EQUITY TRUST COMPANY®



2027 BENEFITS GUIDE

MEDICAL | HEALTH SAVINGS ACCOUNT
DENTAL | VISION | WELLBEING
HEALTH CARE FSA | DEPENDENT CARE FSA
LIFE | DISABILITY | ACCIDENT & CRITICAL ILLNESS
LEGAL SERVICES & ID THEFT | 401(k) PLAN
EMPLOYEE ASSISTANCE PROGRAM
PET INSURANCE | ASSOCIATE DISCOUNTS

NORTH COAST 99
PRESENTED BY ERC

PLAN YEAR: JANUARY 1, 2027 - DECEMBER 31, 2027

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ELIGIBILITY OVERVIEW

Equity is pleased to offer our associates a market competitive benefits program. These benefits are designed to protect you and your family while you are an active associate.

ASSOCIATE ELIGIBILITY

- Associates are eligible for the benefit plans effective the first of the month following their date of hire.
- Associates must work an average of at least 30 or more hours per week to be eligible for medical, dental, vision, FSA, life, AD&D, and disability plans.

SPOUSAL ELIGIBILITY

- Equity Administrative Services, Inc. has a Working Spouse Provision under the medical plan eligibility.
- If your spouse works and is eligible for coverage from their own employer, your spouse will not be eligible to participate in the Equity Administrative Services, Inc. medical plan.
- During open enrollment, you are required to declare whether or not your spouse is eligible for coverage under his/her employer.

ANNUAL ELECTIONS

It is important that you make your choices carefully, since changes to those elections can generally only be made when you first become eligible or during the annual open enrollment period.

Email

Vicki Barone (v.barone@trustetc.com)

or

Katie Plush (k.plush@trustetc.com)

if you have any questions about the benefits or online enrollment process.

QUALIFYING EVENTS

When open enrollment is completed, you will NOT be able to make changes to certain benefit elections during the plan year unless you meet the Internal Revenue Service (IRS) requirements for a "qualifying event" (QE) under Section 125. An associate may not change his or her election throughout the plan year unless he or she experiences a qualifying event. Qualifying events include:

- Birth or an adoption
- Marriage, divorce or legal separation
- Death
- Gain or loss other group coverage
- Change in employment status
- Change in dependent status
- Change in location
- Significant change in the financial terms of health benefits
- Court judgments, decrees, or orders
- Medicare eligibility
- Medicaid eligibility

If you experience a qualifying event and you wish to change your benefit elections, you must notify the Human Resources Department of the qualifying event within 30 days of the qualifying event date. Associates must also provide HR with any required documentation to support the qualifying event.

COBRA CONTINUATION COVERAGE

When you or any of your dependents no longer meet the eligibility requirements for health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

DEPENDENT ELIGIBILITY

Your dependents may also be covered under the medical, dental, vision, voluntary life, critical illness, accident insurance, and Legal/ID Theft benefit plans.

ELIGIBLE DEPENDENTS INCLUDE:

- Legal spouse, as defined by federal law.
- Any child of yours who is:
    - less than 26 years old.
    - 26 or more years old, primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability.



CONTACT INFORMATION

PLAN	CARRIER	PLAN ID	PHONE	WEB ADDRESS
Medical/Prescription	Cigna	3337766	800-244-6224	mycigna.com
Dental	Delta Dental		800-524-0149	deltadental.com
Vision	VSP	-	800-877-7195	vsp.com
Health Savings Account	Cigna	3337766	800-244-6224	mycigna.com
Health Care Flexible Spending Account	Cigna	3337766	800-244-6224	mycigna.com
Dependent Care Flexible Spending Account	Cigna	3337766	800-244-6224	mycigna.com
Basic Life/Basic AD&D	Lincoln Financial Group	1141940	800-431-2958	www.mylincolnportal.com
Voluntary Life	Lincoln Financial Group	1141940	800-431-2958	www.mylincolnportal.com
Disability (STD/LTD)	Lincoln Financial Group	1141940	800-431-2958	www.mylincolnportal.com
Voluntary Accident Insurance	Cigna	3337766	800-244-6224	mycigna.com
Voluntary Critical Illness	Cigna	3337766	800-244-6224	mycigna.com
Wellness Program	Vitality	-	877-224-7117	powerofvitality.com
Employee Assistance Program	Total Care EAP	-	800-252-4555	www.theEAP.com
401(k) Plan Registration & Account Maintenance	Go Retire	2ZZ	800-716-3742	go-retire.com/equitytrust
401(k) Plan – Investment Advisor Strategy & Investment Consultation	Meeder Wealth Management		866-633-3371	meederwealth.com
Auto/Home Insurance Discounts	Farmers Select Group		888-327-6335	farmers.com
Legal Services & ID Theft	Metlife Legal Plan		800-821-6400	metlife.com
Pet Insurance	MetLife Pet Insurance		1-800-438-6388	metlifepetinsurance.com

When contacting any of the above providers, it is important to have the ID number(s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, such as an explanation of benefits, a denial letter, receipts, etc.

MEDICAL & PRESCRIPTION DRUG PLAN INSURANCE

Administered by Cigna

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness or injury. A little prevention usually goes a long way, especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Equity Administrative Services, Inc.

Cigna administers the Medical and Prescription insurance plans. Associates who are active in the medical plan have the opportunity to make changes to their coverage during open enrollment.

The Cigna Open Access Plus (OAP) health benefits plan allows you to choose your health care providers. No referrals required to see a specialist. You have coverage for out-of-network services, but you will have higher out-of-pocket costs, and you may need to file a claim.

Equity Administrative Services, Inc. offers you a few medical plan options. With the medical plan options available, you may select where you receive your medical services. If you use in-network providers, your costs will be lower. Locating a Cigna network provider is easy; just visit www.mycigna.com.

For additional information, please review the Summary of Benefits and Coverage (SBC) for the Standard PPO and High Deductible Health plans posted to the HR For You folder and at https://equitybenefitsconnect.com/.

We have teamed up with Cigna to offer you the use of Cigna's Telehealth Connection and 90 Now prescription refill programs. These programs are available to all medical plan participants.

CIGNA 90 NOW PRESCRIPTION REFILLS

With this maintenance medication program, you now have more choice in how, and where, you can fill your prescriptions. You choose what is best for you.

If you fill your prescription in a 90-day supply, you have to use a 90-day retail pharmacy in the plan network (includes CVS, Target, Giant Eagle, Walgreens, Walmart, Kroger's and many more).

If you fill your prescription in a 30-day supply, you can use any pharmacy in the plan network.

Filling your prescriptions in a 90-day supply means that you will be less likely to miss a dose and you will have to make fewer trips to the pharmacy to refill your medications.

If you use Cigna Home Delivery Pharmacy to fill your prescriptions, you can have your medications delivered to your home in a 90-day supply.

Please refer to the Cigna 90 Now Maintenance Drug List overview which provides more detailed information on the program. The overview is located in the HR For You folder and at https://equitybenefitsconnect.com/.

