OHM 2024

BENEFIT HIGHLIGHTS

Full-time and Full-time Equivalent Employees

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Summary of Material Modification (SMM) for Plan #505 Orchard, Hiltz & McCliment, Inc. Employee Healthcare Plan.
(This is a summary of material modifications (SMM) that reflects an amendment (s) made to the Company SPD Plan Orchard, Hiltz & McCliment, Inc. Employee Healthcare Plan # 505. You should read it carefully and keep it with your summary plan description (SPD) for future reference.)

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please refer to **page 51-52** for further details.

If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time. Please refer to the customer service phone numbers provided in the back of this guide if you have questions or assistance is needed.

BENEFIT PLAN HIGHLIGHTS & WHAT'S NEW FOR 2024

OHM Advisors is committed to the health and wellbeing of you and your dependents. We are happy to offer eligible employees a comprehensive and competitive benefits package as part of total compensation. The OHM Advisors team continues to review the program, plan designs, provider and insurance carrier options as well as national and local benchmarks. Our goal is to provide quality programs that provide significant value to our teams while controlling costs.

This guide is provided to you as a general summary to help you understand the coverage available. For more detailed descriptions of coverage, please refer to the carrier policies and/or certificates of coverage. If any conflict arises between this guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time. You can find these on our website at:

OHM Advisors - Home (sharepoint.com)

Highlighted below is an outline of the benefit plans offered for the upcoming plan year: January 1 - December 31.

- **Medical, Dental, and Vision, Blue Cross Blue Shield of Michigan**
  - ◊ Current plans will continue for 2024 without changes to benefits or employee contributions. Also, OHM Advisors will continue to cover the 100% of the cost for vision.
- **Prescription, Blue Cross Blue Shield of Michigan**
  - ◊ The Pillar RX program will be available for both medical plan options
- **Flexible Spending Account, Health Equity:**
  - ◊ The maximum amounts that can be elected for FSA accounts during 2024 are as follows:
    Healthcare FSA: $3,200 ▪ Dependent Care FSA: $5,000
  - ◊ The amount for Healthcare FSA rollover allowed at the end of the 2024 year is increasing to $640
- **Health Savings Account (HSA), Health Equity:**
  - ◊ The 2024 IRS-indexed HSA maximum contribution limits are shown below. Contributions made by OHM Advisors on your behalf count towards these maximums:
    Employee Only: $4,150 ▪ Couple / Family: $8,300 ▪ Catch-Up for ages 55 and older: $1,000
- **Wellness Plan, US Wellness | Virgin Pulse**:
  - ◊ Employees MUST register on the Virgin Plus Wellness Portal in order to earn points. Anyone that does not register will not be able to earn or receive wellness incentives.
  - ◊ Employees that participate in the program can earn credits for lower medical plan costs in 2025 and AwardCo points too!
  - ◊ All employees are eligible to participate, enrollment in the medical plan is not required.
- **Voluntary Critical Illness benefit being offered NEW for 2024.** Critical Illness pays out a lump sum, based on employees election upon the diagnosis of a covered Critical Illness. Coverage is being offered through Unum.
- **Voluntary Benefits including Optional Term Life, Short-Term Disability, Long-Term Disability, Hospital Indemnity Insurance, and Accident Insurance:** Coverage will continue to be available through Unum.
- **Additional Voluntary Plans that will continue to be offered:**
  - ◊ **Pet Insurance**, Nationwide
  - ◊ **Legal Plan,** Legal Shield
  - ◊ **Identity Theft Plan,** ID Shield

PAYCHECK CONTRIBUTIONS IN 2024

Below is an overview of the employee cost for each offered benefit. The costs shown below reflect the amounts that will be deducted from each paycheck - based on 26 pay periods for the year.

	Medical - HDHP / HSA		Medical - Standard PPO Plan		Dental
	Wellness Credit	No Wellness Credit	Wellness Credit	No Wellness Credit	
Employee Only	$27.93	$37.85	$65.71	$75.64	$5.09
Employee + Spouse	$61.37	$71.29	$143.77	$153.69	$9.58
Employee + Children	$52.37	$62.30	$122.84	$132.76	$11.51
Family	$85.38	$95.30	$200.04	$209.96	$16.10
Spousal Surcharge See page 8 for more information	$46.15	$46.15	$46.15	$46.15	N/A

New Hires will automatically receive the Wellness Credit toward their medical contributions.

	Voluntary Accident	Voluntary Hospital Indemnity
Employee Only	$6.79	$8.18
Employee + Spouse	$12.11	$18.09
Employee + Children	$14.70	$12.66
Family	$20.02	$22.57

Voluntary Short Term Disability (STD)	Voluntary Long Term Disability (LTD)	Critical Illness	Optional Life Insurance
Rates vary depending on your annual earnings		Rates vary depending on age and amount of benefit chosen.	
Additional information on how to calculate your cost is outlined later in this guide.			

ANNUAL OPEN ENROLLMENT

Whether your are a current team member reviewing your benefit options for the new plan year, or a new team member eligible for benefits for the first time, we hope you find this Benefit Guide helpful.

- **Annual Open Enrollment:** Annual Open Enrollment is an opportunity given once a year to existing team members to review the benefit package offered by OHM Advisors, and to make any changes to your current enrollment. Examples of changes that can be made include the following:
  - Signing up for coverage that was previously waived
  - Dropping coverage from a plan in which you are currently enrolled
  - Switching from one plan option to another
  - Adding or removing coverage for your dependents

Our 2024 Open Enrollment period begins on October 31st and ends on November 13th.
Elections and Changes made during Open Enrollment will become effective on January 1, 2024.

Per IRS regulations, any elections that are made during open enrollment, or during a new hire eligibility period must remain in place for the rest of the year without changes. The only time changes can be made outside of this time is when a qualified status change happens. Keeping this in mind, please carefully review your plan options. This Guide provides a brief description of the benefit plans available to you and your family members. Please read it carefully, since understanding the options available to you can help ensure that you choose the right benefit options for you and your family.

MID-YEAR CHANGES

Unless you have a qualifying event, you cannot make changes to the benefits you elect until the next open enrollment period. Examples of qualified changes in status include:

Change in legal marital status ▪ Change in number of dependents ▪ Change in eligibility status of a dependent ▪ Change in employment status of employee, spouse, or dependent ▪ Change in place of residence if the change affects access to providers in a health plan ▪ Loss of certain other coverage ▪ Court judgment, decree, or order ▪ Medicare or Medicaid entitlement ▪ Significant cost or coverage changes ▪ Reduction of hours

There may be conditions and/or limitations that apply to any of these events,
and documentation must be provided as proof for any of these changes.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

The Health Insurance Portability And Accountability Act of 1996 (HIPAA) provides employees additional opportunities to enroll in a group health plan if they experience a loss of other coverage or certain life events. If you are declining coverage at this time for either yourself or your eligible dependents, you may be able to enroll yourself and/or your eligible dependents in coverage at a later date if there is a loss of other coverage. If you experience a qualified "change in status," **you must make any associated enrollment or benefit changes within 30 days of the event** except for a Medicare or Medicaid entitlement event, in which case you must make changes within 60 days of the event. You have the right to elect coverage during the plan year if you or your dependent's Medicaid/Children's Health Insurance Program (CHIP) coverage terminates due to discontinuation of eligibility under the program or if you become eligible for a Medicaid/CHIP premium assistance subsidy (if available in your state) providing you request enrollment within 60 days of the loss of coverage or eligibility for premium subsidy.

