ep Cares

2027 BENEFITS GUIDE

Health Insurance Solutions for Eligible Entertainment Employees

REV 10/26

ep Cares

2027 BENEFITS GUIDE

Health Insurance Solutions for Eligible Entertainment Employees

DID YOU KNOW

your employer pays at least **HALF** of the lowest cost medical premium?

Look for an email from MyEPCares@ep.com about when, where and how to enroll.

Didn't see the email? Check your Spam/Junk folder and/or email us at myepcares@ep.com.

Coverage becomes effective

1st day of the month following 30 days of employment

You must be enrolled by the 27th of the prior month to get coverage

If you miss this opportunity to enroll, you will not be able to enroll unless you have a qualifying life event or during open enrollment (typically in November).

Log in to myepcares.com to review or change your benefits.

Enrollment Meetings are held on the third Wednesday of each month. Join us via Zoom to learn more about your benefits, ask questions, get answers. Register for the meeting now.



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See page 37 for an important notice regarding Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) and pages 41 and 43 for an important notice regarding your Medicare Part D Coverage.

Benefits highlighted in this guide are governed by EP Cares™ plan contracts and policies, applicable state and federal law, and company policy. In the event of a conflict, the policies, contracts, and applicable laws govern. EP Cares™ reserves the right to alter, amend, or terminate any of the benefits described in this guide at any time.

EP Cares™ Quick Start Guide

Step 1

Go to myepcares.com to log in to EP Cares.

Your **username** and your temporary **password** will be your first name, the first initial of your last name, and the last four digits of your Social Security Number (SSN). For example:

Name: Ashley Smith
SSN: XXX-XX-6789
Username: ashleys6789
Temporary Password: ashleys6789

Step 2

The EP Cares™ Online Enrollment Portal will list your **Employer's monthly contribution amount** and all plans available to you based on your home zip code. Review each one and pick a plan option that meets your specific needs.

Step 3

Once you complete the enrollment process on the EP Cares™ Online Enrollment Portal, you have the option to send yourself an email from the system documenting your insurance elections and the effective date of your coverage. We highly recommend you document your selections by sending yourself the email or taking a screenshot of your enrollment.

NOTE: **You must still be working for your current Employer as of the coverage effective date or your benefits will not take effect.**

Additional information on plan details, coverage options, and applicable disclosures can be found in the Summary of Benefits and Coverage (SBC) and the Summary Plan Descriptions (SPD). These documents are available on myepcares.com. A paper copy is also available upon request by contacting the EP Cares™ Contact Center below.

NEED HELP?

Phone: 855.339.7350 | Email: myepcares@ep.com | myepcares.com | Web: ep.com/epc

ID Cards and myCigna

Digital ID Cards are available in the myCigna mobile app or at mycigna.com. Click here to learn more. Cigna will mail physical ID cards upon request only. To request a physical ID card, please contact Cigna at 800.997.1654.

myCigna mobile app

Get the most out of your plan with myCigna.

- Digital ID Cards
- Find doctors, urgent care, hospitals and more
- Manage prescriptions and get them delivered to your home
- Take a health assessment, set goals, and earn incentives
- Set up paperless Explanation of Benefits (EOBs)
- Check on the status of your claims

Once you register for myCigna, you get complete access with easy one-touch, secure sign-on to Cigna.

Download the myCigna mobile app:

Download on the App Store

GET IT ON Google Play

available at amazon appstore

Communication Preferences

Stay Informed: Update Your Communication Preferences

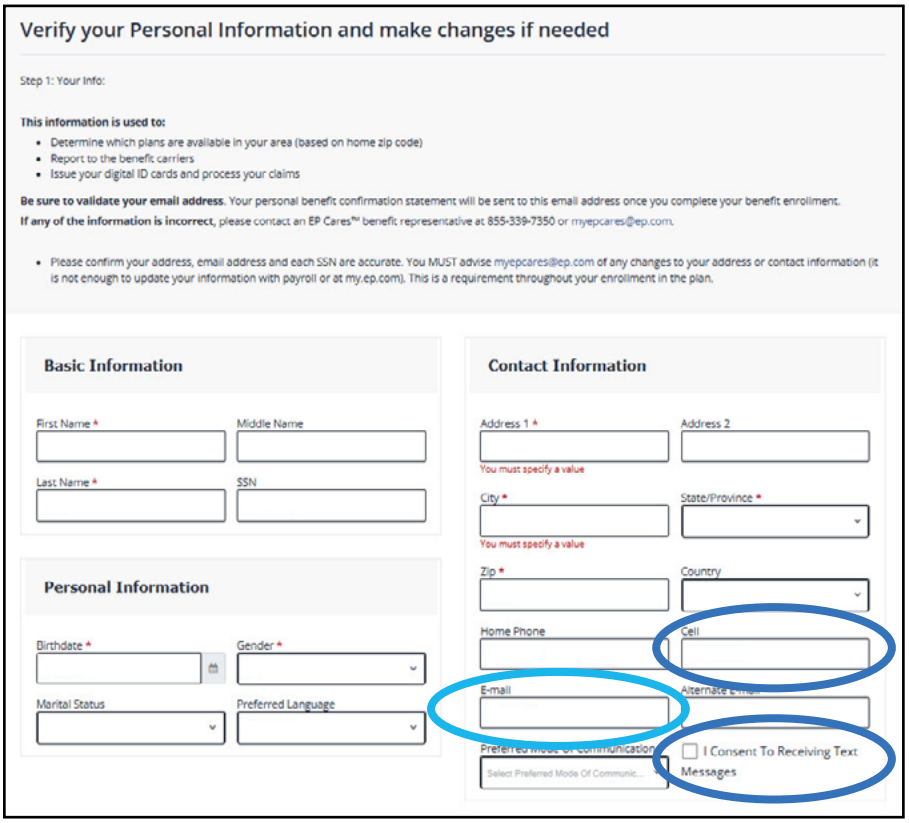
We keep our communications simple and purposeful. You'll typically hear from us:

- When you're a **new hire** or **rehire** with a new enrollment period
- During **Open Enrollment**
- Through our **monthly wellness email**

That's it—so when you get a message from us, you know it matters.

To make sure you never miss a deadline or important update, we **highly recommend opting in for text messages.** Texts are the fastest way to get real-time reminders about benefit enrollment, wellness programs, and other key notices.

Take action now: Log in to **myepcares.com** and update your communication preferences to include your personal email and enable text messaging.



For best results, use a personal email address (not one related to your current company

Add your Cell number and check the box to get enrollment reminders from EP Cares sent to your mobile device.

Eligibility

Employees

All non-union* Employees classified as benefit eligible by Employers offering EP Cares™ are eligible to enroll in EP Cares™ benefit plans. Generally speaking, EP Cares is open to non-union, W-2 employees who work 130 hours or more per month on average.

Dependents

Eligible Employees may also enroll the following dependents:

- **Legally married spouse**
  This includes registered same-sex and opposite-sex domestic partners
- **Children up to age 26**
  This includes natural children, stepchildren, legally adopted children, children for whom you are the legal guardian, foster children, and children for whom you are legally responsible to provide health coverage under a Qualified Medical Child Support Order (QMCSO)
- **Disabled children over age 26** if unmarried, incapable of self-support, dependent on you for primary support, and the disability occurred before the age of 26

If You Cover a Dependent

To control health care costs and meet health plan contract obligations, your Employer or EP Cares may ask to verify family members' eligibility for enrollment in EP Cares™ benefit plans. Your Employer and the insurance carrier(s) reserve the right to request documentation (e.g., marriage and/or birth certificates) to verify eligibility.

Coordination of Benefits

If you currently receive or are eligible for benefits through your spouse or partner, it is your responsibility to check with that plan for specifics surrounding coordination of benefits.

