Financial
www.LincolnFinancial.Com
Advisor: Michael Schimmel
1.571.205.1515 or
Michael@FellowsFG.Com

Game Rules / Enrollment



Who is Eligible to Play the Game?

If you're a full-time employee at Evergreene Homes, you're eligible to enroll in the benefits outlined in this guide. Full-time employees are those who work 30 or more hours per week. In addition, your spouse and dependent children up to the age of 26 are eligible for medical, dental and vision coverage.

Important Note

YOU MUST REQUEST CHANGE IN COVERAGE WITHIN 30 DAYS OF YOUR QUALIFYING EVENT.

ANY CHANGE REQUESTED AFTER 30 DAYS MUST WAIT UNTIL OPEN ENROLLMENT.

How to Begin Play

The first step is to review benefits, make your benefit elections and complete the enrollment online. Once you have made your elections, you will not be able to change them until next year's open enrollment period unless you have a Qualifying Event. If you do not enroll now, you may not be able to make changes until open enrollment December 2025.

How to Make Changes Mid Gameplay

Unless you experience a life-changing qualifying event, you cannot make changes to your Health, Dental and Vision benefits until the next open enrollment period. Qualifying events include events such as:

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

Ineligible Players

- Divorced or legally Separated Spouse.
- Foster Children, Siblings, Parents or In-Laws, Grandchildren, Etc.

United HealthCare AllSavers

Evergreene Homes offers our employees with three options for health care for the 2024 plan year. The following page details additional information regarding the difference between the three plans. Please review carefully and ask questions to make sure that you are selecting the best plan for you and your family.

AllSavers Traditional EPO

The AllSavers Traditional EPO is the most common plan with our employees and includes a network of physicians covering Virginia, Delaware and Maryland. All healthcare services must be provided by a United Healthcare AllSavers network of providers.

AllSavers Traditional PPO

The AllSavers Traditional PPO offers all of the conveniences of the EPO plan, but also adds the option for employees and their dependents to seek Out of Network benefits from providers who may not participate in the AllSavers network of providers.

HSA AllSavers High Deductible Plan

HSA's were created to help people combat the rising costs of healthcare by being able to leverage Pre-Tax funds to pay for health costs. That is a significant advantage but very few people take advantage of this, mostly because of the larger deductibles and the fact that it is a little confusing at first.

It is important for you to take a few minutes to understand our options that we have put together in response to rising healthcare costs. The HSA (Health Savings Account) AllSavers plan was first offered in 2022 and will continue for 2025. This High Deductible Plan is an economical plan that has been designed for employees who do not expect to have major medical expenses, but still have the protection of medical insurance. Preventative and Virtual Visits have a zero-dollar copay so you will have healthcare options with expenses being paid from pre-tax dollars.

The funds contributed to your HSA will be applied to a debit card in an interest-bearing investment fund acting as your personal healthcare account to be used for medical services. The money you allocate to your HSA account must be used for medical services and is yours to keep. Funds will carry over into the new plan year and the plan even has a portability option if you should ever leave the company. Funds can even be treated similar to a 401k saving plan and withdrawn after age 65.

You are also welcome to increase your HSA contributions which will allow you to contribute additional money for medical expenses on a pre-tax basis. Total contributions can accumulate to a maximum of $4,300 for individual coverage or $8,550 for family coverage during the plan year.

Once that money is in your account it is yours to spend tax free on any qualified medical expenses. If you don't spend it all then this money basically behaves like a 401k. Once you reach age 65 you can pull it out (you do have to pay taxes at that point if for non-medical uses) because it is still your money!

Due to their tax-favored status, HSAs have strict rules regarding eligibility and contributions. In order to make or receive HSA contributions, employees must meet the following qualifications:

- Be covered by a high deductible health plan (HDHP) which is Evergreene's HSA plan.
- Not have any other health coverage (with some exceptions).
- Not be claimed as a dependent on another person's tax return.
- Not be covered by Medicare.

We believe that the higher deductibles are a risk worth taking but we also understand that in today's world where everything is tight that risk may be a bridge too far. With that in mind, we have been looking for ways to help. The plan costs for the HSA Plan are less expensive than the traditional health plans. If you have made it this far and we hope that you have, here is another way that Evergreene is prepared to help those that are interested to make this transition. For those that participate in this plan, **Evergreene will make the following contributions to your HSA account**:

HSA Health Insurance Plan Level	Evergreene HSA Monthly Contribution	Evergreene HSA Annual Contribution	Employee HSA Contribution
Employee Only	$100.00	$1,000.00	Optional
Employee Plus Spouse	$150.00	$1,800.00	Optional
Employee Plus Child(ren)	$150.00	$1,800.00	Optional
Employee Plus Family	$175.00	$2,100.00	Optional

Additionally, and on a case by case basis, Evergreene will work to help any employee that in Year 1 incurs higher deductible costs than they would have if they had stayed with the traditional coverage. In Year 2, we will re-evaluate this backstop as we learn more about the HSA exposure. See next page for additional information.

The following bullet points help explain some of the advantages of this plan option.

- Stay in your current plan and pay the cost increases. This option is difficult to swallow because, for example, on a family plan it would require nearly $3,000 in pretax dollars just to pay for this increase.
- The question that is likely on your mind at this point is, what's the catch? Basically, the plan would pretty closely mimic the EPO/PPO plans with the "catch" being that you would have higher deductibles. Instead of $2,000/4,000, your deductible would be $5,000/$10,000.
- Before going any farther here are a two video links that are very much worth watching. One is more of a commercial for HSA's and the second talks more about limitations or things to watch for:
  https://www.youtube.com/watch?v=uQhDgDuewKc
  https://www.youtube.com/watch?v=j-Ks0p95oVY&t=9s

In summary, HSA's make a lot of sense and medical expenses are not getting any easier to contend with. We want to help by encouraging everyone to learn more about what is out there to help us in this fight. You are welcome to contact Keith Jones or Joe Ricketts for additional information regarding this opportunity.

The following table provides an excellent outline of costs associated with premium expenses and potential gaines. Please pay special attention to the section in gray regarding proposed Company contribution for any unforseen medical expense.

SUMMARY ANALYSIS OF INSURANCE PROGRAMS

EPO

Description	Employee	Employee & Spouse	Emp & Child(ren)	Family
Total Premium: UHC Choice EPO (2025)	633.27	1,342.00	1,097.17	1,934.77
EVG Company Contribution %	75.0%	45.0%	60.0%	45.0%
2025 EVG Company Contribution (Monthly)	474.95	603.90	658.30	870.65
Employee Contribution %	25.0%	55.0%	40.0%	55.0%
2025 Employee Payroll Deduction (Monthly)	158.32	738.10	438.87	1,064.12
2025 Employee Payroll Deduction (Annual)	1,899.81	8,857.20	5,266.42	12,769.48

PPO

Description	Employee	Employee & Spouse	Emp & Child(ren)	Family
Total Premium: Choice Plus PPO (2025)	657.56	1,394.83	1,140.13	2,011.46
EVG Company Contribution %	75.0%	45.0%	60.0%	45.0%
2025 EVG Company Contribution (Monthly)	493.17	627.67	684.08	905.16
Employee Contribution %	25.0%	55.0%	40.0%	55.0%
2025 Employee Payroll Deduction (Monthly)	164.39	767.16	456.05	1,106.30
2025 Employee Payroll Deduction (Annual)	1,972.68	9,205.88	5,472.62	13,275.64

HSA

Description	Employee	Employee & Spouse	Emp & Child(ren)	Family
Total Premium: Choice Plus HSA POS 2025	519.48	1,094.53	895.88	1,575.49
EVG Company Contribution %	75.0%	45.0%	60.0%	45.0%
2025 EVG Company Contribution (Monthly)	389.61	492.54	537.53	708.97
Employee Contribution %	25.0%	55.0%	40.0%	55.0%
2025 Employee Payroll Deduction (Monthly)	129.87	601.99	358.35	866.52
2025 Employee Payroll Deduction (Annual)	1,558.44	7,223.90	4,300.22	10,398.23

HSA vs EPO Plan Analysis

Step 1: Analysis of Est. HSA Savings Created

Description	Employee	Employee & Spouse	Emp & Child(ren)	Family
Employee Annual Premium Savings	341.37	1,633.30	966.19	2,371.25
Annual EVG Company Contribution to HSA Acct	1,200.00	1,800.00	1,800.00	2,100.00
Annual Tax Benefit of EVG Contribution (at 20% rate)	300.00	450.00	450.00	525.00
Annual INITIAL HSA SAVINGS Amount	1,841.37	3,883.30	3,216.19	4,996.25

Step 2: Analysis of HSA Deductible Exposure

Description	Employee	Employee & Spouse	Emp & Child(ren)	Family
HSA Deductible	5,000.00	10,000.00	10,000.00	10,000.00
Traditional Plan Deductible	2,000.00	4,000.00	4,000.00	4,000.00
Difference in Deductibles: HSA vs Traditional Plan	3,000.00	6,000.00	6,000.00	6,000.00