MEDICAL & PRESCRIPTION DRUG PLAN INSURANCE

	HIGH DEDUCTIBLE HEALTH PLAN 1 (HSA)		HIGH DEDUCTIBLE HEALTH PLAN 2 (HSA)	
	In-Network	Out-of-Network	In-Network	Out-of-Network
DEDUCTIBLES	**Calendar Year Aggregate Deductible**		**Calendar Year Embedded Deductible**	
Individual	$2,000	$4,000	$4,000	$8,000
Family	$4,000	$8,000	$8,000	$16,000
COINSURANCE				
Plan Pays	80%	60%	100%	60%
You Pay	20%	40%	0%	40%
OUT OF POCKET MAXIMUM	**Deductible & Copays Included**		**Deductible & Copays Included**	
Individual	$3,000	$8,000	$4,000	$12,000
Family	$6,000	$16,000	$8,000	$20,000
OFFICE VISITS				
TeleMedicine	Fee	Not Covered	Fee	Not Covered
Primary Care Physician	20% co-insurance	40% co-insurance	No Charge	40% co-insurance
Specialist	20% co-insurance	40% co-insurance	No Charge	40% co-insurance
Urgent Care	20% co-insurance	20% co-insurance	No Charge	No Charge
Emergency Room	20% co-insurance	20% co-insurance	No Charge	No Charge
Diagnostic Labs & X-Rays	20% co-insurance	40% co-insurance	No Charge	40% co-insurance
Hospitalization	20% co-insurance	40% co-insurance	No Charge	40% co-insurance
Mental Health Office Visit	20% co-insurance	40% co-insurance	No Charge	40% co-insurance
Preventive Care Services	100% coverage No deductible	40% co-insurance No deductible	100% coverage	40% co-insurance
LIFETIME MAXIMUM	Unlimited		Unlimited	

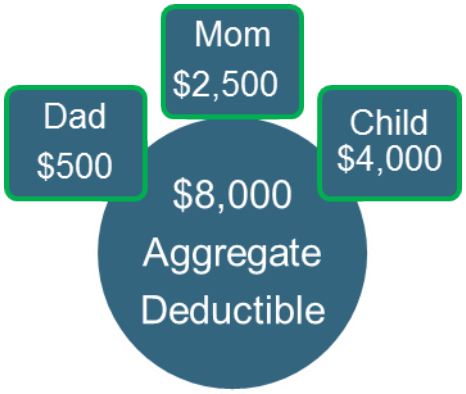
PRESCRIPTION DRUGS	Retail 30-day supply	Mail Order 90-day supply	Retail 30-day supply	Mail Order 90-day supply
Generic	Deductible, 20% coinsurance	Deductible, 20% coinsurance	Deductible, 0% coinsurance	Deductible, 0% coinsurance
Brand				
Non-Preferred				

Preventative care is covered at 100% (in network). Preventative care includes your annual physical, well-woman, well-baby and well-child exams, mammography and colonoscopy screenings, blood pressure and cholesterol testing and intervention for alcohol or substance

DEDUCTIBLE OVERVIEW

AGGREGATE DEDUCTIBLE

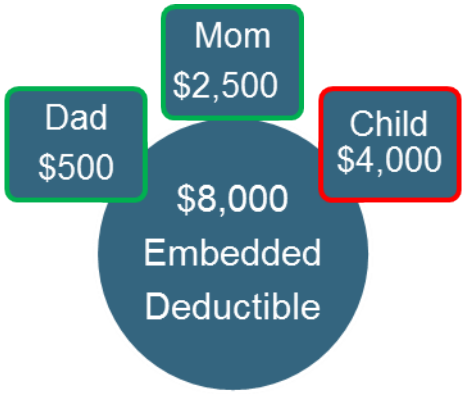
The family deductible amount must be satisfied before any co-insurance takes effect. The family deductible may be satisfied by one family member or a combination of family members. There are no individual deductibles.



Aggregate family deductible not met

EMBEDDED DEDUCTIBLE

A single member of a family doesn't have to meet the full family deductible for co-insurance to take effect. The person's after-deductible benefits will take effect as soon as he or she has met the individual deductible. Once you meet the family deductible, everyone will receive after deductible benefits, even if not everyone has met the individual deductible.



Child has met their individual deductible



The Smith family has an $8,000 deductible.
Their medical bills this year:
Dad $500
Mom $2,500
Child: $4,000
Total Deductible Met: $7,000

HEALTH SAVINGS ACCOUNTS (HSA)

Administered by Cigna

By selecting a High-Deductible Health Plan (HDHP) with Health Savings Account (HSA), you can contribute tax-free money into your HSA that allows you to earn tax-free interest that can be used to pay for qualified health care expenses tax-free. *Triple Tax Advantaged!*

Increased contribution HSA limits for 2027. Associate only coverage $4,500. Associate + Dependent(s) coverage $9,000. Associates age 55 or older may contribute an additional $1,000 catch up contribution. To be eligible to contribute to an HSA, you must be enrolled in a HDHP, you cannot be enrolled in Medicare, you cannot be enrolled in other coverage, and no one can claim you as a dependent on their tax returns.

	HEALTH SAVINGS ACCOUNT
When can I use the funds?	Funds are available as you contribute to the account.
Can I roll over funds each year?	Yes, funds roll over from year-to-year and are yours to keep (even if you leave the company).
How do I pay for eligible expenses?	With your Cigna HSA Bank debit card You can also submit claims for reimbursement online at www.myCigna.com
How much can I contribute each year?	You can contribute $4,500 for individual coverage or $9,000 for family coverage (this total includes employer HSA contribution).
Will I receive an employer contribution to this account?	Yes. Equity Trust will contribute $500 per year for those enrolled in associate only coverage, and $1,000 per year for those enrolled in associate + dependent(s) coverage. Employer contribution for new hires will be pro-rated. All funds are available immediately upon plan start date.
Can I change my contributions throughout the year?	Yes, notify the Benefits Specialist to change semi-monthly HSA contributions at any time during the plan year.
Do I own the account?	Yes, if you were to change jobs the account goes with you. There are no fees to transfer or rollover the account.

EMPLOYER HSA CONTRIBUTION AMOUNT			
ENROLLMENT MONTH	MONTHS OF COVERAGE	SINGLE	FAMILY
January	12	$500.00	$1,000.00
February	11	$458.33	$916.67
March	10	$416.67	$833.33
April	9	$375.00	$750.00
May	8	$333.33	$666.67
June	7	$291.67	$583.33
July	6	$250.00	$500.00
August	5	$208.33	$416.67
September	4	$166.67	$333.33
October	3	$125.00	$250.00
November	2	$83.33	$166.67
December	1	$41.67	$83.33

2027 PLAN YEAR ANNUAL CONTRIBUTION LIMITS	
Single	$4,500
Family	$9,000

HSA Catch-Up Contribution (age 55 yrs and older
$1,000

Prorated Contributions

The IRS states that contribution limits must be prorated by the number of months a person is eligible to contribute to a health savings account. Divide the contribution limit by 12 and contribute that amount.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT (FSA)

Administered by Cigna

The Health Care Flexible Spending Account allows you to set aside up to $3,500 on a pre-tax basis that you can use to pay for certain out-of-pocket health care costs for you, your spouse, and your eligible dependents. You will receive a Visa debit card to pay for qualified health care expenses throughout the plan year. Eligible health care expenses include prescriptions, copays, coninsurance, and other qualified expenses as outlined below and on the Cigna website. You cannot stop or change the amount deducted from each paycheck unless you experience a qualifying event. You may be eligible to carry over up to $700 of unused funds to the following plan year.

Please note only associates enrolled in HRA plan can elect a Health Care FSA. If you are enrolled in either of the HSA plans you are not eligible for the Health Care Flexible Spending Account.

ELIGIBLE EXPENSES FOR HSA OR FSA REIMBURSEMENT

Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs) can be great cost-savings tools. You can use them to reimburse yourself for eligible health care, dental and dependent care expenses. The following is a partial list of expenses that are reimbursable tax-free with an HSA or FSA. For a complete list, visit the IRS's website at **www.irs.gov** and search for "Section 213" expenses or visit the Cigna website at **https://www.cigna.com/qualified-health-care-expenses** for the full listing of HSA and FSA eligible and ineligible expenses. It's also important to keep a record of the expenses you pay with your HSA or FSA in case Cigna asks you to prove that an expense was eligible for reimbursement from your account, or in case you are audited by the IRS. Examples of records you should keep include receipts, Explanation of Benefits (EOB), medical diagnosis/physician diagnosis letters, and prescriptions. Please note that the list is subject to change based on regulations, revenue ruling, and case law.

- Acupuncture (if medically necessary)
- Ambulance service
- Chiropractic care
- Contact lenses (corrective)
- Deductibles
- Diagnostic tests
- Eyeglasses
- Hearing aids and exams
- Injections and vaccinations
- Optometrist fees
- Orthodontic treatment
- Prescription Drugs
- Smoking cessation programs/treatments
- Transportation for local medical care
- Wheelchairs
- X-rays

Don't miss out on the chance to save money on health care expenses!