* If you are working in a union or "non-affiliate" job code, you are ineligible for EP Cares benefits. If you are currently non-union but later switch to a union or non-affiliate position, your EP Cares benefits eligibility will end on the last day of the month and you will not be eligible for COBRA. See the EP Cares COBRA FAQ for more information and alternative benefits options.

Eligibility
(continued)

Waiting Period

New Hires

Coverage takes effect on the first day of the month following the 30-day new hire waiting period. **You must be employed on that day for the benefits to take effect.**

To get insurance, you must complete the enrollment process by the 27th day of the month prior to your effective date.

Example: Michael is hired on January 16. He has until February 27 to enroll in benefits, and his coverage will take effect on March 1.

Re-Hires and Eligibility

The chart on **page 10** illustrates break in service scenarios for those Employees who have made benefit elections and are being re-hired **within the same Controlled Group.**

If an Employee leaves one Controlled Group (parent company) and goes to work for another, the Employee would need to re-satisfy the waiting period before becoming eligible for benefits.

Rehired employees are given a specific deadline to enroll in their rehire offer letter from EP Cares.

Work Performed Outside of the U.S.

Unless otherwise specifically directed by your production company, work performed outside of the U.S. does not count toward your EP Cares eligibility.

Eligibility: Re-hires
(continued)

Re-hire Eligibility Chart

ACA Law requires that rehires (within the same Controlled Group/Parent Company) are offered benefits according to these rules.

Break in Service Length of Time	Benefits eligibility	Eligibility Date	Examples
Break in Service < or = 30 Days	No change to benefits, per ACA laws.	Previously enrolled employee's benefits are reinstated without break.	Date of hire = 3/5 End Date = 5/20 Rehire Date = 6/10 Benefits reinstated as if never terminated.
Break in Service > 30 Days, but < or = 90 Days	Employee may re-enroll in benefits upon rehire. The 30-day waiting period does not apply.	Rehire 1st - 15th of month - benefits retroactive to 1st of month. After that, benefits begin 1st day of following month.	Date of hire = 3/5 End Date = 5/20 Rehire Date = 8/10 Benefits Effective = 8/1 Date of hire = 3/5 End Date = 5/25 Rehire Date = 8/18 Benefits Effective = 9/1
Break in Service > or = 91 Days	Employee may re-enroll in after waiting period.	First of the month following a 30-calendar-day waiting period.	Date of hire = 3/5 End Date = 5/20 Rehire Date = 9/15 Benefits Effective = 11/1

Termination of Benefits and COBRA

Eligibility

Employee benefits may be terminated, either voluntarily or involuntarily, under specific circumstances. The table below gives some common examples. Please contact EP Cares at **855.339.7350** or **myepcares@ep.com** if you have questions.

Scenario	Coverage End Date	Eligible for COBRA benefits continuation?
You are reported as terminated, wrapped, etc. by your Employer (for any reason other than gross misconduct)	The last day of the month of your termination date	Yes
Your Employer notifies us of a change in status to a non-eligible class (e.g. move from full time to part time)	The last day of the month of your change in status date	Yes
EP is notified that you are working in a union or "non-affiliate" position	The last day of the month of your non-union status	No
You fail to pay your full share of the cost of benefits within the grace period	The last day of the month for which you fully paid for your insurance (may be retroactive to previous month)	No
You notify EP Cares of a Qualifying Life Event and the desire to terminate benefits	The last day of the month following the QLE date	No
Your employer cancels coverage with EP Cares	The last day of the month of the employer's contract with EP Cares	No

WHAT IS COBRA?

COBRA is a federal law that may allow you to temporarily keep health coverage after your employment ends, you lose coverage as a dependent of the covered employee, or another qualifying event. If you elect COBRA coverage, you pay 100% of the premiums, including the share the Employer used to pay, plus a small administrative fee.

COBRA
(continued)

Frequently Asked Questions

1. I was recently laid off/my project wrapped/I was terminated. What happens to my EP Cares benefits?

Your Cigna medical, dental, and/or vision insurance will end on the last day of the month in which you stopped working. For example, if your last work date was March 20, your benefits will end on March 31.

2. My benefits with EP Cares are ending. Now what?

You have several options. Losing your EP Cares coverage generally qualifies you for a special enrollment period through the Health Insurance Marketplace, where you can shop for individual and family plans. You usually have 60 days from your loss of coverage to enroll. Depending on your household income, you may qualify for lower monthly premiums and reduced out-of-pocket costs. To compare plans and see if you're eligible for savings, visit **healthcare.gov** or your state's exchange website.

You may also be able to enroll in your spouse's health insurance plan (if applicable) or directly with an insurance carrier.

In most cases, you are also eligible to continue your medical, dental and vision benefits via COBRA. Most MetLife benefits are portable, so you can keep your plans and rates. Contact MetLife directly for assistance.

3. I lost benefits eligibility because I was hired into a union position. What should I do?

You are not eligible for COBRA because the COBRA laws are very specific. The only qualifying events that would make an employee eligible for COBRA are the termination of employment or the reduction of hours that results in a loss of benefits. Changing to union status does NOT count as a qualifying event for COBRA.

However, all the other options in Q2 apply to you. We encourage you to seek insurance through one of those options while you are in the waiting period for union benefits.

NEED HELP?

Phone: 855.339.7350 | Email: myepcares@ep.com | myepcares.com | Web: ep.com/epc

COBRA FAQ
(continued)

4. How does COBRA work?

If you are eligible for COBRA, you can keep the medical, dental, and/or vision insurance you had at the time of your loss of active insurance. You will need to enroll in COBRA and pay the full cost of benefits, plus a 2% administrative fee.

The specific information for your COBRA enrollment will be mailed to the address we have on file at **myepcares.com**. Please watch for an envelope from Wex Health (the COBRA administrator).

5. When does COBRA start?

If eligible, COBRA benefits will be effective on the first day of the month after your active insurance benefits with EP Cares end. For example, if your termination date was March 20, your active benefits will end on March 31. Your COBRA benefits will be effective on April 1 if you choose to enroll – even if you enroll after April 1.

6. When will I receive my COBRA information?

Once your employer advises EP Cares of your termination, the information is processed and sent to Wex health, our third-party administrator for COBRA. The COBRA packet will then be mailed within 14 days to the address we have on file at **myepcares.com**.

7. Can EP Cares email me my COBRA packet?

The law says it must be mailed to you. However, you can retrieve an electronic copy online via the **Wex** website. Please contact **Wex** directly for assistance. Please allow a minimum of two weeks of processing time from your last day of work for your information to be live in the Wex system.

8. How much does COBRA cost?

Your exact costs for the plans you have chosen will be mailed to you with your COBRA packet. In general, you will be charged the full cost of benefits (including what your production/studio used to pay), plus a 2% administrative fee. You can get an idea of those costs by reviewing the full rates on pages **22**, **29**, and **30.**

9. How do I enroll in COBRA?

Once you have received your COBRA packet, you can enroll online or by filling out the paper COBRA election form and mailing it as instructed. Note: Online COBRA enrollment requires a unique password (listed on a page toward the end of the packet). You will not be able to enroll online until you receive this information.

10. When is my deadline to enroll in COBRA?

Your specific deadline to enroll in COBRA will be listed in your COBRA packet. Generally, you have 60 days from the date of the COBRA notice.

COBRA FAQ
(continued)

11. I haven't enrolled in COBRA yet, but I need medical coverage now. What do I do?

If you choose to enroll in COBRA, your benefits will be retroactive as described above in Q5, if you meet the enrollment deadlines described in Q10.

If you need to seek medical services before your COBRA enrollment shows as active with the Cigna system, you will be able to submit any expenses that occurred after the COBRA effective date to Cigna for reimbursement.