Step 3: Compare Est Savings to Deductible Exposure

Description	Employee	Employee & Spouse	Emp & Child(ren)	Family
Year 1 Employee Estimated Exposure	(1,158.63)	(2,116.70)	(2,783.81)	(1,003.75)

Step 4: Calculate EVG "Backstop Contribution"

Description	Employee	Employee & Spouse	Emp & Child(ren)	Family
* Maximum Total EVG "Backstop Contribution"	579.32	1,058.35	1,391.90	501.88

** Notes Concerning the EVG "Backstop Contribution" . On a case by case basis, Evergreene will work to help any employee that, in YEAR 1, incurs higher deductible costs than they would have if they had stayed with the traditional coverages. In YEAR 2 we will re-evaluate this backstop as we learn more about the HSA experience. Please note the following additional conditions for this plan:*

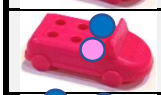
** IN YEAR 1: Evergreene will pay 50% of the overages incurred up to estimated exposure maximum as calculated above*

** The "Backstop Contribution" does not apply to Elective Medical Treatments. Elective treatment expenses would be deducted from any calculation*

** The "Backstop Contribution" does not apply to Out of Network costs incurred. Out of Network expenses would be deducted from any calculation*

** To be eligible, accurate records and receipts must be maintained.*

Medical Plan Comparison

Benefit Description		All Savers Traditional EPO	All Savers Traditional PPO	All Savers HSA High Deductible
		E2000i100LX21B	P2000i100LX21	HP5000257521
Office Visit				
	Preventative Services	No Charge	$0	No Charge
	Primary Office Visit	$25	$25	$25 After Deductible
	Telehealth / Healthiest You	No Charge	$0	No Charge
	Specialist Office Visit	$75	$75	$75 After Deductible
	Urgent Care	$50	$50	$50 After Deductible
	Emergency Room	$300 After Deductible	$300 After Deductible	$300 After Deductible
Surgery / Hospitalization				
	Out-Patient Surgery	$0 After Deductible	$0 After Deductible	$0 After Deductible
	In-Patient Hospitalization	$0 After Deductible	$0 After Deductible	$0 After Deductible
Deductibles / Coinsurance				
	Deductible	$2,000 / $4,000	$2,000 / $4,000	$5,000 / $10,000
	Coinsurance	$0 After Deductible	$0 After Deductible	$0 After Deductible
	Annual Out-of-Pocket Maximum	$4,000 / $8,000	$4,000 / $8,000	$6,900 / $13,800
	Plan Year or Calendar Year Deductible	Plan Year (January thru December)	Plan Year (January thru December)	Plan Year (January thru December)
Prescription				
	RX Deductible	None	None	Combined with Medical
	Pharmacy Copays (30-day supply)	$10 / $35 / $75	$10 / $35 / $75	$10 / $35 / $70
	Mail Order Drug Copays (90-day supply)	$25 / $87.50 / 187.50	$25 / $87.50 / 187.50	$25 / $87.50 / 175.00
Out-of-Network				
	Deductible	Not Covered	$4,000 / $8,000	$10,000 / $20,000
	Coinsurance	Not Covered	50% after Deductible	50% after Deductible
	Annual Out-of-Pocket Maximum	Not Covered	$8,000 / $16,000	$20,000 / $40,000
Lifetime Maximum		Unlimited	Unlimited	Unlimited
		Cost Per Monthly Pay Period		
	Employee Only	$158.32	$164.39	$129.87
	Employee Plus Spouse	$738.10	$767.16	$601.99
	Employee Plus Child(ren)	$438.87	$456.05	$358.35
	Employee & Family	$1,064.12	$1,106.30	$866.52

Telehealth / Live Health Online

Virtual Visit to Care Anytime with Zero Dollar Copay

See a Doctor 24 Hours a day / 7 Days a Week

You will want to consider this alternative healthcare option when scheduling non-emergency services. Note that this service has a ZERO DOLLAR COPAY for all three plans including the HS A plan.

hy healthiestyou™

What is HealthiestYou™:

- Allows you to talk to a doctor from anywhere, anytime without leaving home
- 24/7 virtual visits at no copay or cost to you
- Offers a price-comparison tool that may save you up to 85 percent on prescriptions, often beating your copay
- Allows you to compare prices for procedures and research doctors
- One-stop shop to view your medical plan deductibles in real time

How to sign up for HealthiestYou:

- Go to
- Register for your HealthiestYou account and download the app

Also included is Best Doctors®:

- Provides you and your eligible dependents the guidance and reassurance needed when facing any medical situation
- If you have received a serious diagnosis, are considering multiple treatment options, need help deciding if surgery is right for you or have medical questions, Best Doctors can have a carefully selected expert physician conduct an in-depth review of your medical case and/or questions and provide a personalized response and recommendation

How to sign up for Best Doctors:

- Access Best Doctors through your HealthiestYou app at the click of a button

Understanding Healthcare Options

First and foremost, if there is a **life-threatening situation**, you should **go immediately to the nearest Emergency Room for treatment** and then **report back to your Primary Care Physician**. This will help ensure that your treatment is processed as an in-network benefit.

Below is a list of treatment types and options that might be available to you. Please review this list now and know your options should the need arise for other types of healthcare services.

Copays	Virtual Visit	Urgent Care	Emergency Room
UHC EPO	$0 / Zero Dollar Copay	$50	$300 After $2,000 Deductible
UHC PPO	$0 / Zero Dollar Copay	$50	$300 After $2,000 Deductible
UHC H S A	$0 / Zero Dollar Copay	$50 After Deductible	$300 After $5,000 ($10,000 if Family) Deductible
	Live consultation 24/7 with a board-certified doctor.	**For help with serious illnesses and injuries.**	**For when you have life threatening event.**
	Treatment for: • Cold • Fever • Flu • Allergies • Congestion • Pink eye • Sinus pain • Sore throat • Headache • Vomiting • Bronchitis • Cold sores • Rashes (poison ivy, etc.) • Ear pain • COVID	Treatment for: • Sprains • Strains • Minor broken bones • Minor infections • Small cut that may need a few stitches • Minor burns • X-Rays • COVID	Treatment for: • Heavy bleeding and large open wounds • Sudden change in vision • Chest pain • Sudden weakness or trouble talking • Minor burns • Severe head or spinal injury • Difficulty breathing • Major broken bones • COVID

Urgent Care

EMERGENCY ROOM

Principal Plans

While change is often difficult, it is sometime necessary to continue offering the best benefit package for our employees. That is the reason why Evergreene has decided to form a new partnership with Principal for our **Dental**, **Vision**, **Basic Life**, **Voluntary Life**, **Short-Term Disability, Long-Term Disability** and our **EAP/Employee Assistance** Programs. We will also be introducing a new **Will & Legal Document Center** along with a new **Travel Assistance Program** for anyone who may be interested.

While we understand that some of you may not take advantage of these benefits, we know that it is important to continue exploring all options and not be afraid to make necessary changes as they are presented.

The change to Principal will increase our network providers for both Dental and Vision as well as a lower premium than the plan offered with our current provider.

This change will require additional paperwork / Navigator Online Portal for all employees, but we are confident that you will find this change beneficial to you and your family.

L I F E

Basic Life is Paid in Full by Evergreene Homes

Basic Life Insurance

Life insurance can help provide for your loved ones if something where to happen to you. Evergreene Homes provides full-time employees Life Insurance equal to $25,000 in Group Life and another $25,000 for Accidental Death and Dismemberment (AD&D) insurance.

Evergreene Homes pays for the full cost of this benefit—meaning you are not responsible for paying any monthly premiums.

Voluntary Life Insurance

While Evergreene Homes offers basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. **Voluntary Life is not part of Open Enrollment and your only time to enroll may be at the time you are hired.**

With voluntary life insurance, you are responsible for paying the full cost of coverage through monthly payroll deductions. You can purchase coverage for yourself in $10,000 increments to a guaranteed maximum of $150,000. Additional coverage up to $500,000 with the approval of an Evidence of Insurability.

If you purchase coverage for yourself, you can also purchase coverage for your:

- Spouse in $5,000 increments to a maximum of $50,000 (Coverage cannot exceed the voluntary life you have selected for yourself).
- Dependent Child(ren) up to $10,000 (Coverage cannot exceed the voluntary life you have selected for yourself).

The chart below outlines the monthly cost of purchasing additional coverage.

Monthly Cost for Every $1,000 of Employee and Spouse Life Insurance Coverage										
Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +
Life	$0.065	$0.105	$0.118	$0.132	$0.199	$0.306	$0.573	$0.881	$1.697	$2.754
AD&D	$0.042	$0.042	$0.042	$0.042	$0.42	$0.042	$0.042	$0.042	$0.042	$0.042
Dependent Children	*Benefit is $10,000 – not to exceed 100% of employee coverage* Cost is life $2.00 per month for $10,000 in coverage.									