Enroll in the HSA or FSA

Use Cigna's HSA Calculator Tool to see how much you can save by choosing a health savings account:

http://www.hsabank.com/cigna/home

Use Cigna's FSA Calculator Tool to see how much you can save by choosing a flexible spending account:

http://www.cigna.com/personal/health-and-well-being/tools/fsa-calculator/

DEPENDENT CARE FLEXING SPENDING ACCOUNT

Administered by Cigna

The Dependent Care Flexible Spending Account offered through Cigna is a convenient way to plan and pay for eligible dependent care expenses. Eligible dependents include children age 13 and under, or disabled dependents of any age. The expenses must be necessary to enable you to work. If you are married, your spouse must also work, be a full-time student at a qualified educational organization during each of five calendar months during the taxable year or be physically or mentally handicapped.

For 2027, you can contribute up to $7,500 if you are married and filing jointly, or $3,750 per person if you are filing separate tax returns.

Below is a list of eligible expenses that qualify for reimbursement from the Dependent Care FSA. You'll also find examples of expenses that do not qualify for reimbursement because they are not considered legitimate deductions for federal income tax purposes. To see a full list of IRS-qualified dependent care expenses, visit the Cigna website at www.cigna.com/dependent-day-care-expenses.

ELIGIBLE EXPENSES

- Expenses for a daycare center, summer day camp, or preschool. The facility must be licensed under state or local law if it cares for seven or more children
- Expenses for an unlicensed daycare center that cares for six or fewer children.
- Expenses at an adult daycare facility (but not expenses for overnight nursing home facilities).
- The cost of daycare and housekeeping services in your home for your child or other qualifying individual.
- The cost of meals, lunches, and snacks, supplied by a daycare provider (not the cost of meals while on field trips and outings or those meals included as part of the cost of such trips).

INELIGIBLE EXPENSES

- Food, clothing, and education.
- Overnight summer camp.
- Kindergarten or school tuition for a child age 5 and older.
- Transportation to and from the place where dependent care services are provided.
- Fees paid for a childcare center that provides care for more than six children but does not comply with all applicable laws.
- Payments cannot be made to someone you claim as a dependent on your federal income tax return or to your child if he or she is under age 19. Expenses for which a federal childcare tax credit is taken, or which are claimed under the health care account.
- Search fees for a dependent care provider.

CLAIMS

You can submit your claims online at mycigna.com. Once you are registered and logged in, you can view your account balance(s).

CIGNA RESOURCES

YOUR HEALTH FIRST

If you have a chronic condition such as asthma, low back pain, depression, diabetes, or coronary artery disease *Your Health First* coaches can help you:

- Make more educated decisions about your health and treatment options
- Create a plan to improve your health and identify triggers that affect your condition.
- Understand your medications and doctor's orders

Call 855.246.1873 to speak with a coach.

LIFESTYLE MANAGEMENT PROGRAMS

Weight Management, Tobacco Cessation, or Stress Management

If weight, tobacco, or stress is affecting your health or your ability to live an active life, Cigna can help you reach your goals of changing your lifestyle – at no additional cost to you.

- Learn to manage your weight using a non-diet approach that helps you build confidence, change habits, and become more active
- Develop a personal quit plan to become and remain tobacco-free
- Understand the sources of your stress, and learn to use coping techniques to better manage stress both on and off the job

Call 855.246.1873 to enroll with a coach or go to MyCigna.com for the online program.

MY HEALTH ASSISTANT

Working on personal wellness goals? My Health Assistant can help you break those goals down into smaller manageable steps. Choose your goal and have a weekly plan created. You can adjust as you go and receive encouragement to help you along the way.

Visit myCigna.com > Wellness > My Health Assistant – Online Coaching to get started.

HEALTHY PREGNANCIES, HEALTHY BABIES

Help you and your baby stay healthy during your pregnancy and in the days and weeks after your baby's birth. Talk to a nurse and follow along with a pregnancy journal with tips, charts and tools designed to help you. After successfully completing the program, you may be eligible for a gift/debit card from Cigna.

Download the Cigna Healthy Pregnancy app or call 800.615.2906 to enroll today.

TELEHEALTH

Access telehealth services to treat minor medical conditions. Connect with a board-certified doctor via video or phone when, where, and how it works best for you. The cost of the visit begins at $63 and may vary depending on the provider's specialty. Log on to myCigna.com to access care today.

MENTAL HEALTH WITH VIRTUAL OPTIONS

Get personal and confidential mental health and/or substance use care through your health plan. Not only can you visit a professional in person, but you can also use your smartphone, tablet or computer for online video conferencing for the same out-of-pocket cost. Go to myCigna.com > Find Care & Cost. If you want a virtual visit, search for Virtual Counselor under Doctor by Type. Call to make an appointment and the provider will give you information on how to set up the video-based session if needed.

CIGNA RESOURCES

iPREVAIL EMOTIONAL WELLBEING

iPrevail is designed by experienced clinicians to help you take control of the stresses and challenges of daily life. After an assessment your program will be customized to meet your needs. Work at your own pace to build healthier habits and with a peer coach.

Go to myCigna.com > Stress and Emotional Wellness > iPrevail to get started.

HAPPIFY EMOTIONAL WELLBEING

Everyday stressors can impact your emotional well-being, but Happify can help you can change your outlook. Answer a few questions to determine which science-based games and activities suit you best. Earn points for each activity you complete as you build resilience and better emotional health.

Sign up and download the free app at happify.com/Cigna.

24 HOUR HEALTH INFORMATION LINE

Simple questions about medication or even just a fever in the middle of the night. Get connected with a nurse 24 hours a day to help answer your health questions. Call 800.564.9286

CIGNA WELLNESS PARTNERSHIPS

As a Cigna customer, you have access to exclusive pricing on a wide variety of health and wellness items as well as discount programs and services through select vendors. No referrals or claim forms needed!

Check out all the wellness incentives available by going logging in to myCigna > Wellness.

Visit the Wellness Store by logging in to myCigna > Wellness > More > Store.

ESTIMATE YOUR COSTS TOOL

Medical and Pharmacy Costs

Did you know the costs of medical procedures can vary greatly among facilities? The same is true for medications.

- Estimate your Cost tool on myCigna.com or the app allows you to see what your projected cost might be for an upcoming medical procedure as well as compare pricing among network facilities.
- Medication costs are also available so you can learn the price of your prescription based on your plan at area pharmacies or through Cigna home delivery pharmacy.

Cost estimates are based on your coverage and deductible status and clearly indicate what doctors are in-network to help you make the most of your plan.

CIGNA PHARMACY AND EXPRESS SCRIPTS

Cigna Home Delivery Pharmacy is designed for individuals who take prescription medications on a regular basis.

- Fast, convenient delivery of your prescription medications
- Free refill reminder service will call, text or email you when it's time to refill your prescriptions
- Cigna pharmacists are available 24/7 to answer your medication questions.

Quickswitch® makes filling a prescription simple. We will request a prescription from your doctor and once we receive it, we will fill your medication and mail it to you.

