

# 2026

BENEFITS GUIDE



INFRAMARK



# Here's where to find ...

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This benefits guide describes the highlights of Inframark's benefits in non-technical language and is not designed to address every possible coverage scenario, benefit payment or out-of-pocket charge that you may incur. Your specific rights to benefits under the plan are governed solely, and in every respect, by the official documents and not the information in this benefits guide. If there is any discrepancy between the description of the programs as contained in this guide and the official plan documents, the language of the official plan documents shall prevail as accurate. Please refer to the plan-specific documents published by each of the respective carriers for detailed plan information. Any of these benefits may be modified in the future to meet Internal Revenue Service rules or otherwise as decided by Inframark.

# What's New For 2026

## Health Plan Contributions

Medical plans will have a premium increase in-line with projected health care cost increases. There will not be any other changes to your health benefits. (Refer to page 7 for the 2026 rates.) REMEMBER: For those eligible for the 2026 wellness incentive, you must select either a paycheck bonus or contribution wellness discount during open enrollment.

## Tobacco Surcharge

If you or a covered spouse regularly use tobacco products, the contribution surcharge will be increasing to \$150 per month/per person. You can have this surcharge waived by participating in the Health Advocate Tobacco Cessation Program.

## 401(k) Retirement

Beginning January 1st, 2026, the Inframark 401(k) Retirement and Savings Plan will no longer offer automatic enrollment into the Plan or annual automatic escalation of contributions. You will still have the option to manually increase or change your contributions at any time by visiting [empower.com](https://empower.com) or by calling Empower at 1-855-756-4738.

## Voluntary Benefits

The following voluntary benefits will be discontinued effective January 1st, 2026:

- Farmers Home & Auto
- Kashable: If you have existing loans open with Kashable, you will continue to receive payroll deductions until the loan is paid off in full. You will not be able to open a new loan.
- MetLife Legal
- MetLife Pet
- Norton ID Theft
- SmartDollar

If currently enrolled, you may have the option to continue coverage on an individual basis. Please contact Health Advocate for information on continuing coverage.

# Eligibility and Enrollment

## Benefits Eligibility

All full-time employees scheduled to work at least 30 hours per week are eligible to enroll in employee benefits.

## Covering Your Family Members (Eligible Dependents)

For you to add eligible dependents on your new benefit plans in 2026, you must submit verification documents (including social security numbers).

### Who Are Your Eligible Dependents?

- Your legal spouse
- Your domestic partner
- Your children\* up to age 26
- Your unmarried children of any age, if mentally or physically incapable of self-support

\*Your “children” include your natural children, stepchildren who live with you, or other children of whom you have legal guardianship.

## Changing Your Elections

You need to think carefully about the benefits you choose because you cannot change your elections during the year unless you have a Qualifying Life Event. Examples of Qualifying Life Events Include:

- Your marriage or divorce
- Birth or adoption of your child
- Your child reaches the benefit age limit
- Gain or loss of other coverage due to a change in your or your spouse’s employment or employment status
- Death of your spouse or child

## If You Have a Qualifying Life Event

You must report and provide documented proof of any Qualifying Life Event within 31 days of the event’s effective date.

Please visit [myinframarkbenefits.com](http://myinframarkbenefits.com) > Inframark Benefits Center > I Want To > Change My Benefits for more detailed information regarding Qualifying Life Events.



# How to Enroll in Benefits



1. Access the Inframark Benefits Center at [myinframarkbenefits.com](https://myinframarkbenefits.com) > Inframark Benefits Center > Register.
2. **How to Login:** Within the Inframark Benefits Center, click on Register, then complete the required information to create your username and password.  
Note you must first register via the website, and then you will be able to download and login to the mobile app.
3. To Enroll, click on the Start Here button next to the calendar image at the top of the page.
4. Need Help Choosing Your Benefits? Not sure which benefits are a good fit for you and your family? Choose I'd Like Help Choosing Plans when you enroll and answer a few questions to find the plans that best fit your unique needs.
5. Choose your benefits. Click Submit to review your options. After selecting each plan, you'll have the opportunity to choose which dependents you'd like to cover

## Need Assistance?

Contact an Inframark Benefits Support Representative at 1-888-532-3617 from 9 am to 6 pm EST, Monday through Friday. Spanish-speaking representatives and language translation services are available.

If you need help understanding your benefits or assistance navigating the site, you can always chat with Sofia, your virtual benefits assistant. She's available 24/7 from the site or MyChoice benefits app.



# Medical Benefits

Aetna | [aetna.com](https://www.aetna.com) | 800-238-6716

Inframark is committed to helping you and your family maintain health and wellness by providing you with access to the highest levels of care. We offer you a choice of four medical benefit options for 2026:

- Enhanced PPO Plan
- Basic PPO Plan
- Value Care PPO Plan
- HDHP w/HSA

The High-Deductible Health Plan (HDHP) provides the option of participating in a Health Savings Account (HSA). To learn more about HSAs, please see page 15.

All employees covered under Inframark’s Medical Plan have access to the Aetna Premier Care Network (select Aetna Premier Care Network (APCN) — Choice POS II) where available.

## Something to think about

Providers often change networks. Be sure that your current provider participates in the Aetna Premier Care Network.

Visit [Aetna.com](https://www.aetna.com), click “Find a Doctor”, under the “Guests” section click on “plan from an employer”, enter your location and mile radius, click “search”, under 2026 providers find the “Aetna Premier Care Network (APCN) Choice POS II” plan, click continue, and begin your provider search.