12. How do I pay for COBRA?

Once you have enrolled in COBRA, you can set up recurring ACH payments through the Wex self-service portal. If you prefer to mail a check or money order, payment coupons are included with your COBRA packet. **Review the payment guide here.**

13. Who do I contact for help?

Contact **Wex** online.
Line of Business: COBRA & Direct Bill
Employer Name: EP Cares

14. I need proof of loss of coverage. Can you write me a letter?

The COBRA administrator will provide a COBRA notice, as indicated in Q6.

If you need something sooner than that, the employer (production company/studio) can write a letter on company letterhead, advising that you are losing your medical/dental/vision insurance due to the layoff/termination. The effective date of the loss should be included in the letter. EP Cares cannot provide these letters as we are not the Common Law Employer who offered the health insurance.

Moving Between Projects

EP Cares™ is specifically tailored to the needs of non-union employees in the entertainment industry. One of the many advantages of EP Cares™ is that it provides you with consistent access to medical, dental, and vision benefits as you move between different Employers offering EP Cares™. Some geographic restrictions apply and Production company/Studio contributions may vary. In most cases, you will have access to the same benefit plan options at the same rates. See the scenarios below for examples.

SCENARIO 1: Your tenure on a project ends in March and you begin work at another production company offering EP Cares™ within the same Employer organization (parent company) within 30 days.	You will have benefits through the end of March, provided that you have paid in full for your share of coverage. Upon rehire, your benefits will be reinstated with no lapse in coverage. You will be responsible for your share of premium payments, if any.
SCENARIO 2: Your tenure on a project ends on March 10 and you begin work at another production company offering EP Cares™ within the same Employer organization (parent company) in early May.	You will have benefits through the end of March, provided that you have paid in full for your share of coverage. You will be offered the opportunity to maintain coverage through COBRA during the period of time you are between jobs. You will receive COBRA information via mail upon termination. Since your next project begins less than 13 weeks after you were terminated from the first project, you will be allowed to re-enroll in your benefits upon your first day of work in May, and your coverage will be effective in accordance with the chart on **page 10**.
SCENARIO 3: Your tenure on a project ends on March 10 and you begin work at another production company offering EP Cares™ within the same Employer organization (parent company) in mid-August.	You will have benefits through the end of March, provided that you have paid in full for your share of coverage. You will be offered the opportunity to maintain coverage through COBRA during the period of time you are between jobs. You will receive COBRA information via mail upon termination. Since your next project begins more than 13 weeks after you terminated from the first project, you will be required to satisfy a new hire waiting period. If you elect benefits, your coverage will be effective on the first day of the month (in this example, October 1).

Plan **Enrollment**

New Hire Enrollment

Coverage takes effect on the first day of the month following 30 days from your hire date. To get benefits, you must complete the enrollment process by the 27th day of the month prior to your effective date.

Example: Libby is hired on March 16. She has until April 27 to enroll in benefits, and her coverage will take effect on May 1.



WARNING:

If you miss the new hire enrollment window, you must wait until the next Open Enrollment period or experience a Qualifying Life Event (see page 20) to enroll.

Open Enrollment

Each year, during Open Enrollment, you can add, drop, or make changes to your benefits. Open enrollment is generally in November of each year. You will receive emails and notifications through The Source regarding Open Enrollment dates.

If you choose not to take any action, then your existing selections (if applicable) will apply to the following year.*

New plans and/or rates will apply as of January 1.

Example: Sam selects or changes insurance coverage during Open Enrollment. His new insurance begins on January 1.

* You must be employed with the same production company/studio on January 1 in order for benefits to continue into the following year.

Plan Enrollment
(continued)

Online Benefit Enrollment Portal

EP Cares™ provides you with the ability to enroll in your benefit plans online at **myepcares.com**.

Before you begin, please make sure you have:

Social Security Number (SSN) for all legal dependents

Date of Birth (DOB) for all legal dependents

Log in to myepcares.com:

Your **username** and your temporary **password** will be your first name, the first initial of your last name, and the last four digits of your Social Security Number (SSN). For example:

Name: Elizabeth Munoz
SSN: XXX-XX-4617
Username: elizabethm4617
Temporary Password: elizabethm4617

Please note that first-time users will be prompted to select a new password upon signing in.



NOTE: **Please be sure to review your confirmation statement carefully. Check the plans, prices, and effective dates. You can log back in and make changes at any time within your enrollment window.**

Paying Your Share of Insurance

Payment for your share of premiums (if any) is due on the first of the month and is your responsibility. EP Cares offers payroll deductions or a billing service (depending on your employer) as a courtesy, but ultimately **it is your responsibility to ensure that your monthly premium is paid in full.**

Employees with paycheck from EP	Employees who get payroll checks from EP will be set up with automatic payroll deduction for medical, dental, and vision insurance. Payroll deductions are not available for other policies.*
Employees of projects with payroll outside of EP, COBRA participants	You are responsible for sending payment for your share of the cost of benefits. **Click here** for a detailed payment guide. We highly recommend you set up automated payments via checking or savings account so you never miss a month.

* If you are enrolled in Pet Insurance, you will pay the vendor directly. Payment details provided by vendor upon enrollment.

Paying Your Share of Insurance
(continued)

Grace Period for Late Payment of Premiums

While payments are due on the first of the month, there is an automatic grace period extended through the last day of the month.

If the share of premium you have paid for the month is sufficient to pay for some, but not all of the insurance coverage in which you have enrolled yourself, spouse, and dependents, the premium payments for that month will be applied first to medical insurance, second to dental insurance, third to vision insurance, and then to any additional lines of coverage (if applicable).



WARNING:

Failure to pay your share of premiums will result in the termination of insurance coverage through EP Cares retroactively to the last day of the month for which your share of premiums was fully paid. Full details are provided in the authorization forms you sign during the enrollment process.

If you have questions about your premium, don't see deductions on your paycheck, and/or don't understand how to pay through WEX Health (if your payroll goes through a different company), please contact us.

Similarly, if you normally pay via payroll deduction and are going on hiatus, leave or other break, you must mail or deliver payment to:

Entertainment Partners
2950 N. Hollywood Way
Burbank, CA 91505.

Checks should be made payable to EP Health Insurance Solutions, LLC. Please include your full name and the last four digits of your SSN on your payment.

You are responsible for making sure payments for your insurance are paid on time. Delinquent accounts are subject to cancellation.

Making **Changes** to Your Benefits

Annual Open Enrollment

During annual Open Enrollment, you can re-evaluate and make changes to the plans you and your eligible dependents enroll in for the upcoming year. Open Enrollment for EP Cares™ typically begins in November each year.

Learn more about Open Enrollment by watching a short video.

Qualifying Life Events (QLEs)

The federal government has set guidelines, referred to as Qualifying Life Events, for when you are allowed to make changes outside of Open Enrollment. Examples of QLEs are:

- **Involuntary loss of other group coverage (including loss due to reaching age 26)**
- **Marriage, legal separation, or divorce**
- **Birth or adoption of a child**
- **Change in eligibility of a child**
- **Death of a dependent family member**
- **Change in your or your spouse's/ registered domestic partner's employment status**
- **Your spouse/registered domestic partner reaches age 65 and is covered by Medicare**
- **Enrollment in another group insurance plan such as a spouse's or parent's plan through their employer**
- **If you are moving to a different county or state, please advise. You may qualify and/or be required to make changes.**
- **FMLA special requirements**
- **HIPAA special enrollment rights**
- **Increase of hours that changes employment status**
- **Reduction of hours such that you are expected to work fewer than 30 hours per week (provided you are not in an ACA-designated stability period)**
- **You become eligible to enroll in an exchange or marketplace established under §1311 of the Patient Protection and Affordable Care Act**

How to Report a QLE

If you experience a Qualifying Life Event, as specified by the federal government, you may make changes to your benefit elections within 31 days of the date of the QLE. Please note that any changes to the benefit plans must be consistent with the qualifying event.