CIGNA MAY CALL YOU

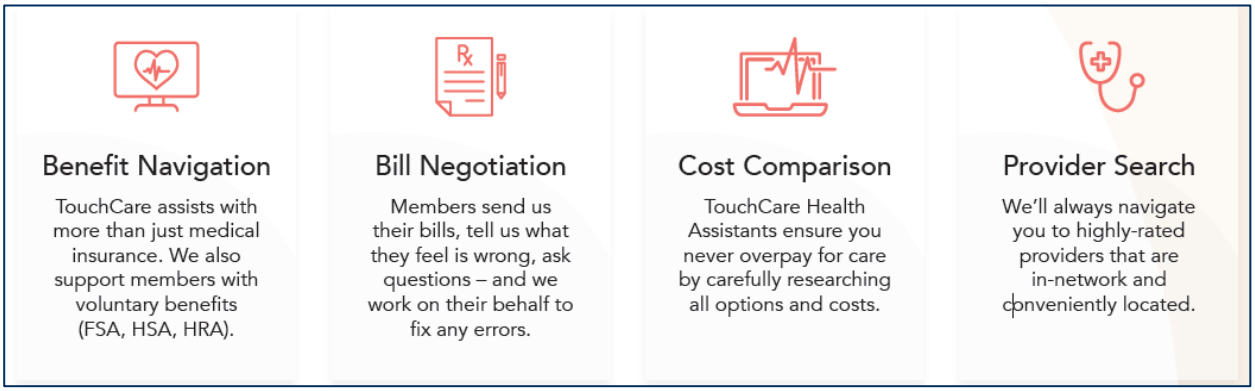
We offer Cigna programs to help you manage your health. Based on your current conditions, you may receive calls from different Cigna specialists to privately connect you to a health coach. The service is included with your medical plan at no cost to you but cannot work if you don't answer the call. Sometimes they start with an automated calling system, but after a few questions you will be connected with a live health coach.

TOUCHCARE

TouchCare is your personal health assistant. They provides free, confidential assistance to help take the stress out of healthcare. TouchCare can help find in-network doctors, get cost estimates, deal with billing issues and explain your benefits.

Healthcare concierge and caring advocacy. Confidential, expert assistance, at *no cost to you.* Associates enrolled in a company sponsored medical plan will automatically be enrolled with TouchCare.

HERE'S HOW TOUCHCARE CAN HELP:



HOW CAN I GET HELP?

You can reach your Health Assistant by:

- Calling 866-486-8242 (Monday-Friday 8AM-9PM EST)
- Visiting www.touchcare.com & logging into the member portal
- Emailing assist@touchcare.com
- Downloading the TouchCare app for your android or IOS device

TOUCHCARE

DENTAL INSURANCE

Administered by Delta Dental

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Equity Administrative Services, Inc. dental benefit plan.

Delta Dental will administer the dental insurance plan. With Delta Dental, you have access to an extensive network of dentists utilizing the Delta Dental network of qualified dentists. With the flexibility of a PPO, you have the option of visiting any provider. However, by choosing an in-network provider, you'll receive the highest level of benefit and save on out-of-pocket costs. When utilizing *out-of-network providers*, remember those benefits will be reimbursed at the in-network discounted reimbursement level. For example, if you undergo a procedure that costs $80 and the in-network reimbursement level is $60, your reimbursement will be based on $60. In this case, you would be responsible for the difference of $20.

You can visit the Delta Dental website to search for a provider. You may also contact Member Services at **800-524-0149** to speak with a representative or follow the prompts to use the automated system.

	Delta Dental PPO	
	In-Network	**Out-of-Network**
BENEFIT		
Preventive Care – exams, cleanings, fluoride, space maintainers	100%, no deductible	100%, no deductible
Basic Services – fillings, crown repair, non-surgical removal of teeth	100%, no deductible	80%, no deductible
Major Services - bridges & dentures, implants, crowns, oral surgery	60% after deductible	50% after deductible
Orthodontia – for covered dependents 18 years or younger	50%	50%
ANNUAL DEDUCTIBLE *Waived for Preventive Services*	**Calendar Year Deductible**	
Individual	$50 per person	$50 per person
Family	$150 per family	$150 per family
CALENDAR YEAR MAXIMUM BENEFIT		
	$1,500 per person	$1,000 per person

VISION INSURANCE

Administered by VSP

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection of the eyes should be a major concern for everyone.

The vision insurance is provided through VSP Vision Care using the VSP Network. The VSP network consists of private practicing optometrists, ophthalmologists, opticians and Visionworks retail locations. You have the option of visiting any provider. However, by choosing a network provider, you will receive the highest level of benefit and save on out-of-pocket costs. You may access a list of participating providers through the VSP website **vsp.com**.

The vision plan provides an annual exam with a $10 copay for each covered family member. In addition, the plan covers prescription eyewear. You may choose between glasses or contacts. If you choose contacts, you will not be eligible to receive glasses (lenses and frame) in the same service period. The contact lens fitting, and evaluation is separated from the materials coverage.

	VISION PLAN	
Benefit	**In-Network**	**Out-of-Network**
Exam *Covered Once Every 12 Months*	$10 copay Covered in full	$45 copay
Lenses *Covered Once Every 12 Months*	$25 copay Applied to lenses & frame	$30 copay for single lenses
Frames *Covered Once Every 24 Months*	$130 allowance $150 Featured Frame Brands allowance 20% savings on the amount over allowance	$70 allowance
Contact Lenses *Covered Once Every 12 Months*	$130 allowance	$105 allowance

EXTRA SAVINGS & DISCOUNTS

Glasses and Sunglasses

- Discover all current eyewear offers and savings at **vsp.com/offers**.
- 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.

Laser Vision Correction

- Average of 15% off the regular price; discounts available at contracted facilities.

Exclusive Member Extras for VSP Members

- Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**.
- Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details.
- Enjoy everyday savings on health, wellness, and more with VSP Simple Values.

ASSOCIATE HEALTH CARE PREMIUMS

Associates are asked to share the cost of their insurance benefits with the Company. Your contribution rates are outlined in the tables below. The contribution rates are based upon semi-monthly payroll deductions (24 pays).

The 2027 insurance premium deductions will start on the January 15, 2027, pay date.

	MEDICAL / RX SEMI-MONTHLY PREMIUM			
	Associate Only	**Associate + Spouse**	**Associate + Child(ren)**	**Family**
High-Deductible Health Plan 1 (HSA)	$118.04	$174.25	$149.81	$201.60
High-Deductible Health Plan 2 (HSA)	$89.02	$113.18	$94.57	$114.31

	DENTAL / VISION SEMI-MONTHLY PREMIUM			
	Associate Only	**Associate + Spouse**	**Associate + Child(ren)**	**Family**
Delta Dental PPO	$4.77	$10.26	$12.90	$18.40
VSP Vision	$0.88	$1.33	$1.39	$2.07

**Associates who participate in the Vitality wellbeing program may be eligible for a wellness credit of up to $100 per month on medical premiums*

SECTION 125 PLAN OVERVIEW

Equity Administrative Services, Inc. will continue to offer an Internal Revenue Code (IRC) Section 125 Premium Conversion Plan that allows you to pay for your healthcare contributions on a pre-tax basis.

By paying your premiums with pre-tax dollars, you can reduce the amount of income and Social Security taxes that you otherwise would be required to pay. The elections you make during the Open Enrollment period are effective for the entire 12-month plan year, January 1st through December 31st. You can only make a change to your elections during the year if you experience a qualifying event (refer to Eligibility Overview for the definition of qualifying event on page #3). If you believe you have experienced a qualifying event and you wish to change your elections, you are required notify HR within 30 days of the qualifying event.

BASIC LIFE AND AD&D INSURANCE

Administered by Lincoln Financial Group

Equity provides associates who work a minimum of 30 hours per week Basic Life and Accidental Death & Dismemberment coverage through Lincoln Financial Group at no cost to the associate. Life insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed at Equity. AD&D insurance is equal to your life insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits in certain injury instances.

You are automatically enrolled in the Company Paid Basic Life and Accidental Death & Dismemberment coverages. If you would like to make a change to your beneficiaries, please log on to the Workday portal.

	BASIC LIFE AND AD&D COVERAGE
Executive & Directors	2 x salary up to $500,000 max
Other Exempt Associates	$100,000
Non-Exempt Associates	$30,000

SHORT-TERM DISABILITY INSURANCE

Equity Administrative Services, Inc. provides associates who work a minimum of 30 hours per week with short and long-term disability income benefits at no cost to the associate through Lincoln Financial Group. In the event that you experience a non-occupational injury or illness that requires time away from work, Equity will provide Weekly Disability Income. In the case of an accidental injury, coverage will begin the eighth day you miss work due to the injury. In the case of an illness, surgery or a specific physical condition, coverage begins on the eighth day. Lincoln Financial Group requires a doctor's certification of any injury/illness covered under the policy.