The **guarantee issue** for **employees under age 70 is $150,000** and for **spouses under age 70 it is $30,000**. At open enrollment voluntary life members who are already enrolled can purchase up to an additional $10,000 with no EOI form as long as their benefit does not go over $150,000. **Employees who are not new hires and not already enrolled in Voluntary Life may be required to complete an Evidence of Insurability.**

Dental

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery. The following chart outlines the dental benefits we offer through Principal.

Principal Dental		
Type of service	**In Network**	**Out of Network**
Preventive Services Exams, Cleaning, X-Rays	100%	100%
Deductible Applies to Basic and Major Medical	$50	$100
Basic Services Filings & Simple Extractions	20% After Deductible	20% After Deductible
Major Services Oral Surgery, Root Canal, Crowns	50% After Deductible	50% After Deductible
Annual Maximum	$1,500	$1,500
Orthodontic Services	50% - Child & Adults (No Deductible)	50% - Child & Adults (No Deductible)
Orthodontic Lifetime Maximum	$2,000	$2,000
Plan Year	Calendar	Calendar
Rollover Benefits Available (Allows portion of unused dollars to roll into next year)	Yes	

Monthly Payroll Deduction	Employee Only	$16.22
	Employee and Spouse	$49.81
	Employee and Child(ren)	$66.69
	Employee and Family	$106.57

Vision

Driving to work, reading a news article, playing your favorite Game of Life and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Evergreene Homes' vision insurance entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

Principal Vision Network is facilitated through **VSP Choice Vision.**

If you seek the services of an in-network provider, your benefits include the following:

Principal VSP Choice Vision	In Network	Out of Network
Exam (Once a Year)	$10 Copay	Up to $45
Frames	Up to $130 plus 20% off Balance	Up to $70 Single
Lenses	$25 Copay	Up to $30 Single / $50 Bi / $65 Tri
Contact Lenses	Up to $130	Up to $105
Additional Savings	Savings on laser vision correction and additional prescription and non-prescription sunglasses.	None

Monthly Payroll Deduction	Employee Only	$3.28
	Employee and Spouse	$9.16
	Employee and Child(ren)	$11.31
	Employee and Family	$17.23

Disability

Evergreene Homes also provides full-time employees with the opportunity to enroll in Voluntary Short and Long-Term disability. Without disability coverage, you and your family may struggle to get by if you miss work due to an injury or illness. In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income.

Disability Insurance is not part of Open Enrollment and your only time to enroll may be the date you are hired.

The costs for Voluntary Short-Term Disability are age band rated and are updated in the Employee Navigator portal. ***Payroll Deduction Premiums will automatically be adjusted with any change in salary.***

	Voluntary Short-Term Disability	*Long-Term Disability*
Benefits Begin	8th day Sickness – 8th day Illness	After 90 days
Percentage of Income Replaced	60% weekly salary	60% monthly salary
Maximum Benefit	$1,000 Weekly	$6,000 Monthly
Maximum Benefit Duration	12 weeks	Social Security Retirement Age

Evergreene Homes provides Disability Insurance as an option for all new hires without requiring an Evidence of Insurability. An Evidence of Insurability form must be completed and approved **after the initial new hire enrollment period**. The EOI form will be submitted to the carrier for approval which could take up to two months for a response. Employee can request termination of coverage at any time for any reason.

You can terminate coverage for Life and Disability at any time, but any increase in coverage will require an Evidence of Insurance form to be completed, submitted and approved by the carrier prior to enrollment after your first 30 days of employment.

Accident Insurance

In additional to Life and Disability insurance, Evergreene Homes has added Voluntary Accident insurance to our benefit portfolio of coverage options. In the event of an Injury, Accident Insurance provides payment directly to the employee. Below is an outline of some of the benefits provided by Principal.

Accident / Injury	Benefit Amount	Accident / Injury	Benefit Amount
Burn	Up to $5,000	Fracture	Up to $10,000
Coma	$15,000	Injury Not Specified	$100
Concussion	$500	Internal Injury	$1,500
Dental Injury	$500	Knee Cartilage Injury with Surgical	$1,500
Dislocation	Up to $7500	Ruptured Disc with Surgical Repair	$1,500
Eye Injury with Surgical Repair	$500	Tendon / Ligament / Rotator Cuff with Surgical Repair	$1,500

Accidental Death Benefits	Employee	$25,000
	Spouse	$12,500
	Child	$6,250

The Summary Plan Description has a complete list of exclusions, but certain limitations apply including but not limited to zero payment for will self-injury, participation in criminal activities, act of war, drug use not prescribed by a physician, intoxication, sickness or disease. Participation in certain activities including but not limited to flying, ballooning, parachuting, parasailing or other aeronautic activities.

Accident Insurance is not part of Open Enrollment and your only time to enroll may be at the time you are hired.

Monthly Payroll Deduction		
	Employee Only	$8.94
	Employee and Spouse	$14.22
	Employee and Child(ren)	$17.27
	Employee and Family	$26.70

You can terminate coverage for Accident Insurance at any time, but the only time you may be eligible to enroll may be at the time you are hired.

Critical Illness

Critical Illness can strike at any time and Evergreene now offers Critical Illness and Infectious Disease insurance for all full-time employees.

Benefits vary by illness and/or disease and below are a sample of benefits. The complete list can be found in the plans Summary Plan Description of Benefits.

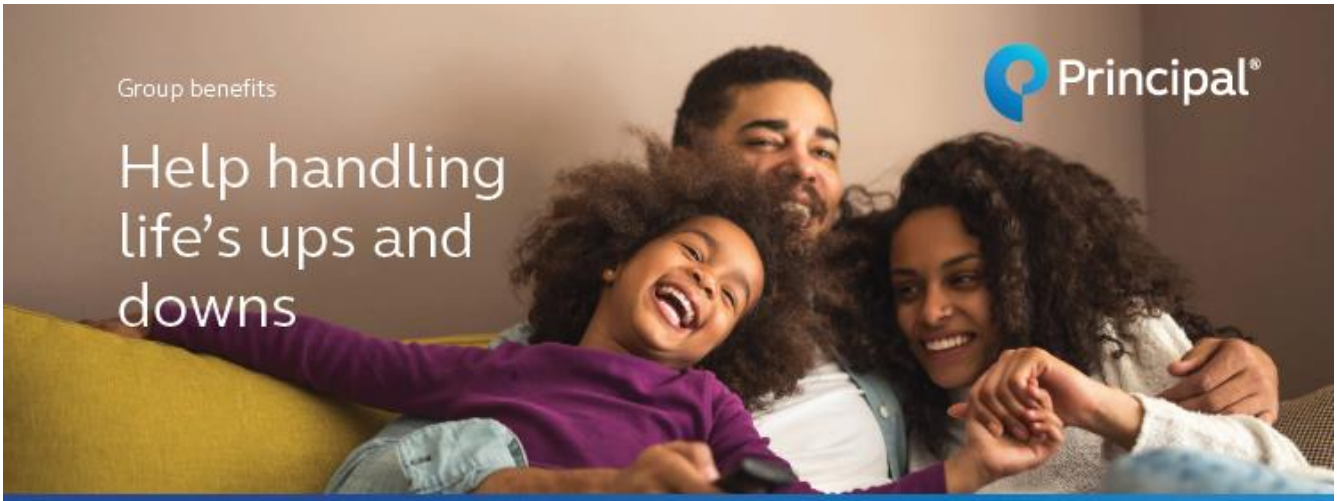
Illness Include But Not Limited To	Benefit Amount for 1st Occurrence		Infectious Disease Include But Not Limited to	Benefit Amount for 1st Occurrence
Alzheimer's Disease	100%		COVID-19	25%
Coma	100%		Diphtheria	25%
Coronary Artery Disease	20%		Legionnaire's Disease	25%
Heart Attack	100%		Lyme Disease	25%
Invasive Cancer	100%		Malaria	25%
Major Organ Failure	100%		Meningitis	25%
Paralysis	100%		Osteomyelitis	25%
Skin Cancer	$250		Rabies	25%
Stroke	100%		Sepsis	25%

Limitations are in effect for subsequent occurrences including timing from first occurrence and possibility of reduced rates.
Benefits for Infectious Disease require participant to be confined to a hospital for at least three days.
Illness or Disease will not be paid for any condition that was treated within six months of enrollment.

The chart below outlines the monthly cost of purchasing voluntary Critical Illness coverage.