ELIGIBILITY

You are eligible for benefits if you are a full-time employee, unless otherwise stated. Full-time employees must be regularly scheduled to work 30 hours or more per week, or must average 30 hours per week over a defined measurement period, following regulation guidelines from The Affordable Care Act.

IF I AM A NEW HIRE, WHEN AM I ELIGIBLE FOR COVERAGE?

Employees hired into full-time positions are eligible for coverage to begin on the 1st of the month following 30 days of full-time employment. Employees hired into positions with variable hours are eligible for coverage to begin after averaging 30 hours or more over a defined Initial Measurement Period. See Human Resources for details.

As a participant in the OHM Advisors benefits program, you may choose coverage for yourself and your eligible dependents. Eligible dependents are defined as:

- Legal spouse*
- Natural child(ren)
- Legally adopted child(ren)
- Child(ren) placed in your home for legal adoption
- Stepchild(ren)
- Child(ren) over whom you have legal guardianship

DEPENDENT CHILDREN ARE ELIGIBLE TO REMAIN ON YOUR PLAN UNTIL:

- Medical, Dental, and Vision: End of the month in which they turn 26.
- Employer Paid Dependent Life Insurance: 19th birthday or until their 26th birthday with full-time student status.
- Voluntary Life, Voluntary Accident, Hospital Indemnity: Their 26th birthday.

Dependents may be able to continue coverage past the age limit above for medical, dental, and vision if your child is incapable of self-support because of mental or physical disability. Proof of mental or physical disability is required and must be approved by the insurance carrier.

***SPOUSAL SURCHARGE INFORMATION:**

If you are married and your spouse has medical coverage available through his/her employer, but declines coverage to be covered by one of OHM Advisors' medical plans, you will be charged a monthly surcharge of $100. The surcharge will not apply if:

- Your spouse does not work
- Your spouse is not eligible for coverage through his/her employer
- Your spouse is also employed at OHM Advisors
- Is covered only by Medicare or a private individual plan
- Is covered on OHM Advisors' plan as secondary

If, at any point your working spouse ceases to be eligible for his/her employer's medical coverage, he/she may be enrolled under your medical plan coverage. You will have 30 days from the loss of eligibility for coverage to enroll your spouse under our plan. If your spouse is covered under an OHM Advisors plan and it is later determined that your spouse was eligible for other group medical coverage, we may hold you financially responsible for providing inaccurate information. OHM Advisors may, at its discretion, take other disciplinary measures up to and including termination of employment. OHM Advisors reserves the right to contact your spouse's employer to verify eligibility for coverage.

MEDICAL PLANS

OHM Advisors offers two comprehensive medical plan options. Both plans are administered by Blue Cross Blue Shield of Michigan and both are Preferred Provider Organization (PPO) Plans.

You can seek health care from any professional you choose, both inside or outside of the plan's network. You are not required to designate a Primary Care Physician, and you can choose specialists without a referral.
You will usually have lower out-of-pocket expenses by choosing a provider that participates in-network, so it is to your advantage to use in-network PPO providers. However, you do have the flexibility to choose providers outside of the PPO network as well. You will generally have higher cost-shares when receiving care from non-PPO providers. In addition to higher cost-shares, providers that are not contracted within the BCBSM PPO network can also "balance-bill" their patients. This means they can charge you for the difference in their charged amount and the amount that BCBSM pays them. PPO providers cannot "balance-bill" members per their contract with BCBSM.

There is no coverage by either plan for members when they choose non-participating hospitals for non-emergency hospital care. There is no coverage when care is received at non-participating mental health or substance abuse facilities, ambulatory surgery facilities, end stage renal dialysis facilities, home infusion therapy providers, hospices, outpatient physical therapy facilities, skilled nursing facilities or home health care agencies.

To find participating PPO providers, start online at www.bcbsm.com and click on "Find a Doctor"
Then click where it says: Search without logging in, and follow the prompts.

HDHP PPO with HSA	BCBSM Standard PPO Plan
All medical services are subject to the deductible before the plan will begin to pay, with the exception of preventive care. Preventive care services are covered at 100% and deductible does not apply.	Services are subject to the cost share outlined in the plan. Some services are subject to deductible before the plan begins to pay, but other services will pay first dollar, and the member will only be required to pay a flat dollar copay.
Prescription drugs are also subject to the deductible before the plan begins to pay.	Deductible does not apply to prescription drug coverage.
The full family deductible must be met under a two-person or family contract before the plan will pay any benefits for any person on the contract.	Deductible is embedded, which means that one member on a family contract only has to satisfy one deductible before the plan begins to pay (not the full family deductible). The family deductible is satisfied when two deductibles have been met.
Eligible to open a tax-advantaged Health Savings Account (HSA). OHM Advisors will help contribute funds into your HSA as follows: ▪ **$750 for a single contract** ▪ **$1500 for a two-person/family contract**	Not eligible for a Health Savings Account (HSA), but you can participate in a Flexible Spending Account (FSA). FSA is money that you put aside on a tax-free basis to help pay for eligible out-of-pocket medical, dental, and vision expenses. OHM Advisors does not contribute FSA funds.

MEDICAL BENEFITS SIDE-BY-SIDE SUMMARY COMPARISON

Orchard Hiltz and McCliment BCBSM Medical Benefit Summary				
Benefit Item	**HDHP PPO with HSA**		**Standard PPO Plan**	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible, Per Calendar Year				
Single	$2,000	$4,000	$1,000	$2,000
Family	$4,000	$8,000	$2,000	$4,000
Coinsurance (Applies after deductible is satisfied, and is the amount that the plan and member share by percentage)				
Plan Pays / Member Pays (of approved amount)	80% / 20% for most services	60% / 40% for most services	80% / 20% for most services	60% / 40% for most services
Coinsurance Maximum Single	N/A	N/A	$2,500	$5,000
Coinsurance Maximum Family	N/A	N/A	$5,000	$10,000
Total Out-of-Pocket-Maximum, Per Calendar Year (Includes Deductible, Coinsurance, and Flat-Dollar Copays)				
Single	$3,000	$6,000	$6,350	$12,700
Family	$6,000	$12,000	$12,700	$25,400
Covered Services				
Preventive Care	100% covered	Not covered	100% covered	Not covered
Primary Care Office Visit	20% after deductible	40% after deductible	$20 copay	40% after deductible
Specialist Office Visit	20% after deductible	40% after deductible	$40 copay	40% after deductible
24/7 Telemedicine/Online Visits	20% after deductible	40% after deductible	$20 copay	40% after deductible
Urgent Care	20% after deductible	40% after deductible	$60 copay	40% after deductible
Emergency Room	20% after deductible	40% after deductible	$150 copay (waived if admitted)	40% after deductible
Outpatient Mental Health & Substance Abuse	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Diagnostic Services	20% after deductible	40% after deductible	20% after deductible	40% after deductible
In-Patient Hospitalization	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Surgery	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Chiropractic Care	20% after deductible	40% after deductible	$30 copay	40% after deductible
	Limited to a combined 12-visit maximum per member per calendar year			
Maternity Services (provided by a physician or certified nurse midwife)				
Prenatal Care Visits	100% covered	40% after deductible	100% covered	40% after deductible
Postnatal Care	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Delivery and Nursery Care	20% after deductible	40% after deductible	20% after deductible	40% after deductible

This is a partial benefit summary. To see additional benefits, see the Summary of Benefits and Coverage available on the Spark intranet.

