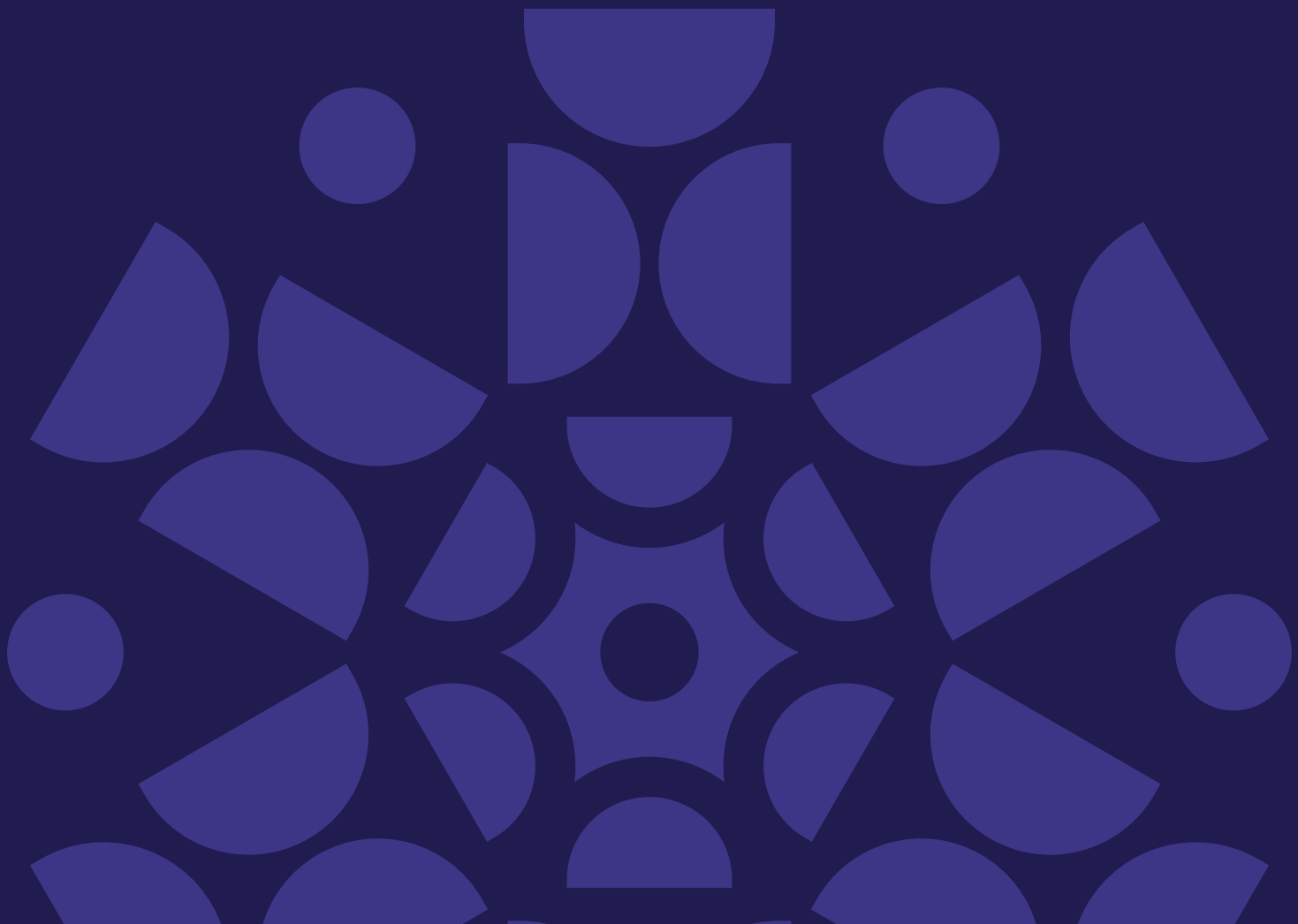
Bamboo Health

Benefits Guide

2023



BENEFITS

Our Benefits at a Glance

At Bamboo Health we provide diverse benefits aligned with our culture that holistically support our employees in their wellness journey. We continually evolve our programs to meet the needs of our employees. Here is a snapshot of our benefits we are proud to offer to enhance your wellbeing.

HEALTH & WELLNESS

- A variety of Medical, Dental and Vision plans with eligibility effective on date of hire.
- Employer contribution toward HSA on high deductible medical plans.
- Robust wellness program offering support on your physical, mental, and financial wellness journey. Substantial reduction in medical premiums upon completion of wellness program.
- Gym reimbursements up to $20 per month.
- Fitness reimbursement up to $200 per year.

MENTAL WELL-BEING

- Employee Assistance Program includes 5 free sessions with a therapist for you or anyone in your household. Availability to speak with a counselor 24/7.
- Free Calm subscription to support your mental health.

FAMILY SUPPORT

- Paid leave for new parents and family care.
- Fertility benefits through our medical plan.
- Pet insurance through Nationwide for your fur family.

FINANCIAL SECURITY

- Company paid basic life insurance, short-term and long-term disability.
- 401(k) plan with employer match of 100% on first 3% and 50% on next 2% of earnings. New hires will be auto enrolled at 5% (can opt out / adjust contribution within Fidelity portal).
- Legal support through Rocket Lawyer for you and your family.
- 1-on-1 financial coaching.

CONTINUOUS LEARNING

- Tuition reimbursement for college level courses up to $3000 per year.
- Training and certification for applicable programs.

FLEXIBILITY &TIME OFF

- Uncapped paid time off for salaried employees. Freedom to take the time you need with the trust you'll do your job well.
- 15 days of PTO for the first year and an additional day each year for hourly employees.
- 12 holidays per year plus a Diversity Designation Day that is voted on by employees every year.

Discover Your Benefits

Let’s explore your benefit plan options, programs and resources.

The benefit information listed on the following pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, claims review and adjudication procedures for each plan, please refer to the plan’s Evidence of Coverage.

Eligibility & Enrollment

Who can enroll?

You can enroll if you **regularly work a minimum of 30 hours per week**. You may choose to enroll family members, including a legal spouse/registered domestic partner and/or eligible children.

When does coverage begin?

You have **31 days from date of hire to enroll**. Coverage begins on your date of hire. Your enrollment choices remain in effect through the end of the benefits plan year, (January 1, 2023 – December 31, 2023). If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a qualifying life event.

Do I have to enroll?