Monthly Cost for Every $1,000 of Critical Illness Coverage											
Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +
Cost per $1k	$0.251	$0.417	$0.518	$0.637	$0.927	$1.137	$2.093	$2.967	$4.352	$6.223	$9.067
$5k	$1.26	$2.09	$2.59	$3.19	$4.64	$5.69	$10.47	$14.84	$21.76	$31.12	$45.34
$10k	$2.51	$4.17	$5.18	$6.37	$9.27	$11.37	$20.93	$29.67	$43.52	$62.23	$90.67
$15k	$3.77	$6.26	$7.77	$9.56	$13.91	$17.06	$31.40	$44.51	$65.28	$93.35	$136.01
$20k	$5.02	$8.34	$10.36	$12.74	$18.54	$22.74	$41.86	$59.34	$87.04	$124.46	$181.34
$25k	$6.28	$10.43	$12.95	$15.93	$23.18	$28.43	$52.33	$74.18	$108.80	$155.58	$226.68
$30k	$7.53	$12.51	$15.54	$19.11	$27.81	$34.11	$62.79	$89.01	$130.56	$186.69	$272.01

EAP / Employee Assistance Program



Life can be unpredictable. And it's not always easy. So it's a big deal to know there's help available when you need it. That's what the employee assistance program (EAP), provided by Magellan Healthcare, is all about.

With an EAP, you and your family have access to **free, confidential** resources to help handle life's everyday—and not so everyday—challenges.

You might use your EAP to help: manage stress, handle relationship issues, balance work and life, work through grief, cope with anxiety, and more. Plus, your EAP gives you access to discounts on major brands and everyday needs.

Services for you and your family

Your EAP offers these services to help you and your family deal with the big and little things.

In-person or virtual counseling

One valuable way to work through personal or work issues is by talking with a professional. You and your family can meet with a licensed, EAP professional in person, via text message, or by live chat, video, or phone sessions. Three counseling sessions per year are included.

Legal, financial, and identity theft services

You and your family have access to these services:

- **Legal services.** Receive a free 60-minute consultation to help deal with issues such as car accidents or family law.
- **Financial wellness.** Receive three free 30-minute consultations. This may include help with budget planning, debt consolidation, or retirement planning.
- **Identity theft resources.** Receive a free 60-minute consultation to help restore your identity if stolen.

Work-life web services

You and your family can access webinars, live talks, and articles on topics such as child and elder care, education, parenting, and more.

Help when and where you need it—day or night

Life's challenges don't always happen during regular business hours. That's why you and your family have 24/7 access to your EAP.

800-450-1327
International: 800-662-4504
TTY: 711

Member.MagellanHealthcare.com
When you create an account, enter **Principal Core** as the program name.

Will & Legal Document Center

If you're like most of us, you want to be in the driver's seat when it comes to your wishes for the future, like who will inherit your assets or make medical decisions for you if you're not able to. Especially since life can be so unpredictable.

That's why it's important to be proactive and make a plan to help protect your family and finances. With your group term or voluntary term life insurance through Principal®, you can do just that with access to resources from the **Will & Legal Document Center** provided by ARAG®.

Resources for help with legal documents

Having the proper documents in place can help ensure you're still in control in case something happens to you. With ARAG's online resources, you and/or your spouse can prepare these documents:

Standard Will. Specify what happens to your property and assets after you die, and appoint the person who will carry out your wishes. You can also name a guardian for your minor children.

Health care power of attorney. Grant someone permission to make medical decisions on your behalf in case you're no longer able to make them yourself.

Durable power of attorney. Grant someone permission to make financial decisions in case you're no longer able to make them yourself.

Living will. Let your family and health care providers know your wishes for medical treatment if you're unable to speak for yourself.

Authorization for a Minor's Medical Treatment. Grant consent for medical personnel to treat your child(ren) if you're away and can't be reached.

HIPAA authorization. Designate person/s to access your protected medical records and health information.

Plus, you can also access:

Personal Information Organizer. Record your personal and financial information—as well as funeral arrangements—in one convenient spot.

Estate planning education, tools, and resources. Get access to a variety of articles and legal resources.

Protect your identity

It's not just inconvenient to have your identity stolen. It can have a direct impact on your credit rating and your financial security. The good news is you can help protect your identity with online resources from ARAG, including:

An Identity Theft Victim Action Kit to help speed your recovery if you experience identity theft. Guidebooks and articles that outline how you can prevent identity theft- and what steps to take if it happens.

Guidebooks and articles that outline how you can prevent identity theft- and what steps to take if it happens.

It's easy to get started

Follow these simple steps to start using these resources today:

1 | Visit aragwills.com/principal.

2 | Register by completing the required fields.

3 | You're in! Complete the forms or download the materials you need.

Let's connect

Need help with registration? Call ARAG Customer Care at **800.546.3718**.
Or, if you have questions about the services, call Principal at **866.539.1728**.

Principal®

Insurance products and plan administrative services provided through Principal Life Insurance Company®, a member of the Principal Financial Group®, Des Moines, IA 50392..

The value-added resources provided through ARAG Services, LLC (ARAG®) are not a part of any insurance products and plan administrative services provided through Principal Life Insurance Company® or affiliated with any company of the Principal Financial Group®. All resources may be changed or canceled at any time. Not available to group policies issued in New York.

The use of resources provided by ARAG should not be considered a substitute for consultation with an attorney or advisor. Principal® is not responsible for any loss, injury, claim, liability, or damages related to the use of the ARAG Will & Legal Document Center resources.

Please remember that the ARAG legal documents are accurate and useful in many situations. Due to possible changes by a state, it is a good idea to periodically review a template used to be sure it is the most current template. Whether or not the document is right for you and your situation depends on your circumstances. If you want specific advice regarding your situation, consult an attorney.

This information is intended to be educational in nature and is not intended to be taken as a recommendation.

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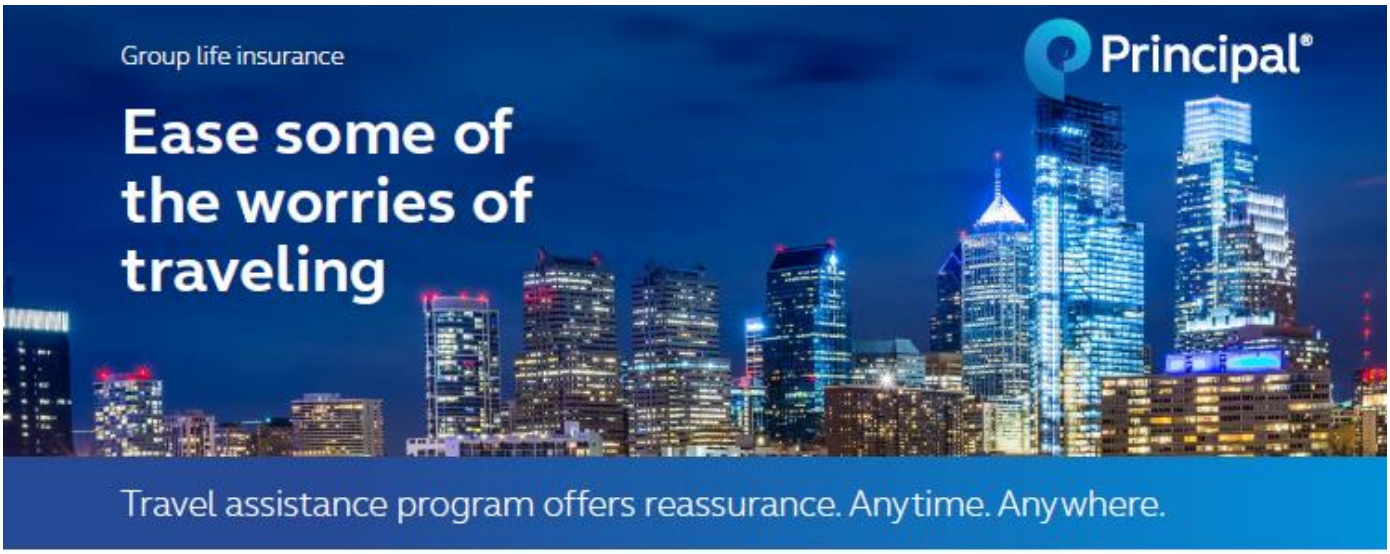
Travel Assistance Program



Whether you're traveling within the United States or leaving the country, you can rely on AXA Assistance USA (AXA) to help your travel experience go off without a hitch. And because you're covered by group term life insurance from Principal®, you have access to many travel assistance services for free—no matter if you're traveling for business or pleasure.

Near or far, you're covered

No matter where you're going—on a cross-country flight, a short road trip, or a destination requiring a passport—consider AXA your trusted travel companion. This program helps address the challenges of travel, like:

Lost or stolen items

We all hope it won't happen to us, but it could. Lost items can be a travel reality. AXA can help you recover or replace lost or stolen items (including cash and credit cards), so you don't miss a beat.

Medical assistance

Getting sick or hurt while traveling is no picnic. AXA is there when you need it most to assist with finding medical and dental care when you're away from home.

Connecting easily

Sometimes, you need more than the phone book. And when you do, AXA is there to help with message delivery, overcoming language barriers, or legal concerns.