PRESCRIPTION DRUGS

PillarRX Drug Discount Program

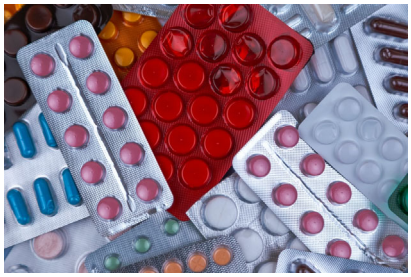
- The Pillar Rx Program is included with both BCBSM medical plans. The program helps members with obtaining copay assistance from drug manufacturers to reduce their out-of-pocket copay expenses for eligible medications. Members taking medications for which copay assistance is available, will be contacted by a professional assistant to help enroll them in any applicable copay assistance programs offered by the drug manufacturer.

About the Prescription Drug Plans

- Whether you take medication on an ongoing basis or simply need a prescription filled from time to time, your BCBSM prescription drug plan offers convenient options, including a national network of participating pharmacies in Michigan and across the country, OptumRX home delivery pharmacy, and AllianceRX Walgreens mail-order specialty option for specialty drugs.
- BCBSM uses a prescription drug formulary. This formulary is updated regularly, and can be viewed on the BCBSM website. Please reference the **Custom Drug List** Formulary.
- If you take a maintenance medication, you can receive a 90-day supply of your medication for the price of two copays by doing either of the following:
  - ◊ Fill your 90 day prescription at participating retail pharmacies; or
  - ◊ Use the OptumRX Home Mail Order Delivery Pharmacy Services
- Specialty drugs are medications that require special handling, administration, or monitoring. If your medication is considered a specialty drug, you can get your prescription drugs delivered to your home by ordering them through AllianceRX Walgreens Pharmacy, BCBSM's Specialty Drug Vendor. You are limited to a 30 day supply.
- To find out if your medication is included in the Specialty Drug List, or to order a Specialty Drug, you can call AllianceRX Walgreens Prime Customer Service at **(866) 515-1355** or download the list/order form from the BCBSM website.

About the Preferred Therapy Drug Program

- BCBSM uses a Preferred Therapy program for prescription drug plans to help manage member care. This program includes a step-therapy approach that encourages physicians to prescribe generic, generic-alternative, or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication.
- Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available on BCBSM's website, along with the preferred medications.
- If you have already tried the preferred medication(s), BCBSM will authorize the prescription. If you have not tried the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.



PRESCRIPTION BENEFIT SIDE-BY-SIDE SUMMARY COMPARISON

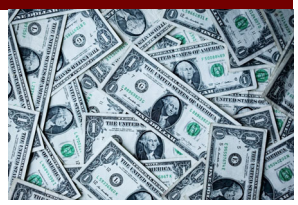
Orchard Hiltz and McCliment BCBSM Prescription Benefit Summary				
	HDHP PPO with HSA		Standard PPO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Tier 1 - Generic				
30-day	After deductible, $10 copay	After deductible: $10 copay, plus 20% of approved amount	$10 copay	$10 copay, plus 25% of approved amount
90-day	After deductible, $20 copay	Not covered	$20 copay	Not covered
Tier 2 - Formulary, Preferred Brand-Name				
30-day	After deductible, $40 copay	After deductible: $40 copay, plus 20% of approved amount	$40 copay	$40 copay, plus 25% of approved amount
90-day	After deductible, $80 copay	Not covered	$80 copay	Not covered
Tier 3 - Nonformulary, Nonpreferred Brand-Name				
30-day	After deductible, $80 copay	After deductible: $80 copay, plus 20% of approved amount	$80 copay	$80 copay, plus 25% of approved amount
90-day	After deductible, $160 copay	Not covered	$160 copay	Not covered

Quick Tips!

You can reduce your prescription drug copay by utilizing manufacturer coupons and discount generic programs through your local pharmacy. Before having your prescription filled, do a little home work and save big bucks!

1. Utilize generic medications—many pharmacies offer them for less than your plan's copay and sometimes they are even free!
   - Meijer—offers free antibiotics, prenatal vitamins, Metformin (commonly prescribed for diabetes) and Atorvastatin Calcium (cholesterol management medication).
2. Coupons...coupons....coupons! You don't have to be an "extreme-couponer" to substantially save with prescription drug coupons. If you're on a name-brand medication, visit the manufacturer's website and check for discounts and coupons.
3. If you are on the BCBSM Standard PPO Plan, and take certain eligible medications, you may qualify for assistance through the Pillar RX program. If you take maintenance medications that qualify, you will be contacted by a professional assistant to help you get enrolled.

HEALTH SAVINGS ACCOUNT (HSA)



Employees that choose to enroll in the OHM Advisors BCBSM PPO High Deductible Health Plan (HDHP) option will automatically be set up with a Health Equity Health Savings Account (HSA).

What is an HSA?

A type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. By using untaxed dollars in a Health Savings Account to pay for deductibles, copayments, coinsurance, and some other expenses, you may be able to lower your overall health care costs. While you can use the funds in an HSA at any time to pay for qualified medical expenses, you may contribute to an HSA only if you have a High Deductible Health Plan (HDHP). With a HDHP-HSA powered health plan, instead of making copayments at the time of service, you will have a deductible to meet. A deductible is the amount you are required to pay out-of-pocket for services before your health plan benefits kick in. While you may see a higher deductible than you're used to, you will typically also see a lower monthly premium. Keep in mind that preventive care is always covered 100%.

More about health savings accounts

By selecting an HSA-powered plan with a higher deductible, you qualify to contribute tax-free money into a health savings account (HSA) with HealthEquity. Your HSA funds then earn tax-free interest, and can be used tax-free to pay for qualified medical expenses. HSAs are similar to retirement accounts in that they rollover year-to-year, they remain yours if you change jobs or retire, and the balance can be invested in mutual funds. Because HSA-powered health plans typically cost less than traditional health plans, the money saved in premium cost can be used to contribute to your HSA.

HSAs provide a triple tax advantage!

1) **Reduces federal income taxes:** When you contribute to an HSA directly from your paycheck, you reduce your federal taxable income by the amount you deposit in your HSA. You are also able to contribute post-tax and claim
that contribution when filing your taxes.
2) **Tax-free interest:** Your money earns interest while it is in the account and you do not pay taxes on the interest earned. Any gains on dollars invested in mutual funds are also tax-free.
3) **Tax-free withdrawals:** You never pay taxes on HSA withdrawals when used to pay for qualified medical expenses, including medical, dental, vision, and pharmacy expenses.

Are you eligible?

To qualify for an HSA, you must be enrolled in an HSA-powered health plan and meet the following requirements:

- Have no other non-HDHP health coverage, such as a FSA, military or VA benefits (see IRS Publication 969).
- Not be enrolled in Medicare.
- Not be claimed as a dependent on someone else's tax return.

If you reach age 65 while you are working full-time and eligible for benefits, you may still enroll in the HDHP medical plan. If you choose to enroll in Medicare once you are eligible, you will no longer be able to contribute to your HSA. This is because Medicare is not a qualified HDHP. You can still access the money in your HSA for eligible medical expenses, but you cannot continue to make contributions. If you choose to delay your Medicare enrollment (including Part A, B, and D) while you are still working and enrolled in the HDHP with HSA, then you can continue contributing to your HSA. Please remember that you MUST stop contributions once you do decide to enroll in Medicare.

HEALTH SAVINGS ACCOUNT (HSA)

OHM Advisors will help you fund your HSA by contributing an annual total of $750 for a single contract and $1,500 for a two-person or family contract!