If you have had a QLE and would like to make changes to your benefits, please email us at **myepcares@ep.com**. Please be sure to include the following information:

- Your first and last name
- Last four digits of your SSN
- The nature of the QLE
- The date of the QLE
- If you have any supporting documentation (birth certificate, marriage certificate, proof of loss of other insurance, etc.), please attach it to the email

Medical Benefits and Rates 2027

	EPO Plans In-Network Only No PCP[3] Required		PPO Plans In-and-Out of Network Coverage No PCP[3] Required	
	Local+ IN 7500	Open Access+ IN 7500	Open Access+ 5000 HDHP	Open Access+ 3000
	Same Plan, Different Regions			
Plan Availability by Region (also refer to map)[1]				
Region 1A (in Local+ ZIP Codes)[2]	✓	✓	✓	✓
Region 1B		✓	✓	✓
Region 2		✓	✓	✓
Region 3			✓	✓
Calendar Year Deductible (The amount you pay for covered healthcare services before your benefit plan coverage begins. Not all services are subject to the deductible.)				
In Network Deductible (Single)	$7,500		$5,000	$3,000
In Network Deductible (2 Or More)	$15,000		$10,000	$6,000
Outpatient (Employee Pays)				
Preventive Benefits	No Copay		No Copay	No Copay
Office Visits	$25		20%*	$30
Specialist Visits	$50		20%*	$60
Urgent Care Facility	$100		20%*	$50
Emergency Room Facility	30%*		20%*	$500
Other Services (Employee Pays)				
Coinsurance	30%*		20%*	20%*
Hospital Inpatient Care	30%*		20%*	20%*
Annual Maximum Out-of-Pocket (single, in-network)	$9,200		$8,500	$9,200
Annual Maximum Out-of-Pocket (2 or more, in-network)	$18,400		$17,000	$18,400
Pharmacy (Employee Pays)				
Deductible	Combined with Med		Combined with Med	N/A
Tier 1	$10		$20*	$20
Tier 2	40%* max $250		$40*	$40
Tier 3	50%* max $250		30%* max $250	30% max $250

This brief summary only displays in-network benefits. Click on the plan name for more information, including out-of-network benefits for the PPO plans.

Emergency Services: Out of Network services are paid at the in-network cost share and deductible. See plan documents for details.

Home Delivery Pharmacy and **Cigna 90 Now at CVS** benefits available with all EP Cares plans for many common recurring medications.

* after deductible

	Local+ IN 7500	Open Access+ IN 7500	Open Access+ 5000 HDHP	Open Access+ 3000
Total Monthly Premium (before Employer Subsidy is applied)				
Employee Only		To see rates, please log in or contact myepcares@ep.com for assistance.		
Employee + Spouse				
Employee + Child(ren)				
Employee + Family				

Figures represent full monthly premiums without Employer subsidy applied.

[1, 2, 3] See following page for footnotes.

Medical Benefits and Rates
(continued)

Medical Plan Comparison Grid

	EPO Plans In-Network Only No PCP[3] Required		PPO Plans In-and-Out of Network Coverage No PCP[3] Required	
	Local+ IN 7500	Open Access+ IN 7500	Open Access+ 5000 HDHP	Open Access+ 3000
	Same Plan, Different Regions			
Cigna Provider Network				
Open Access+, Open Access+ IN		✓	✓	✓
Local+ IN	✓			
Services and Benefits				
Preventive Care Visits Free[4]	✓	✓	✓	✓
Telemedicine Benefits Available	✓	✓	✓	✓
TalkSpace Available	✓	✓	✓	✓
Health Savings Account ("HSA") Compatible			✓	
Infertility Benefits Available	✓	✓	✓	✓
You can see a specialist without a referral	✓	✓	✓	✓

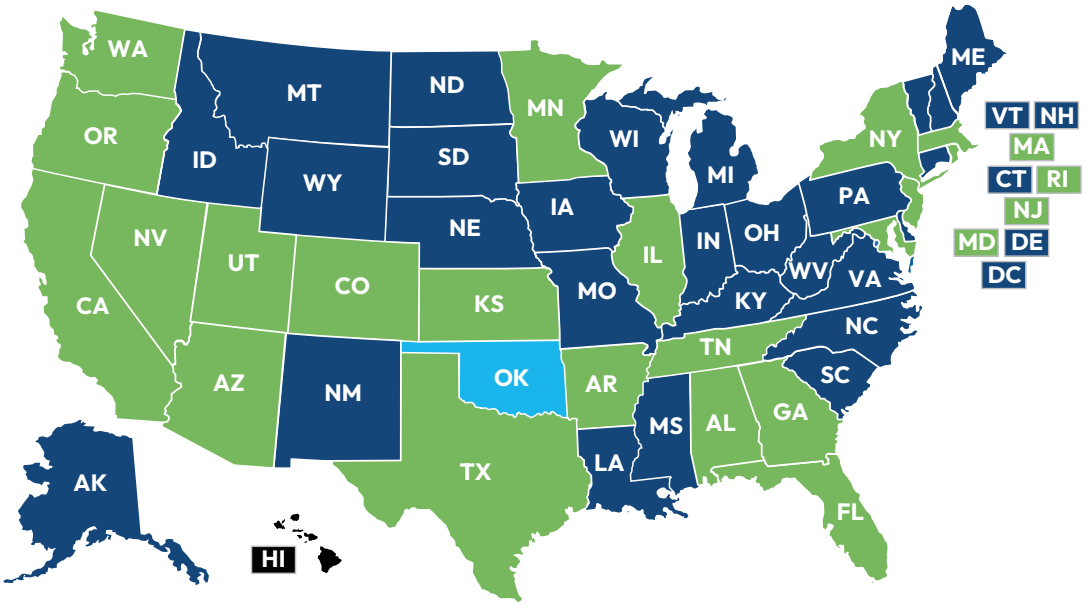
REGION 1A
Local + Zip Codes

REGION 1B
Open Access + Zip Codes

REGION 2

REGION 3

Log in to www.myepcares.com for specific plans and networks available in the medical plan selection area.



Need Help?

Phone: 855.339.7350 | Email: myepcares@ep.com | Web: ep.com/epc

[1] EP Cares is unavailable in HI, GU and PR.
[2] Where available, the lowest cost plan for residents of Region 1 is the Local+ IN 7500 plan. Where the Local+ IN plan is unavailable, the lowest cost plan for Region 1 is the Open Access+ IN 7500 plan.
[3] PCP = Primary Care Physician.
[4] Preventive Care Visits with an in-network provider are covered at 100% if you follow the preventive care guidelines. See plan documents for details.

Finding a **Doctor**

Is your doctor or hospital in your plan's Cigna network? Cigna's online directory makes it easy to find who (or what) you're looking for.

Search Your Plan's Network In Four Simple Steps

Step 1



Go to **Cigna.com**, and click on "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select "Employer or School."

(If you're already a Cigna customer, log in to **myCigna.com** or the myCigna® app to search your current plan's network. To search other networks, use the **Cigna.com** directory.)

Step 2



Change the geographic location to the city/state or zip code you want to search. Select the search type and enter a name, specialty or other search term. Click on one of our suggestions or the magnifying glass icon to see your results.

Step 3



Answer any clarifying questions, and then verify where you live (as that will determine the networks available).

Step 4



Select one of the plans offered by your employer during open enrollment.

Medical Plan Name	Network Name
Local+ IN 7500	Local Plus
Open Access+ IN 7500	Open Access Plus, Open Access Plus Tiered
Open Access+ 5000 HDHP	Open Access Plus, Open Access Plus Tiered
Open Access+ 3000	Open Access Plus, Open Access Plus Tiered
Dental Plan Name	**Network Name**
Dental PPO	Cigna DPPO Advantage
Dental HMO	Cigna Dental Care Access (formerly Cigna Dental Care HMO)

That's it! You can also refine your search results by distance, years in practice, specialty, languages spoken and more.