LONG-TERM DISABILITY INSURANCE

The Long-Term Disability (LTD) plan through Lincoln Financial Group will continue to be offered at no cost to the associate. The LTD plan provides additional continuation of income protection if you are unable to work at the completion of your short-term disability leave. Coverage generally begins 90 days following the initial date of disability. Any Social Security disability benefits and other income an associate may receive will offset Long-Term Disability benefits. Lincoln Financial Group requires proof of earnings and continued disability.

	SHORT-TERM DISABILITY	LONG-TERM DISABILITY
Benefits Begin	8th day of an injury or 8th day of an illness	90 days following your Disability
Benefits Payable	Twice per month*	Monthly
Benefit Amount	70% of weekly earnings	60% of monthly salary
Benefit Maximum	$2,500 per week	$10,000 per month
Maximum Benefit Period	13 weeks	To age 65

Associates already receiving Worker's Compensation Benefits are not eligible for short/long-term disability.

VOLUNTARY LIFE INSURANCE

Administered by Lincoln Financial Group

Associates have the opportunity to purchase Voluntary Life Coverage with Lincoln Financial Group. Voluntary life insurance can be a way to protect your family in the event of your death, particularly if you have financial obligations such as a mortgage or children in college. This will provide an additional life insurance benefit for you, your spouse and/or your dependent child(ren). Contributions for these premiums are 100% associate paid. This is an after-tax benefit.

If you are currently enrolled in the Voluntary Life Insurance and do not want to make changes, no action is required, and your coverage levels will remain the same. If you are increasing your coverage amount or are electing new coverage (and are outside of your 30-day new hire eligibility period) all amounts of insurance will be subject to medical underwriting. Once your Benefit Enrollment election has been submitted online, you will receive a Personal Health Application to your home address for completion to send directly to Lincoln Financial Group. You will be required to provide Evidence of Insurability (EOI). EOI is the documentation of good health in order to be approved for coverage. The carrier will review and determine approval based on EOI documentation. Benefits may be limited and/or denied based on EOI results. Lincoln Financial Group will notify you of their decision when it has completed an evaluation of your application. Your Voluntary Life Insurance coverage will remain at the current amount until Lincoln Financial Group has approved your application.

All rates listed in the table below are based upon semi-monthly payroll deductions (24 pays). The final deduction may vary due to rounding differences. Minimum coverage is $25,000 and maximum coverage is $100,000. You must elect coverage at the associate level to purchase coverage for your dependents.

Lincoln Financial Group has a tool to assist you to determine how much coverage you may need. Please visit www.mylincolnportal.com to view an informative video on purchasing Voluntary Life Insurance.

VOLUNTARY LIFE RATES BASED ON ASSOCIATES AGE
SEMI-MONTHLY PREMIUM

AGE	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$25,000 Policy Election Associate — $25,000 Spouse — $12,500 Child(ren) — $2,500	$.75 $.38 $.21	$.75 $.38 $.21	$.88 $.44 $.21	$1.38 $.69 $.21	$2.25 $1.13 $.21	$3.63 $1.81 $.21	$5.50 $2.75 $.21	$9.63 $4.81 $.21	$16.13 $8.06 $.21	$25.88 $12.94 $.21
$50,000 Policy Election Associate — $50,000 Spouse — $25,000 Child(ren) — $5,000	$1.50 $.75 $.43	$1.50 $.75 $.43	$1.75 $.88 $.43	$2.75 $1.38 $.43	$4.50 $2.25 $.43	$7.25 $3.63 $.43	$11.00 $5.50 $.43	$19.25 $9.63 $.43	$32.25 $16.13 $.43	$51.75 $25.88 $.43
$75,000 Policy Election Associate — $75,000 Spouse — $37,500 Child(ren) — $7,500	$2.25 $1.13 $.64	$2.25 $1.13 $.64	$2.63 $1.31 $.64	$4.13 $2.06 $.64	$6.75 $3.38 $.64	$10.88 $5.44 $.64	$16.50 $8.25 $.64	$28.88 $14.44 $.64	$48.38 $24.19 $.64	$77.63 $38.81 $.64
$100,000 Policy Election Associate — $100,000 Spouse — $50,000 Child(ren) — $10,000	$3.00 $1.50 $.85	$3.00 $1.50 $.85	$3.50 $1.75 $.85	$5.50 $2.75 $.85	$9.00 $4.50 $.85	$14.50 $7.25 $.85	$22.00 $11.00 $.85	$38.50 $19.25 $.85	$64.50 $32.25 $.85	$103.50 $51.75 $.85

BENEFIT REDUCTION SCHEDULE		
	35% at age 65	75% at age 75
	60% at age 70	85% at age 80

CRITICAL ILLNESS INSURANCE

Administered by Cigna

When you least expect it, life happens. Serious illnesses or hospital visits all come with out-of-pocket medical and non-medical expenses that can set you back financially. Critical illness coverage is a flexible, innovative way to fill the insurance gaps for health care coverage. It pays the associate directly when a critical illness unexpectedly affects you or your family. Critical illness pays a lump sum benefit directly to you if you or a covered dependent are diagnosed with a covered illness or condition after the effective date of your insurance. Associates can purchase Critical Illness coverage for themselves, their spouse, and their children (up to age 26). With this added benefit, you can focus on getting better, not your finances. Payroll contributions will be made on a post-tax basis.

	Associate	Spouse	Dependent Child(ren)
BENEFIT AMOUNT OPTIONS	$10,000 $15,000 $20,000	$5,000 $7,5000 $10,000	Can enroll at 50% of Associate Issued Amount for no additional cost
Pre-existing Condition Limitation	None		
Benefit Reduction	None		
Portability	Included		
Wellness Benefit	$50 Associate, Spouse, Dependent Child(ren)		
CORE PLAN BENEFITS			
Heart Attack	100%		
Stroke	100%		
Major Organ Failure	100%		
End Stage Renal (Kidney) Disease	100%		
Invasive Cancer	100%		
Non-invasive Cancer	50%		
Skin Cancer	$250 1x per lifetime		

SEMI-MONTHLY PREMIUM					
Associate					
Benefit Amount	29	39	49	59	69
Per $10,000 Unit Rates	$2.14	$3.23	$5.83	$10.85	$19.46
Spouse					
Benefit Amount	29	39	49	59	69
Per $10,000 Unit Rates	$2.14	$3.23	$5.83	$10.85	$19.46

Rates illustrated are a sample based on the specific age noted.
The Cigna materials will include the complete rate table.

Occurrence of a Different Illness	Occurrence of the Same Illness
90 days	6 Months Treatment Free

ACCIDENT INSURANCE

Administered by Cigna

Accident coverage provides benefits for specific injuries and events resulting from a covered accident. The amount paid depends on the type of injury and care received. Associates can purchase Accident Insurance for themselves, their spouse, and their children (up to age 26). Payroll contribution will be made on a post-tax basis.

Covered Services	
Hospital / ICU Admission	$1,000 within 180 days of accident / $1,500 within 30 days of accident.
Daily Hospital/ICU Confinement	$200 per day up to 365 days/$400 per day up to 15 days.
Ambulance – Ground/Air	$150/$750
Emergency Treatment	$200
Urgent Care	$100
Initial Physician's Office Visit / Follow up- Visit	$100 / $75 per visit; limited to 10 per accident
Follow-up Physical Therapy Visit	$75 per visit; limited to 10 per accident
Prosthesis	$750 per device; limited to 2
Covered Injuries	
Dislocation	Up to $2,625 non-surgical If surgery is required, 2X non-surgical amount
Fractures	Up to $3,500 non-surgical If surgery is required, 2x non-surgical
Laceration (2+ sutures required)	$200 <6 inches / $400 >6 inches
Diagnostic Exam (X-ray or lab)	$50
Blood, plasma, platelets (within 90 days of accident)	$375
2nd and 3rd Degree Burns	$400-$10,000 depending on degree and size
Concussion	$150
Coma	$10,000
Abdominal or Thoracic Surgery	$1,500
Tendon, Ligament, Rotator Cuff, or Knee Surgery • Exploratory • Repair	 $150 $750
Accidental Death Associate* • Loss of Life Accidental Death • Automobile Accidental Death • Common Carrier Accidental Death (bus, plane, train)	 $25,000 $50,000 $75,000

SEMI-MONTHLY PREMIUM	
Associate	$5.73
Associate + Spouse	$9.59
Associate + Child(ren)	$10.64
Family	$ 14.41

- ❑ Includes a $50 Annual Wellness Benefit for one of any covered exams or treatments, including general health exams, routine dental and vision exams, certain blood tests and immunizations, and more!
- ❑ Includes Enhanced Sports Benefit – pays an additional 25% of you are injured during an Organized or Personal Sports Activity
- ❑ No age reduction!

