



VitalCare
Corporation

2026

EMPLOYEE
BENEFITS PACKAGE



Table of Contents

Eligibility & Enrollment _____	1	Additional Employment Benefits _____	28
Variable Hour Eligibility _____	3	FAMLI+ _____	29
Medical _____	4	Insurance Terms and Definitions _____	30
How Your Plan Works _____	6	CHIP Notice _____	32
Where to Seek Care _____	7	Combined Legal Notices _____	34
HSA _____	9	Cobra Notice _____	35
Dental _____	11	Health Insurance Marketplace Notice _____	37
Vision _____	12	RX - Medicare Creditable Coverage Disclosure _____	40
Mental Health - MyStrength Complete _____	13	Michelle's Law _____	41
Accident Insurance _____	14	HIPAA Notice _____	42
Critical Illness _____	16	USERRA Notice _____	45
Hospital Indemnity _____	18	MHPAEA Notice _____	46
Wellness Screening Credit _____	22	No Surprises Act Notice _____	49
Term Life Insurance _____	24	Resources _____	50
Pet Insurance _____	25	Notes _____	51
Colorado Secure Savings _____	27		



Enrolling in Your Benefits

Eligibility & Enrollment

You are eligible for benefits if you are an active full-time employee working **30** or more hours per week, **or** an active variable hour employee working an average of 130 hours per month over a 12-month lookback period.

Your dependents are eligible if they are:

- Your legal spouse or domestic partner
- Your and/or your domestic partner's child(ren) up to age 26*
- Your disabled child(ren) up to any age (if disabled prior to age 19)*
- Dependent verification may be required (includes natural, step, legally adopted/or a child placed for adoption, or a child under your legal guardianship)

About Domestic Partner Coverage

To enroll your same-sex or opposite-sex domestic partner and his or her dependents for coverage, you will be required to submit:

- Proof of domestic partnership
- Appropriate declaration forms

Under federal law, the employer's contribution toward the cost of healthcare coverage for your domestic partner and his or her dependents is considered taxable income to you. Domestic partner premiums will be deducted on a post-tax basis. You may wish to consult with a tax adviser for more information.

When Can I Enroll in Benefits?

You can enroll for benefits:

- **30 days** before becoming eligible for benefits (new hire or becoming a full-time employee)
- During the annual **Open Enrollment** period
- During the plan year, if you experience a **Qualifying Life Event**

When Does Coverage Begin?

Benefits become effective on the **first of the month** following date of hire for full-time employees. **Variable-hour employees** (full-time equivalent, seasonal, and part-time) will be subject to a 12-month lookback period to determine full-time equivalent status.

How Do I Enroll in Benefits?

You must actively enroll in all benefits that require employee contributions. To enroll in benefits, contact Heidi at heidi@vitalcare.us.

Please Note:

Federal regulations require employers to obtain the following information during Enrollment:

- Social Security numbers for you and your dependents covered by the medical plan
- Dates of birth and your relationship to your dependents

Making Changes During the Plan Year

The benefit elections you make during your initial enrollment period will be in effect through the plan year's end. If you have a "qualified life event," you may make changes to certain benefits if you apply for the change and provide supporting documentation to the [benefits administrator](#) within **30 days** of the event. Proof of a life event is subject to the company's approval.

Changes are effective prospectively unless the event is for birth, adoption, or placement for adoption.

Qualifying life events include, but are not limited to:

- Newlywed
- Divorce or legal separation
- Birth, adoption, or placement for adoption of an eligible child
 - If adding a newborn baby to your plan, the baby's Social Security number will not be available right away. Please submit the paperwork without it, and provide it once it's available
- Death of your spouse, domestic partner, or covered child
- Change in your or your spouse/domestic partner's work status that affects benefits eligibility (for example, starting a new job, leaving a job, changing from part-time to full-time, starting or returning from an unpaid leave of absence, etc.)
- Your spouse's Open Enrollment
- A change in your child's eligibility for benefits
- Gain or loss of Medicare or Medicaid during the year
- Relocation

Other qualifying events may also apply. Please get in touch with heidi@vitalcare.us.

Termination of Coverage

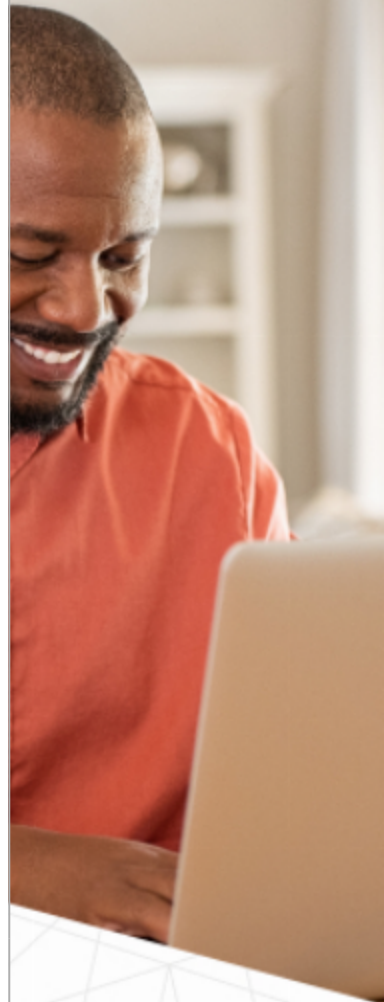
If you or a covered dependent no longer meet the eligibility requirements or if your employment ceases, your coverage will end on the last day of the month in which you become ineligible; however, you may be eligible to elect COBRA for yourself and your eligible dependents for medical and dental coverage.

Should any of your dependents become ineligible for benefits, you are responsible for informing the [benefits administrator](#) within **30 days** of the event. Situations may include a child aging out of eligibility or separation/divorce.

COBRA

Should you lose coverage under an employer's group health plan due to a qualifying event, the [Consolidated Omnibus Budget Reconciliation Act \(COBRA\)](#) is a federal law that requires employers to offer employees, their spouses, and their dependents a **temporary period of continued health care coverage**.

When a qualifying event occurs, such as retirement or reduction in hours, you will receive an election notice regarding your rights to continuation of benefits. Benefits must be elected no more than 60 days after the qualifying event. For more information, please contact heidi@vitalcare.us or benefits@hrxservices.com.



How We Determine If You Qualify for Health Coverage

If you are hired into a position where your hours may vary (sometimes called “variable hour,” “part-time,” or “seasonal”), we use a special process called the “look-back measurement method” to determine if you qualify for health benefits under the Affordable Care Act (ACA).

How the Look-Back Measurement Method Works.

1. Initial Measurement Period (For New Hires)

- When you are first hired, we track the number of hours you work over a 12-month period, starting the first day of the month after your hire date.
- During this time, you may not be eligible for health coverage right away, but your hours are being counted.

2. Administrative Period

- After the 12-month measurement period, there is a short administrative period (1 month) where we review your hours and determine if you qualify for benefits.
- If you averaged at least 30 hours per week (or 130 hours per month) during the measurement period, you will be offered health coverage.

3. Stability Period

- If you qualify, you will be eligible for health coverage for the next 12 months, even if your hours go below 30 per week during that time, as long as you remain employed.
- If you do not qualify, you will not be eligible for coverage during this stability period, but your hours will continue to be tracked for future eligibility.

4. Ongoing Measurement

- After your first cycle, you will be measured on the same schedule as other ongoing employees, using a 12-month measurement period each year.

WHY?

Why This Matters

This process ensures that employees with variable schedules have a fair opportunity to qualify for health benefits, based on actual hours worked over time.

Example

- You are hired on Feb 14.
- Your measurement period starts March 1 and runs through the following Feb 28.
- If you average 30+ hours per week during this time, you will be offered health coverage for the next 12 months, starting after a short administrative period.

If you have questions about how your hours are tracked or your eligibility for benefits, please contact HR for more information.

Medical

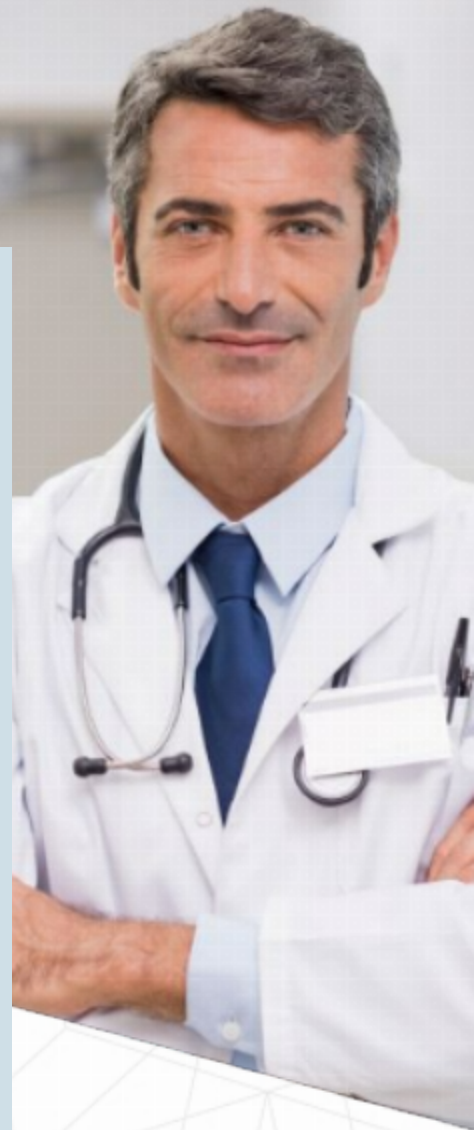
Plan Explanation

VitalCare covers **\$175** of your employee's only premium each pay period (26 pay periods a year). Employees are then responsible for the remaining premium for their covered dependents. Contributions made from each paycheck toward your benefit elections will automatically be deducted from your gross pay before Federal Income taxes and Social Security taxes are calculated. Since these contributions are deducted before your pay is taxed, your taxes will be based on a lower gross pay, and you will end up paying lower taxes on the same salary.

Health Care Reform

If you choose to purchase individual coverage through the Colorado Marketplace, you should know that, because the your company's medical insurance meets specific ACA requirements, you may not be eligible to receive a federal premium subsidy for yourself or your dependents. This takes effect when you first become eligible for benefits, even if you choose not to enroll in the benefits offered by your company.

The ACA also mandates that if you continue to take a premium subsidy on an individual health insurance policy, you will be required to pay the entire subsidy amount back when you file income taxes. Additional information is available at www.healthcare.gov.