You may elect to "waive" your benefits if you have access to coverage through another plan. **To waive coverage, you must make that election in Rippling**. If coverage is waived, the next opportunity to enroll in our benefits will be at our annual open enrollment, unless you have a qualifying life event.

Some states have their own rules requiring individuals to have health coverage. To avoid paying a penalty in those states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as from a State or Federal Health Insurance Exchange.

What if my needs change during the year?

You can make changes to your benefits during the year only if you have a qualifying life event as defined by the IRS.

This includes:

- Marriage, divorce or legal separation.
- New or dissolved domestic partnership.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse's loss or gain of coverage through our company or another employer.
- A change in employment status where you will be expected to average less than 30 hours per week.

You can make a change if you submit your request within 31 days of the qualifying life event.
To enter these changes: Log into Rippling > select the insurance app > choose update benefits > select your qualifying event type > continue to complete steps.

For information regarding Healthcare Reform and the Individual Mandate, please visit www.cciio.cms.gov.

Which Medical Plan is Right for You? Anthem

At Bamboo Health we provide a choice of comprehensive medical plans while at the same time encouraging a consumeristic mindset. This gives you the flexibility to choose a plan that's right for you and enables us to keep your premium costs below our industry benchmarks.

We offer two High Deductible Health Plans (HDHP) and one Preferred Provider Organization (PPO) plan.
What's the difference you might ask?

HDHP

- If you don't usually need much care throughout the year, this plan may make sense for you.
- You must meet your deductible first before the plan starts to pay, and that includes prescription drugs.
- After the deductible is met, you will be responsible for the member coinsurance, not to exceed the out-of-pocket maximum.
- Tax advantages with a Health Savings Account (HSA).
- Costs less out of your paycheck.

PPO

- A PPO is a great choice if your comfortable paying more out of your paycheck in exchange for less out-of-pocket cost.
- You will pay $ copays for services, such as doctor's office visits, and prescription drugs.
- You will be responsible to pay a % coinsurance after the deductible is met for facility claims, such as inpatient & outpatient hospital services.
- Tax advantages with a Flexible Spending Account (FSA).
- Costs more out of your paycheck.

Here is a brief comparison of our three medical plans considering the key elements of medical insurance. You'll want to make sure you take a look at the Plan Details tables on the following pages for specific coverage information.

	HDHP 1	HDHP 2	PPO 3
Deductible	$3,000 Individual $6,000 Family Embedded deductible	$1,500 Individual $3,000 Family Non-Embedded deductible	$1,000 Individual $3,000 Family
Co-Insurance	You pay 10% after deductible	You pay 10% after deductible	You pay 20% after deductible or $ copay
Out-of-pocket Max	$6,000 Individual $12,000 Family	$3,000 Individual $6,000 Family	$4,500 Individual $9,000 Family
Rx Drugs	You pay 10% after deductible	You pay 10% after deductible	$15/$35/$70

- You pay more out-of-pocket
- You pay lower premiums
- Your premium increase is lower year over year

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- You pay less out-of-pocket
- You pay higher premiums
- Your premium increase is higher year over year

Refer to the Wellness section to find out how to participate in our Wellness and pay less for medical coverage.

Cost for Medical Coverage

		PRE-TAX COST PER PAYCHECK	
Plan	**Tier**	**Base Rate**	**Wellness Rate**
HDHP Plan 1 $3000	Employee Only	$58.98	$17.88
	Employee & Spouse/Domestic Partner	$127.62	$48.80
	Employee & Child(ren)	$109.39	$41.82
	Family	$200.20	$80.08
HDHP Plan 2 $1500	Employee Only	$90.09	$51.48
	Employee & Spouse/Domestic Partner	$210.81	$124.32
	Employee & Child(ren)	$176.06	$106.56
	Family	$321.23	$197.68
PPO Plan 3 $1000	Employee Only	$168.12	$122.27
	Employee & Spouse/Domestic Partner	$372.31	$276.02
	Employee & Child(ren)	$319.12	$236.59
	Family	$577.11	$430.38

Terms & Definitions

In-network vs Out-of-network:
In-network doctors and facilities are contracted with the insurance company; i.e. in their network. You will pay less when you stay in-network. If you visit an out-of-network provider, the insurance company will still pay a portion of the cost, but you will pay more than if you'd seen an in-network provider.

Premium: Amount you pay for insurance. Cost is deducted from your paycheck on a pre-tax basis.

Copayment (copay): Fixed amount you pay for the healthcare service or prescription drug.

Deductible: Amount you pay before insurance begins covering certain services.

Co-insurance: Amount you pay after reaching deductible, can be percentage or fixed amount.

Out-of-Pocket Maximum: The most you will pay per plan year for health care expenses includes prescriptions, deductibles, and co-insurance. Once met, the plan pays 100% for the remainder of the plan year.

About Anthem

Medical insurance is provided by Anthem. They can be reached at 888.650.4047 or www.anthem.com. Our group policy # is W29862.

HDHP 1 vs HDHP 2

HDHP 1 has what's referred to as an embedded deductible. This means each individual has their own deductible, but the family also has a maximum total deductible if multiple family members need medical care during the year. Individual family members can meet their individual deductible and begin receiving co-insurance.

HDHP 2 has a non-embedded deductible. This means the total family deductible must be met before co-insurance begins.

How do I find a provider?

To find an in-network PPO provider:

1. Go to www.anthem.com
2. Click on Find Care / Find a Doctor at the top.
3. Click on Members, enter 'OAP' in the search field as this is the prefix for Bamboo Health, then click Search.
4. Enter location, and then you can search by name, specialty, or click on quick searches below.

Need to see a doctor on demand?

Anthem LiveHealth Online

You can access a video visit right from your smartphone, tablet or computer with a virtual care doctor. Both Urgent Care and Behavioral Health Therapy visits are provided via Anthem LiveHealth Online.

LiveHealth Online services are available for the following costs:

- **HDHP Plan 1 & 2:** $59 copay or less per visit
- **PPO Plan 3:** $30 PCP / $60 Specialist

Start your eVisit today!

- **By phone:** 888.548.3432
- **Online:** www.livehealthonline.com
- **Download** LiveHealth Online mobile app

sydney

Make your health care experience easier

Sydney Health makes it easy to find doctors near you, get your member ID card and get important information about benefits and claims. Download the "Sydney Health" app today in the Google Play or Apple App Store.

Prescription Drug (Rx) Benefits

Prescription drug coverage with Anthem is considered a tiered drug plan.
This means there are varying levels of payment depending on the drug's tier.