Unlike a savings account at your local bank, the amount you can deposit into your Health Savings Account is subject to limits defined by the Internal Revenue Service. You will want to be sure that any contributions made to your HSA (including the contributions made by OHM Advisors) do not exceed the IRS limits.

See the chart below for the HSA limits for the 2024 calendar year.

HSA LIMITS

Type of Limit	OHM Advisors Contribution	Your Maximum Allowed Contribution	2024 Total IRS Allowed Contribution
HSA Contribution Limit Single Coverage	$750	$3,400	$4,150
HSA Contribution Limit Family Coverage	$1,500	$6,800	$8,300
HSA Catch Up Contributions allowed for individuals age 55 or older	N/A	$1,000	$1,000

#

After you enroll in a HDHP, HealthEquity will send you an HSA welcome kit, containing your debit card. You will be able to view your balance and claims history by logging into your member portal on www.bcbsm.com, and clicking on *Savings Account*. You can conveniently pay your eligible medical, dental, or vision provider bills from the member portal as well. You can also access your HSA information on your HealthEquity member portal at www.healthequity.com.

FLEXIBLE SPENDING ACCOUNTS

You have the opportunity to pay for out-of-pocket Medical, Dental, Vision, and/or Dependent Care expenses with pre-tax dollars through the Flexible Spending Account (FSA). Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don't pay federal income or FICA taxes on the portion of your paycheck you contribute to your FSA.

Important Note: If you will be funding an HSA, you cannot participate in the Health Care FSA.

- **Plan Year: January 1, 2024 - December 31, 2024**
- **Health Care Contribution Limit: $3,200 | Dependent Care Contribution Limit: $5,000**

A **Health Care FSA** is used to reimburse out-of-pocket health care expenses incurred by you, your spouse and/or your children; whether you cover them or not. Eligible expenses include deductibles, coinsurance, copays for medical, dental, and vision. Your Health Care contribution is pre-loaded to a debit card; you have immediate access to the funds and will pay them back throughout the year via payroll deduction.

A **Dependent Care FSA** lets you use pre-tax dollars towards qualified dependent care. A dependent care FSA can pay for the care of dependent children under age 13 by a babysitter, day care center, or before-school or after school program. Care for a disabled spouse, parent or child is also eligible if the individual lives with the employee and cannot care for himself or herself. Care must be provided to keep the employee and spouse gainfully employed and must be given during normal working hours (for example, babysitting on a weekend for recreational time is not allowed). **Dependent care expenses cannot be reimbursed until they are actually incurred**.

FSA contribution elections cannot be changed outside of open enrollment unless there is a qualifying event. The list of acceptable qualifying events is more restrictive than other benefit plan election changes, so you will want to make an informed decision when deciding on how much to elect for the new plan year!

IMPORTANT INFORMATION ▪ USE IT OR LOSE IT!

- The Healthcare FSA features a carryover allowance of up to **$640**. Unused balances up to **$640** will automatically carryover to the following plan year. **However, any funds exceeding $640 left in the Healthcare FSA account at the end of the year (12/31/2024) will be forfeited**.
- The Dependent Care FSA does not have the carryover feature, so any unused amount remaining in the Dependent Care at the end of the plan year will be forfeited.
- The Dependent Care FSA **does** feature a grace period, so you will have additional time to ***incur*** claims. With the grace period, you can continue to incur claims until **03/15/2025.**
- Both the Health FSA and the Dependent Care FSA allow you some extra time to submit claims that were incurred between 01/01/2024 and 12/31/2024. You will have until 3/31/2025 to submit claims for reimbursement.
- Approximately 30 days after the "run-out period" has ended (end of April), any remaining Healthcare FSA funds that you are able to carry into the new year **(up to $640)** will be credited to your account to be used in the 2025 plan year.

FLEXIBLE SPENDING ACCOUNTS

EXAMPLES OF QUALIFIED EXPENSES

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limbs/teeth
- Birth control pills
- Body scan
- Breast reconstruction surgery
- Chiropractor
- Contact lenses
- Crutches
- Dental treatment (not including teeth whitening)
- Eye exam, Eye glasses, Eye surgery
- Feminine Care Products
- Hearing aids
- Long-term care expenses
- Medications, prescribed and over-the-counter
- Operations
- Optometrist
- Orthodontia
- Over-the-counter medications
- Pregnancy test kit
- Prosthesis
- Psychiatric care/Psychologist
- Stop-smoking programs
- Surgery
- Therapy
- Wheelchairs

EXAMPLES OF NON-QUALIFIED EXPENSES

- Controlled substances
- Cosmetic surgery
- Dancing lessons
- Diapers or diaper service
- Electrolysis or hair removal
- Funeral expenses
- Hair transplant
- Health club dues
- Health coverage tax credit
- Household help
- Illegal operations or treatments
- Insurance premiums
- Maternity clothes
- Medication from other countries
- Nutritional supplements, unless recommended by a medical practitioner as treatment for a specific medical condition
- Personal use items (e.g., toothbrush, toothpaste, dental floss)
- Swimming lessons
- Teeth whitening
- Veterinary fees
- Weight-loss program (unless for a specific disease diagnosed by a physician)

It's easy to use your FSA card to shop online for eligible FSA items!
Here are just a few examples of websites that can accept FSA debit card payments:

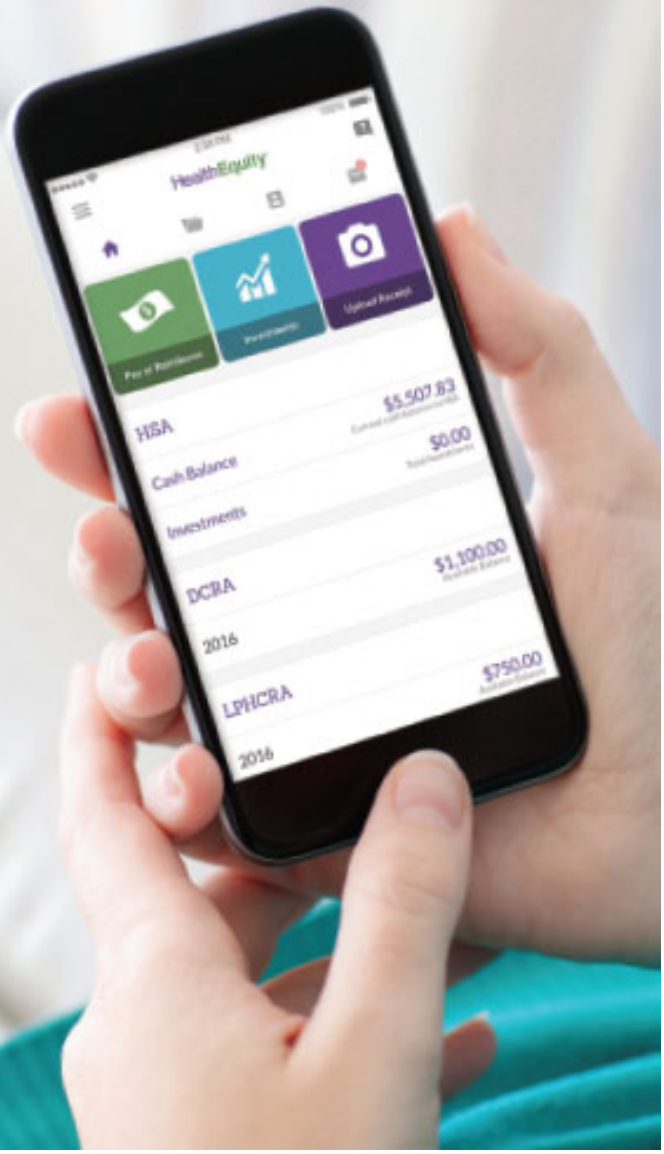
- Amazon
- CVS Pharmacy
- FSA Store
- 1-800-Contacts
- Walgreens
- Zenni Optical

HEALTH EQUITY MOBILE APP

EASY ACCESS

to your ACCOUNT

WHEREVER you are.