United Healthcare | Doctors
[Plan HMO](#)

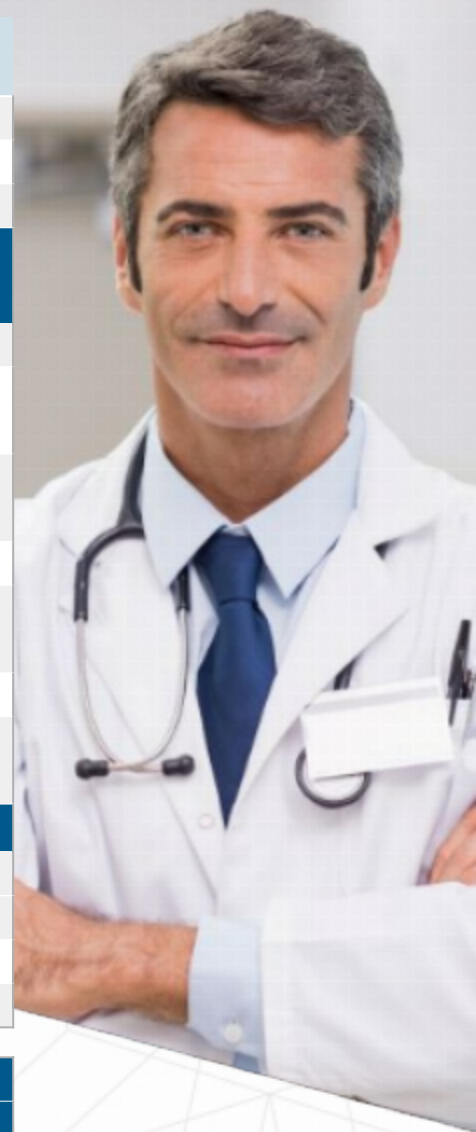
United Healthcare | Choice
[Plus Bronze \(HSA Eligible\)](#)

DEDUCTIBLE	IN-NETWORK		OUT-OF-NETWORK
	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Single	\$8,500	\$6,500	\$7,500
Family	\$17,000	\$13,000	\$15,000
Deductible Period	Jan-Dec	Jan-Dec	Jan-Dec
OUT OF POCKET MAXIMUM			
Single	\$9,700	\$8,350	\$15,000
Family	\$19,400	\$16,700	\$30,000
COMMONLY USED SERVICES			
Primary Care Physician Office Visit	No Charge	\$0 copay	50%*
Specialist Office Visit (referral not required)	\$150	10%*	50%*
Urgent Care	No Charge	10%*	50%*
Emergency Room	40%*	10%*	10%*
Preventive Services	No Charge	No Charge	50%*
MAJOR MEDICAL EXPENSES			
Outpatient Surgery	40%*	10%*	50%*

United Healthcare | Doctors
Plan HMO
United Healthcare | Choice
Plus Bronze (HSA Eligible)

Inpatient Hospitalization / Surgery	40%*	10%*	50%*
CT scan, PT scan, MRI	40%*	10%*	50%*
Hospital Newborn Delivery	40%*	10%*	50%*
PRESCRIPTION DRUG COVERAGE			
Prescription Deductible	\$0	\$0	\$0
Generic (Tier 1)	No Charge	\$0 - \$15 copay*	Not Covered
Brand Name (Tier 2)	\$40	\$55 - \$135 copay*	Not Covered
Non-Preferred (Tier 3)	\$85	\$20 copay*	Not Covered
Specialty (Tier 4)	\$175	10% coinsurance*	Not Covered
Specialty (Tier 5)	\$500	\$0	\$0
Mail Order - 90 day Supply	No copay / \$25 / \$85 / \$175 / \$500	\$0	\$0
PLAN INFORMATION			
Employer Contribution	\$175 per pay period	\$175 per pay period	
Network Type	HMO	POS	
Member Website	www.myuhc.com	www.myuhc.com	
Customer Service Phone Number	1-866-801-4409	1-800-782-3740	

PREMIUM PER EMPLOYEE PAYCHECK				
	EMPLOYEE CONTRIBUTION	EMPLOYER CONTRIBUTION	EMPLOYEE CONTRIBUTION	EMPLOYER CONTRIBUTION
Employee Only	\$101.21	\$175.00	\$142.02	\$175.00
Employee + Spouse	\$377.41	\$175.00	\$459.03	\$175.00
Employee + Child(ren)	\$335.98	\$175.00	\$411.48	\$175.00
Family	\$612.18	\$175.00	\$728.49	\$175.00



Disclaimer

**After plan deductible*

Always confirm you are using a **"contracted in-network"** provider.

This is a partial listing of your covered benefits. For a complete, accurate listing of covered benefits, limitations, and exclusions, refer to your certificate of coverage.

United Healthcare | Choice

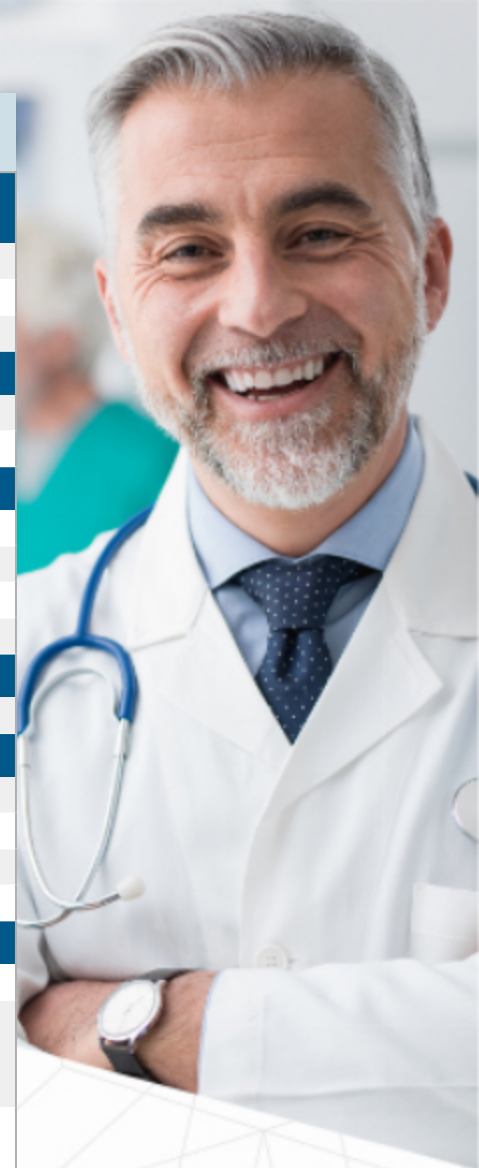
Plus Silver PPO

United Healthcare | Choice

Plus Gold PPO

DEDUCTIBLE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Single	\$3,500	\$7,500	\$1,500	\$7,500
Family	\$7,000	\$15,000	\$3,000	\$15,000
Deductible Period	Jan-Dec	Jan-Dec	Jan-Dec	Jan-Dec
OUT OF POCKET MAXIMUM				
Single	\$8,650	\$15,000	\$6,000	\$15,000
Family	\$17,300	\$30,000	\$12,000	\$30,000
COMMONLY USED SERVICES				
Primary Care Physician Office Visit	\$45 copay	50%*	\$35 copay	\$35 copay
Specialist Office Visit	\$90 copay	50%*	\$70 copay	\$70 copay
Urgent Care	\$75 copay	50%*	\$50 copay	\$50 copay
Emergency Room	40%*	40%*	20%*	20%*
PREVENTIVE CARE				
Preventive Services	No Charge	50%*	No copay	Not covered
MAJOR MEDICAL EXPENSES				
Outpatient Surgery	40%*	50%*	20%*	20%*
Inpatient Hospitalization / Surgery	40%*	50%*	20%*	20%*
CT scan, PT scan, MRI	40%*	50%*	20%*	20%*
Hospital Newborn Delivery	40%*	50%*	20%*	20%*
PRESCRIPTION DRUG COVERAGE				
Prescription Deductible	\$0	\$0	\$0	\$0
Generic (Tier 1)	Retail: \$0 copay / Mail-Order: \$0 copay	Retail: \$0 copay / Mail-Order: \$0 copay	\$20*	\$20*
Brand Name (Tier 2)	Retail: \$15 copay / Mail-Order: \$37.50 copay	Retail: \$15 copay / Mail-Order: \$37.50 copay	\$20*	\$20*
Non-Preferred (Tier 3)	Retail: \$65 copay / Mail-Order: \$162.50 copay	Retail: \$65 copay / Mail-Order: \$162.50 copay	\$65*	\$65*
Specialty (Tier 4)	Retail: \$135 copay / Mail-Order: \$337.50 copay	Retail: \$135 copay / Mail-Order: \$337.50 copay	\$135*	\$135*
Specialty (Tier 5)	Retail: \$400 copay / Mail-Order: \$1,000 copay	Retail: \$400 copay / Mail-Order: \$1,000 copay	\$0	\$0
Mail Order - 90 day Supply	\$0	\$0	\$350*	Not Covered
PLAN INFORMATION				
Employer Contribution	\$175 per pay period		\$175 per pay period	
Member Website	www.myuhc.com		www.myuhc.com	
Customer Service Phone Number	1-800-782-3740		1-866-801-4409	

PREMIUM PER EMPLOYEE PAYCHECK				
	EMPLOYEE CONTRIBUTION	EMPLOYER CONTRIBUTION	EMPLOYEE CONTRIBUTION	EMPLOYER CONTRIBUTION
Employee Only	\$175.21	\$175.00	\$221.11	\$175.00
Employee + Spouse	\$525.42	\$175.00	\$617.22	\$175.00
Employee + Child(ren)	\$472.88	\$175.00	\$557.80	\$175.00
Family	\$823.09	\$175.00	\$953.91	\$175.00



Disclaimer

*After plan deductible

Always confirm you are using a "**contracted in-network**" provider.

This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Here's an example of how the plan's costs come into play.



Virtual Care

Each medical plan includes virtual visits through the UHC app, which provides 24-7-365 access to board-certified primary care doctors and pediatricians by secure video chat or phone. For an illness or injury that is not an emergency, United Healthcare's telemedicine program offers a convenient, cost-effective alternative to hospital emergency rooms and urgent care clinics.

Virtual visits are not intended to replace your relationship with your doctor but to provide healthcare access when reaching the doctor is difficult or inconvenient.

Doctors can diagnose, recommend treatment, and write short-term prescriptions for minor, non-life-threatening conditions including, but not limited to:

- Acne
- Allergies
- Arthritic Pain
- Bronchitis
- Cold/Flu Symptoms
- Ear Infections
- Headaches/Migraines
- Insect Bites
- Sinus Infections
- Nausea/Stomach Aches
- Pink Eye
- Skin Infections
- Sore Throat
- Upper Respiratory Infection

Benefits of Telemedicine Visits

- No travel expenses or time
- Less time away from work
- Less interference with child or elder care responsibilities
- No exposure to other potentially contagious patients

How to Schedule a Virtual Visit

1. Sign in to <https://member.uhc.com/> or the UHC app to start a visit



2. Choose the type of visit.
Virtual visits can be for 24/7 urgent care, primary care, specialty care or therapy
3. Choose a network provider for your visit.

Where to Seek Care

Emergency Care vs. Urgent Care

When you need help in a hurry, you have choices. Of course, when it's a **life-threatening problem**, you should call **911** or go to the nearest hospital emergency room (ER).

In the ER, true emergencies are treated first, so unless your life is in danger, you'll wait – sometimes for hours. The ER is also the most expensive option for care.

For non-life-threatening problems, call your doctor, access Virtual Visit or HealthiestYou services, or go to an urgent care center.