QUESTIONS? Not yet enrolled in Cigna: 888-806-5042
Enrolled in Cigna: 800-244-6224

Be sure to reference "EP Cares" if asked for your employer.

Primary Care Provider (PCP)

How to select or change your Primary Care Provider (PCP)

EP Cares plans do not require a Primary Care Provider, but you may select one if you wish to have a professional who can oversee your care.

Here's how to select or change your PCP:

1. Begin by calling **1-800-Cigna24 (244-6224)**
2. Listen to the prompts and select the number that says you are a customer.
3. You will be prompted to enter your Cigna ID or SSN along with your date of birth.
4. You can then tell the automated system that you wish to speak to a Personal Guide. The system will ask you to confirm if you are calling regarding medical, dental or mental health benefits.
5. Once you reach a representative, you can ask for assistance in selecting a Primary Care Provider.
6. At this time if you have a PCP in mind, your representative can help you make that election (and confirm they are in-network). If you do not have a provider in mind, they will help you find one.

You can also update your PCP through myCigna.com:

1. Register/ login to **myCigna.com**
2. Find your name in the top right corner
3. Click "My Health Team" from the drop-down menu
4. Confirm the provider listed is correct
5. If you would like to change or add a provider to your health team, scroll down the page and select "Search for in-network providers & facilities"
6. Under "Doctor by type" select "Primary Care Physician" or "Doctor by name"
7. Select "See a local provider"
8. Click on your preferred provider and within profile click the "Select PCP" button

Updates made through myCigna.com or the mobile app:

If made before the 15th, the system will reflect the new PCP on the 1st of the month. If a change is made after the 15th, the system will update on the 1st of the following month.

Please note that calling in is the fastest way to make a change and select your preferred PCP.

Supplemental Benefits

Because you are eligible for EP Cares, you can purchase Metlife policies at discounted group rates.

MetLife supplemental benefits are available to everyone who is eligible for EP Cares benefits - even if you choose not to enroll in medical, dental, or vision coverage. These benefits are not medical insurance. Instead, they're designed to complement your core benefits by providing direct cash payments to you.

You can use this cash however you need—whether it's to help cover out-of-pocket medical expenses, pay for groceries, offset lost wages, or manage other unexpected costs. These benefits offer financial flexibility during times when you might be facing health-related challenges.

MetLife offers several types of supplemental coverage through EP Cares:

- **Accident Insurance** – Pays you a lump sum for covered injuries and treatments.
- **Hospital Indemnity Insurance** – Provides cash for hospital stays, which can help with deductibles or other expenses.
- **Critical Illness Insurance** – Offers a payout if you're diagnosed with a covered serious illness like cancer, heart attack, or stroke.
- **Pet Insurance** - Flexible plans with no breed exclusions. Coverage for accidents and illnesses, and preventive care is available for an additional fee.

In addition to these indemnity benefits, MetLife and Aura offer Identity & Fraud Protection benefits. Safeguard your and your family's personal information and finances, and gain access to Life 360, the leading family location tracking and real-world safety app.

See benefits summaries for pricing and coverage details, or contact **MetLife** directly for assistance.

These plans are easy to use, and claims are typically straightforward. The goal is to give you peace of mind and extra financial support when you need it most.

You can enroll in MetLife benefits during Open Enrollment (or upon hire or rehire) by logging into **myepcares.com.** For Pet Insurance quotes and enrollment, please **click here**. If asked for an employer, enter "EP Cares."

Supplemental Benefits
(continued)

The world's #1 app for sleep, meditation and relaxation

EP Cares has a limited number of licenses that we are offering for free to people who are enrolled in a medical, dental, or vision plan through EP Cares.

To claim your EP Cares Calm subscription, scan the QR code or visit **calm.com/b2b/ep/subscribe**

This must be done on a web or mobile browser (not in the app itself).

Once on the page:

- Sign into your existing Calm account or create an account
- Enter the email address that EP Cares has on file to activate the subscription on your Calm account
- Download the Calm app and log in to your account to access the premium content
- Once you've signed up, you can add up to 5 dependents (age 16 years or older) via the "Manage Subscription" page inside your Calm account at **calm.com**.

PerkSpot — Make every dollar count with your employee discount program.

Exclusive deals on everyday essentials to big-ticket buys.

Access to exclusive deals
Access deals in more than 25 categories like groceries, travel, electronics, and more —allowing you to stretch your dollars further.

Watch your savings grow
Have a substantial impact on your savings, unlocking the full potential of everyday life without sacrificing what matters.

Shop effortlessly
Our browser extension and mobile app make discovering savings simple, so you can spend wisely with ease.

Visit **epcares.perkspot.com** to get started today.

Mental Health Resources

Important Crisis Phone Numbers

If you or a loved-one is in crisis, please contact one of the numbers below. Counselors are available to assist you 24/7.

Suicide and Crisis Lifeline







CLICK HERE



CLICK HERE

National Domestic Violence Hotline
800.799.7233 or text LOVEIS to 866.331.9474

Cigna Veteran Support Line
855.244.6211

Cigna customers:
You can also call the number on your ID card or contact your Employee Assistance Program (see below).

TRADITIONAL	TELEMEDICINE	TEXTING & ONLINE
Cigna	MDLIVE	talkspace
All Cigna medical plans through EP Cares include mental health coverage. See the specific plan information for details.	MD Live for Cigna offers private, secure online video therapy with licensed therapists. If you have Cigna medical insurance, **MD Live** is an "in-network" benefit.	TalkSpace offers therapy via texting, audio, and video messages in a private, text-based chatroom. If you have Cigna medical insurance, **TalkSpace** is an "in-network" benefit.

Employee Assistance Program (EAP) through Cigna - see page 34

Dental Benefits and Rates

Through EP Cares™, your Employer is offering a choice of two dental plans: a Cigna Dental DHMO and a Cigna Dental PPO.

Dental Benefit Summaries are available for review at **ep.com/epc**.

	Dental HMO	Dental PPO		
		Total Cigna DPPO Network		Out-of-Network
Network Options	Cigna Dental Care Access	Cigna DPPO Advantage	Cigna DPPO	See Non-Network Reimbursement
ReimbursementLevels	Fee Schedule	Fee Schedule	Discount on Fees	Maximum Reimbursable Charge
Orthodontics	Some Coverage	No	No	No
Must select in-network dentist?	Yes	No. PPO plan allows out-of-network coverage at a lower reimbursement rate.		
Calendar Year Benefits Maximum	N/A	$2,000	$1,500	$1,500
ID Cards Issued	Yes	No. Your provider will use your SSN to confirm enrollment.		

Dental Plan Rates*	
Employee	To see rates, please log in to www.myepcares.com or contact myepcares@ep.com for assistance.
Employee + Spouse	
Employee + Child(ren)	
Family	

* Figures represent full monthly premiums without Employer subsidy applied.

Vision Benefits and Rates 2027

Cigna's Vision Plan through EyeMed allows you to seek care or services from either a vision contracted network provider or a non-contracted provider and still receive a benefit. Seeing a contracted provider typically results in a lower out-of-pocket expense to you.

There are over 169,000 providers in the EyeMed Network, with 35,000+ full service locations.

Generally, you can get a routine eye exam and an eyeglass lens allowance every 12 months. You can opt for contact lens allowance in lieu of eyeglass lenses and frames. The vision plan covers an eyeglass frame retail allowance every 24 months. See plan summary for more information.

Vision Plan Rates*	
Employee	To see rates, please log in
Employee + Spouse	to www.myepcares.com
Employee + Children	or contact myepcares@ep.com
Family	for assistance.