- **Generic formulary (Tier 1):** Generic drugs contain the same active ingredients as their brand-name counterparts but are less expensive.
- **Brand name medications (Tier 2):** A brand-name medication can only be produced by one specified manufacturer and is proven to be the most effective in its class.
- **Non-formulary prescriptions (Tier 3):** Although you may be prescribed non-formulary prescriptions, these types of drugs are not on the insurance company's preferred formulary list. This is because there is an alternative proven to be just as effective and safe, but less costly. Ask your doctor or pharmacist for additional information regarding the generic option.
- **Specialty prescriptions (Tier 4):** Specialty medications most often treat chronic or complex conditions and may require special storage or close monitoring.

Anthem

Plan Details	Plan 1 - HDHP 3000		Plan 2 - HDHP 1500		Plan 3 - PPO 1000	
	In-network (Blue Access)	Out-of-network	In-network (Blue Access)	Out-of-network	In-network (Blue Access)	Out-of-network
Annual Calendar Year Deductible						
Individual	$3,000	$15,000	$1,500	$4,500	$1,000	$2,000
Family	$6,000	$30,000	$3,000	$9,000	$3,000	$4,000
Maximum Calendar Year Out-of-pocket (1)						
Individual	$6,000	$18,000	$3,000	$9,000	$4,500	$9,000
Family	$12,000	$36,000	$6,000	$18,000	$9,000	$18,000
Professional Services						
Primary Care Physician (PCP)	10% After Ded	40% After Ded	10% After Ded	40% After Ded	$30 Copay	30% After Ded
Specialist	10% After Ded	40% After Ded	10% After Ded	40% After Ded	$60 Copay	30% After Ded
Telehealth Visit	10% After Ded	40% After Ded	10% After Ded	40% After Ded	$30 Copay PCP / $60 Copay Specialist	30% After Ded
Preventive Care Exam	No Charge	40% After Ded	No Charge	40% After Ded	No Charge	30% After Ded
Diagnostic X-ray and Lab	10% After Ded	40% After Ded	10% After Ded	40% After Ded	No Charge	30% After Ded
Complex Diagnostics (MRI/ CT Scan)	10% After Ded	40% After Ded	10% After Ded	40% After Ded	20% After Ded	30% After Ded
Acupuncture Services	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Chiropractic Services	10% After Ded (20 visits)	40% After Ded (20 visits)	10% After Ded (20 visits)	40% After Ded (20 visits)	$30 Copay (20 visits)	30% After Ded (20 visits)
Hospital Services						
Inpatient	10% After Ded	40% After Ded	10% After Ded	40% After Ded	20% After Ded	30% After Ded
Outpatient Surgery	10% After Ded	40% After Ded	10% After Ded	40% After Ded	20% After Ded	30% After Ded
Urgent Care	10% After Ded	40% After Ded	10% After Ded	40% After Ded	$60 Copay	30% After Ded
Emergency Room	10% After Ded		10% After Ded		$200 Copay (waived if admitted)	
Mental Health & Substance Abuse						
Inpatient	10% After Ded	40% After Ded	10% After Ded	40% After Ded	20% After Ded	30% After Ded
Outpatient	10% After Ded	40% After Ded	10% After Ded	40% After Ded	$30 copay	30% After Ded
Retail Prescription Drugs (30-day supply)						
Tier 1 - Generic	10% After Ded	50% After Ded	10% After Ded	50% After Ded	$15 Copay	50% (deductible waived)
Tier 2 - Brand	10% After Ded	50% After Ded	10% After Ded	50% After Ded	$35 Copay	
Tier 3 – Non-Preferred Brand	10% After Ded	50% After Ded	10% After Ded	50% After Ded	$70 Copay	
Tier 4 - Specialty	10% After Ded	50% After Ded	10% After Ded	50% After Ded	25% (up to $250)	
Mail Order Prescription Drugs (90-day supply)						
Tier 1	10% After Ded	Not Covered	10% After Ded	Not Covered	$45 Copay	Not Covered
Tier 2	10% After Ded		10% After Ded		$105 Copay	
Tier 3	10% After Ded		10% After Ded		$175 Copay	
Tier 4	N/A		N/A		N/A	

(1) Out-of-pocket maximum is based on the maximum allowable charge the carrier allows. This does not include any balance billing that may occur when using an out-of-network provider.

The above information is a summary only. Please refer to your Evidence of Coverage for complete details of Plan benefits, limitations and exclusions.

Health Savings Account (HSA) RIPPLING

By enrolling in HDHP Plan 1 or 2, you will have access to an HSA which provides tax advantages and is used to pay for qualified healthcare expenses.

The contributions you make towards your HSA are pre-tax and reduce your taxable income. You will be given an HSA card which is similar to a debit card. It makes paying for medical expenses that much easier!

What to know about your HSA

What are the benefits?

Bamboo Health contributes to your HSA!

The amounts below are deposited on a monthly basis (on the first of the month):

- **Employee Only:** $500 annually or $41.66 per month
- **Employee & Spouse / Domestic Partner:** $1,000 annually or $83.33 per month
- **Employee & Child(ren):** $1,000 annually or $83.33 per month
- **Employee & Family:** $1,500 annually or $125 per month

A few rules to keep in mind:

- For 2023, the maximum contribution limit is $3,850 if you are enrolled as an Employee Only, and $7,750 for employees covering dependents.
- If you are 55 or older, you can contribute an additional $1,000 per year to your HSA making your maximum contribution limit $4,850 if enrolled as Employee Only or $8,750 if covering dependents.
- Your contribution, plus Bamboo Health's contribution, count towards the IRS annual limits.
- There is a 20% penalty for using HSA funds for non-qualified expenses if you are under age 65.
- You cannot be enrolled in a Healthcare Flexible Spending Account (FSA). Please read up on FSAs to learn more.

Flexible Spending Accounts (FSAs) RIPPLING

A flexible spending account lets you set aside pre-tax dollars to pay for eligible healthcare and dependent care expenses.

FSA TYPE	DETAIL
Healthcare FSA	• For PPO participants only. • Can reimburse for eligible healthcare expenses. • Maximum contribution for 2023 is $3,050.
Limited Purpose FSA	• For HSA participants only. • This limited purpose FSA may be used to reimburse qualified dental and vision expenses only. • Maximum contribution for 2023 is $3,050.
Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) childcare expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for 2023 is $5,000.