Go to Emergency Room

Heart attack or stroke

Chest pain or intense pain

Shortness of breath

Severe abdominal pain

Head injury or other major trauma

Loss of consciousness

Major burns or severe bleeding

One-sided weakness or numbness

Open fractures

Poisoning or suspected overdose

or



Go to Urgent Care

Moderate fever

Colds, cough or flu

Bruises and abrasions

Cuts and minor lacerations

Minor burns and skin irritations

Eye, ear, or skin infections

Sprains or strains

Possible fractures

Urinary tract infections

Respiratory infections

KNOW BEFORE YOU GO



Lower

Cost and Time

Greater

Virtual care	Convenience care clinic	Healthcare provider's office	Urgent care center	Emergency room
For minor medical conditions. Connect with board-certified doctors via video or phone when, where, and how it works best for you.	For minor medical concerns. Staff nurse practitioners and physician assistants. Located in retail stores and pharmacies. Open nights and weekends.	The best place to go for routine or preventive care or to keep track of medications. Many PCPs offer virtual care. Contact your PCP to schedule an in-person or virtual care visit.	For conditions that aren't life-threatening. Nurses and doctors staff them and usually have extended hours.	For immediate treatment of critical injuries or illness. Open 24/7. Call 911 or go to the nearest ER if a situation seems life-threatening. <i>"Freestanding" ER locations are becoming more common in many areas. Because these ERs are not inside hospitals, they may look like urgent care centers. When you receive care at an ER, you're billed much more than other healthcare facilities.</i>
<ul style="list-style-type: none"> › Colds and flu › Rashes › Sore throats › Headaches › Stomachaches › Fever › Allergies › Acne › Urinary tract infections (UTIs) and more 	<ul style="list-style-type: none"> › Colds and flu › Rashes or skin conditions › Sore throats, earaches, sinus pain › Minor cuts or burns › Pregnancy testing › Vaccines 	<ul style="list-style-type: none"> › General health issues › Preventive care › Routine check-ups › Vaccines and screenings 	<ul style="list-style-type: none"> › Fever and flu symptoms › Headaches › Minor cuts, sprains, burns, rashes › Lower back pain › Joint pain › Minor respiratory symptoms › UTIs 	<ul style="list-style-type: none"> › Sudden numbness, weakness › Uncontrolled bleeding › Seizure or loss of consciousness › Shortness of breath › Chest pain › Head injury/major trauma › Blurry or loss of vision › Severe cuts or burns › Overdose
<ul style="list-style-type: none"> › Costs the same or less than a visit with your primary care provider (PCP) › Appointments typically in an hour or less › Need to leave home or work 	<ul style="list-style-type: none"> › Same or lower than provider's office › No appointment needed 	<ul style="list-style-type: none"> › May charge copay/coinsurance and/or deductible › Usually need an appointment › Short wait times 	<ul style="list-style-type: none"> › Costs lower than emergency room (ER) › No appointment needed › Wait times vary 	<ul style="list-style-type: none"> › Highest cost › No appointment is needed › Wait times may be long

Health Savings Account Advantages

Only available for those enrolled in the High Deductible Medical Plan

A Health Savings Account (HSA) is a tax-advantaged savings vehicle for individuals covered by a High Deductible Health Plan (HDHP). Funds in the account are used to pay for qualified medical, dental, and vision expenses.

An HSA is a great way to save for the future. You can set aside money from each paycheck now and save funds to cover healthcare expenses that come up later. Plus, your contributions are free from federal income tax, so you're stretching your healthcare dollars while lowering your taxable take-home pay amount.

HSA funds can only be used for yourself, your spouse, and your taxable dependents. Expenses for domestic partners and/or other dependents who do not qualify as tax dependents are not reimbursable under the HSA. To obtain an HSA, you can contact your local bank.

Advantages of an HSA

- Balance rolls over each year so you won't lose your contributions
- Triple tax savings — you do not pay federal tax* on:
 - Contributions to the account
 - Spending on qualified expenses
 - Interest that accrues
- Account is portable, so the funds are yours even if you change medical plans or leave the company
- Use the funds (now or in the future) for eligible medical, dental or vision expenses, including coinsurance costs, prescriptions, glasses, orthodontia and more
- Money left in the savings account earns tax-free interest*

**Tax treatment of HSAs for state tax purposes may vary by state.*

Who Can Open an HSA?

You can contribute to an HSA if you:

- Enrolled in a High Deductible Health Plan
- Are not enrolled in Medicare*, TRICARE or TRICARE for Life.
- Cannot be claimed as a dependent on someone else's tax return.
- Have not received Veterans Affairs (VA) benefits within the past 3 months.
- You (or your spouse) do not contribute to a Healthcare FSA.

** Enrollment in Medicare Part A may be retroactive by up to 6 months when you begin taking social security retirement after your Social Security Normal Retirement Age (SSNRA). This may affect your HSA eligibility.*

Other restrictions and exceptions may also apply. For more information, visit www.irs.gov/publications/p969/.

Eligible HSA Expenses

Doctor and Hospital Visits
Prescription Medications
COBRA Premiums

Vision Care, Glasses, Contacts
Long-Term Care Insurance

Dental Care, Braces, Dentures
Medical Expenses & Equipment

A complete list can be found by visiting www.irs.gov Publication 502

HSA Enrollment

Only available for those enrolled in the High Deductible Medical Plan

Employees can open an account through the employer's sponsored HSA provider or an institution of their choice. You will need to provide your account information to payroll so that they can deposit pre-taxed dollars directly from your paycheck to your HSA account. You may also deposit post-tax dollars and work with your accountant at the end of year to receive the "pre-tax" benefit.

	Health Savings Account (HSA)
Annual Limit	\$4,300 Single \$ 8,550 Family (2025) \$4,400 Single \$ 8,750 Family (2026)
Catch-Up Contribution	\$1,000 annually if age 55+
Enrollment Rules	Must be enrolled in an HSA-qualified plan
Who may you use funds for?	You, your spouse, and your tax dependents
Changes allowed for elections	Monthly
Are unused funds forfeited?	N/A. Funds remain in your account
How you access funds	A debit card or checks
Penalty for non-qualified use	20%

IMPORTANT! Be sure to keep your receipts in case the IRS ever audits you. If you use your HSA funds for expenses beyond what the IRS defines as qualified, you will be subject to income tax on the distributions, plus pay an additional 20% penalty if you are younger than 65.

	Without HSA	With HSA
Annual Income	\$40,000	\$40,000
Annual HSA Contribution	\$ -	(\$2,000)
Taxable Salary	\$40,000	\$38,000
Tax Payment (est. 30%)	(\$12,000)	(\$11,400)
Net Take-Home	\$28,000	\$28,600
Annual Savings	\$0	\$600

When you participate in a pre-tax savings account, the funds you set aside from your paycheck are not considered wages for federal income tax purposes. In addition, these amounts are not subject to Social Security or federal unemployment taxes.

Reducing your gross income reduces your tax liability. The example to the left shows how you can increase your take-home pay by participating in the HSA.

Dental

Plan Explanation

VitalCare offers a dental plan through United Healthcare. Employees are responsible for 100% of their and their dependents' premiums. Your choice of dentists can determine the cost savings you receive. In-network providers are paid directly by United Healthcare and agree to accept negotiated fees as "payment in full" for services rendered. When you use out-of-network providers, United Healthcare will apply the applicable percentage of the allowed amount, and you are responsible for paying the balance of the bill. The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider. To search for in-network providers, go to www.uhcdental.com.

United Healthcare | Dental
PPO \$1000

United Healthcare | Dental
PPO \$1500 with Child Ortho

DEDUCTIBLE	IN-NETWORK	IN-NETWORK
Single	\$50	\$50
Family	\$150	\$150
MAXIMUM THE CARRIER WILL PAY		
Annual Maximum	\$1,000	\$1,500
FREQUENCIES		
Cleaning	Limited to 2 times per consecutive 12 months.	Limited to 2 times per consecutive 12 months
DENTAL COVERAGE		
Cleanings	100%	100%
Exams	100%	100%
X-Rays	100%	100%
Sealants	100%	100%
Fillings	80%	80%
Simple Extractions	80%	80%
Root Canal	50%	50%
Periodontal Gum Disease	50%	50%
Oral Surgery	50%	50%
Crowns	50%	50%
Dentures	50%	50%
Bridges	50%	50%
Orthodontia	Not Covered	50%
Orthodontia Lifetime Maximum	Not Covered	\$1,000 per person per lifetime
Orthodontia Maximum Age	Not Covered	Child OnlyUp to Age 19
PLAN INFORMATION		
Waiting Period for Major Services	No waiting period	No waiting period

PREMIUM PER EMPLOYEE PAYCHECK

Employee Only	\$13.57	\$14.36
Employee + Spouse	\$27.13	\$28.73
Employee + Child(ren)	\$30.56	\$34.25
Family	\$46.40	\$51.25

Disclaimer

This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.

Vision

United Healthcare | Vision

Plan Explanation

VitalCare offers a dental plan through United Healthcare. Employees are responsible for 100% of their and their dependents' premium. In-network vision providers may be located at www.myuhcvision.com or by calling (800)638-3120.

VISION COVERAGE	IN-NETWORK	OUT-OF-NETWORK
Eye Exam	\$10	Up To \$40.00
Single Vision Lens	\$25	Up To \$40.00
Lined Bi-Focal Lens	\$25	Up To \$60.00
Lined Tri-Focal Lens	\$25	Up To \$80.00
Lenticular Lens	\$25	Up To \$80.00
Contact Lens Allowance	\$105	Up To \$210.00
Frame Allowance	\$130	Up To \$45.00
FREQUENCIES		
Exam Frequency	Once every 12 months	
Lens Frequency	Once every 12 months	
Frame Frequency	Once every 12 months	
OUT OF NETWORK		
EXPLANATION	Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance	
Member Website	myuhcvision.com	
Customer Service Phone Number	(800) 638-3120	

PREMIUM PER EMPLOYEE PAYCHECK	
Employee Only	\$2.93
Employee + Spouse	\$5.56
Employee + Child(ren)	\$6.52
Family	\$9.18



Disclaimer

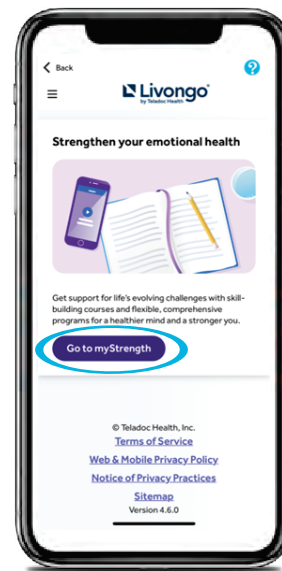
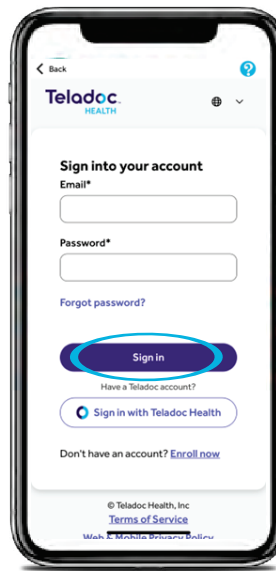
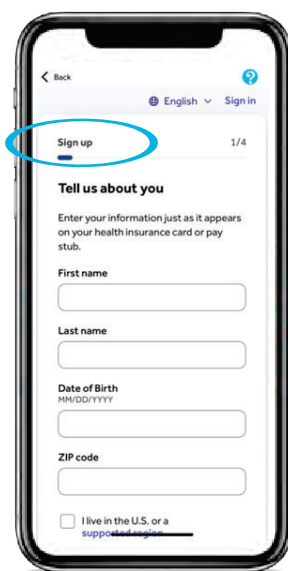
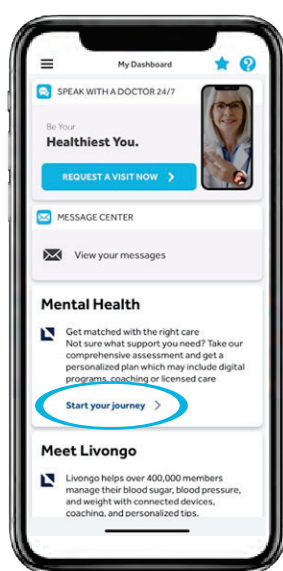
This is a partial listing of your covered benefits. For a complete accurate listing of covered benefits, limitations and exclusions, refer to your certificate of coverage.



