BENEFITS 2022

INFORMATION GUIDE UNDERSTANDING YOUR OPTIONS

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interface rehab, inc.

Comprehensive Rehab & Consultation Services

www.interfacerehab.com

Hello!

Welcome to your 2022 Benefits Information Guide.

At *interface rehab, inc.*, we understand the importance of a well-rounded benefits program and are dedicated to providing you with unique benefits that meet the needs of you and your family. We are proud to offer a range of plans that help protect you in the case of illness or injury. This Benefits Information Guide is a comprehensive tool to help you become familiar with the plans and programs that you and your family can enroll in for the plan year.

Enclosed you will find:

- Step-by-step instructions for how to enroll.
- Summary information about each medical, dental and vision benefit option.
- Information on additional benefits such as life insurance, employee assistance program (EAP) and many more.
- Directory and contact information, in case you have questions.

And much more!

Sincerely,

interface rehab, inc.

We're here to help!

If you have any benefit or enrollment questions at all, please contact your Member Support Team.

888.434.7720

membersupport@MarshMMA.com

The rates quoted for these benefits may be subject to change based on final enrollment and/or final underwriting requirements. This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of the plan or program benefits and does not constitute a contract. Consult your plan documents (Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Booklet, Booklet-certificate, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan. All the terms and conditions of your plan or program are subject to applicable laws, regulations and policies. In case of a conflict between your plan document and this information, the plan documents will always govern.

Getting Started

Your Health

Life & Disability

Work/Life

Costs & Directory

Required Notices

At *interface rehab inc.*, we offer a range of options to fit your lifestyle.

Benefits	Plan Options
Medical	• Kaiser Permanente HMO (NCAL or SCAL) • Blue Shield EPO • Blue Shield Traditional PPO • Blue Shield Affordable PPO w/HSA
Dental	• Aetna Dental Affordable PPO • Aetna Dental Traditional PPO
Vision	• MES Vision PPO
Life & Disability	• Guardian Basic Life / AD&D • Guardian Voluntary Life / AD&D • Guardian Voluntary Short Term Disability
Voluntary Options	• Voluntary Pet Insurance • Voluntary Guardian Benefits
Additional Benefits	• Flexible Spending Accounts (FSA) • Health Savings Account (HSA) • Employee Assistance Program (EAP) • Retirement Options • Continuing Education Benefit • Company Holidays & PTO

Enrollment & Eligibility

Who can Enroll?

Regular full-time employees working a minimum of 35 hours per week are eligible to participate in the benefits program. Eligible employees may also choose to enroll family members, including a legal spouse/ domestic partner (same or opposite sex) and/or eligible children.

Premiums for state registered / unregistered domestic partners who do not meet the tax dependent definition of IRC section 152 for the employee, may be considered taxable income (unregistered domestic partners will not meet the relationship test under IRC section 152). Premiums for children / an employee's domestic partner's children under age 26 are not taxable.

When Does Coverage Begin?

Your enrollment choices will become effective on January 1, 2022 – December 31, 2022. Benefits for eligible new hires will commence as outlined below:

Eligibility Date	Benefit Plan
The first day of the month following your date of hire (you must enroll within 30 days of becoming eligible)	• Medical • Dental and Vison • Health Savings Account (HSA) • Basic and Voluntary Life / AD&D • Voluntary Short Term Disability • Flexible Spending Accounts (FSA) • Employee Assistance Program (EAP) • Voluntary Pet Insurance • Voluntary Guardian Benefits

TIP

If you miss the enrollment deadline, you may not enroll in a benefit plan unless you have a change in status during the plan year. Please review details on IRS qualified change in status events for more information. For a complete explanation of qualified status changes, please refer to the "Legal Information Regarding Your Plans" contents on page 37.

How do I Enroll?

Paycom

To self-enroll, simply follow these steps:

- Access the Paycom employee self-service website at www.paycomonline.com and select “Employee.”
- Enter your username, password and the last four digits of your social security number. Then select “Log in.”
- After logging into Employee Self-Service, you will have an option under the “My Benefits” title in the center of the screen or on the left side of the page for “2022 Benefit Enrollment.” Click this button to be taken through the enrollment process.
- Once you complete the enrollment process, you can select “Complete Enrollment”. You will be brought to the “Sign and Submit” screen. A printable confirmation page is available

What if My Needs Change During the Year?

You are permitted to make changes to your benefits outside of the enrollment period if you have a qualified change in status as defined by the IRS. Generally, you may add or remove dependents from your benefits, as well as add, drop, or change coverage if you submit your request for change within 30 days of the qualified event. Change in status examples include:

- Marriage, divorce or legal separation.
- Birth or adoption of a child.
- Death of a dependent.
- You or your spouse’s / domestic partner’s loss or gain of coverage through our organization or another employer.
- An employee (1) is expected to average at least 30 hours of service per week, (2) has a change in status where he/she will reasonably be expected to average less than 30 hours of service per week (even if he/she remains eligible to be enrolled in the plan); and (3) intends to enroll in another plan that provides Minimum Essential Coverage (no later than the first day of the second month following the month of revocation of coverage).
- You enroll, or intend to enroll, in a Qualified Health Plan (QHP) through the State Marketplace or Federal Exchange and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

If your change during the year is a result of the loss of eligibility or enrollment in Medicaid, Medicare or state health insurance programs, you must submit the request for change within 60 days. For a complete explanation of qualified status changes, please refer to the “Legal Information Regarding Your Plans” contents on page 37.

Do I Have to Enroll?

Although the federal penalty requiring individuals to maintain health coverage has been reduced to $0, some states have their own state-specific individual mandates.

To avoid paying the penalty in some states, you can obtain health insurance through our benefits program or purchase coverage elsewhere, such as coverage from a State or Federal Health Insurance Exchange.

For information regarding Health Care Reform and the Individual Mandate, please contact Human Resources or visit www.cciio.cms.gov. You can also visit www.coveredca.com to review information specific to the Covered California State Health Insurance Exchange.

You may elect to “waive” medical, dental, and/or vision coverage if you have access to coverage through another plan. To waive coverage, you must select “waive coverage” in the Paycom portal. It is important to note that if you waive our medical coverage, you must maintain medical/health coverage through another source. It is also important to note that if coverage is waived, the next opportunity to enroll in our group benefit plans would be on January 1, 2022 or if a qualifying status change occurs.

Member Support

Understanding your employee benefits options can be confusing and complicated. Member Support through Marsh & McLennan Agency provides answers and information at your fingertips as well as help with enrollments!

Have a benefit question or need assistance enrolling in the Paycom portal?

Planning for you and your family's health and welfare needs can be an overwhelming task. Member Support is your resource for guidance when navigating your benefits plan, from enrollment to handling life's many changes.

Just a Call or Click Away

Bilingual Member Support is available Monday through Friday, 8:00 a.m. – 5:00 p.m. Pacific Time.

- **Toll-free:** 888.434.7720
- **Email:** MemberSupport@MarshMMA.com.

Dedicated Benefits Resource

As a company-sponsored benefit, Member Support gives you unlimited direct access to insurance professionals who are dedicated to knowing our plan options inside and out. Whether you're a new employee, looking for information on how to continue your coverage or your insurance needs are changing, you're bound to have questions on your plan options and programs.

TIP

General Benefits Support

- **How to enroll in the Paycom portal**
- **Finding a service provider**
- **General benefit questions**

Life Changing Events

- **Add coverage for your newborn or adopted child**
- **Add/remove coverage due to change in marital or employment status**

COBRA Support

- **Information regarding continuation coverage**
- **Navigate through your individual options**

Health Advocate

Our Personal Health Advocates can answer questions about your benefits and health plan, explain insurance jargon, help you understand your coverage, find doctors and support you through medical issues. Health Advocate has been helping Americans navigate the complexity of the healthcare system for over 16 years and their staff are healthcare experts with extensive experience supporting people with clinical and administrative issues, involving medical, hospital, pharmacy claims and other health care needs, no matter how common or complex. Health Advocate is available at no cost to employees and their eligible family members, and completely confidential.

Help you understand your benefits
We will answer questions about your benefits and coverage, including medical, prescription, dental and vision.

Explain your share of the costs
This includes the deductibles you have to meet before the insurance pays, as well as the copays/ coinsurance for doctor and medical visits.

Confirm your doctors' network status
We can help locate in-network providers and explain your out-of-network benefits, if needed.