Traveling farther away from home

The more miles you're away from home, the more you may need to do additional planning. AXA helps you get ready to head out with pre-trip research, including travel requirements, cultural differences, and precautions you should be aware of.

TRAVEL ASSISTANCE PROGRAM

Call us when you're traveling and need assistance.
888-647-2611 in the U.S.
630-766-7696 call collect outside the U.S.
Learn more and plan for your trip with our website.
principal.com/travelassistance

Who's eligible? You, your spouse, and your dependent children can access this service when traveling 100+ miles away from home for up to 120 consecutive days. And your spouse and dependent children are covered whether or not they're traveling with you.

Emergency medical transportation

Unfortunately, medical emergencies sometimes interrupt a trip, and you just need to get to a hospital—or get home. This service is per member or qualifying dependent per trip for emergency situations, including:

- Emergency medical transportation to a different facility if medically necessary
- Medically supervised return to your home country (known as repatriation)
- Transportation for a family member to join you
- Transportation for a traveling companion to join you in a different hospital or treatment facility
- Transportation home for dependent child(ren)
- Return of vehicle
- Return of mortal remains

To be eligible for services under this program, your treatment must be authorized and arranged by designated staff from AXA. Claims for reimbursement won't be accepted. Please contact AXA for further benefit details.

How to use this service

With two convenient ways to connect, you'll be ready for anything that comes your way:

1 | **Website.** Plan your trip with helpful resources at **principal.com/travelassistance**. Learn how to create an account giving you access to travel information online. You can get medical and security information about a country, search for a local medical provider, and view practical information, like business culture and currency descriptions.

2 | **Phone.** When you're traveling and need assistance, call **888-647-2611 in the U.S.** Or call collect when **outside the U.S. at 630-766-7696**. Help is available 24/7—365 days a year.

This program is not insurance.

Travel assistance services will be provided as permitted under applicable law.

Group life insurance from Principal® is issued by Principal Life Insurance Company®, Des Moines, IA 50392.

Services won't be provided or available for any loss or injury that's caused by, or results from: normal childbirth, normal pregnancy (except complications of pregnancy), voluntary induced abortion, mental or nervous conditions (unless hospitalized), traveling against the advice of a physician, traveling for medical treatment, or traveling to a destination country that is at a Level 4 Travel Advisory.

Participants are responsible for any incurred fees or expenses, including medical. When traveling 100 miles or more away from home for up to 120 consecutive days, medical emergency transportation services include the arrangement and payment for any reasonable and customary charges determined by AXA Assistance USA, Inc. **No reimbursements for out-of-pocket expenses will be accepted.** This service is not a part of any Principal Life insurance contract and may be changed or discontinued at any time. Not available to group policies issued in New York. Although Principal® has arranged to make this program available to you, the third-party provider is solely responsible for its products and services. AXA is not a member of the Principal Financial Group®.

GP60039-07 (SP1484-06) | 05/2022 | 2209280-052022

Name_____

Company _____ **Contract number** _____

The participant is entitled to AXA Assistance USA, Inc. medical and travel services.

El portador de estar tarjeta es miembro de AXA Assistance USA, Inc. y tiene derecho a los servicios personales y de asistencia médica de AXA Assistance USA, Inc.

This program is not insurance.

All services must be provided by AXA Assistance USA, Inc.

No claims for reimbursement will be accepted.

Travel assistance services will be provided as permitted under applicable law.

Pet Insurance

www.ASPCAPetInsurance.Com/Evergreene

ASPCA PET HEALTH INSURANCE

Evergreene HOMES

Visit www.ASPCAPetInsurance.Com/Evergreene and save with your discount!

OUR BEST PROTECTION

Complete Coverage℠

accidents
illnesses
dental diseases
cancer
hereditary conditions
behavioral issues

exam fees • diagnostic imaging • lab tests
hospitalization • surgery • rehabilitation
chemotherapy • acupuncture
stem cell therapy • prescription food*
supplements • and more

We also offer an **Accident-only Coverage** plan.
Preventive Care Coverage can be added to

* To treat a covered condition (not for general maintenance or weight management). Pre-existing conditions are not covered. Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms and conditions visit www.aspcapetinsurance.com/terms. Preventive and Wellness Care reimbursements are based on a schedule. Complete Coverage℠ reimbursements are based on the invoice. Levels 1-4 reimbursements are based on usual and customary eligible costs. Products, schedules, discounts, and rates may vary and are subject to change. More information available at checkout. The ASPCA® is not an insurer and is not engaged in the business of insurance. Through a licensing agreement, the ASPCA receives a royalty fee that is in exchange for use of the ASPCA's marks and is not a charitable contribution. Products are underwritten by United States Fire Insurance Company (NAIC #21113. Morristown, NJ), produced and administered by C&F Insurance Agency, Inc. (NPN # 3974227), a Crum & Forster company.

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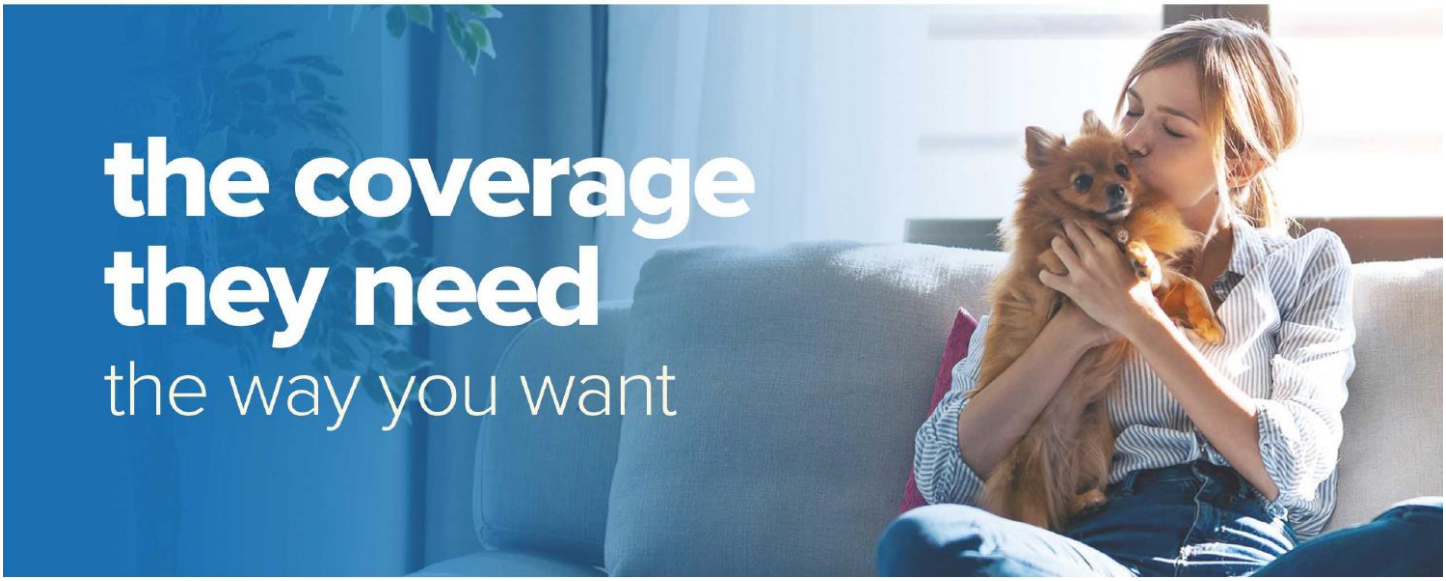
ASPCA® PET HEALTH INSURANCE

Evergreene HOMES



Our best plan ever
Complete Coverage℠

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

Simple to Use

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

Exam Fees, Diagnostics, and Treatments for Covered Conditions

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

Customizable Options

Annual Limit - from $3,000 to $10,000.

Reimbursement Percentage - 90%, 80%, or 70% of your eligible vet bill.

Annual Deductible - select $100, $250, or $500.

You'll only need to satisfy it once per 12-month policy period.

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

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

Let us help you find the perfect plan for you and your pet.

www.aspcapetinsurance.com/Evergreene | Priority Code: EB22EVERGREENE

Pre-existing conditions are not covered. Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms and conditions visit www.aspcapetinsurance.com/terms. Preventive Care coverage reimbursements are based on a schedule. Complete Coverage℠ reimbursements are based on the invoice. Products, schedules, discounts, and rates may vary and are subject to change. More information available at checkout.

Insurance products are underwritten by United States Fire Insurance Company (NAIC #21113. Morristown, NJ), and produced and administered by PTZ Insurance Agency, Ltd. (NPN: 5328528. Domiciled in Illinois with offices at 1208 Massillon Road, Suite G200, Akron, Ohio 44306). (California residents only: PTZ Insurance Agency, Ltd., d.b.a PIA Insurance Agency, Ltd. CA license #0E36937).