Download the mobile app

FOR FREE at

- **Apple® App Store®**
- **Google Play™**

For help with the mobile app, contact HealthEquity at:

866-346-5800

Available 24 hours a day / 7 days a week

DENTAL

OHM Advisors offers a Blue Cross Blue Shield of Michigan (BCBSM) Traditional Plus Dental plan to eligible employees. Claims are paid by OHM Advisors, and the plan is administered through BCBSM.

With Blue Dental PPO, members can choose any licensed dentist anywhere. However, they'll save the most money when they choose a dentist who is a member of the Blue Dental PPO network.

Blue Dental PPO network - Blue Dental members have unmatched access to PPO dentists through the Blue Dental PPO network, which offers more than 535,000 dentist locations nationwide. PPO dentists agree to accept the BCBSM approved amount as full payment for covered services - members pay only their applicable coinsurance and deductible amounts.

Blue Par Select arrangement - Most non-PPO dentists accept our Blue Par Select arrangement, which means they participate with the Blues on a "per claim" basis. Members should ask their dentists if they participate with BCBSM before every treatment. Blue Par Select dentists accept our approved amount as full payment for covered services, members pay only applicable coinsurance and deductibles.

Members who go to nonparticipating dentists are responsible for any difference between our approved amount and the dentist's charge.

To find a PPO/Blue Par Select dentist near you, please visit mibluedentist.com or call 1-888-826-8152.

Orchard Hiltz and McCliment BCBSM Traditional Plus Dental Benefit Summary	
Deductible, per calendar year Applies to Class II and Class III services only	$50 for one member or $150 for the family
Benefit Dollar maximums Annual Maximum (for Class I, II, III services) Lifetime Maximum (for Class IV services)	$1,500 per member $1,500 per member
Class 1 Services	
Oral Exams, teeth cleaning, fluoride treatment set (up to 4) of bitewing x-rays, and other preventive services	100% of approved amount (Frequency limitations may apply)
Class II Services	
Fillings, onlays, crowns and veneer fillings, limited occlusal adjustments, occlusal bite guards, repairs/adjustments of a partial or complete denture, general anesthesia or IV sedation	80% of approved amount (Limitations may apply)
Class III Services	
Removable dentures, Bridges, Oral Surgery including extractions, root canals, scaling and root planing, replacements of crowns, veneers, inlays, onlays and bridges, endosteal implants	50% of approved amount (Limitations may apply)
Class IV Services	
Orthodontic Services for Dependents Under Age 19	50% of approved amount

VISION

OHM Advisors provides vision coverage at no cost to eligible employees. Our vision plan claims are administered by Blue Cross Blue Shield of Michigan (BCBSM). Blue Vision benefits are provided by Vision Service Plan (VSP), the largest provider of vision care in the nation. You may choose to visit any licensed vision care provider. However, your benefits will be greater and your cost may be less if you choose to see a VSP provider. This is because VSP Providers have agreed to accept BCBSM's approved amount as payment in full.

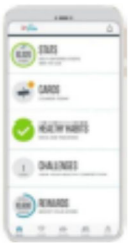
To find a VSP doctor, call 1-800-877-7195 or log on to the VSP Website at vsp.com.

Orchard Hiltz and McCliment BCBS VSP Vision 12 / 12 / 12 Benefit Summary		
Benefits	**VSP Network Provider**	**Non-VSP Provider**
Eye Exam: Complete eye exam by an ophthalmologist or optometrist. Exam includes refraction, glaucoma testing and other tests necessary to determine the overall visual health of the patient.	$5 copay	Reimbursement up to $45 less $5 copay (member responsible for any difference)
One eye exam in any period of 12 consecutive months		
Members may choose between prescription glasses (lenses and frame) or contact lenses, but not both.		
Discounts up to 20% for additional prescription glasses and any amount over the allowance ***plus*** savings on non-covered extra (up to 25%) when obtained from a VSP provider.		
Standard Lenses: (must not exceed 60 mm in diameter) prescribed/dispensed by an ophthalmologist or optometrist. Lenses may be molded or ground, glass or plastic. Also covers prism, slab-off prism and special base curve lenses when medically necessary. Anti-reflective coating is covered when rendered by a VSP provider.	A combined $10 copay	Reimbursement up to approved amount based on lens type less $10 copay (member responsible for any difference)
One pair of lenses, with or without frames, in any period of 12 consecutive months.		
Standard Frames: All VSP network doctor locations are required to stock at least 100 different frames within the frame allowance.	$130 allowance that is applied toward frames (member responsible for any cost exceeding the allowance) less $10 copay (one copay applies to both frames and lenses)	Reimbursement up to $70 less $10 copay (member responsible for any difference)
One frame in any period of 12 consecutive months		
Contact Lenses: Medically necessary contact lenses (requires prior authorization approval from VSP, must meet medically necessary criteria)	$10 copay	Reimbursement up to $210 less $10 copay (member responsible for any difference)
Elective contact lenses that improve vision (prescribed, but do not meet medically necessary criteria).	$130 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)	$105 allowance that is applied toward contact lens exam (fitting and materials) and the contact lenses (member responsible for any cost exceeding the allowance)
Contact lenses up to the allowance in any period of 12 consecutive months		

WELLNESS PROGRAM

LACE UP & GET STARTED

The everyday choices we make can help us live healthier, happier, and more fulfilling lives. Whether that means helping you get or stay healthy. Join the program to make small, everyday changes to your wellbeing that are focused on the areas YOU want to improve the most.



SMALL STEPS LEAD TO BIG CHANGES

- **Download the Virgin Pulse Mobile App** - Get all the core features at your fingertips for on-the-go healthy living.
- **Participate using the online Virgin Pulse portal** - Creating your account is the first step needed to participate in the program. **No points can be earned without registering for portal access!**

UNLEASH THE WINNER WITHIN

ALL EMPLOYEES can earn points for participating in healthy activities to advance through the program levels each quarter by the deadlines outlined below. Earn AWARDCO cash at every level, up to $25 per quarter / $100 annually.

	Level 1	Level 2	Level 3	Level 4	Level 5
Points	1,000	4,000	8,000	15,000	$20,000
AwardCo Cash	$5	$5	$5	$10	Prize Draw

Quarterly Deadline Dates	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	3/31/2024	6/30/2024	9/30/2024	12/31/2024

EMPLOYEES ON THE MEDICAL PLAN - Level up and earn your 2025 Wellness Credit!

- ✓ Complete an annual physical between January 1, 2024 and October 31, 2024 (reported by BCBS).
- ✓ Complete your online Health Risk Assessment between January 1, 2024 and October 31, 2024.

FAQs

Who can participate?	All associates may participate in the wellness program.
Is the program mandatory?	No. The wellness program is a completely voluntary program.
What if I am unable to participate in the wellness program due to a medical condition?	You may be eligible for alternative ways to participate. For more information, check out our Support Page Answers or send us an e-mail!

Ongoing member support: Chat support available 2am – 9pm EST, Monday – Friday via "Help" or "Chat" located on the platform when registering and once logged in.