*Associate Benefit

- Spouses/Domestic Partners receive 50% of Benefit Amount
- Child(ren) receive 25% of Benefit Amount

LEGAL SERVICES & ID THEFT PROTECTION

Administered by MetLife

Planning for the future can seem overwhelming. Equity has partnered with MetLife to offer a combined benefit offering of Legal Services and Aura Identity Protection. MetLife Legal Plans provides our associates affordable, convenient access to experienced attorneys and award-winning financial education workshops to empower them to save money and plan for the future. MetLife Legal Plans provides access to a national network of 14,000+ experienced attorneys, with an average attorney experience of 25 years. Associates and their dependents never have to worry about a legal bill; all the billing is done between MetLife Legal Plans and the attorneys. And with no waiting period, deductibles, copays, usage limits, claim forms, and a money- back guarantee, you can feel confident you're better prepared for life's challenges, whether expected or unplanned.

Aura Identity Protection provides you, your spouse, and child(ren) triple bureau credit monitoring for activity including credit inquiries, delinquencies, and judgements. Aura Identity Protection provides you with a dashboard view of credit scores from all three credit bureaus and one free annual credit report. Restorative services provide full identity theft recovery assistance for advocacy, guidance, and personalized help. Specialist will place fraud alerts, call creditors, file affidavits with law enforcement, pull reports, and more.

Here are just a few ways the MetLife Legal Plans help you and your dependents take control of stressful and expensive personal legal matters. Comprehensive coverage for more than 60 legal matters including:

- Preparation of wills, living wills and trusts
- Debt issues
- Document review and preparation
- Family law
- Adoptions
- Power of attorney
- Elder care matters
- Home purchase, sale and refinancing
- Rental issues
- Tax audits
- Medicare questions
- ID Theft defense

SEMI-MONTHLY PREMIUM
$12.00

Payroll contributions will be made on a post-tax basis.

Enrolled members are required to register their coverage at members.legalplans.com after their coverage is effective.

Note: *No services, including consultations, will be provided for 1) employment related matters, including company or statutory benefits; 2) matters involving the employer, MetLife, and plan attorneys; 3) appeals and class actions; 4) DUI; and additional non-covered services as outlined in the Summary Plan Description.*

EQUITY TRUST 401(K) PLAN

Administered by Go Retire

While retirement may seem like it's a long way off, the sooner you start preparing for it, the longer your investments will have time to grow. Participate in the Equity Trust 401(k) Plan and get free money from the Company match so you can enjoy your retirement at the beach. All associates, at least 18 years of age, are eligible to participate in the Equity Trust 401(k) Plan. Newly eligible associates can participate in the Plan on the 1st day of the month following 60 days of employment. Once you have met your eligibility waiting period, you are eligible to enroll and begin your deferrals at any point in time going forward.

Free Money! Associates who participate in the Equity Trust 401(k) Plan have an opportunity to enjoy the benefit of the Company matching up to 4% of their salary contributed. This is a safe harbor plan with a matching formula that is defined by the IRS.

- 100% Company Match for the first 1-3% contribution
- 50% Company Match the next 2% contribution (up to 5% total)

VESTING	
Associate Payroll Deferrals	100% immediately vested
Safe Harbor Matching Contributions	100% immediately vested

401(k) deferral contributions are not subject to federal or state taxes. That means it costs you less to save more. You will have 24-hour online access to obtain important information and make changes to your retirement account. Here are the specific steps you need to access your account online:

1. Log onto www.go-retire.com/equitytrust
2. Click the Participant Login on the left side.
3. Select Plan Participant in the Login As panel. On the new screen, enter your User ID (your SSN if first time user) and your Initial Personal Identification Number (your Date of Birth – mmddyyyy) and click on the Login button.
4. Select your Plan and view any Plan Messages.

You also have access to a Voice Response System by calling 800-716-3742. You can use the automated system to get account information, or you may talk to a representative Monday through Friday, from 8:00 a.m. – 8:00 p.m. ET.

RETIREMENT PLANNING GUIDANCE

Meeder Wealth Management

meederwealth.com

866-633-3371

Questions about:

- Investments options
- Investment strategy consultation
- Long term comprehensive planning

VOLUNTARY PET INSURANCE

Administered by MetLife

MetLife | Pet Insurance

Visits to the vet can be unpredictable. MetLife Pet can help reimburse you for covered vet visits, accidents, illness, and more. With MetLife Pet, you have the power to customize your pet insurance to meet both your pet's needs and your budget.

How it works:

- **ENROLL** – Select and enroll in the coverage that's right for you and your pet and download the mobile app.
- **CARE** – Take your pet to the vet and pay the bill; manager your pet's health and wellness using the app
- **COVER** – Sent the bill and your claim documents to us and receive reimbursement[1] by check or direct deposit if the claim expense is covered under the policy.

Fetch your quote online by visiting www.metlife.com/getpetquote or call 1-800-GET-MET8

Help protect your dogs and cats while enjoying benefits like:

- flexible coverage with up to 90% reimbursement[1]
- freedom to visit any U.S. licensed vet
- optional Preventive Care coverage [2]
- 24/7 access to Telehealth Concierge Services
- discounts up to 30%[3] and additional offers on pet care, where available

1. Reimbursement options include: 70%, 80% and 90% and a 50% option for MetGen policies and a 65% option for IAIC policies only. Pet age restrictions may apply.
2. For IAIC policies, optional Preventive Care coverage is based on a Schedule of Benefits. For MetGen policies, optional Preventive Care coverage is included in the annual limit.
3. When using multiple discounts, discounts cannot exceed 30%. Each discount may not be available in all states. Please contact MetLife Pet for further details



EMPLOYEE ASSISTANCE PROGRAM

Administered by Total Care EAP

The Total Care Employee Assistance Program (EAP) provides confidential counseling and a broad range of services to help guide you and your family toward better health, wellbeing, and life balance.

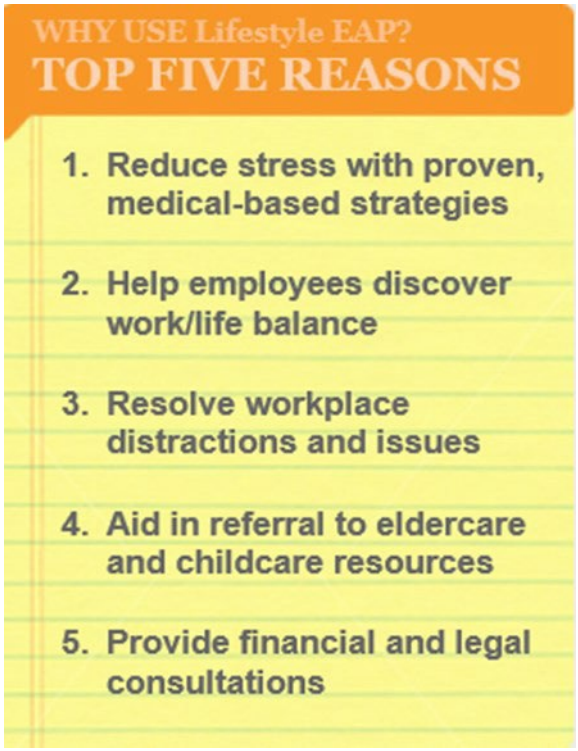
Total Care EAP offers 24/7 phone support from licensed mental health professionals. Face-to-face counseling sessions are available to provide confidential assessment, short-term solution focused counseling, referral assistance, and support when experiencing issues such as family or marital concerns, substance abuse, emotional upset, and financial or legal problems.