Employee Wellness

Vitality®

Whether you'd like to lose weight, become more active, improve your diet, or simply maintain a healthy lifestyle, Vitality is right for you! It's easy to get started. Before you know it, you'll begin to make healthy choices a natural part of your everyday life! You are eligible to participate in the wellness program on your date of hire.

If you have a spouse on your medical plan, they will also have access to Vitality. Complete these same steps for them to get registered.

Registering is easy!

01 Go to www.PowerofVitality.com

02 Choose "register now"

03 Complete all the required fields

04 Create a username and password

And, you're in!

How to receive the wellness subsidy

Complete the Vitality Health Review and obtain Silver status. If you have a spouse on your medical plan, they will also need to complete these same steps to receive the full wellness subsidy potential.

EXISTING EMPLOYEE: Complete the wellness program by the deadline and you will receive the wellness subsidy for the next year.

NEW HIRE: You will receive the wellness subsidy the 1st of the month following completion of the wellness program.

Not enrolled in a medical plan ?
You can participate too! Create your account and earn points to redeem for gift cards.

Check out the Vitality Get Started Guide for more information on how to earn points!

Additional wellness support

To take advantage of these reimbursements, submit your receipt in Workday by choosing the request icon on the homepage.

Fitness Reimbursement
UP TO $200/YEAR

Submit a copy of your receipt for your event within 31 days of the event to get reimbursed. This could be a race fee, intramurals, sports league, or exercise program. Fitness equipment is not included.

Gym Membership
UP TO $20/MONTH

Submit a copy of your receipt showing the monthly fee for your gym membership, Calm app, fitness app, nutrition app, Beachbody membership, mental well-being app, etc. and get reimbursed up to $20/month!

Calm

Through Bamboo Health, you can access Calm at no-cost. Calm is an app designed to help you learn meditation and mindfulness skills from world-class experts. You can choose from hundreds of guided meditations on everything from stress and anxiety management to sleep, focus, and mind-body health.

WAYNE Corporation

The Employee Assistance Program (EAP) is a free benefit to Bamboo Health employees that provides professional help for members struggling with their mental health. Whether its stress, relationship trouble, financial/ legal concerns or substance abuse, this program is designed to help you wherever you are.

- EAP includes 5 free sessions with a therapist
- Availability to speak with a licensed counselor 24/7
- Accessible to you or anyone in your household
- 100% confidential

To get started simply call WayneCorp at (502) 451-8262 or visit waynecorp.com.

Dental Plan

DELTA DENTAL

Our dental plan is designed to give you the freedom to receive dental care from any licensed dentist of your choice.

Get the most value out of your coverage

Similar to medical coverage, the best way to get the most value out of your dental coverage is to visit a dentist in the plan's network. Our plan also comes with access to the Premier Dentist network. The list of participating dentists is slightly larger than the PPO network and it acts like a "safety net" to ensure you can access in-network care.

With PPO Plan 1, you will pay more out of your paycheck in exchange for less out-of-pocket cost as compared to PPO Plan 2.

PLAN HIGHLIGHTS	DELTA DENTAL - PPO PLAN 1		
	PPO Dentist	Premier Dentist	Out-of-network
Plan Year Deductible			
Individual		$50	
Family		$150	
Annual Maximum		$2,000 + carryover	
Preventative	Covered 100%	Covered 80%	Covered 80%
Basic Services	Covered 80%	Covered 60%	Covered 60%
Major Services		Covered 50%	
Orthodontia Services			
Adult		Covered 50%	
Child up to age 26		Covered 50%	
Lifetime Maximum		$1,500	
PLAN HIGHLIGHTS	**DELTA DENTAL - PPO PLAN 2**		
	PPO Dentist	**Premier Dentist**	**Out-of-network**
Plan Year Deductible			
Individual		$50	
Family		$150	
Annual Maximum		$1,500 + carryover	
Preventative	Covered 100%	Covered 80%	Covered 80%
Basic Services	Covered 50%	Covered 40%	Covered 40%
Major Services		Not covered	
Orthodontia Services			
Adult		Covered 50%	
Child up to age 26		Covered 50%	
Lifetime Maximum		$1,500	

Cost for Dental Coverage

PRE-TAX COST PER PAYCHECK		
Dental Plan 1	Employee Only	$13.75
	Employee & Spouse/Domestic Partner	$30.81
	Employee & Child(ren)	$30.66
	Family	$48.27
Dental Plan 2	Employee Only	$7.66
	Employee & Spouse/Domestic Partner	$17.15
	Employee & Child(ren)	$17.08
	Family	$26.87

Need a Dentist?

To find a dentist, visit www.deltadentalky.com and click on the Find a Dentist link.

About Delta Dental

Our dental provider is Delta Dental. They can be reached at 800.955.2030 or www.deltadentalky.com. Our group policy # is 688220.

Vision Plan

Our vision plan allows you to take advantage of the highest level of benefit by receiving services from an expansive list of in-network doctors. You'll pay a copay for in-network care. If you see an out-of-network doctor, you'll pay the full cost at the time of services and then submit for a reimbursement.

PLAN HIGHLIGHTS	VSP VISION PPO	
	In-network	Out-of-network
Exams (every calendar year)	$10 Copay	Reimbursement up to $45
Lenses (every calendar year) Single, Bifocal, Trifocal	$10 Copay	
Frames (every calendar year)	$150 allowance	Reimbursement up to $70
Contacts (every calendar year)	$150 allowance	Reimbursement up to $105
Additional Benefits		
LASIK	Average 15%-20% discount	

Need a Doctor?

To find an eye doctor visit www.vsp.com and click on the Find a Doctor link.

About Delta Vision / VSP

Our vision provider is Delta Vision by Delta Dental administered by VSP. Member Services: Delta Dental of Kentucky 800-955-2030 I VSP 800-877-7195. Our group policy # is 688220 .

Cost for Vision Coverage

PRE-TAX COST PER PAYCHECK		
Vision	Employee Only	$4.85
	Employee & Spouse/Domestic Partner	$7.75
	Employee & Child(ren)	$7.92
	Family	$12.76

Life Insurance

What are the benefits?

In the event of your passing, the following benefit will be paid to your designated beneficiaries. This benefit is paid for by Bamboo Health.

- **Basic Life Insurance:** 1x your annual earnings with a minimum benefit of $50,000 and a maximum benefit of $150,000.
- **Accidental Death & Dismemberment (AD&D):** If your death is the result of an accident or you become dismembered, an AD&D benefit of 1x your annual earnings with a minimum benefit of $50,000 and a maximum benefit of $150,000 may apply.