## Medical and Prescription Drug Plan Summary

| Medical                       | Enhanced PPO Plan    |                | Basic PPO Plan       |                | Value Care PPO Plan*** |                | HDHP w/HSA* |                |
|-------------------------------|----------------------|----------------|----------------------|----------------|------------------------|----------------|-------------|----------------|
|                               | In-network           | Out-of-network | In-network           | Out-of-network | In-network             | Out-of-network | In-network  | Out-of-network |
| <b>Annual Deductible</b>      |                      |                |                      |                |                        |                |             |                |
| Yourself only                 | \$1,500              | \$4,500        | \$3,500              | \$10,500       | \$5,000                | \$12,500       | \$4,000     | \$8,000        |
| Your family                   | \$4,500              | \$13,500       | \$10,500             | \$31,500       | \$12,500               | \$31,250       | \$8,000     | \$16,000       |
| <b>Out-of-pocket maximum</b>  |                      |                |                      |                |                        |                |             |                |
| Yourself only                 | \$4,500              | \$9,000        | \$8,150              | \$16,300       | \$8,150                | \$16,300       | \$6,900     | \$13,800       |
| Your family                   | \$9,000              | \$27,000       | \$16,300             | \$48,900       | \$16,300               | \$48,900       | \$13,800    | \$27,600       |
| Coinsurance                   | 20%                  | 50%            | 30%                  | 50%            | 30%                    | 50%            | 30%         | 50%            |
| <b>Office visit</b>           |                      |                |                      |                |                        |                |             |                |
| Primary care                  | \$25                 | ded./coins.    | \$25                 | ded./coins.    | \$20                   | ded./coins.    | ded./coins. | ded./coins.    |
| Specialist                    | \$50                 | ded./coins.    | \$50                 | ded./coins.    | ded./coins.            | ded./coins.    | ded./coins. | ded./coins.    |
| <b>Emergency care</b>         |                      |                |                      |                |                        |                |             |                |
| Urgent care facility          | \$100                | \$100          | \$100                | \$100          | \$75                   | ded./coins.    | ded./coins. | ded./coins.    |
| Emergency room                | \$350                | \$350          | \$350                | \$350          | ded./coins.            | ded./coins.    | ded./coins. | ded./coins.    |
| <b>Prescription drugs</b>     |                      |                |                      |                |                        |                |             |                |
| <b>Retail (30-day supply)</b> |                      |                |                      |                |                        |                |             |                |
| Generic                       | \$5 copay            |                | \$5 copay            |                | \$5 copay              |                | ded./coins. |                |
| Brand Formulary               | \$40 copay           |                | \$40 copay           |                | \$40 copay             |                | ded./coins. |                |
| Brand Non-Formulary           | \$100 copay          |                | \$100 copay          |                | \$100 copay            |                | ded./coins. |                |
| Specialty                     | \$250                |                | \$250                |                | \$250                  |                | ded./coins. |                |
| Mail order (90-day supply)    | 2x retail cost share |                | 2x retail cost share |                | 2x retail cost share   |                | ded./coins. |                |

All in-network preventive care (e.g., routine physicals, well-child care, mammograms, colonoscopies) is covered at 100% by the plans.

\*HDHP w/HSA Plan enrollees receive an annual company contribution of \$500 (single) or \$1,000 (family) into their HSA.

\*\*See list of medications designated as “preventive” at [myinframarkbenefits.com/Medical](http://myinframarkbenefits.com/Medical).

\*\*\* Value Care PPO is the only plan that offers a \$40.00 co-payment, as opposed to coinsurance, for diagnostic testing such as X-rays and bloodwork.

## Your Bi-Weekly Medical and Prescription Drug Payroll Deductions

|                       | Enhanced PPO | Basic PPO Plan | Value Care PPO Plan | HDHP w/HSA |
|-----------------------|--------------|----------------|---------------------|------------|
| Yourself only         | \$126.37     | \$77.49        | \$60.93             | \$57.75    |
| You + your spouse     | \$297.51     | \$200.81       | \$163.41            | \$145.99   |
| You + your child(ren) | \$254.87     | \$161.14       | \$129.63            | \$121.73   |
| You + your family     | \$471.40     | \$306.15       | \$230.64            | \$218.62   |

\*If you completed the 2025 wellness program, you can earn discounts on your contributions, and pay less out of each paycheck in 2026. If you previously claimed your 2025 wellness reward in cash/gift cards, then you will pay the non-discounted rate in 2026. \*1 Discount = Employee OR Spouse completes wellness activities. 2 Discounts = Employee AND Spouse complete wellness activities.

- If your spouse has access to group medical insurance through their employer and you choose to cover them under the Inframark plan, you will pay a Spousal Surcharge of \$34.62/weekly or \$69.23/bi-weekly.
- If you and/or a covered spouse/domestic partner use tobacco regularly, you will pay an additional charge of \$34.62/weekly or \$69.23/bi-weekly for Inframark medical coverage. You can have this surcharge waived by participating in the Health Advocate Tobacco Cessation Program. If it is unreasonably difficult or medically inadvisable for you to attempt to achieve these standards because of a health condition, contact Health Advocate at 1-855-424-6400. These surcharges are subject to change throughout the year based on any tobacco usage or spousal coverage changes you report.
- If you cover a domestic partner and their child(ren), Inframark is required to calculate the imputed income (also called fair market value) of their health benefits. This means that the imputed income will be added to your W2 and subject to income tax withholding.

## Prescription Benefits

**CVS Caremark | [caremark.com](https://www.caremark.com) | 833-840-7957**

- You are automatically provided with prescription benefits through CVS Caremark when you enroll in an Inframark medical benefits plan.
- Different pricing structures or “tiers” enable you to control costs based on the types of medications you select.
- Be sure to request generic options from your doctor when possible. If you must take a brand name drug, see whether one in the Brand Formulary tier is an option.

### Something to think about

- Use of the Mail Order Program is required for most maintenance medications. Mail order is a convenient, safe, and very cost-effective way to get your maintenance medications. This home-delivery service allows you to purchase up to 90-day supplies of maintenance medications for the cost of two copayments, or 3-for-2-savings. In addition, the mail order program saves you trips to the pharmacy because prescriptions are delivered right to your door.
- If you use insulin, you may be eligible for a program that caps your copay at \$25 for a 30-day supply.
- Go to [Caremark.com](https://www.caremark.com) to price a medication, locate a pharmacy, or see a prescription benefits overview.