Clarify health conditions
We can answer questions about diagnoses and treatments and research the latest treatment options.

Arrange second opinions
We'll connect you with the right specialists and coordinate the transfer of medical records.

Help to make informed decisions
We help you become informed about test results, treatment options, medications, and more.

Resolve claims and billing issues
We'll work on your behalf to resolve complicated medical claims and billing issues.

Help on the go
Quickly reach us any time you like — by phone, email and secure messaging. Easy access to our website and mobile app for articles, tips, tools and more!

Download the app today!

Here's how to register

Visit the site to get started at members.healthadvocate.com

1. Select "Register Now" and enter your personal information
2. Create a unique username, password, and security questions
3. Read and accept Terms and Conditions then click "register"
4. Verify your account through email

Contact your personal Health Advocate Monday through Friday between 8:00 a.m. and 12: a.m. Pacific time, toll-free at 866.695.8622 or visit HealthAdvocate.com/members for additional resources.

Benefits Information on the Go

Here are some helpful mobile apps to download for telehealth services, eligibility, or status on prescription orders. Search the mobile app in the App Store or Google Play to get started!

Kaiser Permanente – On the Go!

The KP mobile app gives you a suite of tools to use on the go! Use this application with your Kaiser Permanente user ID and password to:

- See your health history at your fingertips
- Refill or check the status of prescriptions for yourself or another member
- Schedule, view, and cancel appointments
- Access your message center to email your doctor or another KP department
- Find KP locations and facilities near you
- Telehealth services

myHNAS Flex Mobile– On the Go!

With myHNAS Flex Mobile, you can easily manage your Blue Shield benefits on the go. The mobile app gives you secure 24/7 access to:

- Claims and claims status
- Confirmation of employee eligibility
- Description of plan benefits and important plan form(s)
- ID card ordering

Teladoc

Available only to Blue Shield members, get started now at Teladoc.com! With Teladoc, you can:

- Connect to a board-certified doctor 24/7/365 through the convenience of phone or video consults
- Receive care for colds, the flu, allergies, and minor infections
- Avoid scheduling an appointment or sitting in waiting rooms
- Save yourself time and money

Express Scripts

Available only to Blue Shield members. It's easy to manage your medicine anytime, anywhere! Helpful information is just a tap away.

With Express Scripts, you can:

- Save time and money with home delivery
- Check your order status, claims, and payment history
- Refill and renew your prescriptions
- Find and compare prices with Price a Medication and sign up for medicine alerts

Search for Express Scripts' mobile app in the App Store or Google Play to get started!

Prescription Drug Coverage

Many FDA-approved prescription medications are covered through the benefits program. Important information regarding your prescription drug coverage is outlined below:

Kaiser Permanente and Blue Shield Administered by HNAS

- Tiered prescription drug plans require varying levels of payment depending on the drug's tier and your copayment or coinsurance will be higher with a higher tier number
- The Kaiser HMO and Blue Shield plans include a four-tier prescription benefit. The Blue Shield prescription benefit are through Express Scripts and are offered by RxBenefits
- Tier 1 prescriptions offer the greatest value compared to other drugs that treat the same conditions and are often the lowest cost
- Tier 2 drugs are generally brand name with a moderate copayment. Some drugs may also be Tier 2 because they are "preferred" among other drugs that treat the same conditions
- Tier 3 drugs are a higher copayment compared to the lower tiers, as they are higher cost drugs. Some drugs on this list may have a generic counterpart in Tier 1 or Tier 2
- Many drugs on Tier 4 are "specialty" drugs used to treat complex, chronic conditions, and may require special storage or close monitoring

Mail Order Benefits through Express Scripts (ESI) - Blue Shield Members

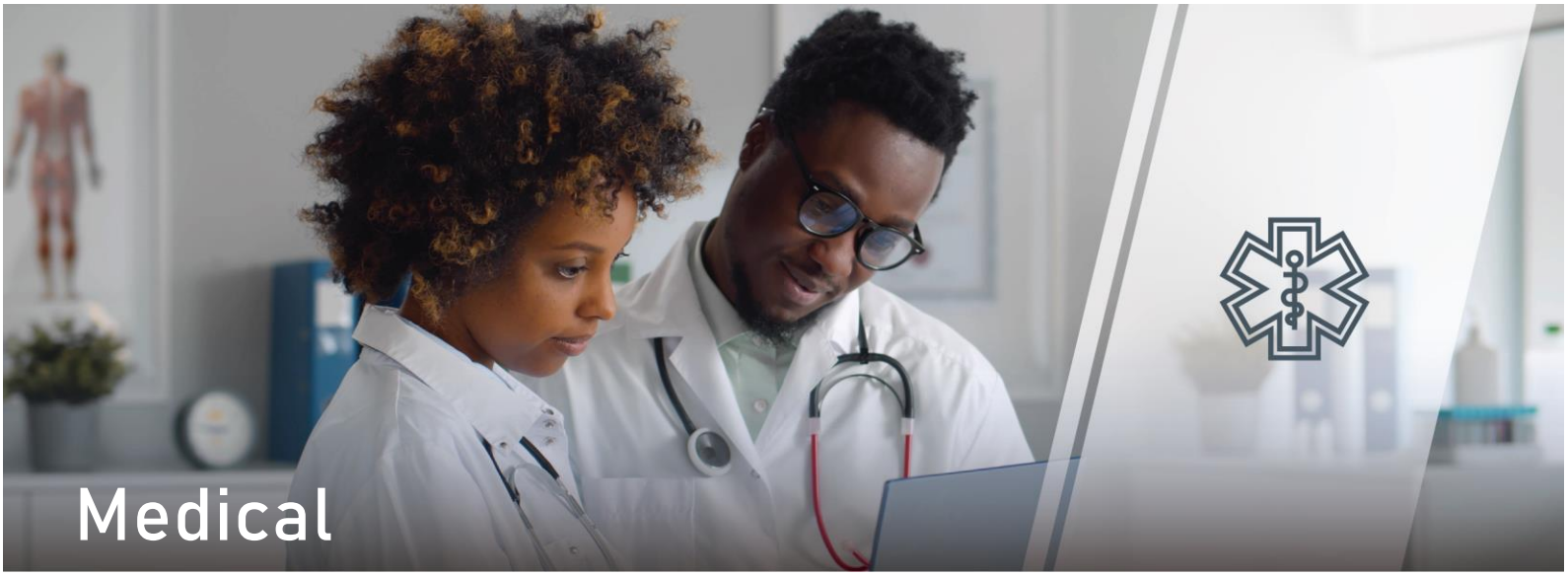
- Compare prices of medicines at multiple pharmacies. Get free standard shipping* from the Express Scripts Pharmacy. (*Standard shipping costs are included as part of your prescription plan benefit.)
- More convenience. Get up to 90-day supplies of your long-term medicine sent to your home. Order refills, check order status, and track shipments. Print forms and ID cards, if needed.
- More confidence. Talk with a pharmacist from the privacy of your home any time, from anywhere. Find the latest information on your medicine, including possible side effects and interactions.
- More flexibility. Download the Express Scripts mobile app to manage your medicines, find nearby pharmacies and get directions, and use your virtual ID card while on the go.
- **To access the member website, register or l**ogin at www.**express-scripts.com** (**You will need Member ID or SSN#**).
- Contact your doctor and request a 90-day prescription that they can ePrescribe directly to Express Scripts o**r** print a form by selecting *"Forms"* or *"Forms & Cards"* from the menu under *'Benefis,'* print a mail order form and follow the mailing instructions or call Express Scripts at 800.334.8134 and they will contact your doctor for you. Please allow 10 to 14 days for your first prescription order to be shipped

If you or your pharmacist have any questions, please contact the RxBenefit Customer Service or the Pharmacy Help Desk:

- Pharmacy Help Desk: 800.922.1557
- RX Customer Service: 800.334.8134
- express-scripts.com

Smart 90 (Voluntary)

- Members on maintenance drugs can receive a 90-day supply of their medication through either the ESI mail order pharmacy or through CVS' retail drug store.
- Members will pay the mail order co-pay for the 90-day supply and must have a prescription written by their physician for the 90-day supply.
- Some medications are not available in a 90-day supply therefore would not be dispensed as a three-month supply.
- Specialty drugs may be excluded from this program.



Medical

What are my options?