* Figures represent full monthly premiums without Employer subsidy applied.

Pharmacy Benefits

All EP Cares medical plans include pharmacy benefits. You can go online to see the current list of medications your plan covers.

myCigna app or myCigna.com

Click on the **Find Care & Costs** tab. Then select **Price a Medication**, and then type in your medication name.

Cigna.com/druglist

Select **Value 3 Tier** from the dropdown menu. Then type in your medication name or view the ful list.

QUESTIONS?
myCigna.com:
Click to Chat
Monday-Friday
9:00am-8:00pm EST
By phone:
Call the toll-free number on your Cigna ID card.

Generic vs. Brand Name

If you request a brand name drug, you will be charged the brand name drug cost plus the difference between the brand and generic drugs (up to the cost of the brand drug).

To avoid this charge, the prescribing physician must indicate "Dispense As Written" (DAW) on the prescription. When DAW is ordered, you will only be charged the cost of the brand name drug. Generally, generic drugs are Tier 1 and brand drugs are Tier 2. If you have questions, please contact Cigna directly.

Save Time by Using Cigna 90 Now

The Cigna 90 Now program makes it easier for you to fill maintenance medications. A maintenance medication is something you take on a regular basis to treat an ongoing health condition like asthma, diabetes, high blood pressure, or high cholesterol.

Cigna 90 Now...

- Provides coverage for 90-day (or 3-month) supplies at select retail pharmacies in your plan's network and through Express Scripts® Pharmacy, Cigna's home delivery pharmacy.
- Provides coverage for 30-day supplies at all pharmacies in your plan's network.
- If you fill a prescription in a 90-day supply, you must use an in-network retail pharmacy that's approved to fill 90-day supplies, or home delivery, to receive coverage.
- Does not include narcotics or specialty medications.

continued >>>

Pharmacy Benefits: Cigna 90 Now
(continued)

Are there any benefits to filling a 90-day supply?

Yes. You'll make fewer trips to the pharmacy for refills. And you're more likely to stay healthy because with a 90-day supply on-hand, you're less likely to miss a dose.[1]

Do I need my doctor's approval to switch to a 90-day prescription?

Yes, you'll need a new prescription for a 90-day supply. You may be able to request the switch via a telemedicine visit or via email if you have refills remaining. Check with your doctor.

How do I switch to Express Scripts® home delivery?

Use one of these three options:

1. Log into the myCigna App or **myCigna.com** to move your prescription electronically. Click on the **Prescriptions** tab and select **My Medications** from the dropdown menu. Then click the button next to your medication name to move your prescription(s).
2. Call your doctor's office. Ask them to send a 90-day prescription (with refills)[2] electronically to Express Scripts Home Delivery.
3. Call Express Scripts® Pharmacy at 800-835-3784. They'll contact your doctor's office to help transfer your prescription. Have your Cigna ID card, doctor's contact information and medication name(s) ready when you call.

I have a 90-day prescription but my pharmacy isn't approved to fill 90-day supplies. How do I switch pharmacies?

Once you find a pharmacy that's approved to fill 90-day supplies, here are two easy ways you can move your prescription:

1. Call your doctor's office. Ask them to send your 90-day prescription electronically to your new pharmacy.

Or,

2. If your prescription still has a refill available, ask the pharmacist at your new pharmacy to contact your current pharmacy to help transfer your prescription.

[1] Internal Cigna analysis performed Jan 2019, utilizing 2019 Cigna national book of business average medication adherence (customer adherent > 80% Proportion Days Covered), 90-day supply vs. those who received a 30-day supply stopped taking antidiabetics, blood pressure medications, and statins.

[2] Some medications aren't available in a 90-day supply and may only be packaged in lesser amounts. For example, three packages of oral contraceptives equal an 84-day supply. Even though it's not a "90-day supply," it's still considered a 90-day prescription.

MDLIVE

MDLIVE provides you with 24/7/365 access to board-certified primary-care doctors and pediatricians by secure video, phone or e-mail. For 2027, MD Live visits are no charge on all medical plans.

Whether you are at home, at work, traveling, or simply want the most convenient way to see a doctor, MDLIVE is easy to use and available on your schedule anytime, anywhere. Our service is secure, confidential, and compliant with all medical privacy regulations.

To get started and make an appointment, call toll-free 888.726.3171 or visit **app.mdlive.com/landing/mdliveforcigna**

When should I use MDLIVE?

If you're considering the ER or urgent care for a non-emergency medical issue

Your primary care physician is not available

At home, traveling or at work

24/7/365, even holidays!

What can be treated?

- Allergies
- Cold and Flu
- Respiratory Infection
- Asthma
- Ear Infections
- Sinus Problems
- Bronchitis
- Joint Aches and Pain
- And More!

Who are our doctors?

Our doctors practice primary care, pediatrics, family and emergency medicine, and have incorporated MDLIVE into their practice to provide convenient access to quality care.

Get Started Today

Register onllne or by phone	Complete medical history	Request a consultation
Register online anytime by visiting **mdllve.com** or calling **888-726-3171** You will need to enter your first name, last name, gender, date of birth and your Cigna Customer ID#.	Just complete your medical history during registration.	Simply pay the applicable in-network copay, deductible or coinsurance. MDLIVE staff is available 24/7/365 by online video or phone!

Employee Assistance Program (EAP)

When you need some extra support, the Cigna Employee Assistance & Work/Life Support Program is just a call or click away. These services are all confidential and available at no additional cost to you and your household members.

We're here to listen to your concerns, get you the information you need and guide you toward the right solution. Our licensed professional employee assistance consultants are available for telephonic consultation for routine or urgent concerns. We can also direct you to a variety of helpful resources in your community.

- **Child Care:** We'll help you find a place, program or person that's right for your family.
- **Financial Services Referral:** Free 30-minute financial consultations by phone and 25% off tax preparation.
- **Identity Theft:** Get a free 60-minute expert consultation by phone for prevention or if you are victimized.
- **Legal Consulting:** Get a free 30-minute consultation with a network attorney and 25% off select fees.†
- **Pet Care:** From vets to dog walkers, we'll help you ensure your pets are well taken care of.
- **Senior Care:** Learn about solutions related to caring for an aging loved one.

Take advantage of the convenience of consultation by phone:

- Confidential
- No cost to you or anyone living in your household
- Work with a licensed EAP clinician
- 20 to 30 minutes in length
- Unlimited number of consultations each year

Online Managing Stress Toolkit:

- Self-assessment tools
- On-demand stress reduction seminars
- Mindfulness exercises for free download
- Helpful articles and information

We're here to listen. Contact us any day, any time.

Call 877-622-4327
Or log in to myCigna.com

Employer ID: **epcares**
(for initial registration only)

If already registered on myCigna.com, simply log in and go to the **EAP** link under the **Review My Coverage** tab.

†Legal consultations related to employment matters are not available under this program.

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Health Savings Account **(HSA)**

Certain high deductible health plans (designated "HDHP") are designed to be compatible with a Health Savings Account (HSA) to give you more control over how your health care dollars are spent. Federal legislation allows you to reduce your taxable income by contributing funds into an HSA. You may then use the funds to pay for qualified health care expenses. Please refer to the table below for IRS imposed annual maximums. If you do not use all of the money in your HSA in a given calendar year, the remaining money "rolls over" for use in future years.

2027 IRS Maximum Contribution Amounts

Individual	$4,500	Family	$9,000

Individuals age 55 and over may contribute an additional $1,000 per year in catch-up contributions.

To take advantage of the tax savings available via an HSA, enroll in the HDHP plan.

You may then open an HSA at the bank of your choice, or contribute to an existing HSA account, if you have one in place. Most HSA providers offer a debit card so you can pay for provider services and prescriptions directly from your HSA. Because of the transitory nature of the production workforce, EP Cares does not administer pre-tax deposits into your HSA accounts. You can still recognize the same tax savings by claiming the deduction when filing your annual taxes. It is simple to do, using **Form 8889**, and you don't need to itemize your deductions to take advantage of this great tax-savings opportunity.