Voluntary Life and AD&D

If you would like to supplement your insurance, you can purchase additional Life and AD&D coverage for you and/or your dependents.

For you:

- $10,000 increments up to a $500,000 maximum
- Guarantee issue benefit of $300,000
- You must enroll within 30 days of your initial eligibility for the guarantee issue to apply, otherwise you must complete an Evidence of Insurability form and submit to The Hartford. This is like a health assessment and depending on the response, The Hartford may choose to deny coverage.

For your spouse:

- $5,000 increments up to a $100,000 maximum
- Amount cannot exceed 50% of your election
- Guarantee issue benefit of $30,000 if you enroll within 30 days of initial eligibility

For your child(ren):

- Benefit pays $10,000
- Newborn to 6 months of age, the plan pays $250

Voluntary AD&D:

- Coverage amounts match the voluntary life insurance listed above

Tax Note:

The IRS requires us to consider a life insurance benefit greater than $50,000 to be considered taxable income. You'll see this small amount on your paycheck.

About The Hartford

Our life insurance provider is The Hartford. They can be reached at 800.549.6514 or www.thehartford.com. Our group policy # is 888897G.

Are your Beneficiaries Up to Date?

Beneficiaries are individuals or entities that you select to receive benefits from your policy.

- You can change your beneficiary designation at any time in Rippling.
- You may designate a sole beneficiary or multiple beneficiaries to receive payment in the percent allocated.

Short & Long Term Disability

If you are unable to work due to a non-work related illness of injury, disability coverage acts as an income replacement. Bamboo Health pays for the entire cost so you can focus on getting back on your feet.

YOUR PLANS	COVERAGE DETAILS
Short Term Disability (STD) (Hourly Employees)	• Bamboo Health will pay 60% of your earnings for up to 12 weeks in a rolling 12 month period.
Short Term Disability (STD) (Salary Employees)	• Less than 6 months of service: Bamboo Health will pay 60% of your earnings for up to 12 weeks in a rolling 12 month period. • More than 6 months of service: Bamboo Health will pay 100% of your earnings for up to 12 weeks in a rolling 12 month period.
Long Term Disability (LTD)	• If your disability extends beyond 90 days, LTD coverage through The Hartford will pay 60% of your earnings, up to maximum of $15,000 per month. • Your benefits may continue to be paid until you reach social security normal retirement age as long as you meet the definition of disability.

Notice:
The state you reside in may provide disability benefits. If so, benefits will be coordinated to not exceed your normal rate of pay.

Paid Family Leave tilt

If you've got a new addition to your family or need to care for a family member with a serious health condition, we've got you covered. Once you've been with us for six months, you're eligible for paid family leave benefits.

Hourly Employees
- Will be paid 60% of their earnings for up to 6 weeks in a rolling 12 month period.

Salary Employees
- Will be paid 100% of their earnings for up to 6 weeks in a rolling 12 month period.

Notice:
The state you reside in may provide disability benefits. If so, benefits will be coordinated to not exceed your normal rate of pay.

Need to start a new leave?
To start a new leave reach out to your People Business Partner. You'll then be connected with our leave of absence partner, Tilt, who will make it simple for you to switch between work and life.

Retirement Fidelity

Our 401(k) plan with Fidelity allows you to plan for your future by investing a portion of your paycheck. Every new hire will be automatically enrolled at 5% and can make any changes / opt out within 35 days of their start date.

Employer match:

100% of the first 3%

50% of the next 2%

5% Contribute this amount to get the full 4% match

Vesting schedule: Company match vests immediately

401(k) Reminder:
Remember to designate your beneficiary by accessing "Profile" on netbenefits.com.

How to make changes to your 401(k)

1. Visit netbenefits.com and verify your identity
2. Set up your username and passcode
3. Confirm your registration and select email preferences
4. And you're done! You can now see your 401(k) account balance, view your contributions, change your investments and more

For login or password assistance, please contact Fidelity Investments at 800.294.4015

Additional 401(k) Information

Auto Enrollment: New hires are auto enrolled at 5%. You will have a 35-day window to make opt-out / changes. There will be no refunds on contributions if the change was not made within this window.

1:1 Financial Assistance: Scott DeDomenic is our financial advisor who can help you with any question you might have. Reach him at SDeDomenic@rwbaird.com

Contribution Limits: For 2023, the IRS annual contribution limits are $20,500 for everyone under age 50 or $27,000 for anyone that is age 50 or over prior to December 31, 2023.

Contribution Changes: You may change or stop your contribution entirely at any time. All changes are made directly at netbenefits.com.

Loans & Hardship Withdrawals: Please see your Total Rewards team for information and requirements for either option.

Rollover Contributions: If you have an outside qualified retirement plan or account such as a 401(k), 403(b), 457(b) or IRA, you may be able to transfer that account into your new plan. Please contact Fidelity Investments at 800.294.4015 for additional information.

Commuter Plan RIPPLING

Commuter benefits allow you to put money from your paycheck aside each month, before taxes, for qualifying mass transit and parking expenses.

What does it cover?

TRAIN **BUS** **SUBWAY** **FERRY** **VANPOOL**

PARKING or parking meter near your place of employment

More info:

- You can contribute up to $280 per month from your paycheck for both Mass Transit and Parking expenses.
- You will use your Rippling card if you are currently enrolled in an FSA or HSA to pay for these expenses. If you do not already have a Rippling card, one will be mailed to you after your enrollment.
- Any money contributed to your mass transit or parking benefit rolls over every month until it is used, or you are no longer eligible. Your funds will no longer be available if you terminate employment.
- To submit a claim, log into your Rippling account and select the Commuter application. Under the Claims tab, select Submit New Claim, then follow the steps to complete the claim.

EXTRAS

Extra Perks

Nationwide Pet Insurance

Our pet insurance benefit covers dogs, cats, birds and other exotic animals!

What is included:

- Plans include 50%, 70%, 90% reimbursement options
- $7,500 annual benefit
- Pre-existing conditions are excluded and will not be covered on any plans
- Multiple pet discount: 2-3 pets 5% discount, 4+ pets 10% discount

Where to enroll:

- Visit https://benefits.petinsurance.com/appriss to enroll
- This will not be payroll deducted – set up your account and pay direct

ROCKETLAWYER Legal Services

Rocket Lawyer can provide you with access to a network of qualified attorneys, legal documents, and discounts on lawyers in your area.