How To Access MyStrength Complete

Our MyStrength service provides specialized digital mindfulness programs that employees can work through on their own.

1. [SIGN IN](#) to the HealthiestYou App
2. Go to the [MENTAL HEALTH](#) file on the dashboard
3. Click [START YOUR JOURNEY](#)
4. [SIGN UP](#) (this will take you out of the *HealthiestYou* dashboard and you will need to Sign Up for MyStrength).
5. [SIGN IN](#) using the new login info that you just created.
6. Click [GO TO MYSTRENGTH](#)



Recommended digital content and resources.
Explore self-guided activities and tools based on your goals and needs.



Get more out of your health plan benefits with these 2 handy digital tools



The UnitedHealthcare® app and myuhc.com®

Whether on the go or online, you'll have access to resources designed to help you:

- View benefit info, claim details and account balances
- Search network providers and facilities for the type of care you may need
- Quickly compare cost estimates before you get care
- Learn about covered preventive care
- Access your health plan ID card and add your plan details to your smartphone's digital wallet

Register once to access both tools

Start by downloading the UnitedHealthcare app or going to myuhc.com and then:

- Tap **Register Now** on the app, or select **Register** on the website
- Fill in the required fields and create your username and password
- Enter your contact information and select SMS text or phone call for two-factor authentication—then, agree to the terms and conditions
- Opt in to paperless delivery from your communication preferences

Now you're registered for—and connected to—the app and the website.

Get connected



Scan this code to download the app and register, or visit myuhc.com

UnitedHealthcare

Certain preventive care items and services, including immunizations, are provided as specified by applicable law, including the Patient Protection and Affordable Care Act (ACA), with no cost-sharing to you. These services may be based on your age and other health factors. Other routine services may be covered under your plan, and some plans may require copayments, coinsurance or deductibles for these benefits. Always review your benefit plan documents to determine your specific coverage details.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under the Find Care & Costs section. Available only for insured plans and self-funded plans with Optum Rx integrated pharmacy benefits.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Health Plan coverage provided by or through a UnitedHealthcare company. Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.

Administrative services provided by United HealthCare Services, Inc. or their affiliates, and UnitedHealthcare Service LLC in NY. Stop-loss insurance is underwritten by UnitedHealthcare Insurance Company or their affiliates, including UnitedHealthcare Life Insurance Company in NJ, and UnitedHealthcare Insurance Company of New York in NY.



ACCIDENT INSURANCE

Offer employees a financial back-up plan for when an accident happens.

Accident insurance helps your employees cover out-of-pocket expenses after an accidental injury.

Life doesn't always go according to plan. Accidents happen. And while medical insurance helps pay for medical expenses, and disability insurance replaces a portion of lost income, they may not cover all the costs associated with an accidental injury. Accident insurance from Principal® helps employees manage expenses after an injury. It provides tax-free⁽¹⁾ cash benefits directly to the employee, regardless of other insurance or actual costs.

Principal accident insurance is designed to be straightforward for employees. It provides an up-front, lump-sum benefit based on covered injuries received. And the benefit isn't dependent on services, tests, or treatments to receive the maximum benefit. This approach allows for a higher amount for the injury, which can help cover other expenses, like ambulance service, medical exams, and post-treatment care. This process helps employees receive payment faster with less paperwork and without any uncertainty about the benefit amount.

Covered injuries

Injury ⁽²⁾	Benefit payable
Burn	Up to \$5,000
Coma	\$15,000
Concussion	\$500
Dental injury	\$500
Dislocation	Up to \$7,500
Eye injury with surgical repair	\$500
Fracture	Up to \$10,000
Injuries not specifically listed	\$100
Internal injury	\$1,500
Knee cartilage injury with surgical repair	\$1,500
Ruptured disc with surgical repair	\$1,500
Tendon/ligament/rotator cuff injury with surgical repair	\$1,500

Product specifics

Accident insurance is only available with another Principal group product.

Coverage type ⁽³⁾	<ul style="list-style-type: none"> • Injury can be on or off the job. • Spouse coverage matches the covered employee
Spouse/child coverage	Employees must enroll to elect coverage for their spouse or children
Funding options	Employee-paid
Enrollment type	<ul style="list-style-type: none"> • Annual open enrollment • Evidence of insurability (EOI) is not required
No maximum lifetime benefit	A maximum lifetime benefit doesn't apply
Organized youth sports ⁽⁴⁾	<ul style="list-style-type: none"> • Any covered child 18 years or younger injured during an organized youth sporting event can receive an increased benefit amount • 25% increase in benefit amount up to \$1,000 • Eligible to receive one benefit amount per calendar year per covered dependent
Accidental death and dismemberment (AD&D) ⁽⁵⁾	<ul style="list-style-type: none"> • Employers have option to remove or include • Employee is covered at \$25,000, spouse \$12,500, and child at \$6,250
Pre-existing conditions	Not included
Health screening benefit for preventive care ⁽⁶⁾	<ul style="list-style-type: none"> • Employers have option to remove • \$50/\$100/\$150 year for each employee, covered spouse, and dependent child
Portability ⁽⁷⁾	<ul style="list-style-type: none"> • Employers have the option to remove • Duration of 3 years, 5 years, or to age 70 • EOI is not required

⁽¹⁾ Based on current federal income tax laws, if insurance premiums are paid with after-tax dollars, the benefits are received income tax-free.

⁽²⁾ Coma, skin graft, eye injury with surgical repair not available in New Hampshire.

⁽³⁾ Off the job is the only option available in New Mexico.

⁽⁴⁾ Not available in New York or Virginia.

⁽⁵⁾ Accidental death and dismemberment also includes loss of use, paralysis, and loss of senses benefits. Benefits may be payable at a percentage of full benefit. Coma is included in this benefit in New Hampshire.

⁽⁶⁾ Not available in Idaho, Michigan, Minnesota, New Hampshire, New Mexico, New York, North Dakota, or Virginia.

⁽⁷⁾ Not available in Colorado, Kentucky, Montana, New Hampshire, New Mexico, Oregon, Utah, Vermont, or West Virginia.

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ACCIDENT INSURANCE PROVIDES LIMITED BENEFITS. This is an overview of the benefits accident insurance provides, but there are limitations and exclusions. For additional details, contact your Principal financial professional. Some provisions may vary or not be available in all states. This flyer is not approved for use in Arizona or New Mexico. OR policy form GC 8000 (ACC) (0915) OR.

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Understand the ins and outs of critical illness insurance

Life doesn't always go as expected. Serious illnesses happen. And while medical insurance helps pay for medical expenses, and disability insurance replaces a portion of lost income, they don't cover all the costs associated with having a serious illness.

Principal® provides critical illness insurance to help employees manage unexpected expenses. When a covered individual is diagnosed with a specific critical illness, they receive a lump-sum cash benefit to use as needed, regardless of other insurance or actual costs.

Covered illnesses⁽¹⁾

- | | | | |
|---|---|---|--|
| <ul style="list-style-type: none"> • Alzheimer's disease • Amyotrophic lateral sclerosis • Benign brain tumor • Carcinoma in situ (25% benefit) • Coma⁽¹⁾ • Coronary artery disease (25% benefit) • Heart attack • Invasive cancer | <ul style="list-style-type: none"> • Loss of hearing⁽¹⁾ • Loss of sight⁽¹⁾ • Loss of speech⁽¹⁾ • Major organ failure • Multiple sclerosis • Occupational infectious disease⁽¹⁾ • Paralysis⁽¹⁾ • Parkinson's disease • Skin cancer (\$250)⁽¹⁾ | <ul style="list-style-type: none"> • Specified infectious disease • Stroke <p>Mental health disorders:⁽²⁾</p> <ul style="list-style-type: none"> • Bipolar disorder I • Post-traumatic stress disorder • Schizophrenia | <p>Childhood conditions:</p> <ul style="list-style-type: none"> • Cerebral palsy • Cleft lip/palate • Cystic fibrosis • Down syndrome • Muscular dystrophy • Spina bifida |
|---|---|---|--|

Product specifications

First occurrence	Benefits are payable the first time a critical illness is incurred under the policy, subject to benefit qualifications and limitations.
Multiple payouts	<ul style="list-style-type: none"> • Benefits for a first occurrence of a different critical illness are payable if incurred more than 12 months after the preceding critical illness.⁽³⁾ • Benefits for additional occurrences of carcinoma in situ, coronary artery disease, heart attack, invasive cancer, major organ failure, and stroke are payable if incurred more than 12 months after the preceding critical illness and 12 months treatment-free.⁽⁴⁾
No maximum lifetime benefit	A maximum lifetime benefit doesn't apply.
Enrollment type	<ul style="list-style-type: none"> • Annual open enrollment • Evidence of insurability (EOI) not required
Family care⁽⁵⁾	<ul style="list-style-type: none"> • First occurrence of infertility for employee and covered spouse at 25% of the benefit payable. • Complications of pregnancy for any covered individual that present up to 12 weeks postpartum at 25% of the benefit payable. Requires at least 2 consecutive days of hospitalization.
Infectious disease benefit⁽⁶⁾	Benefits are payable at 25% of the benefit payable if an infectious disease benefit occurs and requires 3 continuous days of hospitalization.
Pre-existing conditions⁽⁷⁾	<ul style="list-style-type: none"> • 6 months prior/12 months insured. • 3 months prior/12 months insured. • Pre-existing can be removed if 50+ eligible lives.
Spouse⁽⁸⁾⁽⁹⁾/child coverage	<ul style="list-style-type: none"> • Spouse benefit up to 100% of employee benefit. • Children are automatically covered for 25% of the employee's benefit for no additional cost.
Health screening benefit for preventive care⁽¹⁰⁾	<ul style="list-style-type: none"> • Employers have the option to remove. • \$50/\$100/\$150 year for each employee, covered spouse, and dependent child.
Portability (EOI not required)⁽¹¹⁾	<ul style="list-style-type: none"> • Employers have the option to remove. • Duration of 3 years, 5 years, or to age 70. • Must be insured for 12 months, under age 70, and not incurred a critical illness.

Benefit option⁽¹²⁾

Critical illness insurance is only available with another Principal group product.