## Weigh Your Options

This high level overview of your 2026 medical plan options is designed to assist you in selecting the plan that might best meet your needs.

|  | Enhanced PPO   | Basic PPO Plan  | Value Care PPO Plan  | HDHP w/HSA  |
|--|--|---|--|---|
| What Comes Out Of Your Paycheck            | High   | Medium  | Low  | Low   |
| What You Might Spend If You Use Healthcare | Low  | Low   | Medium   | High  |
| Eligible Spending Account Type             | Health Care FSA  | Health Care FSA   | Health Care FSA  | HSA   |
| Inframark Account Contribution             | N/A  | N/A   | N/A  | \$500 single / \$1,000 family   |
| You Might Want To Consider This Plan If... | You have lots of medical expenses and you want to limit what you might have to pay for care out of your own pocket.          | You prefer a more traditional insurance plan with copays that help you understand what you'll be paying for routine care and medications. | You don't generally use a lot of healthcare, but appreciate having access to affordable first-line basic and primary care services.                          | You have low healthcare needs, don't mind shopping to find the best prices for care and find the long-term tax advantages of the HSA to be a valuable financial tool. |
| But, You Should Understand That...         | This is an expensive plan, and you might not really need this level of coverage if you're not a frequent user of healthcare. | If you usually only see the doctor for wellness appointments or preventive care, a higher deductible plan could be cheaper for you.       | Specialist and emergency care are not covered at the same rate as basic care. If you need more complex care, you'll have to pay more out of your own pocket. | In exchange for very low premiums, you pay a larger share of the costs of health care services until your deductible is met.  |



# Dental

United Concordia | [unitedconcordia.com/login](http://unitedconcordia.com/login) | 800-332-0366

Inframark offers you the choice of two dental plans through United Concordia. Our dental plans are designed to give you choice and control over your dental care. Both the High and Low plans provide coverage for preventive services, basic services, and major services. The plans differ by the level of benefits they provide out-of-network and the annual benefit maximum and coverage for orthodontia.

## Dental Plan Summary

|   | High Plan             |                | Low Plan   |                |
|---|-----------------------|----------------|------------|----------------|
|   | In-network            | Out-of-network | In-network | Out-of-network |
| Deductible                                    |                       |                |            |                |
| Yourself only                                 | \$50                  | \$50           | \$50       | \$100          |
| You and your family                           | \$150                 | \$150          | \$150      | \$300          |
| Annual plan maximum (per individual)          |                       | \$2,000        |            | \$1,500        |
| Diagnostic and preventive                     |                       | 100%           | 100%       | 80%            |
| Basic services                                |                       | 80%            | 80%        | 60%            |
| Major services                                |                       | 50%            | 50%        | 30%            |
| Orthodontia coverage                          | Yes (including adult) |                | No         |                |
| Orthodontic services                          |                       | 50%            |            | N/A            |
| Orthodontia lifetime maximum (per individual) |                       | \$2,000        |            | N/A            |

## Your Bi-Weekly Dental Insurance Payroll Deductions

|                       | High Dental Plan | Low Dental Plan |
|-----------------------|------------------|-----------------|
| Yourself only         | \$8.35           | \$6.21          |
| You + your spouse     | \$16.03          | \$12.13         |
| You + your child(ren) | \$16.84          | \$12.74         |
| You + your family     | \$27.56          | \$20.51         |

## Smile for Health

The Smile for Health program can provide you with enhanced benefits for exams and procedures to treat gum disease if you are pregnant or have certain medical conditions like diabetes, rheumatoid arthritis, and heart disease.

# Vision

VSP | [vsp.com](http://vsp.com) | 800-877-7195

Inframark provides you the choice of two vision plans offered through Vision Service Plan (VSP), the Base Plan and the Easy Option Plan. Both plans allow you to receive a complete eye examination and materials (if needed). The plans differ in how they share costs with you and the frequency of when you can receive benefits.

## Vision Plan Summary

|                           | Base Plan      | Easy Option Plan          |
|---------------------------|----------------|---------------------------|
| Eye exams                 | Covered 100%   | Covered 100%              |
| Eyeglasses/contacts       | \$15 copay     | \$15 copay                |
| Lenses                    | Covered 100%   | Covered 100%              |
| Progressive lenses        | Not covered    | Easy Option               |
| Frames allowance          | Up to \$150    | Easy Option (up to \$250) |
| Contacts allowance        | Up to \$150    | Easy Option (up to \$250) |
| Frequency – lenses/frames | 12/24 (months) | 12/12 (months)            |

Note: Out-of-network coverage is available at reduced benefit levels.

### Something to think about

Both plans provide similar vision coverage, however, the Easy Option features a more frequent frames allowance and each family member can choose one of the following upgrades at the time of service:

- \$250 Frame Allowance
- \$250 Contact Allowance
- Covered-in-full photochromic, anti-reflective, or progressive lenses

Note: Members with diabetes have a \$0 copay for retinal screenings.

## Your Bi-Weekly Vision Insurance Payroll Deductions

|                       | Base Plan | Easy Option Plan |
|-----------------------|-----------|------------------|
| Yourself only         | \$1.91    | \$5.44           |
| You + your spouse     | \$3.20    | \$9.14           |
| You + your child(ren) | \$3.36    | \$9.59           |
| You + your family     | \$4.72    | \$13.45          |

# Managing Your Health

## Additional Programs Available to You!

### Teladoc

#### Convenient and Affordable Health Care by Phone or Video



Our Teladoc benefit gives you access to board-certified physicians to get fast treatment (including prescriptions) for common ailments such as the flu, allergies, ear infections, and more. If you are enrolled in any of the PPO medical options, you will pay nothing for virtual visits. HDHP enrollees will be charged \$58 or less for virtual visits, which is still considerably less than an emergency room or urgent care visit.

Teladoc also offers mental health services. You can speak with a licensed counselor, therapist, psychologist, or psychiatrist by phone, web, or mobile app. Teladoc services are available seven days a week from 7 a.m. to 9 p.m. local time. To learn more and get started, call 855-Teladoc (835-2362) or go to [teladoc.com/aetna](https://teladoc.com/aetna).

### Livongo — 100% company paid

#### Diabetes and Hypertension Management



Livongo is a health management program that provides you with a free cellularenabled glucose meter and free unlimited testing supplies or a free blood pressure monitor, digital access to track and share your health progress, and immediate telephonic support from certified coaches to keep your blood sugar and blood pressure in healthy ranges throughout your day. To learn more and get started, go to [healthy.livongo.com/inframark](https://healthy.livongo.com/inframark).

### Hinge Health — 100% company paid

#### Remote Back and Joint Care



Inframark medical plan participants and their covered dependents 18 years old or older, have access to Hinge Health for help with remote back and joint care. Treatment can be done anywhere and can be customized by your physical therapist. The Hinge Health app can help with conquering pain or limited movement, recovering from an injury, staying healthy and pain free, and more! To learn more call (855) 902-2777, or apply at: [hingehealth.com](https://hingehealth.com).