What is included:

- 30 minute telephonic and in-office consultations
- Unlimited Q&A with an attorney
- Legal document library with hundreds of documents

Rocket Lawyer can help with things such as:

- Getting married
- Estate planning
- Will prep
- Immigration issues
- Buying a home
- And much more!

Get started:

- Visit go.rocketlawyer.com/appriss
- Enter your work email
- Rocket Lawyer will send you a confirmation email to enter their site
- Fill out the form and you're all set!
- Need help? Email benefitssupport@rocketlawyer.com

TIME OFF

Time Off

At Bamboo Health we greatly value and celebrate the diversity of our employee community. We are committed to making an inclusive workplace that celebrates all of our diverse backgrounds.

The purpose of Diversity Day is to recognize and promote awareness about the important customs, history, and traditions that are celebrated by many of our employees. Throughout the year we will also recognize and celebrate additional cultural events in addition to Diversity Day, as recognizing and celebrating the diversity of our team is one of the things that makes Bamboo Health a great place to work.

THESE 13 HOLIDAYS WILL BE PAID IN 2023	
(This includes a Diversity Designation Day that is voted on employees every year!)	
Monday, January 2	New Year's Day (observation)
Monday, January 16	Martin Luther King, Jr. Day
Monday, February 20	President's Day
Monday, May 29	Memorial Day
Monday, June 19	Juneteenth
Tuesday, July 4	Independence Day
Monday, September 4	Labor Day
Monday, September 25	**Designated Diversity Day – Yom Kippur**
Friday, November 10	Veteran's Day
Thursday, November 23	Thanksgiving Day
Friday, November 24	Day after Thanksgiving
Friday, December 22	Christmas Eve (observation)
Monday, December 25	Christmas Day

The time off benefits below reflect our investment in both your professional and personal life. We trust you to do your job well and also take the time off you need so long as Bamboo Health can thrive, clients are supported and your colleagues are considered.

Paid Time Off (PTO) for Hourly Employees:

15 days PTO to start and an additional day each year up to 25 days.

Results Only Work Environment (R.O.W.E) for Salaried Employees:

Uncapped paid time off with the freedom to take the time you need with the trust you'll do your job well.

Leave of Absence (LOA):

You may be eligible for a leave of absence for reasons such as your own serious health condition lasting longer than 3 days, to care for a family member with a serious health condition or for the birth or adoption of a child. Please reach out to your People Business Partner.

Continuous Learning

Bamboo Health offers learning and development opportunities to help bolster your career including technical certifications and leadership training. Reach out to your People Partner and Manager to find out more!

Tuition Reimbursement

Employees who have completed 1 year of service may be eligible for tuition reimbursement for college level courses. To ensure the class will support your career at Bamboo Health, you'll need to get approval in advance from your People Partner and Manager in Workday.

You'll then be reimbursed as follows:

- **Pass (A & B):** 100% up to $3,000 per year
- **Pass (C & P) (Pass/fail course):** 75% up to $3,000 per year
- **Fail (D or below):** 0% reimbursed

Remote Communications

As a company that supports remote work and flexibility for our employees, eligible employees will receive an allowance for costs associated with the use of a cell phone, home internet and other home office equipment for job-related purposes, provided certain responsibilities are met by the employee.

All full-time, salaried employees who are in good standing will be eligible for the allowance. Hourly support employees are not eligible for the allowance. The amount of allowance is determined by a person's position at the time of hire and/or promotion..

The set monthly amount breakdown is the following:

- Individual Contributor Positions (non-management) = $50/month.
- Help Desk Positions = $50/month
- Management = $100/month
- Sales, Customer Success and Recruiting Positions = $100/month

The allowance will be included in your regular pay on the 1st paycheck of the month.

Employee Cost for Benefits

The rates below are effective January 1, 2023 – December 31, 2023

	PRE-TAX MONTHLY COST		
Plan	**Tier**	**Base Rate**	**Wellness Rate**
HDHP Plan 1	Employee Only	$128	$39
	Employee & Spouse/Domestic Partner	$277	$106
	Employee & Child(ren)	$237	$91
	Family	$434	$174
HDHP Plan 2	Employee Only	$195	$112
	Employee & Spouse/Domestic Partner	$457	$269
	Employee & Child(ren)	$381	$231
	Family	$696	$428
PPO Plan 3	Employee Only	$364	$265
	Employee & Spouse/Domestic Partner	$807	$598
	Employee & Child(ren)	$691	$513
	Family	$1,250	$933
	PRE-TAX MONTHLY COST		
Dental Plan 1	Employee Only	$28	
	Employee & Spouse/Domestic Partner	$67	
	Employee & Child(ren)	$66	
	Family	$105	
Dental Plan 2	Employee Only	$17	
	Employee & Spouse/Domestic Partner	$37	
	Employee & Child(ren)	$37	
	Family	$58	
	PRE-TAX MONTHLY COST		
Vision	Employee Only	$11	
	Employee & Spouse/Domestic Partner	$17	
	Employee & Child(ren)	$17	
	Family	$28	

Medical rates above are rounded to the nearest dollar. Deductions from your check may vary by cents.

Directory & Resources

INFORMATION REGARDING	GROUP/POLICY #	CONTACT INFORMATION	
Enrollment & Eligibility: Human Resources			
Lauren Winchell, Total Rewards Analyst		502.815.3801	lwinchell@bamboohealth.com
Stacey Langan, Director, Talent Development		502.815.5538	slangan@bamboohealth.com
Medical Coverage: Anthem			
Medical Plan 1 – HDHP 3000 Medical Plan 2 - HDHP 1500 Medical Plan 3 – PPO 1000	W29862	888.650.4047	www.anthem.com
Dental Coverage: Delta Dental			
PPO	688220	800.955.2030	www.deltadentalky.com
Vision Coverage: VSP / Delta Dental			
PPO	688220	800.955.2030	www.vsp.com
Life, AD&D: The Hartford			
Basic Life and AD&D Voluntary Life and AD&D	888897G	800.549.6514	www.thehartford.com
Leave of Absence			
Tilt	Nicole Sulpizio		https://appriss.ourtilt.com/login nicole.sulpizio@ourtilt.com
Flexible Spending Accounts, Health Savings Accounts, and Commuter Plans			
Rippling			https://app.rippling.com/dashboard
401(k) Retirement Plan Adviser: Fidelity Investments			
Scott DeDomenic		800.294.4015	www.netbenefits.com SDeDomenic@rwbaird.com
Employee Assistance Plan			
Wayne Corp		800.441.1327	www.waynecorp.com
Additional Benefits			
Nationwide – Pet Insurance		877.738.7874	benefits.petinsurance.com/appriss
Rocket Lawyer – Legal Plan			go.rocketlawyer.com/appriss
Calm			www.calm.com
Benefits Broker			
Alium Insurance Partners	Marci Johnson	859.619.0450	help@alium.com

Legal Information Regarding Your Plans

You can stop reading here if you like! We are just required to provide these notices to you!