# Eligible		Employee	Spouse
5+	Minimum benefit	\$5,000	\$2,500
5-99	Guaranteed issue	\$20,000	\$20,000
	Maximum benefit	\$50,000	\$50,000
100-999	Guaranteed issue	\$30,000	\$30,000
	Maximum benefit	\$100,000	100,000
1,000+	Guaranteed issue	\$35,000	\$35,000
	Maximum benefit	\$100,000	100,000

- ⁽¹⁾ In Idaho, these illnesses are not covered: coma, loss of hearing, loss of sight, loss of speech, and paralysis. In New Jersey, these illnesses are not covered: coma or skin cancer. In California, skin cancer is referred to as specified skin cancer, and there are no benefits for occupational infectious disease.
- ⁽²⁾ Mental disorders are payable at 25%. In New Jersey, first occurrence is payable at 100%.
- ⁽³⁾ In Connecticut and Pennsylvania, no waiting period for a first occurrence of a different critical illness. In Tennessee, the waiting period is 30 days. In Georgia and Maine, the waiting period is 6 months.
- ⁽⁴⁾ In Georgia and Maine, the waiting period is 6 months for additional occurrences of the same critical illness.
- ⁽⁵⁾ Not available in Mississippi, Montana, or Pennsylvania. In Alaska, infertility includes dependent children. In California, family care is referred to as complications of pregnancy and infertility. In New Jersey, benefit payable at 100% and complications of pregnancy not allowed.
- ⁽⁶⁾ In Maine, New Hampshire, and New Jersey, hospitalization not required. In New Jersey, first occurrence is payable at 100% and COVID-19 is not a covered condition.
- ⁽⁷⁾ In California, pre-existing conditions are 6 months prior/12 months insured, or none. In Pennsylvania, pre-existing conditions are 3 months prior/12 months insured. In Colorado, Maine, New Hampshire, New Jersey, and Utah, pre-existing conditions are 6 months prior/6 months insured.
- ⁽⁸⁾ State-registered domestic partner, as recognized by states.
- ⁽⁹⁾ In Washington, references to spouse include state-registered domestic partner.
- ⁽¹⁰⁾ Not available in Colorado or Michigan. In New Jersey, \$50 or none.
- ⁽¹¹⁾ Not available in Colorado, Kentucky, Montana, New Hampshire, Oregon, or Utah. In Alaska, Connecticut, and New Jersey, requirements vary.
- ⁽¹²⁾ In Florida, the maximum benefit is the guaranteed issue amount. In New Jersey and Idaho, the minimum benefit for spouses is \$2,000. Guaranteed issue amounts for spouses: 5-99 eligible is \$10,000; 100-999 eligible is \$14,000; 1,000+ eligible is \$16,000. The maximum benefit for spouses: 5-99 eligible is \$24,000; groups of 100+ use the same limits listed in the chart above.

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Understand the ins and outs of hospital indemnity insurance.

Coverage that helps pay the expenses related to hospitalization and treatment due to a sickness or injury.

Life doesn't always go as expected. Serious illnesses and injuries happen that require hospitalization and treatment. While health insurance helps pay for medical expenses, it doesn't cover all the costs associated with treatment.

That's why Principal® offers a way to help employees financially prepare for their expenses if the unexpected happens. With hospital indemnity insurance, the employee can focus on recovery and worry less about the cost of hospitalization or treatment. When a covered employee or family member is admitted to the hospital for a sickness or injury, they get a lump-sum cash benefit to use any way they choose—regardless of other insurance they may have, or actual expenses incurred.

Available benefits¹

We offer both Health Savings Account (HSA) and non-HSA compatible plans.² Our flexible designs offer a wide range of benefits and days payable, allowing you to design coverage that meets your needs. Here's an example of an HSA compatible plan that may be selected:

Benefit	Benefit payable	Days payable
First day hospital confinement	\$1,000	1
Daily hospital confinement³	\$100	30
First day Intensive Care Unit (ICU) confinement	\$2,000	1
Daily ICU confinement	\$200	30
Newborn nursery confinement	\$100	1
Health screening benefit	\$50	1

→ Tiered benefit

Offering a tiered benefit allows a higher daily hospital and daily ICU benefit payable the longer the stay in the hospital. This feature is available with daily hospital benefits payable with 30, 60, and 90 days. Using the example HSA plan, here's how the tiered benefit could be paid:

Days payable	Daily hospital benefit	Daily ICU benefit	Days hospitalized
30 days	\$100 daily	\$200 daily	2-10 days
	\$150 daily	\$300 daily	11-20 days
	\$200 daily	\$400 daily	21-30 days

Enhanced injury

Offering enhanced injury allows a benefit to be payable at a higher benefit amount for an injury vs a sickness.

Benefit	Sickness	Injury
First day hospital confinement	\$1,000	\$2,000
First day ICU confinement	\$2,000	\$4,000
Daily hospital confinement	\$100	\$200
Daily ICU confinement	\$200	\$400
Emergency room	\$200	\$400

Additional options for non-HSA plans

- Air ambulance
- Chiropractic care
- Companion lodging
- Doula care
- Durable medical equipment
- Emergency room
- Family care
- General anesthesia
- Ground or water ambulance
- Home health service
- Hospice care
- Inpatient surgery
- Invasive diagnostic procedure
- Lab tests or x-ray
- Major diagnostic procedures
- Medical travel
- Mental disorder inpatient treatment facility
- Mental disorder outpatient
- Observation unit
- Outpatient surgery
- Pet care
- Physician visits and telemedicine
- Prescription drugs
- Rehabilitation facility⁴
- Skilled nursing facility
- Substance abuse inpatient treatment facility
- Substance abuse outpatient
- Therapy services
- Urgent care facility

Product specifics

Hospital indemnity insurance is only available with another Principal group product.

Plan type⁵	Plans can be chosen to cover the following: <ul style="list-style-type: none"> • Sickness and injury • Sickness only • Injury only
Choice type (voluntary coverage only)	Employers can allow their employees to elect different plan designs by job class: <ul style="list-style-type: none"> • Dual choice • Triple choice
Coverage type	<ul style="list-style-type: none"> • Injury can be on or off the job • Spouse coverage matches that of the covered employee
Spouse/child coverage	<ul style="list-style-type: none"> • Employees must enroll to elect coverage for their spouse or children • Spouse and children's benefits can be up to 100% of employee benefit
Funding options	<ul style="list-style-type: none"> • Employee-paid • Contributory • Employer-paid
Enrollment type	<ul style="list-style-type: none"> • Annual open enrollment • Evidence of insurability (EOI) is not required
Maternity options	<ul style="list-style-type: none"> • Full maternity • Complications only⁶ • Full maternity after 10 months⁷
Pre-existing conditions⁸	<ul style="list-style-type: none"> • 12 months prior/12 months insured • 6 months prior/12 months insured • 3 months prior/12 months insured • Pre-existing can be removed if full maternity after 10 months is selected⁹
Health screening benefit for preventive care¹⁰	<ul style="list-style-type: none"> • Employers have option to remove • \$50/\$100/\$150 year for each employee, covered spouse, and dependent child
Portability¹¹	<ul style="list-style-type: none"> • Employers have option to remove • Duration to age 70 • Must be insured for 12 months and under age 70 • EOI is not required

- ¹ Benefits not available in every state. In Connecticut and Idaho, only hospitalization benefits are available—skilled nursing, hospice (Connecticut only), and mental and substance abuse facility are allowed if follow hospitalization. In Maryland, a second opinion benefit is always required. In New Jersey and Oregon, only hospitalization benefits are available. In Massachusetts and North Carolina, general anesthesia is not available. In North Dakota, medical travel, companion lodging, family care, pet care, and mental disorder inpatient treatment facility are not available. In Pennsylvania, family care, pet care, and blood products are not available. In Kansas, chiropractic care is referred to as spinal manipulation care. In Washington, skilled nursing facility is referred to as nursing home, and pet care is referred to as pet boarding.
- ² The Internal Revenue Service (IRS) limits the types of supplemental insurance that an individual who participates in an HSA may have while maintaining the tax-exempt status of HSA contributions. If you have or plan to open an HSA, please consult your tax and legal advisors about the features offered in this plan as there may be tax implications of combining these plans.
- ³ Daily hospital confinement is always required.
- ⁴ Hospitalization required.
- ⁵ In Montana, New Jersey, Oregon, and Pennsylvania, sickness only and injury only not available. In Washington, skilled nursing facility is referred to as nursing home, and pet care is referred to as pet boarding.
- ⁶ In Montana, complications only not available.
- ⁷ In Maryland, 10-month maternity not available (pre-existing required).
- ⁸ In Florida, Idaho, Montana, and Wyoming, 12 months prior/12 months insured option not available. In New Hampshire, pre-existing conditions are 6 months prior/6 months insured. In Pennsylvania, pre-existing conditions are 3 months prior/6 months insured. In New Jersey and Utah, pre-existing conditions are 3 months prior/6 months insured or 6 months prior/6 months insured. In California, pre-existing conditions are 6 months prior/12 months insured.
- ⁹ Any case of 10 lives or less requires pre-existing.
- ¹⁰ Not available in all states
- ¹¹ Not available in Colorado, Kentucky, Montana, New Hampshire, Oregon, Utah, or Vermont.



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Wellness/health screening benefit

Be well—and enjoy the financial incentives.

Maintaining a healthy lifestyle has plenty of advantages. In fact, with this benefit from Principal®, employees and covered family members have a financial incentive for completing a covered test or procedure.

What is the wellness/health screening benefit?

The wellness/health screening benefit pays out when an employee or insured dependent has a covered wellness screening or procedure.

One benefit is payable once per calendar year for each employee and insured dependent, and there's no family limit.

Employees with two or more coverages (critical illness⁽¹⁾, accident, or hospital indemnity) are eligible to receive benefits by submitting only one claim.

The benefit is paid regardless of the results or cost of the test or procedure—even if the test is covered by medical insurance.

Eligible tests and procedures

- Adult and child immunization⁽²⁾
- Annual physical
- Bone density screening⁽²⁾
- Cancer screening
 - › Bone marrow cancer screening (serum protein electrophoresis)
 - › Breast cancer screening (CA 15-3, clinical breast exam, mammogram, MRI, thermography, ultrasound)
 - › Cervical cancer screening (pap smear)
 - › Colorectal cancer screening (CEA, colonoscopy, double contrast barium enema, fecal occult blood test, sigmoidoscopy)
 - › Ovarian cancer screening (CA 125)
 - › Prostate cancer screening (digital rectal exam, PSA blood test)
- Skin cancer screening
- Cardiac stress test or electrocardiogram (EKG/ECG)—resting or stress
- Chest x-ray
- Completion of a smoking cessation program
- Completion of a weight reduction program
- COVID testing
- Doppler screening for peripheral vascular disease (arteriosclerosis) or carotid doppler ultrasound
- Genetic screening testing
- Human Papillomavirus (HPV) vaccine
- Mental health assessment
- Sampling of blood or tissue to test for genetic susceptibility for the risk of cancer
- Standard blood chemistry profile or lipid panel (cholesterol, triglycerides, HDL, LDL, fasting blood glucose, hemoglobin A1c)
- Ultrasound screening of the abdominal aorta for abdominal aortic aneurysm⁽²⁾
- Vision testing

Submitting claims

It's easy to submit a claim online.

- Log in on principal.com.
- New users select **create an account** and enter the requested information.
- No need to provide proof or an explanation of benefits. We'll just need the name of the facility or provider, their phone number, plus the date of service and the test completed.

Don't want to submit the wellness/health screening claim online? Search for it on principal.com, then complete and return the form.

⁽¹⁾ Specified disease in New York.

⁽²⁾ Not available in New York.



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ACCIDENT, CRITICAL ILLNESS, AND HOSPITAL INDEMNITY INSURANCE PROVIDE LIMITED BENEFITS. This is an overview of the wellness/health screening benefit available on accident, critical illness, and hospital indemnity policies from Principal Life Insurance Company. The wellness/health screening benefit and/or tests or procedures may not be available in all states. Accident, critical illness, and hospital indemnity insurance have limitations and exclusions. For additional details, contact your employer. This flyer is not approved for use in Arizona and New Mexico. Oregon policy forms GC 8000 (ACC) (0915) OR, GC 5700 (CI)-1 0220, and GC 2200 (GHI) OR 0123.