Use the chart below to help compare medical plan options and determine which would be the best for you and your family.

	HMO	EPO	PPO	HDHP w/HSA
	Kaiser	**Blue Shield (Administered by HNAS)**	**Blue Shield (Administered by HNAS)**	**Blue Shield (Administered by HNAS)**
Required to select a Primary Care Physician (PCP)	Yes	No	No	No
Seeing a Specialist	Yes referral required in most cases	No referral required		
Deductible Required	Yes	Yes	Yes	Yes
Finding a Provider	• Visit kaiserpermanente.org for SoCal or kaiserpermanente.org for NorCal • Click "**Doctors & locations**" • Select the region, "**California – Southern"** or • **"California – Northern"** • Search by doctor name, zip code, or specialty and click Search	• Visit www.blueshieldca.com • Click the "**Doctors & Specialist**" icon • Under the "**Where are you located?**" enter zip code or city you reside in and select Continue • Select 2022 Employer Group Plans (101+Employees) • Then select a Plan: **EPO Full PPO or PPO Plan** • Search by "**Doctor Type**" or "**Doctor Name**" and select Search • Select a Doctor from the list of providers		
Claims Process	• Typically handled by Kaiser	• Network providers submit claim forms	• Network providers will submit claims • You submit claims for out-of-network services	
Other Important Tips	• This plan requires that you see a doctor in Kaiser to receive coverage. • Out-of-Network services without proper PCP referral will not be covered. • Emergencies covered worldwide.	• Except for emergencies, generally provides coverage for in-network care only. • Emergencies covered worldwide.	• You may choose in or-out-of network care, however in-network care provides you a higher level of benefit. • Emergencies covered worldwide. • Out-of-network providers will bill the balance to the member for amounts not covered	• Although this plan has a higher deductible than most plans, it requires lower payroll deductions. • The HSA account provides a tax-favored vehicle to help you manage your out-of-pocket expenses. • Emergencies covered worldwide.

Please note, the above examples are used for general illustrative purposes only. Please consult with your Human Resources department for more specific information as it relates to your specific plan. Detailed view of your medical plan summaries are available in your Paycom account.

Plan Highlights	Kaiser HMO	Blue Shield EPO
Be sure to check in PAYCOM or contact Member Support to make sure your home or office zip code is eligible for the HMO medical plan of your choice.	**In-network Only**	**In-network Only**
Annual Calendar Year Deductible		
Individual	$1,000	$250
Family	$2,000	$500
Maximum Calendar Year Out-of-pocket (1)		
Individual	$3,000	$2,000
Family	$6,000	$4,000
Professional Services		
Primary Care Physician (PCP)	$20 Copay / visit	$20 Copay / visit
Specialist	$20 Copay / visit	$20 Copay / visit
Preventive Care Exam	No Charge	No Charge
Well-baby Care	No Charge	No Charge
Diagnostic X-ray and Lab	$10 Copay / encounter	No Charge
Complex Diagnostics (MRI/CT Scan)	20% (up to $150 / procedure)	$100 Copay / procedure
Therapy, including Physical, Occupational and Speech	$20 Copay / visit	$20 Copay / visit (limited to 20 visits / year)
Telehealth	No Charge	$10 Copay / visit
Hospital Services		
Inpatient	20% (2)	20% (2)
Outpatient Surgery	20% (2)	20% (2)
Emergency Room	20% (2)	$100 Copay / visit
Urgent Care	$20 Copay / visit	$20 Copay / visit
Maternity Care		
Physician Services (prenatal or postnatal)	No Charge	No Charge
Hospital Services	20% (2)	20% (2)
Mental Health & Substance Abuse		
Inpatient	20% (2)	20% (2)
Outpatient	$20 Copay / office visit	$20 Copay / office visit
Retail Prescription Drugs	(30-day supply) (3)	(34-day supply) (3)
Tier 1 – Generic	$10 Copay	$10 Copay
Tier 2 – Brand	$30 Copay	$30 Copay
Tier 3 – Non-Formulary	$30 Copay	$50 Copay
Tier 4 – Specialty Drugs	20% (Up to $250 / Rx)	30% (Up to $300 / Rx)
Mail Order Prescription Drugs	(100-day supply) (3)	(90-day supply) (3)
Tier 1 – Generic	$20 Copay (100-day supply)	$20 Copay (90-day supply)
Tier 2 – Brand	$60 Copay (100-day supply)	$60 Copay (90-day supply)
Tier 3 – Non-Formulary	$60 Copay (100-day supply)	$100 Copay (90-day supply)
Tier 4 – Specialty Drugs	Not Covered	30% (Up to $300 / Rx and limited to 31 day supply)

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

(2) After Annual Deductible has been satisfied

(3) If a member is dispensed a brand medication when there is a generic medication available, the member will pay the difference between the brand and the generic plus the generic co-pay for the script. If a drug is excluded from the Formulary the member will be responsible for 100% of the cost

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

Plan Highlights

Blue Shield Traditional PPO

	In-network	Out-of-network
Annual Calendar Year Deductible		
Individual	$500	$500
Family	$1,000	$1,000
Maximum Calendar Year Out-of-pocket [1]		
Individual	$3,500	$10,500
Family	$7,000	$21,000
Professional Services		
Primary Care Physician (PCP)	$35 Copay / visit	40% [2]
Specialist	$35 Copay / visit	40% [2]
Preventive Care Exam	No Charge	Not Covered
Well-baby Care	No Charge	Not Covered
Diagnostic X-ray and Lab	No Charge	40% [2]
Complex Diagnostics (MRI/CT Scan)	20% [2]	40% [2]
Therapy, including Physical, Occupational and Speech (limited to 20 visits / year)	$35 Copay / visit	40% [2]
Telehealth	$10 Copay / visit	Not Covered
Hospital Services		
Inpatient	20% [2]	40% [2]
Outpatient Surgery	20% [2]	40% [2]
Emergency Room	$100 Copay + 20% [2]	
Urgent Care	$35 Copay / visit	40% [2]
Maternity Care		
Physician Services (prenatal or postnatal)	No Charge	40% [2]
Hospital Services	20% [2]	40% [2]
Mental Health & Substance Abuse		
Inpatient	20% [2]	40% [2]
Outpatient	$35 Copay / office visit	40% [2]
Retail Prescription Drugs (31-day supply) [3]	Annual Drug Deductible: $250 Individual / $750 Family	
Tier 1 – Generic	$10 Copay	$10 Copay
Tier 2 – Preferred Brand	$30 Copay	$30 Copay
Tier 3 – Non-Preferred Brand	$50 Copay	$50 Copay
Tier 4 – Specialty Drugs	$50 Copay	$50 Copay
Mail Order Prescription Drugs (90-day supply) [3]	Annual Drug Deductible: $250 Individual / $750 Family	
Tier 1 – Generic	$25 Copay	Not Covered
Tier 2 – Preferred Brand	$75 Copay	Not Covered
Tier 3 – Non-Preferred Brand	$125 Copay	Not Covered
Tier 4 – Specialty Drugs	$125 Copay	Not Covered

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

[2] After Annual Deductible has been satisfied

[3] If a member is dispensed a brand medication when there is a generic medication available, the member will pay the difference between the brand and the generic plus the generic co-pay for the script. If a drug is excluded from the Formulary the member will be responsible for 100% of the cost

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

Plan Highlights

Blue Shield Affordable PPO (HSA)