## Looking to Stay Connected? There's an App for That!

### Aetna Medical App



The Aetna® Mobile app provides instant access to your family's critical health information. You can find a physician or facility near you, check the status of a claim, use the Cost Estimator, and track spending and progress toward deductibles. You can download your FREE Aetna Mobile app by texting Aetna to 90156.

### CVS Pharmacy App



The CVS app provides you a secure, simple way to manage your prescription benefits and member information. Find a pharmacy no matter where you are. Learn about your medication and get information you can trust day or night. Do all this — and much more — at your convenience.

### Health Advocate Lifeline® App



Get 24/7 access to your Health Advocate benefits as well as a one-touch connection to a live Personal Health Advocate who can help you find the right doctor, untangle insurance claims, secure second opinions, schedule appointments, clarify complex conditions, and estimate health care costs. Check your smartphone's app store to download.

### United Concordia Dental App



The United Concordia® Dental app allows you to find a dentist near you, access your benefits information, get a virtual ID card, manage your account, and learn about oral health and wellness. To learn more and get started, go to [unitedconcordia.com](https://www.unitedconcordia.com).

### VSP Vision App



The VSP app provides easy access to locate VSP participating providers near you, your member ID card, summary of your vision benefits, glasses and contacts, and more. VSP providers meet the highest quality standards for credentialing and for providing both comprehensive eye care and full-service vision hardware services.



## Health Advocate

### EmpoweredHealth

Health Advocate EmpoweredHealth is a fully-integrated program that provides you with a personal health advocate who can help you navigate the complex world of health care. This benefit is 100% company-paid.

Your personal health advocate can help you with things like:

- Finding a physician
- Weight management
- Coordinating your care among many health care providers
- Nutrition
- Processing insurance claims and paperwork
- Stress management
- Negotiating fees for health care services
- Chronic health conditions (such as diabetes, asthma, or depression)
- Arranging for second opinions
- and more!

You'll also have access to interactive online coaching programs, unlimited telephonic support from health professionals, and a 24-hour Nurse Line.

### Perks at Work

Perks at Work is a FREE discount program that offers savings on products and services from thousands of merchants. You can invite up to 10 family members to join the program! Perks at Work allows you to:

- Save on travel, electronics, tickets, restaurants, flowers, home products, apparel, and more
- Access the best prices on educational programs to help you and your family learn and grow
- Earn WOW points on everything you buy, that can be redeemed like cash to use towards your next purchase from your favorite merchants
- Get exclusive rates on electronics, cell phones, and car rentals

#### Visit Perks at Work:

1. Log on to our member website or mobile app
2. Click **EAP: Life & Work**
3. Scroll toward the bottom of the page and select **Visit Perks at Work**
4. Explore the perks and discounts available to you.

#### GET STARTED TODAY!

- 855-424-6400
- Email: [answers@HealthAdvocate.com](mailto:answers@HealthAdvocate.com)
- Web: [HealthAdvocate.com/inframark](http://HealthAdvocate.com/inframark)

# Health Savings Account (HSA)

**Empower Retirement/Optum Bank | [empowermyretirement.com](https://empowermyretirement.com) | 844-553-7130**

If you enroll in the High Deductible Health Plan, you also have the opportunity to establish a Health Savings Account (HSA). An HSA is an account that can be used to build long-term tax-deferred savings to pay for qualified health care expenses. Account management is available through [empowermyretirement.com](https://empowermyretirement.com).

An HSA provides you with great tax savings:

- Contributions made to your HSA via paycheck deduction are pre-tax;
- Earnings growth through interest and investments is not taxed; and
- Withdrawals from your account are tax-free, if used for qualified healthcare expenses.

Inframark will contribute funds to your HSA to get you started on the road to saving for your healthcare expenses. For 2026, you will receive:

|            | Employer contribution |
|------------|-----------------------|
| Individual | \$500                 |
| Family     | \$1,000               |

For the 2026 plan year, if you enroll in the High Deductible Health Plan, you can contribute up to the following amounts to your HSA

|            | 2026 HSA Annual Maximum contribution |
|------------|--------------------------------------|
| Individual | \$4,400                              |
| Family     | \$8,750                              |

\*Those age 55+ and not enrolled in Medicare can contribute an additional \$1,000 "catch-up" contribution.

The amount that Inframark contributes into the account on your behalf counts towards the annual maximums listed above.

An HSA is an excellent opportunity to save for future medical expenses for you and your family or to simply save for your future. However, it is important that you understand how to contribute funds to an HSA, how to withdraw funds you have contributed and what, if any, tax implications there are associated with your HSA fund.

## HSA Eligibility

You are eligible to open and fund an HSA if:

- You are not enrolled in any other non-HSA qualified health insurance plan.
- You are not covered by your spouse's health plan (unless it is a qualified HDHP), flexible spending account (FSA), or health reimbursement arrangement (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare, TRICARE, or TRICARE For Life.
- Care received through the VA in the preceding three calendar months was dental, vision, or preventive care or was provided to a veteran who has a disability rating from the VA.

## Spending Your Money

HSA distributions are tax-free if they are used to pay for qualified medical expenses.

- Qualified medical, dental, and vision expenses not covered by insurance
- Qualified long-term care services and long-term care insurance
- Continuation of coverage required by federal law (i.e., COBRA)
- Health insurance for the unemployed
- Medicare expenses (but not Medigap)
- Retiree health expenses for individuals aged 65 or older

Distributions made for any other purpose are subject to income tax and a 20% penalty. The 20% penalty is waived in the case of death or disability. The 20% penalty is also waived for distributions made by individuals aged 65 or older.

**Please note:** The IRS provides a list of eligible services and products that you can purchase with your health savings account. It is your responsibility to make sure you are eligible to contribute to your HSA, your contributions are within the IRS limits, and you are using your HSA for qualified medical expenses. For more details, see Publication 969 at [irs.gov/forms-pubs/about-publication-969](https://www.irs.gov/forms-pubs/about-publication-969). Once there, go to the current revision and choose Publication 969 PDF to learn more about this type of account. Visit [irs.gov/forms-pubs/about-publication-502](https://www.irs.gov/forms-pubs/about-publication-502) for a list of qualified medical expenses.