The ASPCA® is not an insurer and is not engaged in the business of insurance. Through a licensing agreement, the ASPCA receives a royalty fee that is in exchange for use of the ASPCA's marks and is not a charitable contribution.

U1022-COVERAGE

401k / Retirement

The Company offers a 401(k) Employee Incentive Plan designed to provide additional economic security after retirement. All employees who are at least 21 years old and expect to work at least 1,000 hours/year are eligible to enroll on the first day of the month following the first anniversary from date of employment.

For the 2025 tax year, employees may defer up to 100% of their pre-tax salary, but not more than $23,500.00 (adjusted annually) for investment in their choice of several investment options. Employees 50 and older may choose to have an additional $7,500 catch-up contribution to bring their total annual 401k deductions up to $31,000.

The Company currently pays all plan expenses and may also make a discretionary contribution at the end of the plan year if you are an active participant at the end of the plan year.

Enroll online! It's fast and easy.

- Online Account Access is available at: **https://www.LincolnFinancial.Com**
- Follow the prompts, and after registration, you will be directed to your account page to enroll and update your plan information.
- Choose your contribution rate and investment options.

You are always 100% vested in the contributions you choose to defer and funds may be withdrawn without special tax consequences by an employee or beneficiary in the event of:

- Retirement
- Total and/or permanent disability
- Death
- Termination of Employment

Additional details on the plan and a copy of the plan document are available from Human Resources.

Paid Time Off

The Company combines vacation, sick and personal time into one policy called Paid Time Off or PTO. PTO is provided to all Full-Time, Non-Temporary employees and can be used for Vacation, Sick or Personal Time.

Employees become eligible to begin accruing PTO on their first day of employment with the Company and must be actively employed (not on leave) to accrue time.

Although not earned, employees are allowed to begin using PTO at the beginning of their employment and the beginning of each calendar year. PTO does not become fully earned at the end of each calendar year. Employees accrue PTO time for each pay period they remain active and not on a Leave of Absence. The PTO that employees receive each year increases with the length of employment:

Years of Eligible Service	*PTO Days Each Year*
During first calendar year of employment	1.16 day for each calendar month of service
January 1st following your 1st Service Anniversary	Fourteen (14) Days
January 1st following your 5th Service Anniversary	Twenty (20) Days
January 1st following your 10th Service Anniversary	Twenty-Two (22) Days

Employees who have a service anniversary in the middle of the year will receive a pro-rated new accrual rate for the appropriate number months following the service anniversary.

Employees should submit Paid Time Off (PTO) requests to their manager as far in advance as possible. Approval will be evaluated and approved based on various factors including but not limited to workload and staffing considerations. You will know that your PTO has been approved when you receive the calendar invite adding the time to you, your manager and the Human Resource outlook calendars.

Employees taking time off for unexpected events such as illness should submit a PTO form to their manager immediately upon their return to work. The completed form should then be forwarded to Human Resources for recordkeeping.

Employees with PTO Days remaining at the end of the year will be permitted to carry over a maximum of 5 days from the current calendar year into the next calendar year. Up to 5 Days will be automatically added to the PTO balance for each employee. Days accrued in excess of 5 Days at the end of the calendar year will be forfeited.

Should you voluntarily resign from the company, earned but unused PTO will be paid. If an employee has been paid for more PTO time than earned at the time of separation, the time in excess of time earned will be deducted from the final pay. In the event an employee is terminated for misconduct, all accrued PTO pay may be forfeited.

Holiday Pay

All full-time, non-temporary personnel are eligible for holiday pay. The following are the holidays included in this compensation:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Day
- Floating Holiday

Holiday dates will be determined at the beginning of each calendar year. Full time employees will receive their regular salary for Company designated holidays. Eligible employees will receive pro-rated pay based on their average work hours. You must work the scheduled workday before and the day after the holiday to be eligible to receive holiday pay. If a holiday occurs before, during or after your scheduled PTO, you are eligible for holiday pay. You are not eligible to receive holiday pay when you are on a leave of absence.

If you are a full time hourly/non-exempt employee and you are required to work on a holiday, you will receive your regular pay for all hours worked as well as for the eight hours holiday pay.

If you are an exempt employee and required to work on a holiday, you may, upon approval of your Supervisor, receive a "substitute" holiday during the same pay period. Holiday comp time cannot be carried into any subsequent pay periods. Requests for employees to work on scheduled holidays require the approval of the appropriate Supervisor.

Bereavement Leave

Should you be faced with this unfortunate occurrence, we will make every effort possible to accommodate your personal needs. Family Bereavement leave is available in the event of the death of an immediate family member including parent, spouse, child, brother or sister. Employees will be granted up to three (3) days Bereavement Leave with pay, due to the death of these family members.

Payday

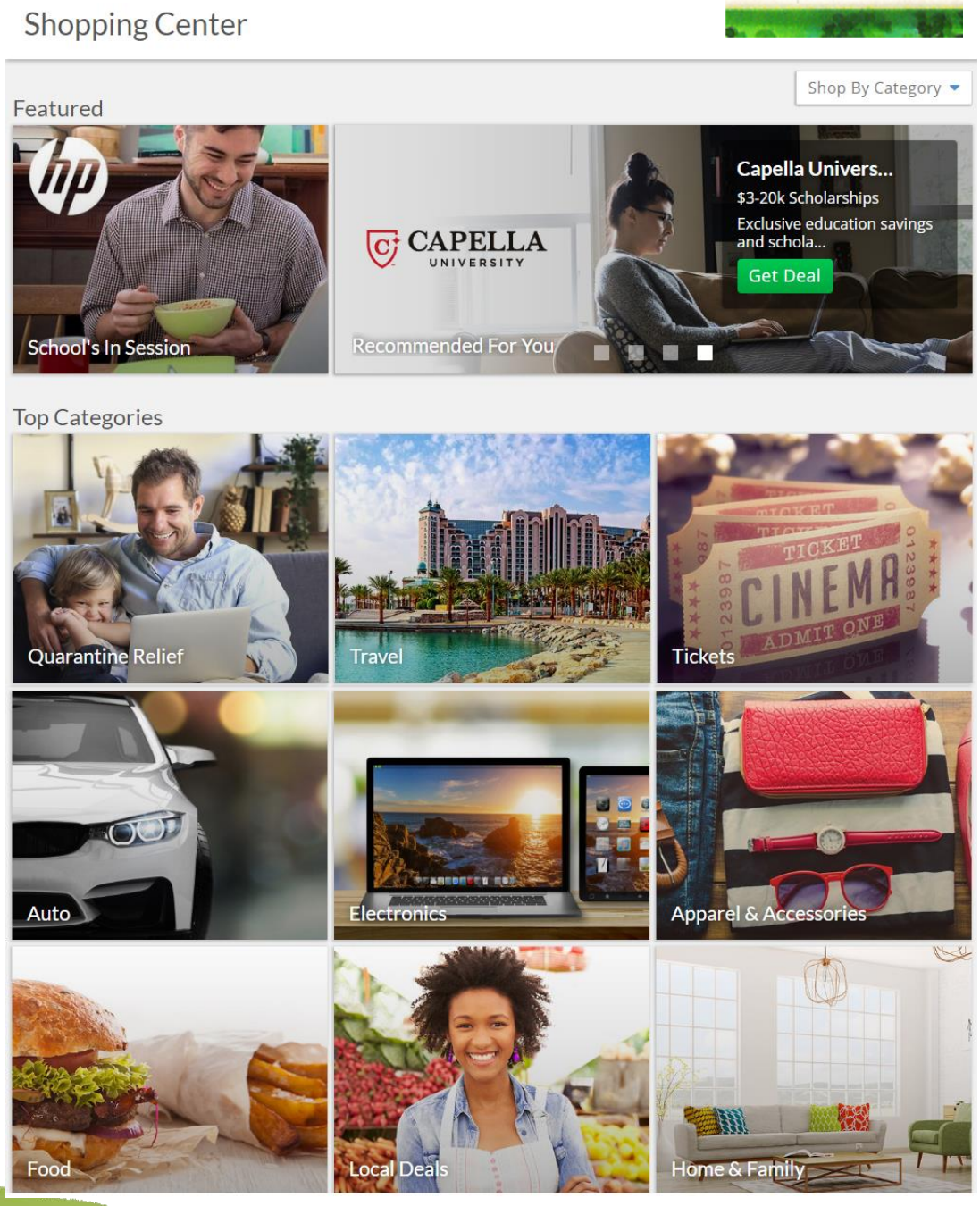
You will be paid on a monthly pay cycle with payday on the third business day of the month for services performed during the previous month. The monthly pay schedule is made up of twelve (12) pay periods per year. The Company strongly encourages the use of direct deposit to avoid any unintended delays in receipt of payment.

Should you notice an error in your pay statement, please bring it to the attention of the Human Resource department immediately so that the appropriate correction can be made.

Benefit Hub Discount Program

You have landed on the Benefit Hub Discount Program and you can now move ahead 10 spaces and celebrate with a night out on the town or discounted shopping experience!