	In-network	Out-of-network
Annual Calendar Year Deductible		
Individual	$2,700	$6,000
Family	$5,400	$12,000
Maximum Calendar Year Out-of-pocket [1]		
Individual	$5,000	$10,000
Family	$10,000	$20,000
Professional Services		
Primary Care Physician (PCP)	20% [2]	40% [2]
Specialist	20% [2]	40% [2]
Preventive Care Exam	No Charge	Not Covered
Well-baby Care	No Charge	Not Covered
Diagnostic X-ray and Lab	20% [2]	40% [2]
Complex Diagnostics (MRI/CT Scan)	20% [2]	40% [2]
Therapy, including Physical, Occupational and Speech (limited to 20 visits / year)	20% [2]	40% [2]
Telehealth	$10 copay / visit	Not Covered
Hospital Services		
Inpatient	20% [2]	40% [2]
Outpatient Surgery	20% [2]	40% [2]
Emergency Room	20% [2]	
Urgent Care	20% [2]	40% [2]
Maternity Care		
Physician Services (prenatal or postnatal)	No Charge	40% [2]
Hospital Services	20% [2]	40% [2]
Mental Health & Substance Abuse		
Inpatient	20% [2]	40% [2]
Outpatient	20% [2]	40% [2]
Retail Prescription Drugs (31-day supply) [3]	Must satisfied Annual Deductible before plan begins to pay	
Tier 1 – Generic	$10 Copay [2]	$10 Copay [2]
Tier 2 – Preferred Brand	$30 Copay [2]	$30 Copay [2]
Tier 3 – Non-Preferred Brand	$50 Copay [2]	$50 Copay [2]
Tier 4 – Specialty Drugs	$50 Copay [2]	$50 Copay [2]
Mail Order Prescription Drugs (90-day supply) [3]	Must satisfied Annual Deductible before plan begins to pay	
Tier 1 – Generic	$25 Copay [2]	Not Covered
Tier 2 – Preferred Brand	$75 Copay [2]	Not Covered
Tier 3 – Non-Preferred Brand	$125 Copay [2]	Not Covered
Tier 4 – Specialty Drugs	$125 Copay [2]	Not Covered

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

[2] After Annual Deductible has been satisfied

[3] If a member is dispensed a brand medication when there is a generic medication available, the member will pay the difference between the brand and the generic plus the generic co-pay for the script. If a drug is excluded from the Formulary the member will be responsible for 100% of the cost

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

Health Savings Account (HSA)

What is it?

By enrolling in the Blue Shield high-deductible health plan, you will have access to a Health Savings Account (HSA), which provides tax advantages and can be used to pay for qualified health care expenses, such as your deductible, copayments, and other out-of-pocket expenses.

What are the benefits?

Administered by HealthEquity, an HSA accumulates funds that can be used to pay current and future health care costs.

- You can contribute to your HSA on a pre-tax basis, for federal tax purposes, or you can contribute on a post-tax basis and take the deduction on your tax return.
- Generally, HSA funds can grow on a tax-free basis, subject to state law.[1]
- An HSA reduces your taxable income and may allow you to make tax-free withdrawals from the account when paying for qualified health care expenses (tax regulations vary by state).
- Because you own the HSA, there are no "Use it or Lose it" provisions, so unused HSA funds roll over from year-to-year, and can be used to reimburse future eligible out-of-pocket expenses.
- You may enjoy lower monthly premium payments as compared to traditional PPO medical plans.
- Because you own the HSA, the money in your account is yours to keep if you leave the company.
- *Interface rehab, inc.* does not contribute to your HSA.

How do I qualify for an HSA?

The IRS has guidelines regarding who qualifies for an HSA. You are considered eligible if:

- You are covered under a qualified medical plan.
- You are not enrolled in non-qualified health insurance outside of *interface rehab*'s HSA PPO plan.
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else's tax return (excluding a spouse).
- You are not enrolled in a general Health Care Flexible Spending Account (Health FSA) or general Health Reimbursement Arrangement (HRA).

How do I get started?

Great news! If you elect an HSA qualified plan, *interface rehab, inc.* will send your plan information to HealthEquity. Keep an eye out for your welcome kit from Health Equity. The kit is sent approximately three weeks from your election date and will have login instructions to activate your account.

We have posted Health Equity education material in Paycom in the Resource Library under Health Equity.

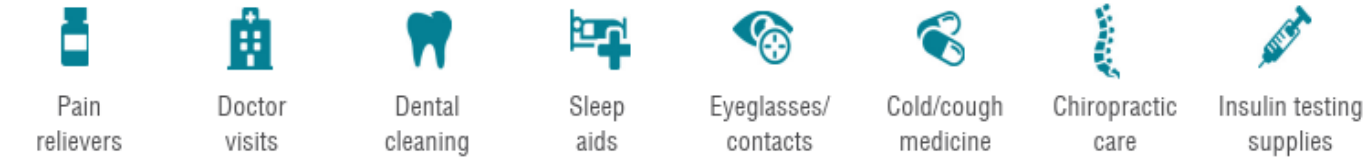
Once the HSA is activated, you can manage and access your account at any time by visiting healthequity.com. If questions arise regarding account activation, contact HealthEquity at 877.857.6810. Consult your tax advisor for taxation information or advice.

(1) Please consult your tax advisor for applicable tax laws in your state.

A few rules you need to know:

- For 2022, the maximum contribution limit for employee and employer contributions in an employee's HSA account is $3,650 if you are enrolled in the HSA-PPO for employee-only coverage, and $7,300 for employees with dependent coverage.
- It's important to monitor your contributions to avoid going over the IRS limit, as contributions in excess of the IRS limit are subject to standard income tax rates, plus a 6% excise tax.
- There is a 20% penalty for using HSA funds on non-qualified health care expenses if you are under age 65. For more details about what are considered qualified health care expenses, visit www.healthequity.com.
- You may not be able to contribute to your HSA if you are entitled to Medicare. However, funds accumulated before Medicare entitlement may be used to reimburse your qualified medical expenses.
- You may not contribute to your HSA if you are covered under any medical benefits plan which is not an HSA-qualified high deductible medical plan (e.g., a spouse's non-HDHP medical plan, a general purpose Health Care FSA, or Medicare). However, you may be covered by a Limited Purpose Health Care FSA, or an FSA which can be used after your HDHP deductible is met.
- Typically, the maximum amount an employee is eligible to contribute to an HSA per calendar year is based upon a **pro-rata** portion of the number of months an employee is eligible to contribute to an HSA. For example, an employee would normally be able to contribute 4/12 of the maximum annual limit in his/her first year of enrollment into the HSA plan, if the employee first joins the HSA plan on September 1. However, under the full contribution rule, an employee is allowed to contribute the maximum annual amount, regardless of the number of months he/she was eligible to contribute to an HSA in the first year, if he/she is eligible to contribute to an HSA on December 1 of the first year and continues to be eligible to contribute to an HSA until December 31 of the following year (i.e., for the entire subsequent year).

Save big on thousands of qualified medical expenses, including:

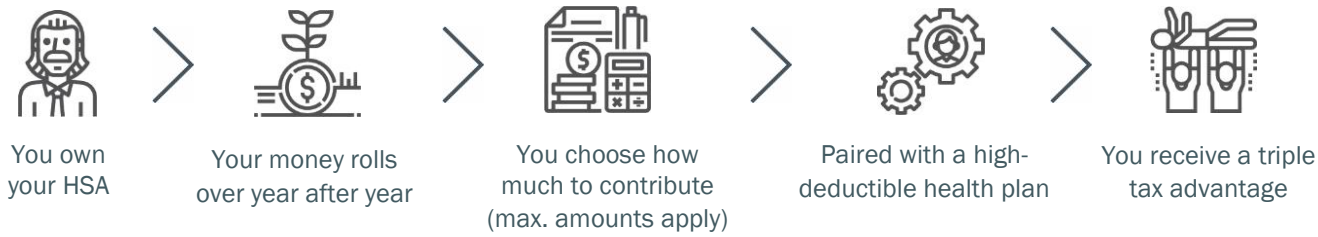


TIP

How do I manage my HSA?

- **The most convenient way to pay for qualified expenses is to utilize the debit card**
- **You can also use your own cash or a personal credit card and reimburse yourself through your online HSA account**
- **It is recommended that you keep receipts of HSA purchases, should you ever be audited by the IRS**
- **View the status of your claims and check your HSA balance at healthequity.com**

WHAT TO KNOW ABOUT YOUR HEALTH SAVINGS ACCOUNT



myHNAS Online Member Benefits

HealthNow Administrative Services

Welcome to myHNAS!

Access your claims, ID card, and other valuable plan information, 24/7, through myHNAS. You will find important documents, links to health-related resources, and answers to frequently asked questions. Here's what you can do with myHNAS:

Online Claims

Review claims details for you and your covered dependents, as well as prescription drug history, if applicable.

Benefits

- Review deductible information and the plan start and end dates for you and your covered dependents
- Access an electronic summary of benefits and locate participating doctors or hospitals
- View your temporary health plan ID card

Online Customer Service

View various benefit-related questions. In some circumstances, you can also submit information and then receive electronic notification as the requests are processed.

Health Management Solutions

You'll have access to tools and information to help you stay healthy.