HSA ACCOUNTS

An HSA functions much like a regular bank account, except that the funds in the account can only be used for qualified medical expenses. The money in the HSA is yours to keep. There is no "use it or lose it" timeframe for HSA funds. You may use the funds at any time for qualified medical expenses. Just like a regular bank account, you can contribute funds to the HSA throughout the year, so long as you are enrolled in a qualified High Deductible Health Plan (HDHP).

Want to learn more? Watch a quick video:
Everything You Need to Know about HSAs

IMPORTANT! SAVE YOUR RECEIPTS

Be sure to save all of your receipts for expenses related to your HSA account in case you are later asked by the IRS to justify your expenses.

Contact Information

EP Cares Contact Center

M-F, 5:00 AM - 8:00 PM (Pacific Time)
855.339.7350
myepcares@ep.com

General information

Password resets

Inquiries about how much your employer pays toward the cost of benefits

Address changes (see below)

Cigna Pre-Enrollment Line

888-806-5042

Specific information on medical, dental, or vision plan details

Questions about doctors, networks

Questions about what is covered under the plans

WEX Health

866.451.3399
Contact Wex online

Line of Business: COBRA & Direct Bill
Employer Name: EP Cares

Calm

support.calm.com

MetLife

800.638.5433
Contact MetLife

Perkspot

866-606-6057
cs@perkspot.com

When Contacting EP Cares

Please provide:

- **Full name (as it appears on payroll)**
- **Last four digits of SSN**
- **Project/Show**

When Contacting an Outside Vendor

- **Cigna**
- **WEX Health**
- **Calm**
- **MetLife**
- **Perkspot**

Be sure to reference "EP Cares" if you are asked for your "employer."

Address Changes

If you change your address, you must notify EP Cares in writing immediately (**myepcares@ep.com**). If you are enrolled in COBRA when your address changes, please notify the COBRA administrator (WEX Health) directly.

Note: Updating your address through payroll or at my.ep.com is insufficient. You must also notify EP Cares directly.

Required Notices

See page 41 or 43 for an important notice regarding your Medicare Part D Coverage.

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 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 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 askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility.

ALABAMA
Medicaid
myalhipp.com
Phone: 1-855-692-5447

ALASKA
The AK Health Insurance Premium Payment Program
myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility
health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS
Medicaid
myarhipp.com
Phone: 1-855-MyARHIPP (855-692-7447)

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

U.S. Department of Labor
Employee Benefits Security Administration
dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Premium Assistance Under Medicaid and CHIP
(continued)

CALIFORNIA

Health Insurance Premium Payment (HIPP) Program
dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO

Health First Colorado
healthfirstcolorado.com
Member Contact Center: 1-800-221-3943
State Relay 711
Child Health Plan Plus (CHP+)
hcpf.colorado.gov/child-health-plan-plus
Customer Service: 1-800-359-1991
State Relay 711
Health Insurance Buy-In Program (HIBI)
mycohibi.com
Customer Service: 1-855-692-6442

FLORIDA

Medicaid
flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA

HIPP
medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA
medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

ILLINOIS

Medicaid Premium Assistance Information
abe.illinois.gov
HIPP
Hotline: 217-524-8268
Email: hfs.boc.hipp@illinois.gov

INDIANA

Family and Social Services Administration
in.gov/fssa/dfr/
Phone: 1-800-403-0864
All other Medicaid
in.gov/medicaid/
Phone: 1-800-457-4584

IOWA

Medicaid
https://hhs.iowa.gov/medicaid
Phone: 1-800-338-8366
CHIP (Hawki)
hhs.iowa.gov/programs/welcome-iowamedicaid/iowa-health-link-hawki
Phone: 1-800-257-8563
HIPP
https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program
Phone: 1-888-346-9562

KANSAS

Medicaid
kancare.ks.gov
Phone: 1-800-792-4884
HIPP
Phone: 1-800-967-4660

KENTUCKY

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP
kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid
chfs.ky.gov/agencies/dms

LOUISIANA

Medicaid
ldh.la.gov/healthy-louisiana
Phone: 1-888-342-6207
email: healthy@la.gov
Health Insurance Premium Program (LaHIPP)
ldh.la.gov/lahipp
phone: 1-877-697-6703
email: La.HIPP@la.gov
fax: 1-888-716-9787

MAINE

Medicaid
mymaineconnection.gov/benefits/
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium
maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

Premium Assistance Under Medicaid and CHIP
(continued)

MASSACHUSETTS
Premium Assistance
mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA
Medicaid
mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI
Medicaid
https://dss.mo.gov/mhd/hipp
Phone: 573-751-2005

MONTANA
Medicaid
dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA
Medicaid
ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA
Medicaid
dhcfp.nv.gov
Phone: 1-800-992-0900

NEW HAMPSHIRE
Medicaid
dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
HIPP
Toll Free: 1-800-852-3345, ext 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY
Medicaid
nj.gov/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP
Premium Assistance Phone: 609-631-2392
njfamilycare.org
Phone: 1-800-701-0710
TTY: 711

NEW YORK
Medicaid
health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA
Medicaid
medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA
Medicaid
hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA
Medicaid/CHIP
insureoklahoma.org
Phone: 1-888-365-3742

OREGON
Medicaid
healthcare.oregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA
Medicaid
pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP
pa.gov/en/agencies/dhs/resources/chip.html
Phone: 1-800-986-KIDS (5437)

RHODE ISLAND
Medicaid/CHIP
eohhs.ri.gov/
Phone: 1-855-697-4347
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA
Medicaid
scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA
Medicaid
dss.sd.gov
Phone: 1-888-828-0059

TEXAS
Medicaid
hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

Premium Assistance Under Medicaid and CHIP
(continued)

UTAH
Medicaid
medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion
medicaid.utah.gov/expansion/
Medical Buyout Program
medicaid.utah.gov/buyout-program/
CHIP
chip.utah.gov/

VERMONT
Medicaid
dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA
Premium Assistance
coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
coverva.dmas.virginia.gov/learn/premium-assistance/health-insurancepremium-payment-hipp-programs
Medicaid/CHIP
Phone: 1-800-432-5924

WASHINGTON
Medicaid
hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA
dhhr.wv.gov/bms/
mywvhipp.com
Medicaid
Phone: 304-558-1700
CHIP
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN
Medicaid/CHIP
dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING
Medicaid
health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

Paperwork Reduction Act Notice

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 (expires 5/31/2029).

Medicare Part D Creditable Coverage Notice

Important Notice From the Company About Your Prescription Drug Coverage and Medicare

(For all versions of the following plans: Local+ IN 7500, Open Access+ IN 7500, Open Access+ 3000)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

Enrolling in Medicare—General Rules

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

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15th through December 7th. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty). If after your initial Medicare Part D enrollment period, you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

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

Special Enrollment Period Exceptions to the Late Enrollment Penalty

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

Important Notice from the Company About Your Prescription Drug Coverage and Medicare (continued)

LOCAL+ IN 7500

OPEN ACCESS+ IN 7500

OPEN ACCESS+ 3000

prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

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

Compare Coverage

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

Coordinating Other Coverage with Medicare Part D

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

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

For more information about this notice or your current prescription drug coverage...

Contact the Plan Administrator 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 the Company changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage...