1. Please go to: summitinsurance.benefithub.com/
2. Click on any offer
3. Complete registration



Plan Definitions

Plan Definitions

Deductible: The amount that you must pay toward covered services before the insurance plan will begin to pay their portion.

Copay: The amount you pay when visiting a provider.

Coinsurance: Your share of the costs of a covered health care service, calculated as a percentage of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for a hospital stay is $1,000 and you've met your deductible, your coinsurance payment of 20% would be $200. The health insurance or plan pays the rest of the allowed amount.

Out-of-Network: Means that the doctor or facility providing your care does not have a contract with our insurance plan. You'll generally pay more to see an out-of-network provider than an in-network provider. Your policy will explain what those costs may be. Out of network providers usually balance bill the amount between our plan allowance and the total billing.

Out-of-Pocket Maximum: Yearly amount an individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Copays, deductibles and coinsurance will all apply towards your out-of-pocket maximum.

Preventive Services: Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease or other health problems. Under the Patient Protection and Affordable Care Act (PPACA) most health plans are required to cover asset of preventive services at no cost to the member.

PPO (Preferred Provider Organization): Allows member to access in-network provider without a referral. Members have the option of seeking care out-of-network, but may be responsible for charges in excess of the plan allowance

HMO (Health Maintenance Organization): Allows member to access in-network benefits and generally requires a referral to see a specialist.

Questions and Answers

Questions and Answers

When will my benefits become effective?
Annual enrollment changes become effective on January 1st and benefits for new hires become effective on the first of the month following 30 days of service.

How do I know if I am eligible for these benefits?
All full-time/regular (not seasonal) employees working more than an average of 30 hours a week will become eligible for benefits.

What is Evergreene Homes benefit plan year?
Evergreene Homes plan year is January 1st to December 31st.

When does open enrollment occur?
Open Enrollment will occur in December with plan changes going into effect on January 1st.

Can I enroll in one or more of Evergreene Homes benefit plans outside of open enrollment?
New hires may enroll in any of Evergreene Homes benefit plans during their first 30 days of employment. All other employees must have a qualifying event to enroll outside of open enrollment or to make benefit changes.

Where can I find copies of Evergreene Homes benefit plan summaries and additional information?
Plan summaries, claim forms and additional information can be found in your Human Resource Department.

I have not received my medical ID card or I need a replacement medical ID card. Where can I request this?
ID cards can be ordered via your personal online account at www.MyUHC.Com. You can log in or register at this link to request new cards.

Which health plan is the best choice for my family and me?
That depends on you and your personal situation including where you and your dependent live and how committed you are to your current physician. You will need to evaluate the benefits, physicians, medical facilities and cost associated with each plan to make the best decision for you and your family.

How will I know if my doctor accepts United Healthcare AllSavers?
You can review the information on the AllSavers website, but we recommend that you contact your doctor directly to confirm if they are in the medical network of the plan you are selecting.

I have checked with my doctor and they do not participate in our network; what should I do?

Good job, you are several steps ahead of others. If your doctor does not accept AllSavers, you will have a choice of selecting another doctor who accepts our plan enroll in a plan with Out of Network benefit options. Again, this is up to you and your family.

If I say I do not want to elect medical coverage beginning January 1st, can I enroll later in the year?

Unfortunately, no. Your opportunity to enroll in these benefits will be during Open Enrollment. The only exception to this is if you have a Qualifying Event that would allow you or your family's eligibility status to change to allow you to enroll midyear.

Who is considered an eligible dependent?

In addition to covering yourself, you may also elect to cover your spouse and your children to age 26. Coverage for your children will last until the end of the month they turn 26.

I see I all the plans have a copay for doctor office visits, so why is there also a deductible?

The deductible does not apply to the doctor visits, but it would apply to other services such as hospitalization that may have a copay or coinsurance (percentage of billing).

Should I expect United Healthcare AllSavers to remain as our healthcare carrier as long as I work at Evergreene Homes?

As much as we would like to say yes and maintain consistency, we will continue to evaluate our health and welfare options each year. Any decision to change or even remain with UHC will obviously be made with both you and the company's best interest.

I am enrolled in the Local plan and have an emergency out of town, what should I do?

Go immediately to the emergency room for complex or critical needs including life and limb threating situations. Your care will be processed as in-network. Notify your Primary Care Physician as soon as you are able to ensure your emergency visit will be processed as in-network emergency services.

I did not previously enroll in Disability; can I enroll later in the year?

That is a tricky question. Disability is not part of Open Enrollment and you can complete an application or cancel coverage at any time. Completing an application does not guarantee coverage and prior health conditions will be taken into consideration during the insurance company's review of your application. The review process generally takes 30 to 60 days.

I enrolled in an HSA plan and did not use all of my funds; does this mean that I forfeited the money?

No, any unused HSA funds remaining at the end of the year will be carried into the next plan year.

Legal Notices

As a sponsor of benefit plans, Evergreene Homes is periodically required to provide notices and disclosures to employees. This packet includes some of those documents. Other notices can be found within benefit enrollment materials and the Human Resource Department.

Medicare Part D Creditable Coverage Notice

Important Notice from The Evergreene Companies About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Evergreene Companies has determined that the prescription drug coverage offered by your health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing drug coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current The Evergreene Companies coverage may be affected. If you do decide to join a Medicare drug plan and drop your current The Evergreene Companies coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up be 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 the higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About this Notice or Your Current Prescription Drug Coverage…

Contact the person below for further information. NOTE: you'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The Evergreene Companies changes. You may also request a copy of this notice at any time.
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover 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 more information about this extra help, visit Social Security online 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 (penalty). You must give a copy of this notice to your Medicare-eligible dependents who are covered under the The Evergreene Companies plan.

Date: 2/8/2024
Name of Entity/Sender: The Evergreene Companies
Contact: Keith Jones
Address: 3684 Centerview Drive Suite 120
Chantilly, VA 20151
Phone Number:703 - 667-7869

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

You're protected from balance billing for:

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

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

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

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

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

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

If you think you've been wrongly billed, you may contact your plan administrator for more information on your rights. The federal phone number for information and complaints is 1-800-985-3059.

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

State Balance Billing Laws & Protections

In addition to the federal balance billing protections, state protection laws may apply to you. Approximately 14 states have implemented broad surprise billing laws while many other states have laws that address certain issues related to surprise billing, such as a method for determining payment for emergency services. These state laws differ significantly in a variety of ways, including (1) the types of plans, items, services, and specialties to which the laws apply; (2) how the applicable out-of-network payment amount is determined; (3) the methodology used to resolve payment disputes; and (4) how they interact – and whether they are superseded by – federal law.

These state laws generally only apply to fully-insured plans, although self-insured plans may opt-in to state balance billing protections in some states. State balance billing laws have limited applicability to out-of-state providers. If providers or facilities are not covered under state law, disputes with those providers will be resolved under the federal No Surprises Act. Contact your state insurance department or your plan administrator for more information about whether and to what extent state balance billing laws and protections may apply.

Health Insurance Exchange Notice

Health Insurance Marketplace Notice Coverage Options and Your Health Coverage

Part A: General Information

To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I save money on my health insurance premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if our employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does employer health coverage affect eligibility for premium savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your

family) is more than 9.5% (indexed annually) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. 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% of such costs.

NOTE: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution – as well as your employee contribution to the cost of employer-sponsored coverage – is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?

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

The Evergreene Companies
Attention: Human Resources
3684 Centerview Drive Suite 120
Chantilly, VA 20151
703 - 667-7869 - KJones@EvergreeneHomes.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 The Evergreene Companies		Employer Identification Number (EIN) 27-5259813
Employer Address 3684 Centerview Drive Suite 120		Employer Phone Number 703 - 667-7869
City Chantilly	State VA	ZIP 20151
Who can we contact about employee health coverage at this job? Keith Jones		
Phone Number 703 - 667-7869		Email Address KJones@EvergreeneHomes.Com

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

Notice of Special Enrollment Rights

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

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

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

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

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

Notice of Privacy Practices

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your health plan recognizes your right to privacy in matters related to the disclosure of health-related information.
The Notice of Privacy Practices *(provided in the plan certificate booklet)* details the steps your plan has taken to assure your privacy is protected. The Notice also explains your rights under HIPAA. A copy of this notice is available to you at any time, free of charge, by request through your health plan.

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

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

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

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the deductibles and coinsurance you will be subject to depends on the coverage provided by your health plan.

Michelle's Law Notice

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage.

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 of the 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).