# Flexible Spending Account (FSA)

**My Choice Accounts | [myinframarkbenefits.com](https://myinframarkbenefits.com) | 888-532-3617**

A great way to plan ahead and save money over the course of a year is to participate in a Flexible Spending Account. A Flexible Spending Account lets you redirect a portion of your salary on a pretax basis into a reimbursement account, saving money on taxes. If you are interested in participating, then each year you must select the type of account you'd like to enroll in and designate your contributions.

|   | Annual contribution limits (2026)                   |
|---|---|
| Healthcare flexible spending account      | \$3,400 per household*                              |
| Dependent care flexible spending account  | \$7,500 filed jointly<br>\$3,750 filed individually |
| Limited-purpose flexible spending account | \$3,400 per household*                              |

\*IRS limits subject to change.

Inframark offers three types of FSAs that can help save on a pretax basis for out-of-pocket expenses.

## Healthcare Flexible Spending Account

The health care flexible spending account (FSA) gives you the ability to save money on a pre-tax basis for any IRS-allowed health expenses not covered by your insurance.

Eligible health care FSA expenses include deductibles, copayments and coinsurance payments, uninsured dental expenses, vision care expenses (e.g. eyeglasses or contact lenses), hearing care expenses (e.g. a hearing aid), and orthodontia. Eligible and ineligible healthcare expenses are defined and listed in IRS Publication 502, available online at [irs.gov/publications](https://www.irs.gov/publications).



## Limited Purpose FSA (For HSA Participants Only)

Enrollees in the High Deductible Health Plan (HDHP) that open an HSA may participate in a Limited Purpose FSA, as well as a Dependent Care FSA. Due to federal guidelines concerning HSAs, participants are not eligible to enroll in a traditional Healthcare FSA in conjunction with their HSA.

A Limited Purpose FSA may be used for eligible dental and vision care expenses. You will also be able to receive reimbursement for medical services covered under the HDHP once you have satisfied your annual deductible. In order to receive reimbursement for eligible medical expenses, you must submit documentation that states your annual deductible has been met.

### Something to think about

- By contributing roughly \$19 per pay to a health care FSA, you can save \$125 in taxes and have \$500 to put toward your health care expenses! (Assumes 25% tax bracket)
- Although the Health Care FSA is a use-it-or-lose-it account, you can roll over up to \$680 of unused funds to use in the next year
- Plans offer convenient claim submission options (online/fax/mail)
- Total annual contribution available for use on day one of the plan year
- You must actively elect your annual Health Care FSA contribution each year during annual enrollment
- Automatic reimbursements with the flex debit card; weekly processing for submitted claims with direct deposit or check payments options
- Account management/online tools available through [businessolver.com/mychoice-accounts/](https://businessolver.com/mychoice-accounts/)

## Dependent Care Flexible Spending Account

A Dependent Care FSA gives you the ability to set aside money on a pre-tax basis for day care expenses for your child, disabled parent, or spouse that enable you and your spouse (if applicable) to work full-time and/or attend school on a full-time basis. Generally, expenses will qualify for reimbursement if they are the result of care for:

- Your children, under the age of 13, for whom you are entitled to a personal exemption on your federal income tax return.
- Your spouse or other dependents, including parents, who are physically or mentally incapable of self-care.

Eligible and ineligible dependent day care expenses are defined and listed in IRS Publication 503, available online at [irs.gov/publications](https://www.irs.gov/publications).

### Something to think about

- Dependent Care FSA elections cannot be carried over from year to year. You must make new elections during the open enrollment period
- The dependent care FSA is a use-it-or-lose-it account
- The plan offers convenient claim submission options online or through fax and mail
- Automatic reimbursements with the flex debit card; weekly processing for submitted claims with direct deposit or check payments options
- Account management/online tools available through [businessolver.com/mychoice-accounts](https://businessolver.com/mychoice-accounts/)

## Tax-advantaged Accounts

### Health Savings Accounts & Flexible Spending Accounts

|                             | Health Savings Account   | Healthcare FSA   |   | Dependent Care FSA  |
|-----------------------------|--|--|---|---|
|                             |  | Traditional Healthcare FSA   | Limited Purpose FSA   |   |
| Inframark Contribution:     | <ul style="list-style-type: none"> <li>Individual coverage level: \$500</li> <li>All other coverage levels: \$1,000</li> </ul>   | None   | None  | None  |
| Eligibility:                | Enrolled in the HDHP w/HSA Medical Plan or waived medical coverage   | Enrolled in the PPO Medical Plan or waived medical coverage                                  | Enrolled in HDHP w/ HSA Medical Plan  | Available to all employees regardless of medical plan enrollment status                               |
| Annual Contribution Limits: | <ul style="list-style-type: none"> <li>Individual coverage level: \$4,400</li> <li>All other coverage levels: \$8,750</li> </ul> | \$3,400  | \$3,400   | \$7,500 (or \$3,750 if both you and your spouse elect the benefit and you file your taxes separately) |
| Fund Availability:          | Funds are available as deposited/ contributed.   | Total annual contribution available for use on day one of the plan year                      | Total annual contribution available for use on day one of the plan year                                     | Funds become available for use as they are contributed  |
| Eligible Expenses:          | Medical, prescription, dental, and vision expenses   | Medical, prescription, dental, and vision expenses   | Dental and vision expenses only (medical expenses may be eligible once your medical plan deductible is met) | Daycare, adult daycare, children's summer camp, preschool tuition, after school programs, etc.        |
| Do Funds Carry Over?        | Funds roll over from year to year. The HSA is portable.  | Any funds left in your account at the end of the plan year exceeding \$680 will be forfeited |   | Any funds left in your account at the end of the plan year grace period will be forfeited             |



# Life and AD&D Insurance

Prudential | [prudential.com/mybenefits](https://prudential.com/mybenefits) | 800-524-0542

## Basic Life Insurance\*

Inframark provides eligible employees with a Basic Life Insurance benefit that equals 1 times your base annual salary up to a maximum of \$200,000. This coverage is 100% company-paid. Please Note: Any amount exceeding \$50,000 in coverage will be subject to taxation as imputed income.