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Group life insurance

Easily get life insurance during open enrollment.

Then gradually increase your coverage every year.

Protecting the people who mean the most to you is important. That's why Principal® makes it easy for you to purchase—or increase—voluntary term life insurance. It's available through your employer for yourself, spouse, and children.

Increase your voluntary term life insurance

Open enrollment is a great time to increase your coverage. You can add an additional \$10,000 or \$20,000¹ in coverage for yourself—with no health questions asked. That means no medical appointments and quick approval. And every year during open enrollment, you can continue to increase your coverage—up to the maximum benefit. If you have coverage for yourself, you can also add or increase coverage for your spouse and children²—with no health questions asked.

Purchase coverage for the first time

Don't already have voluntary term life insurance? Easily get coverage for the first time during open enrollment. You can purchase \$10,000 or \$20,000¹ in coverage for yourself—with no health questions asked. And when you have coverage, your spouse and children² can also get coverage.

Higher levels of coverage

During open enrollment, you or your spouse² can request to add or increase even more coverage by providing proof of good health.

Let's look at an example

When Jordan started working for the company, voluntary term life insurance wasn't purchased. A few years later, Jordan bought a house and saw the need for coverage, so purchased \$20,000 in coverage during the company's open enrollment. Jordan plans to increase the coverage by \$10,000 each year after that. Jordan also bought \$10,000 of spouse coverage and an additional \$5,000 for their children.



¹ Amount provided is for illustrative purposes only. Options available will vary by benefit design, and your policy may be different.

² Coverage for your dependents is limited, based on your coverage. Refer to your policy for details.

Term Life Insurance and Supplemental Voluntary Plans (per month)

Term Life and AD&D

Age	Employee*	Spouse*
0-29	\$0.076	\$0.076
30-34	\$0.090	\$0.090
35-39	\$0.143	\$0.143
40-44	\$0.216	\$0.216
45-49	\$0.327	\$0.327
50-54	\$0.536	\$0.536
55-59	\$0.855	\$0.855
60-64	\$1.299	\$1.299
65-69	\$2.200	\$2.200
70+	\$3.947	\$3.947

*Rates Per \$1000 Benefit

Coverage Amount	Child
\$5,000	\$1.00
\$10,000	\$2.00
\$15,000	\$3.00
\$20,000	\$4.00
\$25,000	\$5.00

Accidental Death & Dismemberment

\$0.023

*Rates Per \$1000 Benefit

Critical Illness

Age	Employee*	Spouse*
0-24	\$0.113	\$0.113
25-29	\$0.209	\$0.209
30-34	\$0.235	\$0.235
35-39	\$0.273	\$0.273
40-44	\$0.382	\$0.382
45-49	\$0.551	\$0.551
50-54	\$0.790	\$0.790
55-59	\$1.074	\$1.074
60-64	\$1.518	\$1.518
65-69	\$2.125	\$2.125
70+	\$3.138	\$3.138

*Rates Per \$1000 Benefit

Hospital

Employee Only	\$26.10
Employee + Spouse	\$48.61
Employee + Child(ren)	\$38.32
Employee + Family	\$63.12

Accident

Employee Only	\$5.06
Employee + Spouse	\$7.98
Employee + Child(ren)	\$8.45
Employee + Family	\$13.22



worry less about cost
and focus on care

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ASPCA® Pet Health Insurance plans can help you follow your vet's recommendations and worry less about cost.

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to get started!**

*Group discount may not be available in all states

Pre-existing conditions are not covered. Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms and conditions visit www.aspcapetinsurance.com/terms. Preventive Care coverage reimbursements are based on a schedule. Complete Coverage™ reimbursements are based on the invoice. Products, schedules, and rates may vary and are subject to change. Discounts may vary and are subject to change. More information available at checkout. Insurance products are underwritten by either Independence American Insurance Company (NAIC #26581. A Delaware insurance company located at 11333 N. Scottsdale Rd, Ste. 160, Scottsdale, AZ 85254), or United States Fire Insurance Company (NAIC #21113. Morristown, NJ). Please refer to your policy forms to determine the underwriter for your policy. Insurance is produced by PTZ Insurance Agency, Ltd. (NPN: 5328528. Domiciled in Illinois with offices at 1208 Massillon Road, Suite G200, Akron, Ohio 44306). (California residents only: PTZ Insurance Agency, Ltd., d.b.a PIA Insurance Agency, Ltd. CA license #0E36937). The ASPCA® is not an insurer and is not engaged in the business of insurance. Through a licensing agreement, the ASPCA receives a royalty fee that is in exchange for use of the ASPCA's marks and is not a charitable contribution. U0923-QPIG-PDF

the coverage they need the way you want



Our best plan ever **Complete CoverageSM**

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

Simple to Use

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

Exam Fees, Diagnostics, and Treatments for Covered Conditions

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

Customizable Options

Annual Limit - from \$2,500 to unlimited.

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

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

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

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

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

**ASPCA[®] PET HEALTH
INSURANCE**

*Group discount may not be available in all states

Pre-existing conditions are not covered. Waiting periods, annual deductible, co-insurance, benefit limits and exclusions may apply. For all terms and conditions visit www.aspcapetinsurance.com/terms. Preventive Care coverage reimbursements are based on a schedule. Complete Coverage™ reimbursements are based on the invoice. Products, schedules, and rates may vary and are subject to change. Discounts may vary and are subject to change. More information available at checkout. Insurance products are underwritten by either Independence American Insurance Company (NAIC #26581. A Delaware insurance company located at 11333 N. Scottsdale Rd, Ste. 160, Scottsdale, AZ 85254), or United States Fire Insurance Company (NAIC #21113. Morristown, NJ). Please refer to your policy forms to determine the underwriter for your policy. Insurance is produced by PTZ Insurance Agency, Ltd. (NPN: 5328528. Domiciled in Illinois with offices at 1208 Massillon Road, Suite G200, Akron, Ohio 44306). (California residents only: PTZ Insurance Agency, Ltd., d.b.a PIA Insurance Agency, Ltd. CA license #0E36937). The ASPCA® is not an insurer and is not engaged in the business of insurance. Through a licensing agreement, the ASPCA receives a royalty fee that is in exchange for use of the ASPCA's marks and is not a charitable contribution. U0923-COVERAGE

Live Long and Live Well with Colorado SecureSavings



VitalCare offers a Roth Individual Retirement Account (IRA) through Colorado SecureSavings. This is a savings program created by the Colorado SecureSavings Board in the Office of the State Treasurer that can help you save for retirement through automatic payroll contributions to your own IRA. Setting up an account is easy, and you can decide how much to save. There are two ways to participate:

- **Do nothing and save automatically.** VitalCare Corporation will add you to the program. **If you choose to do nothing, after 30 days you will be enrolled automatically with the default savings and investment options.** The default savings rate is 5% of your gross pay, and that amount is deducted from your paycheck after taxes have been taken out.
- **Customize your account.** You can choose to customize your contribution amounts, investment options, and beneficiaries. Once enrolled, you'll start saving a percentage of your paycheck automatically in your own retirement savings account — a Roth IRA.

The total amount you save must be within the federal government's Roth IRA contribution limits dependent on your Modified Adjusted Gross Income (MAGI), which is essentially annual employment income plus any other income from investments and other sources. Your contribution limit also depends on how you file your taxes.

Contributions Limits

Filing status	MAGI	Age 49 or younger	Age 50 or Older
Single filer	Less than \$165,000	\$7,000	\$8,000
Married filing jointly	Less than \$246,000	\$7,000	\$8,000

For more information, please visit <https://coloradosecuresavings.com/>



COLORADO
SecureSavings



Additional Employment Benefits

Employee Handbook

Employee Assistance Program (EAP)

VitalCare provides an in-house Employee Assistance Program (EAP) to support the well-being of our team members. Employees may meet with one of VitalCare's counselors **at no cost** and may schedule **up to three sessions per situation**. If additional or ongoing support is needed, VitalCare will assist with referrals to appropriate outside resources.

Observed Holidays

- New Year's Day
- MLK Jr. Day
- Presidents Day
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve
- Christmas Day

VitalCare provides paid holidays to eligible employees based on their employment classification.

- Full-time: *Eligible for Paid Holidays*
- Guaranteed Hours (Tier 2 and 3): *Eligible for Paid Holidays*
- PRN and Guaranteed Hours (Tier 1): *Not eligible for Paid Holidays*

Personal Time Off

Personal time is offered to eligible employees based on their Job Classification.

- Full-time Exempt: *Eligible to accrue Personal Time Off*
- Guaranteed Hours (Tier 1, 2 and 3): *Eligible to accrue Personal Time Off*
- PRN: *Not eligible to accrue Personal Time Off*

Please refer to your employee handbook for more details.

Employee Massage Benefit

Effective January 1, 2026, employees will have access to on-site massage services at a rate of **\$20 per 15-minute session increment**. Session length and structure will be determined by the licensed massage therapist based on individual needs and availability.

Referral Bonus

VitalCare offers a referral bonus to existing employees. When you refer someone that VitalCare hires, you can receive up to a \$300 bonus. You will earn \$150 when your referral attends New Hire Orientation and another \$150 when they complete 6 months of employment.



Family & Medical Leave Insurance (FAMLI)

Colorado Family and Medical Leave Insurance (FAMLI) provides eligible employees with job-protected, partially paid time off. This state-mandated benefit can be used, for example, to bond with a new child, care for a seriously ill family member, or care for your own serious health condition, including pregnancy or childbirth complications. You may also take FAMLI leave to attend to medical, legal, or other needs that arise from domestic violence, harassment, sexual assault, or stalking.

Enrollment in the Colorado FAMLI benefits is automatic, and the cost of this coverage is shared between your employer and you. Your portion of the cost is paid through payroll deductions.

Submitting a Claim

Start by selecting **Get Started** on the [My FAMLI+](#) portal. Once you've created your account, you'll see a **Start Claim** button where you will be navigated through the following steps:

- Personal Details
- Employment
- Leave Details
- Payment
- Review & Submit

Colorado FAMLI at a Glance

Who is Eligible

As set by the Colorado FAMLI statute and regulations, Employees who have \$2,500 over the previous year for work performed in the state of Colorado.

Types of Leave Covered

- Employee's own serious health condition
- Parental bonding
- Family member's serious health condition
- Qualifying military exigency
- Care for a service member
- Safe leave

Weekly Benefit Calculation

The portion of your average weekly wage that is equal to or less than 50% of average is paid at a rate of 90%, and the portion of your average weekly wage more than 50% of the state average is paid at a rate of 50%.

FAMLI Maximum Weekly Benefit \$1,100

Maximum Benefit Period

Up to 12 weeks of leave with an additional 4 weeks for pregnancy or childbirth complications.

Insurance Terms and Definitions

NETWORK TYPE

An HMO (Health Maintenance Organization) is a type of insurance network. In this type of network, **you must stay in your network to obtain care under your plan.** There are no benefits paid out for services obtained outside the network. In some instances, HMO's may require that you have a referral from your primary care physician to obtain services from a specialist.