Phone: 888-671-9395 | Email: support@virginpulse.com
Hours of phone/email support: 8am – 9pm EST, Monday – Friday

BCBS/BCN VIRTUAL CARE

NEW Virtual Care for 2024! Previously Blue Cross Online Visits.

Virtual care that's always there

Virtual Care by Teladoc Health is for you and everyone on your plan.
It includes:

- **Virtual 24/7 care** for minor illnesses and injuries, talk with U.S. board-certified doctors. You don't need an appointment.
- **Virtual mental health** to meet your mental health needs. Choose from licensed therapists and U.S. board-certified psychiatrist. Available by appointment, including nights and weekends

How much does it cost?

Medical visits are $65 or less. If you have a plan with a copay, it's generally equal to or less than what you pay for a primary care office visit. Costs for mental health visits vary depending on the type of provider and the services you receive. Your out-of-pocket costs are based on your existing outpatient behavioral health benefits. You'll see your cost before you start your visit. Be sure you've added your Blue Cross health plan information to your Virtual Care account.

24/7 CARE

Your primary doctor is still your best option for treatment, but Virtual Care can be helpful when you're sick and your own doctor isn't available.

- Have a virtual visit with a U.S. board certified doctor for minor illnesses such as colds, sore throats, urinary tract infections and pink eye. Visits are available for adults and children.
- Medical visits are available 24/7, anywhere in the U.S. when your primary care provider isn't available. You don't need an appointment and average wait time is 10 minutes. Prescriptions, if needed, can be sent to your preferred pharmacy.

MENTAL HEALTH

Through the Mental Health option, you can connect with a licensed therapist or U.S. board-certified psychiatrist when you're dealing with stressful situations or issues such as grief, anxiety and depression. Mental health visits require an appointment, but many therapists and psychiatrists have evening and weekend availability.

How do I get started?
Mobile – Download the Teladoc app from the App Store® or Google Play
Web – Visit bcbsm.com/virtualcare
Phone – Call 1-800-835-2362
Family members ages 18 and older will need to create their own Virtual Care accounts. When updating or creating an account, choose your plan name and enter your member ID so your coverage is applied correctly. Call the number above with any questions about your account or to arrange a phone visit.

Share information with your primary care physician

Tell your primary care physician when you use online health care to make sure your doctor can stay on top of your care. After your visit, you can share an optional visit summary with your primary care provider.

All Virtual Care services from Teladoc Health are separate from virtual care other providers may offer. Remember to follow up with your primary care provider. Your plan may have copayments, deductibles and out-of-pocket costs.

HOW TO REGISTER AT BCBSM.COM

Enjoy the convenience — and freedom — you get with your online account:

- Check your balance and coverage.
- Track your claims and explanation of benefits statements.
- Find care and look up costs
- Shop exclusive member discounts.
- Plus, you can access your member ID card, health and well-being resources and more.

ACTIVATE YOUR ACCOUNT IN ONE OF THREE WAYS:

Go online.

1. Go to bcbsm.com/register and select Register Now.
2. Once your account is activated, you can set up one for each of your dependents.

Use the BCBSM app.

Download the app from the App Store® or Google Play™ (search BCBSM).

1. Tap the  app and then Register.
2. Use the app to snap a photo of your ID card. Your enrollee ID number will be entered for you.

Text BCBSM.

1. Text REGISTER to 222764 to start setting up your Blue Cross member account.*

If you need help with registration, call 1-888-417-3479

*Message and data rates may apply. Visit bcbsm.com for our Terms and Conditions of Use and Privacy Practices.

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BCBSM MOBILE APP

Get the Blue Cross mobile app

- Check your coverage, claims and balances.
- Show and share your plan's ID card.
- Find in-network care and compare costs.
- Check hospital and doctor quality.

Get the app

Apple® App Store®

Google Play™

Search BCBSM

Or, text APP

to 222764

Your health care plan — at your fingertips.

Blue365 ▪ SAVE MONEY AND LIVE HEALTHIER

Membership has its benefits

Blue Cross Blue Shield of Michigan and Blue Care Network members can score big savings on a variety of health-related products and services from businesses in Michigan and across the United States.

Member discounts with Blue365 offers exclusive deals on things like:

- Fitness and wellness: Health magazines, fitness gear and gym memberships
- Healthy eating: Cookbooks, cooking classes and weight-loss programs
- Lifestyle: Travel and recreation
- Personal care: Lasik and eye care services, dental care and hearing aids

Cash in on discounts

Start saving today! Show your Blue Cross or Blue Care Network ID card at participating local retailers or use an offer code online to take advantage of these savings. For a full list of discount offers, log in or register at bcbsm.com and click Member Discounts with Blue365® on your home page. You can also conveniently access discounts on the go with the Blue Cross mobile app. Search BCBSM in Google Play™ or the App Store® to download our mobile app.

Member discounts with Blue365

Take advantage of discounts from the businesses listed below and many more.

You can conveniently access discounts from any device — anytime, anywhere.

BLUE DISTINCTION TOTAL CARE

When you need specialty care, choosing the right hospital or other health care facility is as important as choosing your doctor. But how do you decide?

Blue Cross Blue Shield of Michigan can help put your mind at ease. The Blue Cross and Blue Shield Association has evaluated hospitals and facilities across the country for certain specialty care procedures to make it easier for you to find high-quality care at the location that's right for you.

The national Blue Distinction Specialty Care program recognizes hospitals and other health care facilities that provide high-quality care in 10 specialties. These health care providers have a proven history of delivering care with better results than other hospitals and facilities that have not earned designation.

The Blue Distinction Specialty Care program has helped patients face their specialty care procedures with confidence since 2006. It offers you the tools and knowledge you need to make smart, informed decisions about where to receive high-quality, cost-efficient specialty care.

Hospitals and other health care facilities earn designation as Blue Distinction Centers or Blue Distinction Centers+ for delivering superior care in:

♦ Bariatric surgery	♦ Cancer care	♦ Cardiac care
♦ Knee and hip replacement	♦ Maternity care	♦ Spine surgery
♦ Transplants	♦ Fertility care	♦ Cellular immunotherapy CAR-T
♦ Gene therapy – ocular disorders		

The Blue Distinction Specialty Care program evaluates health care providers against objective, nationally consistent quality and affordability criteria that were developed with input from medical experts.

Hospitals and other health care facilities may earn Blue Distinction Center or Blue Distinction Center+ designations for one specialty area or several. Blue Cross evaluates the existing centers and new applicants regularly before awarding designations based on quality of care, including:

- Expertise in the specialty care treatment
- Number of procedures performed
- Track record of results for the procedure

Visit the Hospital Quality page at bcbsm.com/hospital-quality, to learn more about Blue Distinction Centers and to find other resources about the quality of hospital care.

Find a Blue Distinction Center near you.

You'll find Blue Distinction Centers and Blue Distinction Centers+ in 48 states and the District of Columbia.

- Go to bcbsm.com and log in to your member account, if you have one. If you don't, click on Register now.
- After logging in, click on Find a doctor under the Doctors and Hospitals tab.
- Scroll down, and click on the Find care link.
- Type "hospital" in the search field, and press Enter.
- Select a procedure type from the Blue Distinction list on the left side of the screen.
- Choose the hospital or facility that's right for you.

TOBACCO CESSATION COACHING

Give up tobacco products. For good.

Try the Blue Cross Tobacco Coaching program, and take the first step toward better health.

Quitting tobacco products can be difficult, but we can help you achieve your goal of becoming tobacco-free.