## Basic AD&D Insurance\*

In addition to Basic Life Insurance, Inframark provides eligible employees with a Basic AD&D Benefit. Similar to your Basic Life Insurance, this benefit equals 1 times your base annual earnings up to a maximum of \$200,000. This coverage is 100% company-paid.

\*Benefit reduces to 65% at age 70 and 50% at age 75

### Something to think about

- You get Basic Life and AD&D Insurance automatically as part of your employee benefits.
- If you'd like to buy additional life insurance coverage for yourself, your spouse, or your children, see page 21.
- IRS regulations require taxation of company-paid life insurance that exceeds \$50,000.

## Remember to Designate Your Beneficiaries

A beneficiary is the person(s) who will receive your Life/AD&D benefits should the unfortunate happen. It is important to keep your beneficiary designation as up-to-date as possible. Should something happen to you, your benefits will be paid to the most recent beneficiary(ies) on file (or to your estate if no beneficiary is on file).



# Voluntary Life and AD&D

Prudential | [prudential.com/mybenefits](https://prudential.com/mybenefits) | 800-524-0542

You may purchase Supplemental Term Life Insurance for yourself, your spouse, and your children. If you elect this coverage, you are responsible for paying 100% of the benefit cost.

Employee Supplemental Life Insurance lets you purchase coverage of 1 to 5 times your salary up to a maximum of \$500,000. Evidence of insurability is required for amounts over \$250,000, which is the guaranteed issue amount.

Spouse Supplemental Life Insurance lets you purchase coverage in increments of \$10,000 up to a maximum of \$200,000. Evidence of insurability is required for amounts over \$50,000, which is the guaranteed issue amount. Coverage up to \$50,000 can be elected without evidence of insurability.

Child Supplemental Life Insurance lets you purchase coverage for \$5,000 up to \$10,000. Your unmarried dependent children may be covered up to age 26.

| Voluntary life employee (and spouse)* monthly rates |                  |       |                  |
|---|------------------|-------|------------------|
| Age   | Rate per \$1,000 | Age   | Rate per \$1,000 |
| Under 25  | \$0.058          | 50-54 | \$0.305          |
| 25-29   | \$0.070          | 55-59 | \$0.562          |
| 30-34   | \$0.094          | 60-64 | \$0.949          |
| 35-39   | \$0.106          | 65-69 | \$1.488          |
| 40-44   | \$0.118          | 70+   | \$2.507          |
| 45-49   | \$0.176          |       |                  |

| Dependent Child(ren) monthly rates |                  |
|------------------------------------|------------------|
| Election Amount                    | Rate per \$1,000 |
| \$5,000                            | \$1.00           |
| \$10,000                           | \$1.91           |
| \$20,000                           | \$3.82           |

\* Spouse rates will be determined by the employee age.

**To determine your cost for coverage, use the following formulas:**

- Coverage Amount ÷ 1000 x rate x 12 ÷ 52 = weekly cost
- Coverage Amount ÷ 1000 x rate x 12 ÷ 26 = bi-weekly cost

## Evidence of insurability (also known as medical questions or EOI)

If you are currently enrolled in this benefit, you may increase coverage by 1x earnings, not to exceed the guarantee issue limit of \$250,000, without completing an EOI form. Elected amounts in excess of 1x earnings or any amount in excess of \$250,000 is subject to evidence of insurability. It's your responsibility to complete and submit the EOI to the life insurance carriers and to ensure your application has been processed and approved.

# Short- and Long-Term Disability

Prudential | [prudential.com/mybenefits](https://prudential.com/mybenefits) | 800-524-0542

Short-Term and Long-Term Disability Insurance can help if you become disabled and are unable to work due to a covered injury or sickness.

## Short-Term Disability (STD)

Short-Term Disability benefits begin on the 15th day of your absence, after the 14-day elimination period is complete. Inframark automatically provides you with basic coverage of 65% or 80% (if you have five or more years of service) of your salary. During the elimination period, this benefit can be supplemented with accrued sick, vacation, and floating holiday time.

The STD benefit is paid for by Inframark; there is no cost to you. However, any income replacement benefits received are taxable.

## Long-Term Disability (LTD)

Long-Term Disability benefits begin after you have been disabled for a total of 90 calendar days. Inframark automatically provides you with basic coverage of 60% of your monthly salary to a maximum of \$10,000/month.

### Something to think about

You should review and understand the important tax implications of Long-Term Disability Insurance. By default, unless you opt out, we will apply taxes to the value of your company-paid LTD benefits (“Tax Me Now”), which ensures you a tax-free benefit if you become disabled.



# Employee Assistance Program (EAP)

Health Advocate | [HealthAdvocate.com/inframark](https://HealthAdvocate.com/inframark) | 855-424-6400

Call the Health Advocate Employee Assistance Program (EAP) for 24/7 access to confidential counseling and referral services to help you and your eligible dependents manage life's problems. Some issues the EAP can help with include:

- Daycare
- Occupational performance
- Eldercare
- Self-esteem
- Family/relationships
- Smoking cessation
- Financial stress
- Substance abuse
- Legal concerns

## GET STARTED TODAY!

- 1-855-424-6400
- Email: [answers@HealthAdvocate.com](mailto:answers@HealthAdvocate.com)
- Web: [HealthAdvocate.com/inframark](https://HealthAdvocate.com/inframark)
- If asked for a registration code, use:  
INFRAMARK



# 401(k) Retirement

Empower Retirement | [empower.com](https://empower.com) | 1-855-756-4738

One way to save for your future retirement is to participate in a 401(k) Plan now. Inframark offers employees a 401(k) Savings Plan to help you save for your retirement. The 401(k) Savings Plan is managed by Empower Retirement. The plan enables you to contribute to a tax-deferred savings account to increase your retirement income. Here are some of the features of our plan:

- Administered by Empower Retirement
- For tax year 2026, the maximum elective deferral to a 401(k) plan is \$23,500. Employees 50 years old and older can make additional catch-up contributions of up to \$7,500.
- 50% company matching on employee contributions up to 6% (net 3% match)
- 5-year graduated vesting on employer contributions (20% per year); broad array of funds available to diversify your investments
- You have the option to contribute Pre-tax, Roth, or After-Tax
- Rollover your retirement savings from another eligible retirement plan
- Contact Empower at 1-855-756-4738 if you have questions
- Go to [empower.com](https://empower.com) to register for your account, select your deferrals and investments and designate your beneficiaries.
- Account changes can be made at any time on the Empower website, and are not tied to our annual benefits Open Enrollment.