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

For more information about Medicare prescription drug coverage:

- **Visit medicare.gov**
- **Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,**
- **Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.**
- **If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).**

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

Date: October 1, 2026
Name of Sender: EP Cares

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

Medicare Part D Creditable Coverage Notice

Important Notice From the Company About Your Prescription Drug Coverage and Medicare

(For all versions of the Open Access+ 5000 HDHP plan)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Company has determined that the prescription drug coverage offered by the Company Employee Health Care Plan ("Plan") is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays, and is considered "non-creditable" coverage. This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you only have prescription drug coverage from the Plan. It's also important because if you delay your enrollment in a Medicare drug plan you may have to pay a late enrollment penalty later, when you do enroll in a Medicare drug plan. See the discussion below about late enrollment penalties that might apply when you move from "non-creditable" coverage to a Medicare drug plan after your first opportunity to do so.

3. You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join. Read this notice carefully—it explains your options.

Consider joining a Medicare drug plan. You can keep your coverage from the Company. You can keep the coverage regardless of whether it is "creditable" or "non-creditable," that is, regardless of whether it is as good as a Medicare drug plan. However, because your existing coverage is "non-creditable" coverage, meaning that on average it's NOT at least as good as standard Medicare prescription drug coverage, you may pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a 7-month initial enrollment period. That period begins three months prior to your 65 birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information, you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

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

If after your initial Medicare Part D enrollment period you go 63 continuous days or longer without "creditable" prescription drug coverage (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage after your initial enrollment period.
For example, if you do not enroll in a Medicare drug plan during your Medicare Part D initial enrollment period, and you then go 19 months without "creditable" prescription drug coverage before enrolling in a Medicare drug plan, your Medicare drug plan premium may be at least 19 percent

Important Notice from the Company About Your Prescription Drug Coverage and Medicare (continued)

OPEN ACCESS+ 5000 HDHP

higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage.

Please note again that the Company has determined the prescription drug coverage you currently have through its plan is NOT "creditable" coverage. This means that if you do not enroll in a Medicare drug plan during your initial enrollment period, and don't have or acquire "creditable" prescription drug coverage during the ensuing 63 days, you will pay a late enrollment penalty when you ultimately enroll in a Medicare drug plan.

Special Enrollment Periods and Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to enroll in a Medicare drug plan months or even years after you first became eligible to do so. Whether you will be required to pay a late enrollment penalty when you enroll in a Medicare drug plan during a special enrollment period depends on whether you are moving to a Medicare drug plan from creditable or non-creditable prescription drug coverage.

If after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored prescription drug coverage, you will be eligible to enroll in a Medicare drug plan during a 2 month special enrollment period. If your employer- or union-sponsored prescription drug coverage was "creditable" coverage, your enrollment in a Medicare drug plan will be without penalty (assuming you did not have a 63-consecutive-day or longer break in "creditable" coverage after your Medicare Part D initial enrollment period). On the other hand, if the coverage was "non-creditable" your enrollment in the Medicare drug plan will be subject to a late enrollment penalty unless you had non-creditable coverage for fewer than 63 consecutive days after your Medicare Part D initial enrollment period.

In addition, if through no fault of your own you otherwise lose creditable prescription drug coverage (e.g., your employer- or union-sponsored plan's coverage changes from creditable to non-creditable, or you lose creditable prescription drug coverage under an individual policy), you will be able to join a Medicare drug plan without penalty. This special enrollment period ends two months after the month in which your other coverage ends.
Please note again that the Company has determined the prescription drug coverage you currently have through its plan is NOT "creditable" coverage. This means when you lose or decide to leave coverage under the Company health plan after your initial Medicare Part D enrollment period you will pay a late enrollment penalty when you ultimately enroll in a Medicare drug plan.

Compare Coverage

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

Coordinating Other Coverage With Medicare Part D

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

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

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

Contact the Plan Administrator 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 the Company changes. You also may request a copy.

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

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

Important Notice from the Company About Your Prescription Drug Coverage and Medicare
(continued)

OPEN ACCESS+ 5000 HDHP

For more information about Medicare prescription drug coverage:

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

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

Date: October 1, 2026
Name of Sender: EP Cares

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

HIPAA Notice of Privacy Policy and Procedures

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice is provided to you on behalf of the Company about the Plan. It pertains only to health care coverage provided under the Plan.

This notice is provided to you on behalf of:
***The Company**

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

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

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

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

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

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

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

HIPAA Notice of Privacy Policy and Procedures
(continued)

management, and medical necessity reviews.

- Examples of "health care operations" include disease management and case management activities.

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

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

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

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

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

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities;
- When required for judicial or administrative proceedings;
- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

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

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

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

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant

HIPAA Notice of Privacy Policy and Procedures
(continued)

to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

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

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

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

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

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

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

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

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

HIPAA Notice of Privacy Policy and Procedures
(continued)

(3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

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

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

22. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 23). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

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

Privacy Official
The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:
Senior Manager,
Benefits Compliance & Analytics
818.955.6022
Email: aca@ep.com

Effective Date
The effective date of this notice is: October 1, 2026

24. Substance Use Disorder Treatment: The group health plan may receive certain substance use disorder (SUD) treatment records that are protected by Federal law under 42 C.F.R. Part 2 ("Part 2"). These records are subject to privacy protections that are more stringent than the HIPAA privacy rules. The group health plan will follow all applicable Part 2 requirements for safeguarding, maintaining, using, and disclosing any SUD treatment information it receives.
If the group health plan receives or maintains SUD information protected by Part 2, the group health plan may not use or disclose Part 2 records unless: (i) the plan has your written consent that meets the requirements of Part 2; (ii) the disclosure is expressly permitted by Part 2 regulations; or (iii) a court issues an order that complies with Part 2. Examples of permitted disclosures include medical emergencies, certain audit or evaluation activities by authorized agencies, or other limited circumstances allowed under Part 2.

Part 2 records generally may not be used or disclosed in any civil, criminal, administrative, or legislative proceeding to which you are a party unless you provide written consent in accordance with requirements of Part 2; or a court orders the disclosure after following the procedures required under Part 2.

The group health plan will not disclose any Part 2 records for fundraising purposes unless you are first provided with a clear and conspicuous opportunity to opt out of receiving fundraising communications. If Part 2 records are disclosed to another party, federal law may prohibit the recipient from redisclosing that information unless further disclosure is expressly permitted by Part 2.

As applicable, you have the right to: (i) request access to your Part 2 records maintained by the plan; (ii) request restrictions on disclosures, including those permitted under Part 2; and (iii) revoke your consent to disclosures permitted under Part 2, except to the extent we have already relied on it.

HIPAA Notice of 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, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

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

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

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

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

To request special enrollment or more information, email myepcares@ep.com or call 855.339.7350.

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

Michelle's Law Notice

(To Accompany Certification of Dependent Student Status)

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

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

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

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

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

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

Women's Health and Cancer Rights Notice

The Company's Employee Health Care Plan is required by law to provide you with the following notice:

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

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

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

Local+ IN 7500/Open Access+ IN 7500	**In-Network**	**Out-of-Network**
Individual Deductible	$7,500	Not covered
Family Deductible	$15,000	Not covered
Coinsurance	30%	Not covered
Open Access+ 5000 HDHP	**In-Network**	**Out-of-Network**
Individual Deductible	$5,000	$10,000
Family Deductible	$10,000	$20,000
Coinsurance	20%	50%
Open Access+ 3000	**In-Network**	**Out-of-Network**
Individual Deductible	$3,000	$6,000
Family Deductible	$6,000	$12,000
Coinsurance	20%	50%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description/Policy booklet or contact the Plan Administrator.

Continuation Coverage Rights Under COBRA

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.

Continuation Coverage Rights Under COBRA
(continued)

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 Plans, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- 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 any of the following qualifying events happens:

- 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 the COBRA Qualifying Event Period from when the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA 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:

Continuation Coverage Rights Under COBRA
(continued)

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

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

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

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

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

For more information visit medicare.gov/medicareand-you

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. 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 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 healthcare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let EP Cares 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 EP Cares.