An EPO (Exclusive Provider Organization) is a type of insurance network that allows you to obtain care in or out of your network. If you choose to visit a In-Network provider, your out of pocket expense will be significantly less than if you visit a provider outside your network. The reason for this is the In-Network provider agrees to accept set, contracted rates as payment in full for their services in return for being part of the insurance carrier's Exclusive Provider network.

A PPO (Preferred Provider Organization) is a type of insurance network. In this type of network, you may choose to obtain care in or out of your network. If you choose to visit a "Preferred", or "In-Network", provider, your out of pocket expense will be significantly less than if you visit a provider outside your network. The reason for this is the In-Network provider agrees to accept set, contracted rates as payment in full for their services in return for being part of the insurance carrier's Preferred Provider network.

DEDUCTIBLE & EMBEDDED DEDUCTIBLE

The deductible is amount you pay before the insurance carrier starts sharing the expense of your medical care. Major medical expenses apply to the deductible like inpatient/outpatient surgeries, MRI's, CT Scans, etc. In an Embedded deductible, no member of the family unit can satisfy more than the single deductible during the deductible period. Even though the family is subject to the family deductible as a whole, no one person can satisfy more than the single deductible.

CALENDAR YEAR DEDUCTIBLE

Your plans are on a calendar year deductible (January 2025 - December 2025). This is the 12 month time period in which all medical expenses that would apply to your deductible accumulate. Your deductible will reset after this period ends. This time period is important to note, because it does not align with your plan year (August 2025 - July 2026).



CO-INSURANCE & CO-PAYS

After you've reached your deductible for the year, you'll be subject to **co-insurance**. Your carrier will split the balance of the major medical expense with you. They pay a percentage and you pay a percentage of your medical expense until you've reached your Out of Pocket Maximum. **Co-pays** are a set dollar amount you pay when you receive medical care from a PCP, Specialist, Urgent Care, Emergency Room, or Pharmacy. It's called a co-pay, because you pay the set dollar amount and your insurance carrier pays the rest of the actual charge from the doctor/facility. Co-pays DO NOT apply to the deductible.

OUT OF POCKET MAXIMUM

This is the maximum amount you will pay for covered medical expenses during your deductible period

NEGOTIATED RATE (CONTRACTED RATE)

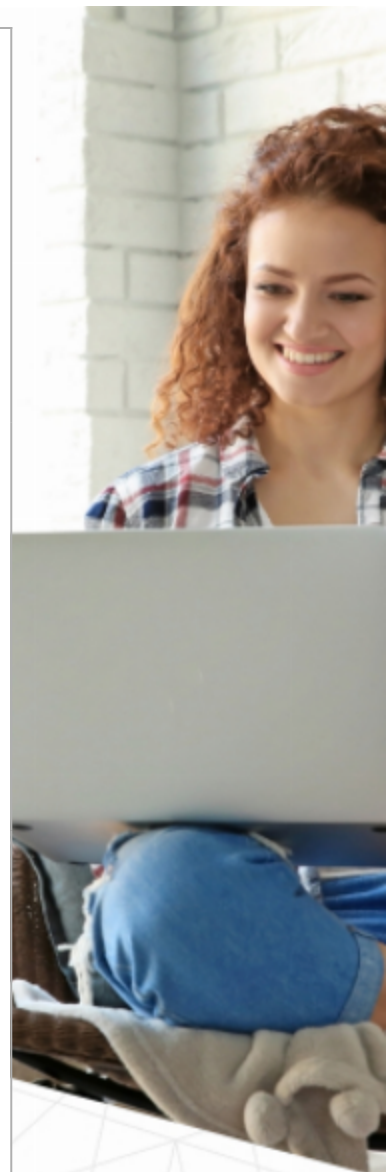
When a Provider (doctor, facility, pharmacy or hospital) contracts with an insurance carrier, they are considered In-Network. Part of the contract states that the provider will accept a lower payment (lower than what they normally charge) from the insurance carrier as payment in full. This lower payment is the Negotiated Rate.

EXPLANATION OF BENEFITS

Commonly referred to as an "EOB". The EOB is a very useful document as it explains how the insurance carrier processed your claim. It shows the billed charges from the provider, the network discount applied, and what the resulting Negotiated Rate is. (Provider Charge - Network Discount = Negotiated Rate) It also shows whether the service was applied to your deductible or paid as a co-pay. It is not a bill, but merely an explanation of how the insurance carrier paid your claim.

HEALTH SAVINGS ACCOUNT (H S A)

This is an Employee Owned savings account that allows you to pay for Qualified Medical Expenses (IRS Publication 502) through tax free contributions. The maximum contributions for 2025 are \$4,300 for single coverage and \$8,550 for family coverage. Members ages 55-64 can contribute an additional \$1,000. If you are age 65 or older, you are no longer eligible to contribute to the H S A. This is a true savings account plan, so you can rollover all unused funds from year to year. With an H S A, money has to be in the account for you to be able to use it.



What are HMO, PPO, EPO, and POS health insurance plans?

	HMO Plans	PPO Plans	EPO Plans	POS Plans
Overview	<p>HMO plans typically require you to choose a primary provider, or primary care physician (PCP), in the HMO plan network. This provider will refer you to other network providers as needed.</p> <p>Premiums are often lower because of the defined network which can help control costs. These plans may also offer low or no deductible options.</p>	<p>PPO plans tend to give you more flexibility to choose the providers you prefer to visit for care. If you choose an out-of-network provider, you'll likely pay more.</p> <p>Premiums tend to be higher and are commonly paired with a deductible.</p>	<p>EPO plans generally let you see any network provider you choose. There's no requirement to choose a primary care physician or get referrals to see a specialist.</p> <p>These plans do not offer out-of-network benefits.</p>	<p>POS plans usually require you to get referrals to see specialists. Most plans will have some coverage for out-of-network care — often with a higher copay.</p> <p>These plans are like a combination of an HMO and PPO plan.</p>
Doctor/provider details	Providers or doctors either work for the HMO or contract for set rates.	Networks include providers and facilities that have negotiated lower rates on the services they perform. PPO health plans have access to those negotiated rates.	Doctors and facilities that participate in an EPO are paid per service. They don't directly work for or contract with the EPO carrier for a set rate. Instead, they have negotiated lower rates on services they perform for plan members.	Network providers have negotiated rates on medical services for members with a POS health plan.
Network vs out-of-network care	<p>For most plans, you're required to use health care facilities or doctors that are in the HMO network.</p> <p>Out-of-network care is typically allowed in emergency cases only.</p>	<p>When you choose a provider in the network, you may have lower out-of-pocket costs than if you choose out-of-network providers.</p> <p>Out-of-network care is usually included in the benefit plan, but it may be at a reduced level of coverage and benefits.</p>	<p>May restrict your coverage to care in the plan network.</p> <p>Out-of-network coverage may only be available for emergencies.</p>	<p>Coverage is generally for care in the plan network for services.</p> <p>Out-of-network services may be authorized in limited cases. Benefits and coverage for out-of-network care may be less than if you stay in the plan network.</p>
Referrals	With most plans, you'll need to choose a PCP. This PCP is your main health care contact and care is often coordinated through them. You may need to get a referral from your PCP to see a specialist.	It's less likely that you'd need to choose a PCP and less likely to need a referral to see a specialist. But some plans may require this, so check the network requirements to understand the details of your plan.	It's less likely that you'll be required to have a PCP or get a referral to see a specialist. Generally, you can get care from any provider if you stay in the plan network.	Often a PCP will coordinate your health care. You'll need referrals from your PCP to see a specialist or go out-of-network for care.
Preapprovals	You may need to get advanced approval before having certain medical services performed. In many cases preapproval will be handled through your PCP, if you have one.	Almost every network requires preapprovals for some medical services. Because a PPO plan gives more freedom to choose your preferred providers, you may need to get more preapprovals.	Preapprovals are more likely needed before having certain health care services, because you're not required to have a PCP overseeing your care.	Some health care services will need preapproval. However, if you have a PCP, they will often take care of preapprovals for you.

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

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

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

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

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

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

ALABAMA – Medicaid Website: http://myalhipp.com/ Phone: 1-855-692-5447	ALASKA – Medicaid The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	CALIFORNIA – Medicaid Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+) Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	FLORIDA – Medicaid Website: https://www.flmedicaidtplecovery.com/flmedicaidtplecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	INDIANA – Medicaid Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki) Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	KANSAS – Medicaid Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	LOUISIANA – Medicaid Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	MASSACHUSETTS – Medicaid and CHIP Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspreassistance@accenture.com
MINNESOTA – Medicaid Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	MISSOURI – Medicaid Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

U.S. Department of Labor

Employee Benefits Security Administration

<https://www.dol.gov/agencies/ebsa>

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

<https://www.cms.hhs.gov>

1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

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

Special Enrollment Notice

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

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 Matt Dolph, CEO, 720-458-0642, matt@vitalcare.us.

Patient Protection Model Disclosure

For plans and issuers that require or allow for the designation of primary care providers by participants or beneficiaries, insert:

United Healthcare generally **REQUIRES** 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 Matt Dolph, CEO, 720-458-0642, matt@vitalcare.us.

For plans and issuers that require or allow for the designation of a primary care provider for a child, add: For children, you may designate a pediatrician as the primary care provider.

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider, add: You do not need prior authorization from United Healthcare 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 Matt Dolph, CEO, 720-458-0642, matt@vitalcare.us

Newborn's Act Disclosure

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

WHCRA Enrollment Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: .

If you would like more information on WHCRA benefits, call your plan administrator 720-458-0642

WHCRA Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 720-458-0642 for more information.

General Notice of COBRA Continuation Coverage Rights

(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA ****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

RETIREE COVERAGE ONLY:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to VitalCare Corporation, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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;
- Retiree coverage only: Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Matt Dolph, CEO, 720-458-0642, matt@vitalcare.us

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.02% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.02% of the employee's household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact your employer via the information provided below.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1. Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2024.
2. An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name VitalCare Corporation		4. Employer identification Number (EIN) 81-3469354
5. Employer Address 1400 W 122nd Ave, Suite 140		6. Employer Phone Number 720-458-0642
7. City Westminster	8. State Colorado	9. Zip Code 80234
10. Who can we contact about employee health coverage at this job? Matt Dolph, CEO, 720-458-0642, matt@vitalcare.us		
11. Phone number (If different from above) 720-458-0642		12. Email address matt@vitalcare.us

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

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

☒ All Employees, Eligible employees are:

☐ Some Employees, Eligible employees are:

Full-time employees working 30+ hours a week.

- With respect to dependents:

☒ We do offer coverage, Eligible dependents are:

Your legal spouse or domestic partner Your and/or your domestic partner's child(ren)* up to age 26 Your disabled child(ren) up to any age (if disabled prior to age 19)* Dependent verification may be required * Includes natural, step, legally adopted/or a child placed for adoption, or a child under your legal guardianship

☐ We do not offer coverage.

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

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

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

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

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

☐ **Yes** (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?
_____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ **Yes** (Go to question 15) ☐ **No** (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$_____

b. How often ? ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Quarterly ☐ Yearly

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

16. What change will the employer make for the new plan year? _____

☐ Employer won't offer health coverage

☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$_____

b. How often ? ☐ Weekly ☐ Every 2 weeks ☐ Twice a Month ☐ Monthly ☐ Quarterly ☐ Yearly

*An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Important Notice from VitalCare Corporation About Your Prescription Drug Coverage and Medicare

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current VitalCare Corporation coverage WILL be affected. .