Beginning January 1st, 2026, the Inframark 401(k) Retirement and Savings Plan will no longer offer automatic enrollment into the Plan or annual automatic escalation of contributions. You will still have the option to manually increase or change your contributions at any time by visiting [empower.com](https://empower.com) or by calling Empower at 1-855-756-4738.



# Supplemental Health

Aetna | [aetna.com](https://www.aetna.com) | 1-800-607-3366

## Accident Plan

This plan pays you lump-sum cash benefits for covered accidents and treatments — including follow-up care, medical imaging, X-rays, dislocations, fractures, physical therapy, and more. The money can help pay medical bills or everyday living expenses like groceries, car payments, or rent. You can also sign up for direct deposit to get your benefits faster.

### Additional Plan Highlights

- Two plan options
- Organized sports benefit pays you an additional 25% of total benefits
- \$50 wellness benefit
- On/off job coverage

## Critical Illness Plan

This plan pays you lump-sum cash benefits for a wide range of covered critical illnesses — including a heart attack, stroke, cancer, end-stage renal failure, and more. A new covered diagnosis must occur on or after your plan's effective date. Use the money to help pay medical bills or everyday living expenses like groceries, car payments, or rent. You can also sign up for direct deposit to get your benefits faster.

### Additional Plan Highlights

- Four plan options: \$5,000, \$10,000, \$20,000, or \$30,000
- Childhood illness benefit
- Infectious disease benefit
- \$100 wellness benefit

### Works with your health plan

There are no doctor exams to take or medical questions to answer. So, you won't be denied coverage based on your health. And the plan pays you regardless of any other insurance you may have. This means it pairs well with your major medical plan.

### Contact information

- If you have questions about the plans, call Aetna member services at 1-800-607-3366 (TTY: 711).
- Convenient hours of operation, Monday – Friday, 8 am – 6 pm in all time zones.

Translation support in Spanish and other languages available.

## Accident Rates

|                       | Low Plan        |                    | High Plan       |                    |
|-----------------------|-----------------|--------------------|-----------------|--------------------|
|                       | Weekly paycheck | Bi-weekly paycheck | Weekly paycheck | Bi-weekly paycheck |
| Youself only          | \$1.53          | \$3.06             | \$2.43          | \$4.87             |
| You + your spouse     | \$3.06          | \$6.11             | \$4.84          | \$9.69             |
| You + your child(ren) | \$3.21          | \$6.42             | \$5.11          | \$10.22            |
| You + your family     | \$4.74          | \$9.47             | \$7.54          | \$15.09            |

| Critical Illness Insurance Weekly Rates For \$5,000 of Coverage |          |            |            |            |            |            |            |            |            |            |          |  |
|---|----------|------------|------------|------------|------------|------------|------------|------------|------------|------------|----------|--|
|   | <25 yrs. | 25–29 yrs. | 30–33 yrs. | 34–39 yrs. | 40–44 yrs. | 45–49 yrs. | 50–54 yrs. | 55–59 yrs. | 60–64 yrs. | 65–69 yrs. | 70+ yrs. |  |
| Youself only  | \$0.67   | \$0.69     | \$0.84     | \$1.08     | \$1.50     | \$2.13     | \$3.07     | \$4.32     | \$6.15     | \$9.24     | \$13.51  |  |
| You + your spouse   | \$1.23   | \$1.27     | \$1.48     | \$1.82     | \$2.39     | \$3.29     | \$4.55     | \$6.21     | \$8.67     | \$12.78    | \$18.75  |  |
| You + your child(ren)   | \$1.27   | \$1.29     | \$1.44     | \$1.68     | \$2.10     | \$2.75     | \$3.68     | \$4.92     | \$6.75     | \$9.84     | \$14.10  |  |
| You + your family   | \$1.82   | \$1.87     | \$2.08     | \$2.42     | \$2.99     | \$3.89     | \$5.15     | \$6.81     | \$9.27     | \$13.38    | \$19.36  |  |

| Critical Illness Insurance Bi-Weekly Rates For \$5,000 of Coverage |          |            |            |            |            |            |            |            |            |            |          |  |
|--|----------|------------|------------|------------|------------|------------|------------|------------|------------|------------|----------|--|
|  | <25 yrs. | 25–29 yrs. | 30–33 yrs. | 34–39 yrs. | 40–44 yrs. | 45–49 yrs. | 50–54 yrs. | 55–59 yrs. | 60–64 yrs. | 65–69 yrs. | 70+ yrs. |  |
| Youself only   | \$1.34   | \$1.38     | \$1.68     | \$2.17     | \$3.00     | \$4.27     | \$6.14     | \$8.63     | \$12.30    | \$18.48    | \$27.02  |  |
| You + your spouse  | \$2.47   | \$2.54     | \$2.95     | \$3.65     | \$4.78     | \$6.58     | \$9.09     | \$12.42    | \$17.33    | \$25.57    | \$37.50  |  |
| You + your child(ren)  | \$2.54   | \$2.58     | \$2.88     | \$3.37     | \$4.20     | \$5.49     | \$7.36     | \$9.83     | \$13.50    | \$19.68    | \$28.20  |  |
| You + your family  | \$3.65   | \$3.74     | \$4.15     | \$4.85     | \$5.98     | \$7.78     | \$10.29    | \$13.62    | \$18.53    | \$26.77    | \$38.72  |  |

Benefits can be selected in \$5,000, \$10,000, \$20,000, and \$30,000 amounts.

To calculate your cost of coverage beyond \$5,000 multiply the above amounts by 2 for \$10,000 worth of coverage; 4 for \$20,000 worth of coverage or 6 for \$30,000 worth of coverage.