You and your dependents also have unlimited access to work/life counselors, financial planners and/or legal
advisors via phone (during regular business hours) or through online tools and resources.

This confidential EAP service is available at no cost to you or your dependents. The EAP counselors will make every effort to coordinate referrals for ongoing treatment with any health insurance coverage as well as within the participant's ability to pay. Total Care EAP can be contacted by calling 800-252-4555 or you may log on to
www.theEAP.com.

TotalCare EAP
A division of ESI

www.theEAP.com
1.800.252.4555



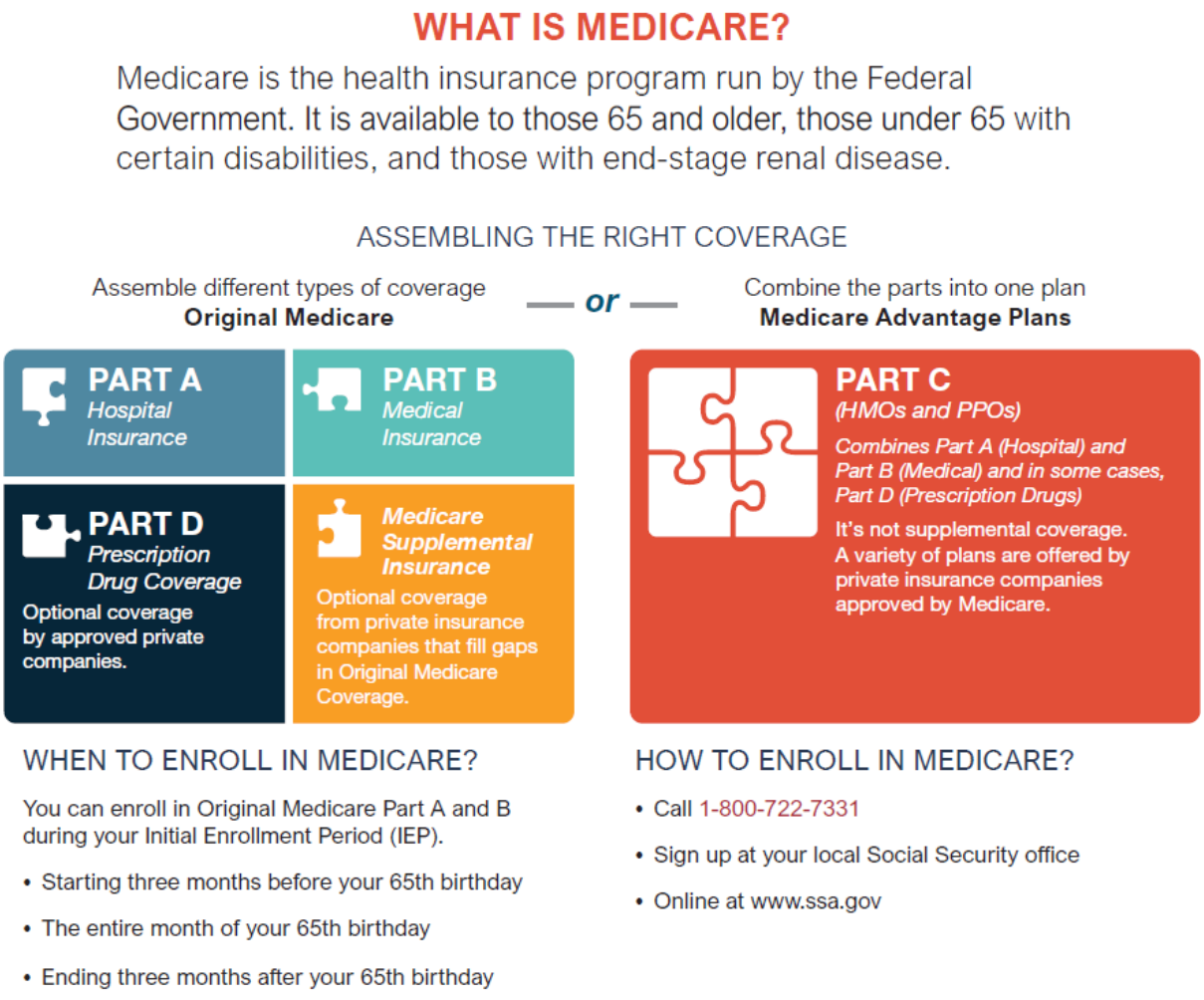
Medicare Assistance

Administered by UROne Benefits

Whether you're getting ready to turn 65 or you're already on Medicare, UROne Benefits can help you and your loved ones navigate through the confusion and select the best Medicare health plan.

Their caring Medicare experts are ready to answer all your questions in plain language to help you understand your options and then select a plan that fits your needs and budget.

Want to learn more? Contact *UROne Benefits®* at **800-722-7331**



Click to learn more: [Home | UROne Benefits®]

ASSOCIATE DISCOUNTS

TICKETS AT WORK

Equity Trust has partners with Tickets at Work to offer travel and entertainment discounts for hotels, theme parks, concerts, movie tickets, ski resorts, rental cars, gift cards, and more. To access the site, sign up here and use company code: ***CPEQUIT***

VERIZON

Verizon offers all Equity associates 15% off their monthly Verizon bill. To take advantage of this offer:

1. Visit verizon.com/support/employee-discount-validation-faqs/
2. Follow the set up process for new users or existing users
3. When prompted for your email address, enter everything that comes before the "@" symbol followed by *"@trustetc.com"*
   Ex. j.doe@equitytrustinstitutional.com becomes j.doe@trustetc.com

Once completed, you will receive an email with information on how to receive your discount.

VITAMIX

Vitamix has special promotions as well as offering all blenders, containers, and accessories for 15% off with free shipping. Contact Vicki Barone (vbarone@trustetc.com) for the latest promotion code.

DELL

Equity associates are eligible for discounts on Dell products. Click here to learn more and start shopping.

FARMERS SELECT GROUP

Equity Trust has partnered with Farmers Select Group to provide associates with access to group discounts for auto and home insurance. This program provides you with special savings, outstanding customer service, and a full suite of products to meet your diverse insurance needs. Detailed information can be found in the HR For You folders. In addition to auto and homeowners insurance, Farmers Select Group offers a variety of other insurance policies including:

- Personal excess liability
- Boat
- Motorcycle
- RV
- Personal property

Program Discounts and features

- A group discount of up to 15%
- Automatic payment options
- Good driving records
- A loyalty discount for your years of service
- Multi-policy discounts
- Multi-vehicle savings
- 24/7 superior service

To take advantage of these special savings and superior service from Farmers Select Group, call **800-422-4272**.

Notice Regarding Wellness Program

If a Constituent Benefit Program listed is a voluntary wellness program available to all employees, it is intended to be administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, depending upon that program, it may include a voluntary health risk assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include blood tests or other diagnostic tests. Please note that this is voluntary, and you are not required to participate in these evaluations or examinations.

In certain wellness programs, employees who choose to participate in the wellness program will receive an incentive that is disclosed to you in the open enrollment information for the Constituent Benefit Program. Although you are not required to complete the assessments or participate in the biometric screening, only employees who do so will receive the incentive. Additional incentives up to the maximums permitted by law, may be available for employees who participate in certain health-related activities or those who achieve certain health outcomes. If so, these will be described in your program materials or otherwise communicated to you.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Plan Administrator listed in your Summary Plan Description. The information from any assessment and any results from your examinations or screenings will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Consistent with the disclosures in this Notice regarding the protection of your health and personally identifiable health information, any information gathered in the Constituent Benefit Program that is a wellness program, will be confidential. The wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, but it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Notice Regarding Wellness Program (continued)

Also, your health information will not be sold, exchanged, transferred, or otherwise disclosed (except as permitted or required by law) to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving any incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a wellness program nurse, or physician or other health coach staff for purposes of the wellness program. You may inquire about who specifically has access to your information in this regard.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Precautions deemed appropriate will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. Finally, you may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. Any questions should be directed to the Plan Administrator as listed in your Summary Plan Document.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Notice of Creditable Coverage

Your prescription drug coverage provided under Equity Administrative Services Health & Welfare Plan is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage".