Genetic Information Nondiscrimination Act (GINA) Disclosure

Genetic Information Nondiscrimination Act of 2008

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

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

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

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

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

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

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

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA - Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program- reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website:	Website: https://www.kancare.ks.gov/ Phone: 1-800-792- 4884 HIPP Phone: 1-800-967-4660

https://dhs.iowa.gov/ime/members/medicaid- a-to-z/hipp
HIPP Phone: 1-888-346-9562

KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.as px Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?languag e=en _US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1- 800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855- 632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1- 800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855- 4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844- 854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid 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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543- 7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250- 8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor Employee Benefits Security Administration **www.dol.gov/agencies/ebsa** 1-866-444-EBSA (3272)	U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services **www.cms.hhs.gov** 1-877-267-2323, Menu Option 4, Ext. 61565

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.

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

USERRA Notice
Your Rights Under USERRA

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

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

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

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

C. Right to be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service,

Then an employer may not deny you:

- Initial employment;
- Reemployment;
- Retention in employment;
- Promotion; or
- Any benefit of employment

Because of this status.

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

A. Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health coverage for you and your dependents for up to 24 months while in the military.

Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service- connected illnesses or injuries.

B. Enforcement

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

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

If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS and may be viewed online at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.

U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

General Notice of COBRA Rights Continuation Coverage Rights Under COBRA Introduction

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

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

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

What is COBRA continuation coverage?

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

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child." The end of employment or reduction of hours of employment;

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment.
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Keith Jones
3684 Centerview Drive
Suite 120
Chantilly, VA 20151
KJones@EvergreeneHomes.Com

How is COBRA continuation coverage provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying

event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA continuation coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period* to sign up for Medicare Part A or B, beginning on the earlier of:

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

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

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

For more information visit https://www.medicare.gov/medicare-and-you.
* https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage- start

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

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

Plan contact information

Keith Jones
3684 Centerview Drive, Suite 120
Chantilly, VA 20151
703 - 667-7869
KJonesj@EvergreeneHomes.Com

General FMLA Notice
Employee Rights Under the Family and Medical Leave Act

The United States Department of Labor Wage and Hour Division

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

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

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

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

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

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

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

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

Eligibility Requirements

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

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

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

Requesting Leave

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

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

Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

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

Employer Responsibilities

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

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

Enforcement

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

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

For additional information or to file a complaint:

1-866-4-USWAGE
1-866-487-9243 TTY: 1-877-889-5627
www.dol.gov/whd

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

Online Enrollment:

Online Benefit Enrollment / Employee Navigator

Our benefits are maintained by an online portal that will allow all users the opportunity to complete their enrollment during their own time. You can also log into the system to view your benefits at any time throughout the year.

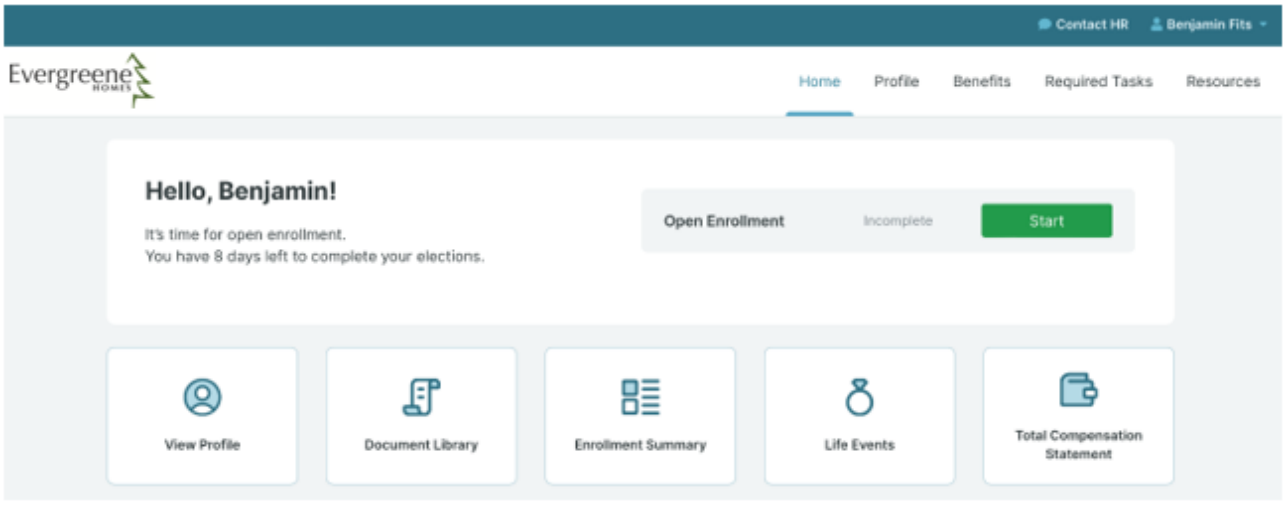
Web Link: www.EmployeeNavigator.Com

Company Identifier: **Evergreene Homes**

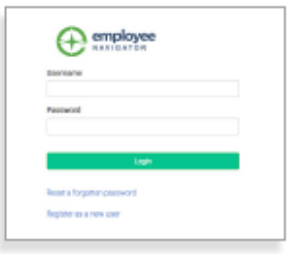
Most people find that the enrollment process is so simple that they do not need any further direction, but if needed, following are Step-by-Step directions for your Online Enrollment.

Once completed, you will have an opportunity to electronically sign your enrollment which will automatically be forwarded to Human Resources for review.

Should there by any issue, Human Resources will contact you within 48 hours of your submission.



ENROLL IN YOUR BENEFITS: One step at a time



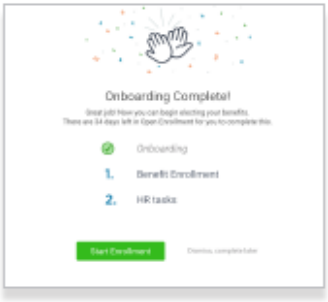
Step 1: Log In

Go to www.employeenavigator.com and click **Login**

- **Returning users:** Log in with the username and password you selected. Click **Reset a forgotten password**.
- **First time users**: Click on your Registration Link in the email sent to you by your admin or **Register as a new user.** Create an account, and create your own username and password.
- **Company Identifier: Integrity Homes**

Step 2: Welcome!

After you login click **Let's Begin** to complete your required tasks.

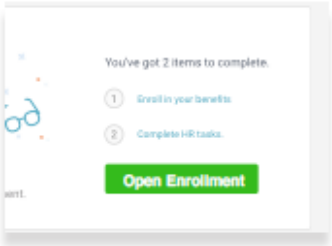


Step 3: Onboarding (For first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click **Open Enrollment** to begin your enrollments.

TIP

If you hit **"Dismiss, complete later"** you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking **Open Enrollment**



Step 4: Open Enrollment

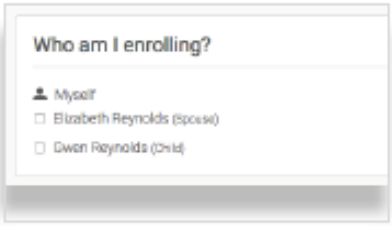
After clicking **Open Enrollment** you'll need to complete some personal & dependent information before moving to your benefit elections.

TIP

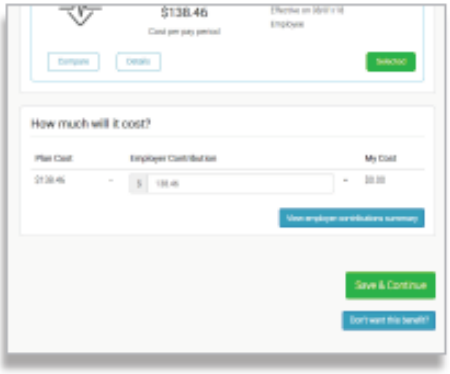
Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.

Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**



Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

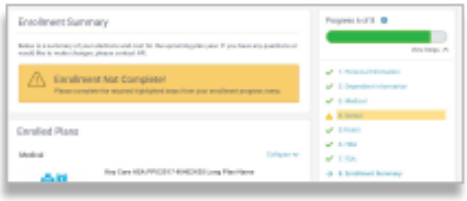


Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

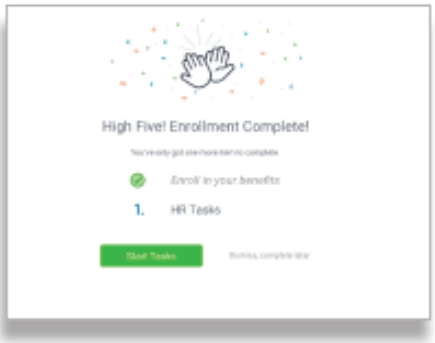


Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

TIP

If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.



Step 8: HR Tasks (If applicable)

To complete any required HR tasks, click **Start Tasks**. If your HR department has not assigned any tasks, you're finished!

You can login to review your benefits 24/7


START
START CAREER
PAY DAY
CAREER CHOICE
STOP
START COLLEGE
RETIRE
GET MARRIED
BUY A HOUSE
Evergreene Homes
Centerview Title
Countryside Acres
MILLIONAIRE ESTATES
3684 Centerview Drive
Evergreene Homes
Centerview Title
The Game of LIFE
By Milton Bradley