# Contacts

## Benefit Support

### Inframark

Phone: 888-532-3617  
 Website: [myinframarkbenefits.com](https://myinframarkbenefits.com)

## Medical

### Aetna

Phone: 800-238-6716  
 Website: [aetna.com](https://aetna.com)

### Teladoc

Phone: 855-835-2362  
 Website: [teladoc.com/aetna](https://teladoc.com/aetna)

## Prescription Services

### CVS Caremark

Phone: 833-840-7957  
 Website: [caremark.com](https://caremark.com)  
 Group number: RX24MU

## Wellness Program

### Health Advocate

Phone: 855-424-6400  
 Website: [HealthAdvocate.com/inframark](https://HealthAdvocate.com/inframark)

## HSA

### Empower Retirement/Optum Bank

Phone: 844-553-7130  
 Website: [empowermyretirement.com](https://empowermyretirement.com)

## Healthcare and Dependent care FSA

### My Choice Accounts

Phone: 888-532-3617  
 Website: [myinframarkbenefits.com](https://myinframarkbenefits.com)

## Dental

### United Concordia | Elite Plus Network

Phone: 800-332-0366  
 Website: [unitedconcordia.com/login](https://unitedconcordia.com/login)  
 Policy number: 903656

## Vision

### VSP

Phone: 800-877-7195  
 Website: [vsp.com](https://vsp.com)  
 Policy number: 30043183

## Life and AD&D

### Prudential

Phone: 800-524-0542  
 Website: [prudential.com/mybenefits](https://prudential.com/mybenefits)  
 Control Number: 72332

## Short- and Long-Term Disability/Leave of Absence

### Prudential

Phone: 800-524-0542  
 Website: [prudential.com/mybenefits](https://prudential.com/mybenefits)

## Employee Assistance Program

### Health Advocate

Phone: 855-424-6400  
 Website: [HealthAdvocate.com/inframark](https://HealthAdvocate.com/inframark)

## Retirement

### Empower Retirement

Phone: 855-756-4738  
 Website: [empowermyretirement.com](https://empowermyretirement.com)

## Accident, Cancer, Critical Illness and Hospital Indemnity Insurance

### Aetna Group

Phone: 800-607-3366  
 Website: [MyAetnaSupplemental.com](https://MyAetnaSupplemental.com)  
 Policy number: 847892

# Inframark, LLC.

## HEALTH PLAN NOTICES

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3. HIPAA Comprehensive Notice of Privacy Policy and Procedures
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7. Women's Health and Cancer Rights Notice
8. Michelle's Law Notice
  - This notice is still required when a health plan permits dependent eligibility beyond age 26, but conditions such eligibility on student status. Further, the notice is still necessary if the plan permits coverage for non-child dependents (e.g., grandchildren) that is contingent on student status. The notice must go out whenever certification of student status is requested.
9. Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

### IMPORTANT NOTICE

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

## MEDICARE PART D CREDITABLE COVERAGE NOTICE

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Inframark, LLC. has determined that the prescription drug coverage offered by the Inframark, LLC. Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

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

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

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

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

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

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

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

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

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

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

### **Compare Coverage**

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Inframark, LLC. Plan’s summary plan description for a summary of the Plan’s prescription drug coverage. If you don’t have a copy, you can get one by contacting us at the telephone number or address listed below.

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

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

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

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

Contact the person listed below for further information, or call 267-465-1064. **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 Inframark, LLC. changes. You also may request a copy.

### **For More Information About Your Options Under Medicare Prescription Drug Coverage...**

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

For more information about Medicare prescription drug coverage:

- Visit [www.medicare.gov](http://www.medicare.gov).
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help,

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

|                          |   |
|--------------------------|---|
| Date:                    | October 15, 2025  |
| Name of Entity/Sender:   | Gina Mack   |
| Contact—Position/Office: | Director of Total Rewards                                   |
| Address:                 | 2002 W. Grand Parkway North, Suite 100<br>Katy, Texas 77449 |
| Phone Number:            | 267-465-1064  |

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

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

**INFRAMARK, LLC.  
IMPORTANT NOTICE  
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES**

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

This notice is provided to you on behalf of:

**Inframark Benefit Plans\***

\* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, Inframark, LLC. is referred to as Company.

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

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

**3. Protected Health Information:** The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format.

Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

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

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

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

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

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

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

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

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities;
- When required for judicial or administrative proceedings;
- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;

- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

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

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

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

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to

investigate or determine the group health plan's compliance with the privacy regulations.

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

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

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

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

disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other than the health plan on behalf of the individual) has paid the covered entity in full.

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

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

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

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

**19. Right to Receive an Accounting of Protected Health Information Disclosures:** You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting

within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

**20. The Right to Receive a Paper Copy of This Notice Upon Request:** If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 23).

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

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

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

### **Privacy Official**

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

Gina Mack  
Director of Total Rewards  
267-465-1064

### **Effective Date**

The effective date of this notice is: October 15, 2025.

## NOTICE OF SPECIAL ENROLLMENT RIGHTS

### INFRAMARK, LLC. EMPLOYEE HEALTH CARE PLAN

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

Loss of eligibility includes but is not limited to:

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

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

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

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

To request special enrollment or obtain more information, contact:

Gina Mack  
Director of Total Rewards  
267-465-1064

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

## GENERAL COBRA NOTICE

### Introduction

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

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

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

### What is COBRA continuation coverage?

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

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

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

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

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

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

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

### **When is COBRA continuation coverage available?**

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

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

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.**

### **How is COBRA continuation coverage provided?**

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

### **Are there other coverage options besides COBRA Continuation Coverage?**

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period<sup>1</sup> to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

### **If you have questions**

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

### **Keep your Plan informed of address changes**

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

### **Plan contact information**

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

Gina Mack  
Director of Total Rewards  
2002 W. Grand Parkway North, Suite 100  
Katy, Texas 77449  
267-465-1064

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

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

Inframark, LLC. Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan issuer.

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

You do not need prior authorization from Inframark, LLC. Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Inframark, LLC. Employee Health Care Plan at:

Gina Mack  
Director of Total Rewards  
267-465-1064

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

Inframark, LLC. Employee Health Care Plan is required by law to provide you with the following notice:

The Women’s Health and Cancer Rights Act of 1998 (“WHCRA”) provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

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

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

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

Gina Mack  
Director of Total Rewards  
267-465-1064

## MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

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

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

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

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

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

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

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Gina Mack, Director of Total Rewards, 267-465-1064.

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

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

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

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

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

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

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

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

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

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

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

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

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

### Paperwork Reduction Act Statement

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

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

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