Why This is Important

This information is to help you decide whether or not you want to join a Medicare drug plan. It is important for those eligible for both Medicare and a group health plan to look ahead and weigh the costs, benefits, and participation terms of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

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. Equity Administrative Services has determined that our prescription drug coverage under Equity Administrative Services health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing 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 May You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current Equity Administrative Services coverage may or may not be affected as well as dependent coverage. Additional guidance is available at https://www.cms.gov/medicare/prescription-drug-coverage/creditablecoverage?redirect=/creditablecoverage/
which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Notice of Creditable Coverage Continued

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 Equity Administrative Services coverage 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 Equity Administrative Services changes. You also may request a copy of this notice at any time.

Contact--Position/Office: Chief People & Human Resources Officer
Address: 1 Equity Way, Westlake, OH 44145
Phone Number: (440) 323-5491

For More Information Regarding 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:

1. Visit www.medicare.gov
2. 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
3. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

HIPAA Notice of Privacy Practices

You are receiving this Privacy Notice because you are eligible to participate in an employer sponsored group health plans. The Health Plans are committed to protecting the confidentiality of any health information collected about an individual. This Notice describes how the Health Plan may use and disclose, "protected health information" (PHI). For information to be considered "PHI", it must meet three conditions:

Information is created or received by a health care provider, health plan, employer, or health care clearinghouse; Information relates past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and the information either identifies the individual or provides a reasonable basis for believing that it can be used to identify the individual.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to an individual. Additionally, the Health Plan is required by law to:

Maintain the privacy of an individual's "protected health information" (PHI) and provide you with the Privacy Notice of its legal duties and privacy practices with respect to an individual's PHI and follow the terms of its Privacy Notice that is currently in effect.

Employees of the plan sponsor who administer and manage this Health Plan may use PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These individuals must comply with the same requirements that apply to the Health Plan to protect the confidentiality of PHI.

Dependent Coverage

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Effective first day of the Plan Year that began on or after September 23, 2010.

Lifetime Limitations

The lifetime limit on the dollar value of benefits under the Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the Plan Administrator.

Rescission

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud, or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review. See the Claims Procedure Section under the Plan for more information.

Uses and Disclosures of Protected Health Information (PHI)

The following categories describe the ways that the Health Plan may use and disclose protected health information. For each category of uses and disclosures, examples will be provided. Not every use or disclosure in a category will be listed. However, all the ways the Health Plan is permitted to use and disclose information will fall within one of these categories.

Treatment Purposes. The Health Plan may disclose PHI to a health care provider for the health care provider's treatment purposes. For example, if an individual's Primary Care Physician (PCP) or treating medical provider refers the individual to a specialist for treatment, the Health Plan can disclose the individual's PHI to the specialist to whom they have been referred so (s)he can become familiar with the individual's medical condition, prior diagnoses and treatment, and prognosis.

Payment Purposes. The Health Plan may use or disclose health information for payment purposes; such as, determining eligibility for plan benefits, obtaining premiums, facilitating payment for the treatment and services an individual receives from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans. Examples of payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a specific treatment is covered under the plan

Health Care Operations. The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

To a Business Associate of the Health Plan. The Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, provided a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so or provides services to the Health Plan such as legal, actuarial, accounting, consulting, or administrative services. Examples of Business Associates include the Health Plan's Third-Party Administrators (TPAs), Actuary, and Broker.

To the Health Plan Sponsor. The Health Plan may disclose PHI to the Plan Sponsor as long as the sponsor has amended its plan documents, provided a certification to the Health Plan, established certain safeguards and firewalls to limit the classes of employees who will have access to PHI, and to limit the use of PHI to plan purposes and not for non-permissible purposes, as required by the Privacy Rule. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Some examples may include: disclosure for claims appeals to the Plan's Benefits Committee, for case management purposes, or to perform plan administration functions.

The Health Plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "Summary Health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

Uses and Disclosures of Protected Health Information (PHI) (continued)

Required by Law or Requested as Part of a Regulatory or Legal Proceeding. The Health Plan may use and disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, the Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

There are limits on the Plan's use and disclosure of PHI in regard to disclosures related to Reproductive Health Care. In regard to such requests, if a request may impact Reproductive Health Care, as defined in the Policy and the HIPAA Regulations, the Plan must obtain an Attestation to verify that the requested use or disclosure if not for a Prohibited Purpose, as defined by Regulations. Prohibited Purposes in this regard include the following; 1)to conduct criminal, civil or administrative investigation into any person for the mere fact of seeking, obtaining, providing or facilitating lawful reproductive healthcare; 2)to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, provoking , or facilitating lawful reproductive health care; and/or 3) to identify any person for purposes of items (1) and (2). Certain types of requests automatically require Attestation.

In Addition, when substance use disorder treatment related to PHI is requested, there are limits on permitted disclosures related to civil, criminal, administrative, or legislative proceedings against the individual, unless based on written consent, or a court order after notice an opportunity to be had is provided to the individual or the holder of the record. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before PHI can be used or disclosed.

Public Health Activities or to Avert a Serious Threat to Health or Safety. The Health Plan may disclose PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Law Enforcement or Specific Government Functions. The Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with an individual's written authorization or that of their legal representative, and the individual may revoke such authorization as provided by section 164.508(b) (5) of the Privacy Rule. Any disclosures that were made when the individual's Authorization was in effect will not be retracted.

An Individual's Rights Regarding PHI

An individual has the following rights with respect to their PHI:

Right to Inspect and Copy PHI. An individual has the right to inspect and copy health information about them that may be used to make decisions about plan benefits. If they request a copy of the information, a reasonable fee to cover expenses associated with their request may be charged.

Right to Request Restrictions). An individual has the right to request restrictions on certain uses and disclosures of their PHI (although the Health Plan is not required to agree to a requested restriction).

Uses and Disclosures of Protected Health Information (PHI) (continued)

Right to Receive Confidential Communications of PHI). An individual has the right to receive their PHI through a reasonable alternative means or at an alternative location if they believe the Health Plan's usual method of communicating PHI may endanger them.

Right to Request an Amendment. An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI but is required to provide the individual with a response in either case.

Right to Accounting of Disclosures. An individual has the right to receive a list or "accounting of disclosures" of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual's Authorization, or to the individual. An individual's request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12-month period.

Breach Notification. An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so, required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Genetic Information If the covered entity under the Plan engages in underwriting an individual's genetic information will not be used for underwriting except for long term care plans.

Right to Paper Copy. An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

The Health Plan's Responsibilities Regarding an Individual's PHI

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI. The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to all actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice.

The complaint will be investigated, and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20210

Uses and Disclosures of Protected Health Information (PHI) (continued)

HIPAA Plan Special Enrollment Notice

If you are declining your enrollment under the Plan, or declining coverage for your spouse or one of your dependents, because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing toward such other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends, or after the period for which the employer ceased contributing toward such other coverage if such payment applied to your circumstances.

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

To request special enrollment or obtain more information, please contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for furtherinformation.

Genetics Information Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Mental Health/Substance Use Disorder Parity

Effective for Plan Years on and after July 1, 2010, benefits under Plans that provide Mental Health Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Uses and Disclosures of Protected Health Information (PHI) (continued)

Newborns and New Mothers Care Disclosure

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

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual and Regular Notice

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, notwithstanding anything herein to the contrary, the Plan provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for further information.

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, 2026. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

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

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

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

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



2027 BENEFITS GUIDE

Email Vicki Barone (v.barone@trustetc.com) or Katie Plush (k.plush@trustetc.com if you have any questions about the benefits or online enrollment process.

EQUITY TRUST COMPANY®