Blue Cross Blue Shield of Michigan's Tobacco Coaching program, powered by WebMD®, provides you with the support and resources you need to establish and embrace a tobacco-free life. The 12-week program includes over-the-phone coaching for quitting all types of tobacco products, including electronic cigarettes and other vaping devices. And, it's offered at no extra cost to you.

To be eligible for the program, you must:

- Be ready to set a quit date within the next 30 days
- Have used a tobacco product within the past seven days of your initial call to WebMD

When you engage in the program, you'll receive:

- Five calls from a specially trained health coach over a 12-week period
- Unlimited calls to a health coach
- Online resources

And, about seven months after the program ends, your health coach will contact you to check on your progress.

Health coaches are available seven days a week, so it's easy to schedule your coaching appointments at a time that's convenient for you.

Health coaches are available:

- Monday through Thursday 9 a.m. to 11:30 p.m.
- Friday 9 a.m. to 8 p.m.
- Saturday 9:30 a.m. to 6 p.m.
- Sunday 1 p.m. to 11:30 p.m.

Call 1-855-326-5102 to schedule your first Tobacco Coaching session. All hours are Eastern time.

BLUE CROSS VIRTUAL WELL-BEING

Let Blue Cross Virtual Well-Being give you the guidance and support you need on your personal well-being journey.

Virtual Well-Being:

- Features short, high-energy, live webinars on Wednesdays and Thursdays at noon Eastern time.
- Focuses on a different well-being topic each week.
- Topics include mindfulness, resilience, social connectedness, emotional health, financial wellness, physical health, gratitude, meditation and more.
- Offers informational materials you can download to save and share.

Conveniently watch Virtual Well-Being webinars on your computer, tablet or mobile phone. Learn more, register or watch past webinars at bluecrossvirtualwellbeing.com.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

All employees and their families have access to an Employee Assistance Program (EAP) and Work/Life services provided through Health Advocate and Unum.

Eligibility: Available to employees, eligible dependents, parents and parents-in-law.

EAP and Work/Life Services include:

Call Centers:

- 24/7 access to master's level staff clinicians for information, assessment, short-term problem resolution and referrals.
- Consultation regarding (but not limited to):
  - Relationship issues, stress, coping with change, grief and loss, family and marital issues
  - Adjustment disorder, depression, anxiety, drug and alcohol abuse, gambling, and domestic violence
  - Parenting skills, positive discipline, child development, safety, becoming a parent and special needs issues
  - Work related issues such as coworker relationships, burnout, and workplace stress
  - Case management for inpatient and outpatient treatment

Phone Consultations and In-Person Sessions:

- Unlimited telephonic support
- Up to 3 face-to-face sessions per issue for assessment and short-term problem resolution
- Secure, HIPAA compliant video EAP sessions for those in rural communities, those with transportation concerns, or those that may prefer the use of technology to receive services.

Work/Life Resources:

- Consultation regarding (but not limited to):
  - Child care issues, such as family child care homes, nanny agencies, summer camps, babysitter tips, community resources
  - Referrals for local in-home or daycare options with confirmed vacancies
  - Elder care issues, such as nursing homes, assisted-living facilities, independent living facilities, home healthcare, hospice, respite care, geriatric care managers, senior centers, adult day care centers, community services

Financial Services

- Financial consulting via telephone for topics such as debt management, budgeting, college funding, retirement strategies, life insurance needs
- Financial planning with certified financial professionals
- Credit management, budget analysis, home buying, mortgage refinancing evaluation, retirement planning, 401(k) plan questions, basic estate planning, tax questions

Medical Bill Saver

- Can help lower your out-of-pocket costs on medical bills not covered by your insurance.
- Will work with your providers to lower the balance on any uncovered medical or dental bill over $400.
- Can assist with negotiating bills to help reduce balances that get applied to deductibles and coinsurance.

And More!

To utilize these services, you can:
Call toll free 24/7 at 1-800-854-1446 (multi-lingual)
Go online at www.unum.com/lifebalance

CRISIS TEXT LINE

Whether it's your friends, family, or community, everyone needs someone to lean on.

If you don't know where to turn, you can text **HOME** to **741741**.

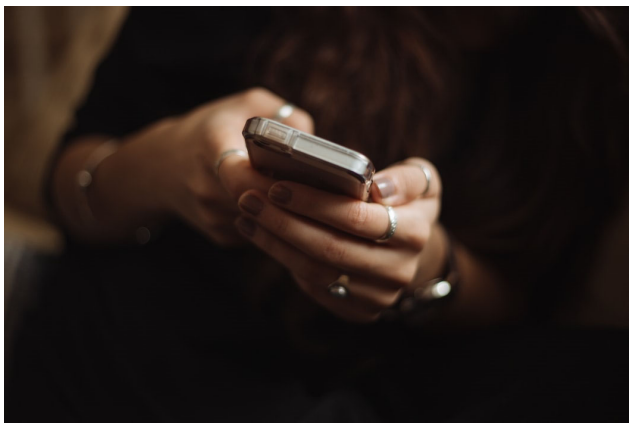
A volunteer Crisis Counselor with Crisis Text Line will be there for you. It's free and 24/7.

FREE 24/7 SUPPORT AT YOUR FINGERTIPS

Send a Text

or

Message on Facebook.



CRISIS TEXT LINE

How does it work?

- Anytime you are struggling with difficult situations or painful emotions, and you feel you need some support, or someone to talk to—you can quickly reach out for support by sending a text message to **741741**.
- The first two responses are automated. They tell you that you're being connected with a Crisis Counselor and invite you to share a bit more.
- The Crisis Counselor is a trained volunteer, not a professional. They can provide support, but not medical advice.
- It usually takes less than five minutes to connect you with a Crisis Counselor (it may be longer during high-traffic times). Once you've reached a Crisis Counselor, they'll introduce themselves, reflect on what you've said, and invite you to share at your own pace.
- You'll then text back and forth with the Crisis Counselor. You never have to share anything you don't want to. The Crisis Counselor will help you sort through your feelings by asking questions, empathizing, and actively listening.
- The conversation typically ends when you and the Crisis Counselor both feel comfortable deciding that you're in a "cool," safe place. After the conversation, you'll receive an optional survey so you can give feedback on your experience.
- The goal of any conversation is to get you to a calm, safe place. Sometimes that means providing you with a referral to further help, and sometimes it just means being there to listen.

BASIC TERM LIFE / AD&D

OHM Advisors provides eligible employees with Term Life and Accidental Death & Dismemberment (AD&D) coverage. OHM Advisors pays the full cost of this coverage, and the policy is insured by Unum. Eligible employees are automatically enrolled in this plan.

Term Life Insurance covers you for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also included, which can pay a benefit if you survive an accident but have certain serious injuries. It can pay an additional amount if you die from a covered accident.

TERM LIFE BENEFIT	
Employee	Full-time employees will receive a benefit equal to 2X annual earnings up to $100,000. Benefits reduce for employees age 70 and older.
Spouse	If eligible (see delayed effective date), your spouse can receive $5,000 in coverage.
Children	If eligible (see delayed effective date), your children can receive coverage as follows: • $1,000 for children from live birth to 6 months. • $2,000 for children 6 months until 19, or 26 with full-time student status.
Delayed Effective Date	If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Refer to the plan booklet for details.
ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	
Employee	Full-time employees will receive a benefit equal to 2X annual earnings up to $100,000.
FEATURES INCLUDED	
Living Benefit	If you are diagnosed with a terminal illness with less than 12 months to live, you can request 100% of your life insurance benefit while you are still living. This amount will be taken out of the death benefit and may be taxable.
Portability	You may be able to keep coverage if you leave the company, retire, or have a reduction in hours. If interested, you will need to contact Unum within 30 days of your status change.