1. Go to portal.myhnas.com
2. The first time you log in, please click "Signup" at the bottom of the page.
3. Read the agreement and click "Agree"
4. Enter the required fields and click "Next"
5. Create a username and password and click "Next"

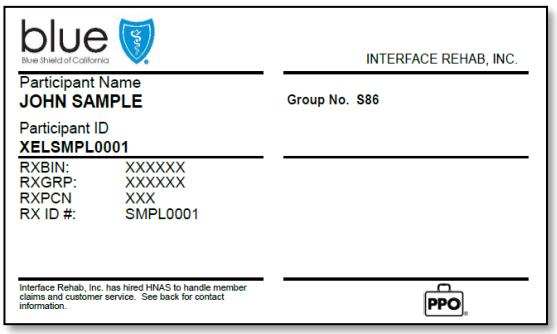
   Note: Your username must be at least eight characters long. Acceptable characters are alphanumeric and special characters; (- _ ! # $ % ^ & * / ? \ + @)
6. Click "Finish" to complete your registration

Health Plan ID Card

HealthNow administrates the Blue Shield medical programs and an ID card will be sent to your home for you and up to one dependent. Below are instruction to view your ID card online. If you wish to have additional ID cards, please call HealthNow at 877.356.0666.

ID Card View and Where to Look!

Visit portal.myhnas.com to access your health plan ID card 24/7 – an image of your actual ID card is viewable in PDF format and may be downloaded or printed. Select Temporary ID Card from the Benefits menu. You will see your ID card similar to the sample image below.



Dental Plan

Your Dental PPO Plans

Administer by HealthNow. This year, you and your eligible dependents have the opportunity to enroll in one of the Dental Preferred Provider Organization (PPO) plans offered by Aetna.

Using the Plan

The Dental PPO plans are designed to give you the freedom to receive dental care from any licensed dentist of your choice. Keep in mind, you'll receive the highest level of benefit from the plan if you select an in-network PPO dentist versus an out-of-network dentist who has not agreed to provide services at the negotiated rate. Additionally, no claim forms are required when using in-network PPO dentists.

Plan Highlights	Affordable DPPO		Traditional DPPO	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible				
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
Annual Maximum	$1,000	$1,000	$2,000	$2,000
Preventive	100%	100%	100%	100%
Basic Services	80%	80%	80%	80%
Major Services	50%	50%	50%	50%
Orthodontia Services				
Adult	Not Covered	Not Covered	Not Covered	Not Covered
Child up to age 19	Not Covered	Not Covered	50%	50%
Lifetime Maximum	N/A	N/A	$2,000	$2,000

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

TIP

Choose your Dentist

When using a Dental PPO plan, you can receive services from dental providers both in and out of your insurance network. However, you'll receive better coverage when you use an in-network dentist. To determine whether your dentist is in or out of your insurance network, go to www.aetna.com/docfind/custom/aetnadentalaccess to search the Provider Network or simply call HealthNow (dental administrator) at 877.356.0666.

Vision Plan

Your Vision Plan

Administer by HealthNow, your vision coverage is offered by MES Vision as a Preferred Provider Organization (PPO) plan.

Using the Plan

As with a traditional PPO, you may take advantage of the highest level of benefit by receiving services from in-network vision providers and doctors. You would be responsible for a copayment at the time of your service. However, if you receive services from an out-of-network doctor, you pay all expenses at the time of service and submit a claim for reimbursement up to the allowed amount. To view a complete plan summary, login to your Paycom account.

To find a vision provider, go to www.mesvision.com

Plan Highlights	MES Vision PPO	
	In-Network	**Out-of-Network**
Exam – Every 12 months	$10 Copay	Up to $50
Lenses – Every 12 months		
Single	$25 Copay	Up to $48
Bifocal	$25 Copay	Up to $60
Trifocal	$25 Copay	Up to $75
Frames – Every 12 months	Up to $130 allowance	Up to $48
Contacts – Every 12 months, in lieu of lenses & frames		
Non-Elective	No Charge	Up to $250
Elective	Up to $130 allowance	Up to $130
Additional Benefits		
Additional Pairs of Glasses	20% Discount	N/A

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

TIP

Five Tips for Superior Vision

Don't take your eyes for granted! The following pointers can help you keep your vision strong:

- **Eat lots of leafy greens and dark berries**
- **Get regular eye exams**
- **Give your eyes a rest from staring into the computer screen**
- **Wear sunglasses to protect your eyes from bright light**
- **Wear safety eyewear whenever necessary**

Cost of Coverage

The rates below are effective January 1, 2022 – December 31, 2022.

Coverage Level	Employee Cost Per Check
Kaiser HMO (So. Cal)	
Employee Only	$87.03
Employee and Spouse [1]	$353.39
Employee and Child(ren)	$324.38
Employee and Family	$609.20
Kaiser HMO (No. Cal)	
Employee Only	$239.20
Employee and Spouse [1]	$788.28
Employee and Child(ren)	$728.48
Employee and Family	$1,315.62
Blue Shield EPO	
Employee Only	$66.86
Employee and Spouse [1]	$134.39
Employee and Child(ren)	$127.03
Employee and Family	$199.25
Blue Shield Traditional PPO	
Employee Only	$275.63
Employee and Spouse [1]	$554.04
Employee and Child(ren)	$523.71
Employee and Family	$821.41
Blue Shield Affordable HSA	
Employee Only	$93.47
Employee and Spouse [1]	$187.89
Employee and Child(ren)	$177.60
Employee and Family	$278.56
Dental Affordable PPO	
Employee Only	$5.02
Employee and Spouse [1]	$31.06
Employee and Child(ren)	$36.60
Employee and Family	$68.50
Dental Traditional PPO	
Employee Only	$23.16
Employee and Spouse [1]	$66.41
Employee and Child(ren)	$83.72
Employee and Family	$124.92
Vision PPO	
Employee Only	$0.63
Employee + One	$2.38
Employee and Family	$5.27

[1] Includes registered and Unregistered Domestic Partner

Flexible Spending Accounts (FSA)

A flexible spending account lets you use pre-tax dollars to cover eligible health care and dependent care expenses. There are different types of FSAs that help to reduce your taxable income when paying for eligible expenses for yourself, your spouse, and any eligible dependents, as outlined below:

FSA Type	Detail
 Health Care FSA	• Can reimburse for eligible health care expenses not covered by your medical, dental and vision insurance. • Maximum contribution for 2022 is $1,000.
 Limited Purpose FSA	• Option for employees enrolled in a Health Savings Account (HSA) eligible plan. • Use this FSA to reimburse for eligible preventive care, dental and vision expenses. • Maximum contribution for 2022 is $1,000.
 Dependent Care FSA	• Can be used to pay for a child's (up to the age of 13) child care expenses and/or care for a disabled family member in the household, who is unable to care for themselves. • Maximum contribution for 2022 is $5,000.

What are the benefits?

- Your taxable income is reduced and your spendable income increases!
- Save money while keeping you and your family healthy.

How do I use it?

You must enroll in the FSA program within 30 days of your hire date or during annual open enrollment. At this time, you must establish an annual contribution amount within the maximum limit. Once enrolled, you will have online access to view your FSA balance, check on a reimbursement status, and more. Visit portal.myhnas.com to access HealthNow's online portal.

A few rules you need to know:

- Although the plan year runs from January 1, 2022 through December 31, 2022, the plan allows a 2 1/2 month grace period allowing you to seek reimbursement for any eligible expenses incurred from January 1, 2022 to March 15, 2023. All eligible claims must be submitted for reimbursement by the runout deadline of March 31, 2023.
- For the Day Care FSA, you must submit claims no later than 90 days after the end of the Plan Year.
- FSA funds do not roll over to the next year, it's a use it or lose it. Any monies left at the end of the Plan Year and after the Grace Period will be forfeited.

For more details about using an FSA, contact HealthNow at 877.356.0666.

Basic Life and AD&D

Protect your loved ones

In the event of your death, Life Insurance will provide your family members or other beneficiaries with financial protection and security. Additionally, if your death is a result of an accident or if you become dismembered, your Accidental Death & Dismemberment (AD&D) coverage may apply.

Your coverage

Paid for in full by *interface rehab inc,* the benefits outlined below are provided by Guardian:

- Basic Life Insurance of $25,000
- AD&D of $25,000
- Please note, benefits may reduce when you reach age 65.