Medicare Part D Notice

Important Notice from Bamboo Health About Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bamboo Health 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. Bamboo Health has determined that the prescription drug coverage offered by the Bamboo Health Health & Welfare Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing 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 prescription drug plan.

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

If you decide to join a Medicare drug plan while enrolled in Bamboo Health coverage as an active employee, please note that if your Bamboo Health coverage is subject to the Medicare Secondary Payer rules, the Bamboo Health will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced if your Bamboo Health coverage is subject to the Medicare Secondary Payer rules, which applies to all employers with 20 or more employees. Medicare will usually pay primary for your prescription drug benefits if you participate in Bamboo Health coverage as an individual who loses eligibility under the plan (e.g., termination, reduction in hours).

You may also choose to drop your Bamboo Health coverage. If you do decide to join a Medicare drug plan and drop your current Bamboo Health coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Bamboo Health 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 Bamboo Health 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 the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA 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 prescription 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: 10/29/21 / Name of Entity/Sender: Courtney Davis / Contact-Position/Office: Manager, Total Rewards
Address: 9901 Linn Station Road, Louisville, KY 40223 / Phone Number: 502.815.5538

Medicare Part D Notice

Important Notice From Bamboo Health About Your Prescription Drug Coverage and Medicare
Model Individual NON-CREDITABLE Coverage Disclosure
Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Bamboo Health 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Bamboo Health has determined that the prescription drug coverage offered by the Bamboo Health Health & Welfare Benefits Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Bamboo Health Health & Welfare Benefits Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from Bamboo Health Health & Welfare Benefits Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

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.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan while enrolled in Bamboo Health coverage as an active employee, please note that if your Bamboo Health coverage is subject to the Medicare Secondary Payer rules, the Bamboo Health will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced if your Bamboo Health coverage is subject to the Medicare Secondary Payer rules, which applies to all employers with 20 or more employees. Medicare will usually pay primary for your prescription drug benefits if you participate in Bamboo Health coverage as an individual who loses eligibility under the plan (e.g., termination, reduction in hours).
You may also choose to drop your Bamboo Health coverage. If you do decide to join a Medicare drug plan and drop your current Bamboo Health coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under Bamboo Health Health & Welfare Benefits Plan is not creditable you may pay a penalty to join a Medicare drug plan depending on how long you go without creditable prescription drug coverage. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (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 Bamboo Health 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 the Social Security Administration (SSA) online at www.socialsecurity.gov or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Date: 10/29/21 / Name of Entity/Sender: Courtney Davis / Contact-Position/Office: Manager, Total Rewards
Address: 9901 Linn Station Road, Louisville, KY 40223 / Phone Number: 502.815.5538

Required Notices

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits 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.
Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements
Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.
These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) 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.
Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

- COBRA (or state continuation coverage) exhaustion
- Loss of other coverage (1)
- Acquisition of a new spouse or dependent through marriage (1), adoption (1), placement for adoption (1) or birth (1)
- Loss of state Children's Health Insurance Program coverage (e.g., Healthy Families)
- (60-day notice) (1)
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-day notice)

Important Information on How Health Care Reform Affects Your Plan

Primary Care Provider Designations

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

- Your HMO 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 your Human Resources office

For plans and issuers that require or allow for the designation of a primary care provider for a child:

- 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:

- You do not need prior authorization from your insurance provider 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 your Human Resources office.

Grandfathered Plans
If your group health plan is grandfathered then the following will apply. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator.

Prohibition on Excess waiting Periods
Group health plans may not apply a waiting period that exceeds

90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

Preexisting Condition Exclusion
Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

Continuation Coverage Rights Under COBRA

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.

1. Indicates that this event is also a qualified "Change in Status"
2. Indicates this event is also a HIPAA Special Enrollment Right
3. Indicates that this event is also a COBRA Qualifying Event

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

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

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

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

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

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

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

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

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

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

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 (1) to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (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
Courtney Davis
Manager, Total Rewards
9901 Linn Station Road
Louisville, KY 40223
502.815.5538

For More Information
This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.
If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your Human Resources Representative.

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, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov.

Employee Rights & Responsibilities Under the Family Medical Leave Act

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition; or
- For a serious health condition that makes the employee unable to perform the employee's job.

(1)https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods

Military Family Leave Entitlements
Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness (1); or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. (1)

Benefits & Protections
During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.
Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months (2), and if at least 50 employees are employed by the employer within 75 miles.

1. The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition"
2. Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TYY: (877) 889-5627 www.wagehour.dol.gov

How to Continue Coverage
If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You do not Elect to Continue Coverage?
If you fail to submit a timely, completed Election Form as

instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.
If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage
The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued
If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Reporting to Work / Applying for Reemployment
Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to work environment
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as possible
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible
181 days or more	Submit an application for reemployment within 90 days after completion of your service
Any period if for purposes of an examination for fitness to perform uniformed service	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definitions
For you to be entitled to continued coverage under USERRA, your absence from work must be due to "service in the uniformed services."

- "Uniformed services" means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency
- "Service in the uniformed services" or "service" means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active
- and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS)

HIPAA Privacy Notice

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.
This notice is EFFECTIVE: 1/1/2023
This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

This notice is for participants in the Company Health & Welfare Plan (referred to as the "Plan"), including its component plans.

Required by Law

- The Plan must make sure that health information that identifies you is kept private.
- The Plan must give you this notice of our legal duties and privacy practices with respect to health information about you.
- The Plan must obtain written authorization from you for the use and disclosure of your PHI related to psychotherapy notes; when for purposes of marketing; and/or for disclosures constituting a sale of PHI.
- The Plan must follow the terms of the notice that are currently in effect.

Permitted Plan use of Your Health Information
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, contact the Plan Privacy Officer.

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; and contact you for fundraising efforts.

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

The Plan will never share your information unless you give us written permission for: marketing purposes and the sale of your information.

Treatment: The Plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the Plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also 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.