If you do decide to join a Medicare drug plan and drop your current VitalCare Corporation coverage, be aware that you and your dependents WILL be able to get this coverage back.

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

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 01/01/2026

Name of Entity/Sender: VitalCare Corporation

Contact: Matt Dolph, CEO, 720-458-0642, matt@vitalcare.us -- Position/Office: CEO

Phone Number: 720-458-0642

Address: 1400 W 122nd Ave, Suite 140, Westminster, Colorado, 80234

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Michelle's Law Notice

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the VitalCare Corporation group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of VitalCare Corporation group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the VitalCare Corporation group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the VitalCare Corporation group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

- The VitalCare Corporation group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary; and
- .

To obtain additional information, please contact: Matt Dolph, CEO, 720-458-0642, matt@vitalcare.us.

VitalCare Corporation

1400 W 122nd Ave, Suite 140, Westminster, Colorado, 80234

<https://vitalcare.us/>

720-458-0642, matt@vitalcare.us

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing Purposes
- Sale of your Information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you.
- Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

- We can use and disclose your health information as we pay for your health services.
- Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

- We may disclose your health information to your health plan sponsor for plan administration.
- Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Special Notes: We never sell or market your personal information

Greater limits on disclosures: We will never share any substance abuse treatment records without your written permission.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date of this notice: 2026-01-01

OHCA notice:

Privacy Official: VitalCare Corporation, matt@vitalcare.us, 720-458-0642

YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

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

REEMPLOYMENT RIGHTS	HEALTH INSURANCE PROTECTION
<p>You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:</p> <ul style="list-style-type: none"> • you ensure that your employer receives advance written or verbal notice of your service; • you have five years or less of cumulative service in the uniformed services while with that particular employer; • you return to work or apply for reemployment in a timely manner after conclusion of service; and • you have not been separated from service with a disqualifying discharge or under other than honorable conditions. <p>If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.</p>	<ul style="list-style-type: none"> • If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military. • Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.
RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION	ENFORCEMENT
<p>If you:</p> <ul style="list-style-type: none"> • are a past or present member of the uniformed service; • have applied for membership in the uniformed service; or • are obligated to serve in the uniformed service, <p>then an employer may not deny you:</p> <ul style="list-style-type: none"> • initial employment; • reemployment; • retention in employment; • promotion; or • any benefit of employment <p>because of this status.</p> <p>In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.</p>	<ul style="list-style-type: none"> • The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations. • For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at https://www.dol.gov/agencies/vets/. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra • If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation. • You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

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

U.S. Department of Labor
1-866-487-2365

ESGR
1-800-336-4590

FORM TO REQUEST DOCUMENTATION FROM AN EMPLOYER-SPONSORED HEALTH PLAN OR A GROUP OR INDIVIDUAL MARKET INSURER CONCERNING TREATMENT LIMITATIONS

Background: This is a tool to help you request information from your employer-sponsored health plan or your group or individual market insurer regarding treatment limitations that may affect your access to mental health or substance use disorder benefits. You can use this form to request:

- **General information** about treatment limitations, like your plan's preauthorization policies for both medical/surgical and mental health treatment.
- **Specific information** about why benefits were denied. For example, you can ask about the criteria for "failure to show medical necessity" that your health insurance company may have used to deny your claim.

Your plan or insurer is required by law to provide you with this information in certain instances. In some cases, a request can result in more information than you may want. Talk to your plan or insurer about what documents you wish to request, and, if you prefer, how you can receive the documents electronically.

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), many health plans and insurers must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that financial requirements and treatment limitations applied to mental health or substance use disorder benefits cannot be more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements — such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- Treatment limitations — such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization).

If you, a family member, or someone you are helping obtains health coverage through a private employer health plan, federal law requires the plan to provide certain plan documents about your or their benefits, including coverage limitations on those benefits, on request. For example, you may want to obtain documentation as to why your health plan requires pre-authorization for visits to a therapist before it will cover the visits. Generally, private employer plans must provide the documents within thirty (30) calendar days of the plan's receipt of your request. **Contact your health plan or health insurance company directly to submit your request.**

This form is designed to help you request information from your plan about treatment limitations. Many common types of treatment limits are listed on this form. If the type of treatment limitations being imposed by your plan does not appear on the list, you may insert a description of the treatment limitation about which you would like more information under "Other".

Instructions: Complete the attached form to request general information from your plan or insurer about treatment limitations or specific information about why your mental health or substance use disorder benefits were denied. This information may help you appeal a claim denial, but you must separately initiate the plan's general review and appeals process if you want to appeal the claim denial with your plan or insurer. You do not have to use this form to request information from your plan. Consult your summary plan description (SPD) or certificate of coverage to see how to request information from the plan, or how to appeal a denied claim.

If you are helping someone request information about his/her health coverage, a plan or insurer may require you to submit, with your request for information, additional documentation signed by the person you are helping (if you have not already done so).

If you have any questions about this form and you are enrolled in a private employer health plan, you may visit the Employee Benefits Security Administration's (EBSA's) website at www.dol.gov/ebsa for answers to common questions about private employer health plans. You may also contact EBSA electronically at www.askebsa.dol.gov or call toll free 1-866-444-3272.

You can also use this form if you are enrolled in coverage that is not through a private employer health plan—for example, if you have individual health coverage or coverage sponsored by a public sector employer, like a city or state government. You may contact the Centers for Medicare & Medicaid Services (CMS) at phig@cms.hhs.gov or 1-877-267-2323 ext. 61565 for questions about your individual health coverage or public sector health plan.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1080. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Date _____

Mental Health and Substance Use Disorder Parity Disclosure Request

NOTE: This disclosure request form is NOT designed to initiate a formal claim for benefits or an appeal of a denied claim; however, the information obtained through this form may help you appeal a medical claim denial with respect to your mental health and substance use disorder benefits. Submitting this form is voluntary and does NOT replace your health plan's claims or appeals process.

To: United Healthcare

(If you are a provider or another representative who is authorized to request information for the individual enrolled in the plan, provide the information below.)

I am an authorized representative requesting information for the following individual enrolled in the plan:

Attached to this request is an authorization signed by the enrollee.

(Complete this section if you're requesting general information about treatment limitations.)

General Information Request

I am requesting information concerning the plan's limitations related to coverage for:

- Mental health and substance use disorder benefits, generally.
- The following specific treatment for my mental health condition or substance use disorder: _____.

(Complete this section if you're requesting specific information about limitations that led to a denial of benefits.)

Claim/Denial Information Request

- I was notified on _____ [Insert date of denial] that a claim for coverage of treatment for _____ [Insert mental health condition or substance use disorder] was, or may be, denied or restricted for the following reason[s] shown immediately below:

(Based on your understanding of the denial of, limitation on, or reduction in coverage, check all that apply)

- I was advised that the treatment was not medically necessary.
- I was advised that the treatment was experimental or investigative.
- The plan requires authorization before it will cover the treatment.
- The plan requires ongoing authorizations before it will cover my continued treatment.
- The plan is requiring me to try a different treatment before authorizing the treatment that my doctor or therapist recommends.
- The plan will not authorize any more treatments based on the fact that I failed to complete a prior course of treatment.
- The plan's prescription drug formulary does not cover the medication my doctor is prescribing.
- My plan covers my mental health or substance use disorder treatment but does not have any reasonably accessible in-network providers for that treatment.
- I am not sure whether my plan's calculation of payment for out-of-network services, such as its methods for determining usual, customary and reasonable charges, complies with parity protections.
- Other: (Specify basis for denial of, limitation on, or reduction in coverage):

Because my health coverage is subject to the parity protections, financial requirements or treatment limitations cannot be applied to mental health or substance use disorder benefits unless those limits are comparable to financial requirements or treatment limitations applied to medical and surgical benefits. Therefore, for the limitations or terms of the benefit plan specified above, **within thirty (30) calendar days from the date of receipt** of this request, I request that the plan:

- 1. Provide the specific plan language regarding the limitation(s) and identify the medical/surgical and mental health or substance use disorder benefits to which it applies in the relevant benefit classification described in the regulations under the Mental Health Parity and Addiction Equity Act;
- 2. Identify the factors used in the development of the limitation(s) (examples of factors include, but are not limited to, excessive utilization, recent medical cost escalation, high variability in cost for each episode of care, and safety and effectiveness of treatment);
- 3. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above. Examples of evidentiary standards include, but are not limited to, the following:
 - Excessive utilization as defined by two standard deviations above average utilization per episode of care;

- Recent medical cost escalation as defined by medical costs for certain services increasing 10% or more per year for 2 years;
 - High variability in cost per episode of care as defined by episodes of outpatient care being 2 standard deviations higher in total costs than the average cost per episode 20% or more of the time in a 12-month period; and
 - Safety and efficacy of treatment modality as defined by 2 random clinical trials required to establish that a treatment is not experimental or investigative;
- 4. Identify the methods and analysis used in the development of the limitation(s); and
 - 5. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Printed Name of Individual Enrolled in the Plan or his or her Authorized Representative

Signature of Individual Enrolled in the Plan or his or her Authorized Representative

Member Number (number assigned to the enrolled individual by the Plan)

Claim Number (if seeking information regarding a specific claim)

Address

Date

E-mail address (if email is a preferred method of contact)

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

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

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

You're protected from balance billing for:

Emergency services

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

Coloradans are protected from certain surprise medical bills under both state and federal law when a covered individual receives: -Most emergency services; -Non-emergency services from an out-of-network provider at an in-network facility, such as a hospital; -Service from a private ground ambulance provider (not from a fire department or government entity); and -Service from an out-of-network air ambulance service provider. Colorado law and the federal No Surprises Act ban out-of-network cost-sharing (like out-of-network coinsurance or copayments) for most emergency and some non-emergency services. You can't be charged more than in-network cost-sharing for these services.

Certain services at an in-network hospital or ambulatory surgical center

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

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

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

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

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

If you think you've been wrongly billed, contact If you receive a surprise bill and have questions about which law is applicable, contact our Consumer Services Division for assistance. 303-894-7490 / 800-930-3745 (outside the Denver Metro area) DORA_Insurance@state.co.us Monday - Friday, 8:00 a.m. - 5:00 p.m.. The federal phone number for information and complaints is: 1-800-985-3059

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

Visit: <https://doi.colorado.gov/insurance-products/health-insurance/health-insurance-initiatives/federal-no-surprises-act/colorado> for more information about your rights under state laws.

Resources

Medical

877-797-8812

www.myuhc.com

Dental

800-822-5353

www.dbp.com

Vision

800-638-3120

www.myuhcvision.com

Life and Supplemental Insurance

800-986-3343

www.principal.com

Pet Insurance

877-343-5314

www.aspcapetinsurance.com

Colorado SecureSavings

844-711-5001

www.coloradosecuresavings.com

VitalCare Microsite

Benefits documents and links

<https://ebthree.com/microsite/vitalcare>

Benefits Administrators

Benefits

benefits@hrxservices.com

970-541-1940

Human Resources

hr@hrxservices.com

970-893-7677

Director of Operations

Heidi Lacey

heidi@vitalcare.us

720-458-0642

Enrollment Portal

Employee Navigator

www.employeenavigator.com

Company Identifier: VitalCare2024



This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.

This Benefit Booklet

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HRx Benefits LLC

Agency Website : www.hrxbenefits.com