IRS Regulation: Employees can receive employer paid life insurance up to $50,000 on a tax-free basis and do not have to report the payment as income. However, an amount in excess of $50,000 will trigger taxable income for the “economic value” of the coverage provided to you.

TIP

Required! Are Your Beneficiaries Up to Date?

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

- **You can change your beneficiary designation at any time**
- **You may designate a sole beneficiary or multiple beneficiaries to receive payment in the amount percentage**
- **To select or change your beneficiary, login to your Paycom account or contact Human Resources**

Voluntary Life and AD&D

If you would like to supplement your employer paid insurance, additional Life and AD&D coverage for you and/or your dependents is available for purchase on a payroll deduction basis through Guardian.

- **For employees:** Increments of $10,000 up to a $300,000 maximum with a guarantee issue benefit of $300,000 if you enroll in the plan within 30 days of your initial eligibility.
- **For your spouse:** Increments of $5,000 up to a $75,000 maximum with a guarantee issue benefit of $75,000 if you enroll in the plan within 30 days of your initial eligibility.
- **For your child(ren):** Date of birth to 14 days, $500; from 14 days to age 26, increments of $1,000 up to maximum benefit of $10,000.
- **Life benefit reduces:** 35% at age 65 and 50% at age 70
- **Optional AD&D:** Coverage is available for purchase in the same amounts as optional life insurance amounts above.

Any amounts of insurance over the guarantee issue benefit are subject to review of good health by the insurance company. Insurance amounts subject to review will not be effective until the insurance company approves.

Evidence of Insurability (EOI) is required for amounts over the Guarantee Issue (GI). If you did not enroll in the plan within the initial enrollment period (new hire or newly benefit eligible window), you will be required to complete an EOI form for any amount showing proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

Please note: Benefits coverage may reduce when you reach age 65. Restrictions may apply if you and/or your dependent(s) are confined in the hospital or terminally ill. Please refer to your Summary Plan Description for exclusions and further detail.

Employee & Spouse*
(Voluntary Life and AD&D Monthly Rates)

Age of Insured	Employee Rate per $10,000	Spouse Rate per $5,000
Less than 25	$0.77	$0.39
25–29	$0.77	$0.39
30–34	$0.87	$0.44
35–39	$1.17	$0.59
40–44	$1.77	$0.89
45–49	$2.67	$1.34
50–54	$3.97	$1.99
55–59	$6.87	$3.44
60–64	$11.17	$5.59
65–69	$17.77	$8.89

Dependent*
(Voluntary Life and AD&D Rates)

Benefit Amount	Monthly Rate
$1,000	$0.18
$2,000	$0.35
$3,000	$0.53
$4,000	$0.71
$5,000	$0.89
$6,000	$1.06
$7,000	$1.24
$8,000	$1.42
$9,000	$1.59
$10,000	$1.77

* Voluntary life and AD&D rates illustrated above are bundled.

Disability

Added protection

Should you experience a non-work related illness or injury that prevents you from working, disability coverage acts as income replacement to protect important assets and help you continue with some level of earnings. Benefits eligibility may be based on disability for your occupation or any occupation.

Your Plans	Coverage Details
Voluntary Short-Term Disability (STD)	• Administered by Guardian, STD coverage provides a benefit equal to 75% of your earnings, up to $2,129 per week for a period up to 52 weeks. • The plan begins paying these benefits at the time of disability/after you have been absent from work for 7 consecutive days.
State Disability Insurance	• The state you reside in may provide a partial wage-replacement disability insurance plan • For more information regarding statutory disability programs, contact Human Resources

If you did not enroll in the plan within the initial enrollment period (new hire or newly benefit eligible window), you will be required to complete an EOI form showing proof of good health, which is subject to approval by the insurance company before the insurance is effective. For more information regarding this plan, review the plan summary detail.

TIP

Disability Facts and Figures

- **One in every 7 people will become disabled for five years or more in their lifetime.**
- **30% of people use disability coverage.**
- **Nearly half (46%) of all foreclosures are caused by financial hardship due to a disability.**

Source: www.affordableinsuranceprotection.com/disability_facts

Tax considerations

As an optional employee paid benefit, disability coverage is available to you on a post-tax basis:

- **After-tax:** If you pay your disability coverage on an after-tax basis, you will not have to pay income taxes on any STD benefit you receive.

Please note: Consult your tax advisor for additional taxation information or advice.

Retirement Options

Your 401(k) Plan Option

Administered by Fidelity Investments, the 401(k) plan allows you to plan for your future by investing a portion of each paycheck. Once you become eligible, you may elect to have a percentage of your paycheck withheld and invested in your 401(k) account, subject to federal law and plan guidelines. See Human Resources to confirm eligibility and enrollment dates.

Enrollment & Account Access

- To enroll in the 401(k) plan, please visit www.401k.com to enroll online or contact your Benefits Department to receive your enrollment forms.
- Check your 401(k) account balance, view your contributions, change your investments, and more by visiting www.401k.com. For login or password assistance, please contact Fidelity Investments at 800.835.5097.

Additional 401(k) Information

Contribution Limits: For 2022, the IRS annual contribution limits are $20,500 for everyone under age 50 or $27,000 for anyone that is age 50 or over prior to December 31, 2022. If you have multiple employers during the year, these limits are combined for all plans that you contribute to during the year. Restrictions may apply to these limits based on plan documents and annual testing requirements.

Contribution Changes: Check with Human Resources for frequency and process for changing your contributions. You may also stop your contribution entirely at any time. Requests to change or stop your contributions must be made through the provider website or in writing to Human Resources.

Employer Contributions: Check with Human Resources for current status of any employer contributions to the plan.

Loans & Hardship Withdrawals: If allowed by the plan document, please see Human Resources for information and requirements for either option.

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

Termination of Employment: Upon termination of employment from our organization, regardless of reason, you will be entitled to request a full distribution of your vested account balance. This may be done as a rollover to another plan or IRA. You may also request a lump-sum cash payment to yourself. Please be aware of possible taxes and penalties which may apply to any payment other than a rollover.

Voluntary Benefits

Guardian is available to you as part of your benefits package to help offset out of pocket costs associated with medical expenses. Cash benefits are paid directly to you for qualified claims, and you can use the money received as necessary and needed to give peace of mind and added protection for you and your family.

Accident Plan

Accidents happen when you least expect them and can include motor vehicle accidents, sports injuries, slips, falls or just every day mishaps! Guardian's policy may pay cash to help families offset the expenses associated with accidents or injuries.

Benefits may be paid for:

- Emergency room and doctor visit
- Follow up and physical therapy visits
- Hospital admission and confinement
- Ambulance
- Medical Equipment (crutches, leg braces, etc.)

Critical Illness coverage

Critical illness coverage offered on a voluntary basis through Guardian pays you a lump sum benefit if you are diagnosed with a covered illness or condition. All benefits are paid directly to you and you may use the funds as you see fit.

What can Critical Illness coverage pay for?

- Medical expenses, such as copays, deductibles or co-insurance
- Lost Income
- Everyday expenses such as groceries and utilities
- Alternative treatments
- Lodging and travel to a specialist

Examples of covered illnesses or conditions:

- Cancer
- Heart Attack
- Stroke
- Kidney Failure
- Organ Transplant

Hospital Protection

Planned or unplanned, a trip to the hospital can be unsettling, especially if your primary medical insurance doesn't cover the majority of your costs. Hospital Insurance offered on a voluntary basis through Guardian pays out cash to you or your family to offset both medical and non-medical bills resulting from a hospital stay.

How can Hospital insurance help?

The cash benefits can be used to pay for services or expenses your traditional medical plan might not cover. Since benefits are paid directly to you, you choose how to use them. Here are a few examples:

- Copayments
- Deductibles
- Transportation expenses
- Child care
- Lodging expenses for a companion
- Lost income

Voluntary Benefits (cont.)

Cancer Care

Offered by Guardian, Cancer Care will help reduce expenses associated with life-threating diseases. Some of the covered benefits include:

- A lump-sum benefit payable on initial cancer diagnosis
- A wellness benefit payable for cancer screening
- Benefits for radiation, chemotherapy, experimental treatments and cancer surgery
- Transportation and lodging benefits payable for travel to receive treatment
- Extended care, Home Health Care and Hospice

If you are considering these types of coverage, you must enroll when you first become eligible or during the annual open enrollment period. For more information regarding cost and how to enroll, please refer to your Summary Plan Description for exclusions and further details or contact Guardian with any questions.