Payment for Health Services and Administration of the Plan: The Plan can use and disclose your health information when paying for your health services. For example, the Plan may share information about you with your dental plan to coordinate payment for your dental work. The Plan may disclose your health information to your health plan sponsor for plan administration. For example, where your company contracts with an insurer to provide a health plan, and the Plan provides your company with certain statistics to explain the premiums charged.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.
As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.
Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement and other Government Requests: We may disclose your health information for law enforcement purposes or with a law enforcement official, in response to a valid subpoena or other judicial or administrative request/order, with health oversight agencies for activities authorized by law, or for special government functions such as military, national security, and presidential protective services.

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: 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 or for purposes of health research.

Your Rights Regarding Your Health Information
Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information where concerning a service already paid for.
- Obtain a paper copy of the notice of health information practices promptly (even if you have agreed to receive the notice electronically) by requesting it from the Plan Privacy Officer.
- Ask to see or get a copy of your health and claims records and other health information we have about you. 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.
- Inspect and obtain a copy of your PHI contained in a "designated record set." A designated records set includes medical and billing records; enrollment, payment, billing, claims adjudication and case or medical management record systems; or other information used in whole or in part by or for the covered entity to make decisions about individuals. A written request to access your PHI must be submitted to your company Privacy Officer. Requested information will be provided within 30 days if maintained on site or 60 days if maintained off site.
- Request an amendment/correction to your health information: you can ask us to correct your health and claims records if you think they are incorrect or incomplete. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- 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.
- **Obtain an accounting of disclosures of your PHI during the preceding six years, who we shared it with, and why, with the exception of disclosures made for purposes of treatment, payment or health care operations, and certain other disclosures (such as any you asked us to make); made to individuals about their own PHI; or, made through use of an authorization form. A reasonable fee may be charged for more than one request per year.**
- **Request confidential communications of your health information be sent in a different way (for example, home, office or phone) or to a different place than usual (for example, you could request that the envelope be marked "confidential" or that we send it to your work address rather than your home address). We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.**
- **Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.**
- **Receive notification within 60 days (5 day for California residents) for any breaches of your unsecured PHI.**
- **Assign someone as your medical power of attorney or your legal guardian, who 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.**

Plan Responsibilities

- **The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:**
- **Maintain the privacy and security of your health information.**
- **Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, 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.**
- **Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.**
- **Abide by the terms of this notice.**
- **Notify you if we are unable to agree to a requested restriction, amendment or other request.**
- **Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).**
- **Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.**

The Plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA. The plan is prohibited from using or disclosing PHI that is genetic information of an individual for any purposes, including underwriting.
For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Your Right to File a Complaint
If you believe your privacy rights have been violated, you can file a formal complaint with the Plan Privacy Officer; or with the U.S. Department of Health and Human Services (by mail or email). We will not retaliate against you and you will not be penalized for filing a complaint.

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.

Contact Person
If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the Plan Privacy Officer. All requests must be submitted in writing to the address shown below.

Bamboo Health
Attention: Courtney Davis
Manager, Total Rewards
9901 Linn Station Road
Louisville, KY 40223
502.815.5538

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 January 31, 2021. Contact your State for more information on eligibility.

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ **Phone:** 1-855-692-5447	**Health First Colorado Website:** https://www.healthfirstcolorado.com/ **Health First Colorado Member Contact Center:** 1-800-221-3943/ State Relay 711 **CHP+:** https://www.colorado.gov/pacific/hcpf/child-health-plan-plus **CHP+ Customer Service:** 1-800-359-1991/ State Relay 711 **Health Insurance Buy-In Program (HIBI):** https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program **HIBI Customer Service:** 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program **Website:** http://myakhipp.com/ **Phone:** 1-866-251-4861 **Email:** CustomerService@MyAKHIPP.com **Medicaid Eligibility:** http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	**Website:** https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html **Phone:** 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ **Phone:** 1-855-MyARHIPP (855-692-7447)	**Website:** https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp **Phone:** 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	**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)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members **Medicaid Phone:** 1-800-338-8366 **Hawki Website:** http://dhs.iowa.gov/Hawki **Hawki Phone:** 1-800-257-8563 **HIPP Website:** https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp **HIPP Phone:** 1-888-346-9562	**Website:** http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP **Phone:** 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ **Phone:** 1-800-792-4884	**Website:** http://www.ACCESSNebraska.ne.gov **Phone:** 1-855-632-7633 **Lincoln:** 402-473-7000 **Omaha:** 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium **Payment Program (KI-HIPP) Website:** https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx **Phone:** 1-855-459-6328 **Email:** KIHIPP.PROGRAM@ky.gov **KCHIP Website:** https://kidshealth.ky.gov/Pages/index.aspx **Phone:** 1-877-524-4718 **Kentucky Medicaid Website:** https://chfs.ky.gov	**Medicaid Website:** http://dhcfp.nv.gov **Medicaid Phone:** 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – 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)	**Website:** https://www.dhhs.nh.gov/oii/hipp.htm **Phone:** 603-271-5218 **Toll free number for the HIPP program:** 1-800-852-3345, ext 5218

MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms **Phone:** 1-800-442-6003 **TTY:** Maine relay 711 **Private Health Insurance Premium Webpage:** https://www.maine.gov/dhhs/ofi/applications-forms **Phone:** 800-977-6740. **TTY:** Maine relay 711	**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
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa **Phone:** 1-800-862-4840	**Website:** https://www.health.ny.gov/health_care/medicaid/ **Phone:** 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp **Phone:** 1-800-657-3739	**Website:** https://medicaid.ncdhhs.gov/ **Phone:** 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** 573-751-2005	**Website:** http://www.nd.gov/dhs/services/medicalserv/medicaid/ **Phone:** 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org **Phone:** 1-888-365-3742	**Medicaid Website:** https://medicaid.utah.gov/ **CHIP Website:** http://health.utah.gov/chip **Phone:** 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html **Phone:** 1-800-699-9075	**Website:** http://www.greenmountaincare.org/ **Phone:** 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx **Phone:** 1-800-692-7462	**Website:** https://www.coverva.org/hipp/ **Medicaid Phone:** 1-800-432-5924 **CHIP Phone:** 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ **Phone:** 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	**Website:** https://www.hca.wa.gov/ **Phone:** 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov **Phone:** 1-888-549-0820	**Website:** http://mywvhipp.com/ **Toll-free phone:** 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov **Phone:** 1-888-828-0059	**Website:** https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm **Phone:** 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ **Phone:** 1-800-440-0493	**Website:** https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ **Phone:** 1-800-251-1269


Bamboo
Health