Pet Insurance

For many of us, our pets are just as special and loved as our family members. That's why it's important we protect their health too! *interface rehab, inc.* makes Pet Insurance Benefit available, offered by Nationwide Pet Insurance, covers dogs, cats, birds and some other exotic animals. Nationwide Pet Insurance Includes:

Plan Highlights	My Pet Protection with Wellness	My Pet Protection
Accidents, including poisonings and allergic reactions	✓	✓
Injuries, including cuts, sprains and broken bones	✓	✓
Common illnesses, including ear infections, vomiting and diarrhea	✓	✓
Serious/chronic illnesses, including cancer and diabetes	✓	✓
Hereditary and congenital conditions	✓	✓
Surgeries and hospitalization	✓	✓
X-rays, MRIs and CT scans	✓	✓
Prescription medications and therapeutic diets	✓	✓
Wellness exams	✓	
Preventive dental cleaning	✓	
Vaccinations	✓	
Spay/neuter	✓	
Flea and tick prevention	✓	
Heartworm testing and prevention	✓	
Routine blood tests	✓	

Nationwide pet insurance does not cover pre-existing conditions. However, however they do offer extra features such as **emergency boarding, lost pet advertising and more**. Plus, both plans have a low $250 annual deductible and a generous $7,500 maximum annual benefit. **To enroll go to www.petinsurance.com/affiliates/interfacerehab or call 877.738.7874 to discuss the best coverage for your animal.**

Additional Benefits & Perks

Employee Assistance Program (EAP)

interface rehab, inc. understands that you and your family members might experience a variety of personal or work-related challenges. Through the EAP, you have access to resources, information, and counseling that are fully confidential and no cost to you.

Program Component	Coverage Details
Who Can Utilize	All employees, dependents of employees, and members of your household
Topics May Include	• Childcare • Eldercare • Legal services • Identity theft • Marital, relationship or family problems • Bereavement or grief counseling • Substance abuse and recovery • Financial support • Educational materials
Number of Sessions	3 face-to-face sessions per year per member per incident

TIP

How to Access:

- **By Phone: 800.386.7055**
- **Online: www.ibhworklife.com**
- **User ID: Matters**
- **Website password: WLM70101**

Additional Benefits & Perks (cont.)

Continuing Education Benefit

On March 4, 2020, the Governor proclaimed a State of Emergency in California as a result of the impacts of COVID-19. Social distancing is one of the key components in preventing the spread of Covid-19.

To adhere to social distancing guidelines from the CDC, *interface rehab, inc*. has partnered with Continued.com to establish a Continuing Education University ("CEU"), which will provide a safe and secured online CEU courses until further notice in order to meet our obligation of the licensing state board requirements for license renewals, and to continuously expand our horizons in our therapy skills.

We recommend strongly to take courses that will support your clinical skills for your assigned facility's resident population.

Program Eligibility

Effective August 3, 2020, all full-time, part-time, or per-diem licensed Physical Therapists, Occupational Therapists, Speech-Language Pathologists, and licensed Assistants are eligible based on the eligibility requirement as follow:

- Full-time licensed staff employees, upon successful completion of three months of continuous employment, are eligible to register for unlimited online CEU course free of charge.
- Part-time licensed staff employees, upon successful completion of three months of continuous employment, are eligible for the unlimited online CEU courses with a paid 50% of the discounted fees rate, which is only $39/year.
- Per-diem licensed staff employees, upon hire, are eligible to register for the unlimited online CEU courses at a discounted rate of $89.00 per year.

To access the unlimited online CEU courses, eligible employees can sign-up at interface-rehab.continued.com with a registered work or personal email address on our *interface rehab, inc.* file. Any employee who sign-up using an unregistered work or personal email address, not available on our HR records, will result in termination of access to the CEU automatically.

interface rehab, inc. has already incurred the cost upfront for providing access to CEU to all eligible employees, and because of this we will not reimburse for any other online courses, or in-person/hands-on courses until July 31, 2022. We will review this interim policy one year from the effective date.

Perks, Fun & Discounts!

interface rehab, inc. is pleased to offer Working Advantage. Save up to 60% on tickets, travel and shopping!

Entertainment – Save on movie tickets, museums, zoos, attractions, aquariums and more. Whether you're taking a vacation cross country or planning an afternoon at your favorite local theatre, Working Advantage can get you into some of the best places for up to 40% off the regular ticket price.

Theatre & Events – From Tony Award®-winning Broadway shows to the circus, from concerts to baseball games, Working Advantage has a huge selection of theatrical productions, family and sporting events nationwide. Be a spectator at some of the country's most exciting shows and games.

Shopping – Working Advantage has partnered with some of the most respected online vendors in the country to bring you excellent discounts on apparel and accessories, books and music, electronics, flowers, gourmet food, office supplies and more. Each vendor is selected for exceptional quality and value. Take advantage of online shopping savings today!

Gifts – Have a birthday, wedding or anniversary coming up? Send a gift without breaking the bank when you purchase through Working Advantage. Shop online or purchase Broadway tickets, movie tickets, gift certificates, and more.

Advantage Points – Earn rewards while you save. Look for the Advantage Point symbol when you purchase online. You can redeem points for a variety of products, including movie tickets and gift cards. Plus—when you register for your online account, jump start your point balance with 100 bonus Advantage Points!

Get started today!

- Visit or register over the phone by calling (800) 565-3712
- Company's Member ID #719018882

working ADVANTAGE

Additional Benefits & Perks (cont.)

Paid Time Off and Holidays

To round out your benefits package, we offer these additional perks to support both your personal and professional needs.

Eligibility

The company offers this Paid Time Off plan to full-time/part-time employees, however, it becomes available at the successful completion of a 90 day waiting period.

Accrual and Payment of Paid Time Off (PTO)

PTO accruals are earned on an hourly basis. The length of service determines the rate at which the employee will accrue PTO. Paid Time Off is accrued upon the successful completion of the 90-day waiting period from the date of hire or transfer into a regular full-time/part-time position. Paid Time Off does not accrue during any periods of Short Term Disability (STD), unpaid leaves of absence, or PTO cash outs upon termination. Employees accrue Paid Time Off time as follows:

Year(s) of continuous service	Accrual Rate per Hour Worked	Max Accrual per Pay Period	Annual Max Accrual
1 Year	0.0577	5.5385	120
2 Year	0.0615	5.9077	128
3 Year	0.0654	6.2769	136
4 Year	0.0692	6.6462	144
5 Year	0.0731	7.0154	152
6 Year	0.0769	7.3846	160
7 Year	0.0808	7.7538	168
8 Year	0.0846	8.1231	176
9 Year	0.0885	8.4923	184
10 Years	0.0923	8.8615	192
11 Years	0.0962	9.2308	200
12 Years	0.1000	9.6000	208
13 Years	0.1038	10.3385	216
14 Years	0.1077	10.3385	224
15 Years	0.1115	10.7077	232
16 Years or More	0.1154	11.0769	240

Other Time off such as for family or medical reasons may be honored based on state and federal law.

Holidays

All full-time/part-time employees are eligible for the holiday pay; however, employees must report for their scheduled work shift prior to and after a holiday and must work a complete scheduled shift to be eligible for holiday pay.

The following 6 paid holidays will be observed:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

Directory & Resources

Below, please find important contact information and resources for *interface rehab, inc*.

Information Regarding	Group /Policy # and Contact Information		
Enrollment & Eligibility			
Human Resources • Benefit Administrator	-	714.646.8908	Benefits@interfacerehab.com
Claim Assistance, Coordinate Care, & Benefit Questions			
Health Advocate	-	866.695.8622	answers@HealthAdvocate.com
Benefit and Enrollment Assistance			
MMA's Member Support	-	888.434.7720	membersupport@MarshMMA.com
Medical Coverage			
Kaiser • NCAL HMO / SCAL HMO	604509 / 231604	800.464.4000	kaiserpermanente.org
Blue Shield (Administer by HNAS) • EPO • PPO • HDHP w/HSA	S86	877.356.0666	www.hnas.com
RxBenefits (Express Scripts) • Pharmacy Member Services	-	800.334.8134	express-scripts.com RxHelp@rxbenefits.com
Dental Coverage			
Aetna • Affordable PPO • Traditional PPO	S86	877.356.0666	www.hnas.com
Vision Coverage			
MES Vision • PPO	S86	877.356.0666	www.mesvision.com
Life, AD&D, Disability, and Voluntary Benefits			
Guardian • Basic Life and AD&D • Voluntary Life and AD&D • Short Term Disability • Voluntary Benefits	550078	800.525.4542	www.guardianlife.com
Flexible Spending Accounts (FSA) and COBRA			
HealthNow Administrative Services	-	877.356.0666	www.hnas.com
Employee Assistance Plan			
Guardian: Work Life Matters	User Name: Matters Password: WLM70101	800.386.7055	www.ibhworklife.com
Pet Insurance			
Nationwide (formerly VPI)	-	877.738.7874	www.petinsurance.com/affiliates/interfacerehab
401(k) Retirement Plan Adviser			
Fidelity Investments	-	800.835.5097	www.401k.com
Benefits Broker			
Marsh & McLennan Insurance Agency LLC 1 Polaris Way, Suite 300 Aliso Viejo, CA 92656	 Nate Natzke Lisa Farrell Alex Penafiel Analise Marquez	800.321.4696 714.357.1545 949.425.7326 949.900.1780 949.425.7304	www.MarshMMA.com Nate.Natzke@MarshMMA.com Lisa.Farrell@MarshMMA.com Alex.Penafiel@MarshMMA.com Analise.Marquez@MarshMMA.com

Guidelines/Evidence of Coverage

The benefit summaries listed on the previous pages are brief summaries only. They do not fully describe the benefits coverage for your health and welfare plans. For details on the benefits coverage, please refer to the plan's Evidence of Coverage. The Evidence of Coverage or Summary Plan Description is the binding document between the elected health plan and the member.

A health plan physician must determine that the services and supplies are medically necessary to prevent, diagnose, or treat the members' medical condition. These services and supplies must be provided, prescribed, authorized, or directed by the health plan's network physician unless the member enrolls in the PPO plan where the member can use a non-network physician.

The HMO member must receive the services and supplies at a health plan facility or skilled nursing facility inside the service area except where specifically noted to the contrary in the Evidence of Coverage.

For details on the benefit and claims review and adjudication procedures for each plan, please refer to the plan's Evidence of Coverage. If there are any discrepancies between benefits included in this summary and the Evidence of Coverage or Summary Plan Description, the Evidence of Coverage or Summary Plan Description will prevail.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. You are protected from balance billing for:

Emergency services

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

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

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

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

In the case of non-emergency services, the law lays out specific notice and consent requirements that, if met, permit balancing billing. This exception does not apply to the ancillary services, described above.

Providers who are eligible to request a consent waiver must include a written notice to the patient not later than 72 hours before the date on which the items or services are provided. The notice must include the following information:

- Notification that the provider or facility is out-of-network
- Clear statement that consent is optional and the patient can seek care from an in-network provider
- Good faith estimate of the amount the patient may be charged
- If the service is to be furnished by an out-of-network provider in an in-network facility, a list of in-network providers who are able to provide the service
- Information on whether prior authorization is needed.

Once the patient receives the notice, they have the option to consent. The notice must be signed by the patient where the patient acknowledges that they were provided with written notice and informed about the payment and how it may affect cost-sharing.

Out of Network Providers, when balanced billing is allowable:

Services from Out-of-Network Providers could be balanced billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes. If the services are not rendered at an in-network facility, is not an emergency care service, or fall under the aforementioned protections for the member, the provider may balance bill.

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

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

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

If you believe you've been wrongly billed, you may contact your insurance carrier to assist in resolving the matter.

Visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for more information about your rights under federal law.

Medicare Part D notice

Important Notice from Interface Rehab About Your Prescription Drug Coverage and Medicare

Model Individual CREDITABLE Coverage Disclosure

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

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

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

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

You should also know that if you drop or lose your current coverage 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 your Human Resources Department 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 your employer changes. You also may request a copy of this notice at any time.

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

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

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

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

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

Legal Information Regarding Your Plans

REQUIRED NOTICES

Women's Health & Cancer Rights Act

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

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

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

Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

"HIPAA Special Enrollment Opportunities" include:

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

IMPORTANT INFORMATION ON HOW HEALTH CARE REFORM AFFECTS YOUR PLAN

Primary Care Provider Designations

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

- Your HMO generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Human Resources office

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

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

For plans and issuers that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

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

Grandfathered Plans

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

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

Prohibition on Excess waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan.

Preexisting Condition Exclusion

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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

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

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

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA (CONTINUED)

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

How is COBRA continuation coverage provided? (Continued)

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Interface Rehab, Inc
Attn David Dai, Director of People Operations
774 S. Placentia Ave. Suite 200
Placentia, CA 92870-6832

For More Information

This notice doesn't fully describe continuation coverage or other rights under the plan. More information about continuation coverage and your rights under the plan is available in your summary plan description or from the Plan Administrator.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact your Human Resources Representative.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.healthcare.gov.

EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER THE FAMILY MEDICAL LEAVE ACT

Basic Leave Entitlement

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

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

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

Military Family Leave Entitlements

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

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

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements

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

[1] The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition"

[2] Special hours of service eligibility requirements apply to airline flight crew employees

Definition of Serious Health Condition

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

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

Use of Leave

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

Substitution of Paid Leave for Unpaid Leave

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

Employee Responsibilities

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

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

Employer Responsibilities

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

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

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

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

Enforcement

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

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

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

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

UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT NOTICE OF 1994, NOTICE OF RIGHT TO CONTINUED COVERAGE UNDER USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

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

What Happens if You do not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

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

Length of Time Coverage Can Be Continued

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

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

Reporting to Work / Applying for Reemployment

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

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

Definitions

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

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

HIPAA PRIVACY NOTICE

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is EFFECTIVE 1/1/2022

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to provide information about the legal protections that apply to your health information. HIPAA includes numerous provisions that are designed to maintain the privacy and confidentiality of your Protected Health Information (PHI). PHI is health information that contains identifiers (such as your name, address, social security number, or other information that identifies you) and information related to your past, present or future health condition and treatments.

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

Required by Law

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

Permitted Plan use of Your Health Information

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, contact the Plan Privacy Officer.

You have both the right and choice to tell us to: share information with your family, close friends, or others involved in payment for your care; share information in a disaster relief situation; and contact you for fundraising efforts.

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

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

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

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees. We may also use and disclose your information to run our organization and contact you when necessary. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. The Plan is also not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

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

Business Associates: There are some services provided in our organization through contracts with business associates. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy rules and HIPAA security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law (this includes the Department of Health and Human Services if it wants to see that the Plan is complying with federal privacy law).

To Respond to Organ and Tissue Donation Requests and Work with a Medical Examiner or Funeral Director: We may share health information about you with organ procurement organizations; and may share health information with a coroner, medical examiner, or funeral director when an individual dies.

Workers' Compensation: We may release health information about you for workers' compensation programs or claims or similar programs. These programs provide benefits for work-related injuries or illness.

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

Public Health and Research: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation). Additionally we may share health information about you when: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; preventing or reducing a serious threat to anyone's health or safety or for purposes of health research.

Your Rights Regarding Your Health Information

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

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

Plan Responsibilities

The Plan is required to maintain the privacy of PHI and to comply with the terms of this notice. The Plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you within 60 days of the effective date of any material change to the rights and duties listed in this notice. The Plan is required to:

- **Maintain the privacy and security of your health information.**
- **Make reasonable efforts not to use, share, disclose or request more than the minimum necessary amount of PHI needed to accomplish the intended purpose, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**
- **Follow the duties and privacy practices described in this notice with respect to information we collect and maintain about you and provide you a copy of the notice.**
- **Abide by the terms of this notice.**
- **Notify you if we are unable to agree to a requested restriction, amendment or other request.**
- **Notify you of any breaches of your protected health information that may have compromised the privacy or security of your information within 60 days (5 days for California residents).**
- **Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.**

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

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

Your Right to File a Complaint

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

Changes to the Terms of This Notice

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

Contact Person

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

Interface Rehab, Inc
Attn David Dai, Director of People Operations
774 S. Placentia Ave. Suite 200
Placentia, CA 92870-6832

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2023)

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Prepared by: Marsh & McLennan Insurance Agency LLC
www.MarshMMA.com | CA Insurance Lic: 0H18131