For more detailed descriptions of coverage, limitations, and exclusions, please refer to the Unum benefit booklet. You can find these on our website at: **OHM Advisors - Home (sharepoint.com)**

OPTIONAL TERM LIFE

OHM Advisors offers eligible employees the option to purchase additional life insurance through Unum. You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

New Hires: All newly eligible employees have the opportunity to elect coverage up to the guarantee issue amounts listed below without having to answer any medical questions via an Evidence of Insurability form.

Open Enrollment: Employees that are already enrolled in at least $10,000 of Optional Life coverage can choose to increase coverage during Open Enrollment, and will not have to answer medical questions/submit Evidence of Insurability (EOI). Employees that initially waived Optional Life during their initial eligibility period will need to submit an EOI form to be considered for enrollment.

OPTIONAL TERM LIFE BENEFIT		**When is Evidence of Insurability (EOI) Required?**
Employee	$10,000 increments to the lesser of 5X your earnings or $300,000. (Guarantee Issue = $200,000)	▪ If you are electing more than $200,000. ▪ If you previously waived coverage and wish to enroll now.
Spouse	$5,000 increments to the lesser of 100% of your benefit amount or $300,000. (Guarantee Issue = $25,000)	▪ If you are electing more than $25,000 for your spouse. ▪ If you previously waived spouse coverage and wish to enroll now. (No EOI is needed if you elect to add spouse coverage within 30 days of getting married).
Child	$2,000 increments to the lesser of 100% of your benefit amount or $10,000. (Guarantee Issue = $10,000)	▪ EOI is not required for children.
Delayed Effective Date	If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Refer to the plan booklet for details.	

For more detailed descriptions of coverage, limitations, and exclusions, please refer to the Unum benefit booklet. You can find these on our website at: **OHM Advisors - Home (sharepoint.com)**

OPTIONAL TERM LIFE

Calculate your costs

1. **Enter the coverage amount you want.**
2. **Divide by the amount shown.**
3. **Multiply by the rate. Use the rate table below to find the rate based on age.**

Choose the age you will be when your coverage becomes effective on 01/01/2024. To determine your spouse rate, choose the age the spouse will be when coverage becomes effective on 01/01/2024.

4. **Enter your monthly cost**
5. **Multiply by 12, then Divide by # of pay deductions per year (26)**
6. **Enter your per pay cost**

	1	2	3	4	5	6
Employee	$_____,000	÷ $10,000 = $_____	X $_____	= $_____	X 12, then ÷26	= $_____
Spouse	$_____,000	÷ $5,000 = $_____	X $_____	= $_____	X 12, then ÷26	= $_____
Child	$_____,000	÷ $2,000 = $_____	X $_____	= $_____	X 12, then ÷26	= $_____
			Total cost			

	Employee monthly rate	Spouse monthly rate	Child monthly rate
Age	Per $10,000 of coverage	Per $5,000 of coverage	$.500 per $2,000 of coverage
	Cost	Cost	
15-24	$0.590	$0.295	
25-29	$0.600	$0.300	
30-34	$0.800	$0.400	
35-39	$0.930	$0.465	
40-44	$1.470	$0.735	
45-49	$2.470	$1.235	
50-54	$4.280	$2.140	
55-59	$7.030	$3.515	
60-64	$9.340	$4.670	
65-69	$14.650	$7.325	
70-74	$25.770	$12.885	
75+	$42.580	$21.295	

VOLUNTARY SHORT TERM DISABILITY

OHM Advisors offers a Short Term Disability (STD) plan to all eligible employees. STD pays you income if you are disabled from work due to a non-work related illness or injury. This plan is insured by Unum.

NOTE! New hires will automatically be enrolled in this plan.
If you want to decline coverage, you must submit a ticket to the HR Service Desk

Guarantee Issue / Evidence of Insurability (EOI)

- Newly Eligible Employees: STD enrollment is guaranteed without having to answer any medical questions.
- Ongoing Employees: If you previously waived coverage when it was first offered to you, you can request to enroll in coverage as a late entrant, but enrollment will be subject to medical questions submitted on an EOI form. Unum can limit or deny coverage based on the EOI.

ITEM	STD BENEFIT
Weekly Benefit	60% of earnings up to a maximum benefit of $2,500 per week.
Elimination Period	Benefits begin on the 1st day for disabilities caused by an injury and on the 8th day for disabilities due to an illness.
Benefit Period	Benefits are payable for up to 13 weeks, minus any applicable elimination period. The standard benefit amount for maternity leave is 6 weeks, (8 weeks for Cesarean section) minus the applicable elimination period. Benefit period may vary by diagnosis. Subject to approval from Unum.
Definition of Disability	Disability is the inability to perform the substantial duties of your regular occupation due to injury or sickness causing a 20% or more loss in weekly earnings.

Calculate your benefit and cost

You pay for STD coverage on a post-tax basis, so that any benefit you receive will be tax-free.

Disability worksheet

1. Calculate your weekly disability benefit.

$_____ ÷ 52 = $_____ X 60% = $_____

Your annual earnings	Your weekly earnings	Max% of Income earned	Max weekly benefit available (if the amount exceeds the plan max of $2,500, enter $2,500).

2. Calculate your cost per paycheck.

$_____ ÷ 10 = $_____ X $0.305 = $_____ X 12 = $_____ ÷ 26 = $_____

Your weekly Benefit amount	Your rate	Your monthly cost	Your annual cost	Number of paychecks per year	Total cost Per paycheck

Your coverage effective date or any increase in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. For more detailed descriptions of coverage, limitations, and exclusions, please refer to the Unum benefit booklet. You can find these on our website at: **OHM Advisors - Home (sharepoint.com)**

VOLUNTARY LONG TERM DISABILITY

OHM Advisors offers a Long Term Disability (LTD) plan to provide income to employees who are disabled for an extended period of time. This plan is also insured by Unum.

Guarantee Issue / Evidence of Insurability (EOI)

- Newly Eligible Employees: LTD enrollment is guaranteed without having to answer any medical questions.
- Ongoing Employees: If you previously waived coverage when it was first offered to you, you can request to enroll in coverage as a late entrant, but enrollment will be subject to medical questions submitted on an EOI form. Unum can limit or deny coverage based on the EOI.

ITEM	LTD BENEFIT
Weekly Benefit	60% of earnings to a monthly maximum of $7,500.
Elimination Period	90 days for illness or injury.
Benefit Period	Benefits are payable up to normal Social Security retirement age. See the Unum booklet for disabilities occurring at age 62 or after . Benefits are limited to 24 months in a person's lifetime for mental illness conditions, unless you are confined to a hospital. Benefits are limited to 24 months per occurrence for substance abuse, and disabilities based primarily on self-reported symptoms.
Definition of Disability	Disability is the inability to perform the substantial duties of your regular occupation due to injury or sickness causing a 20% or more loss of indexed monthly earnings.
Pre-existing Conditions	Benefits aren't payable for a disability that is caused by, or contributed to by a pre-existing condition, if the disability starts before the end of your first twelve months of coverage. A sickness or injury is pre-existing if, during the three months before your coverage effective date, you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines.

Calculate your benefit and cost

You pay for LTD coverage on a post-tax basis, so that any benefit you receive will be tax-free.

Disability worksheet

1. Enter your annual earnings and calculate your maximum monthly benefit available.

$_____ ÷ 12 = $_____ X 60% = $_____

Your annual earnings	Your monthly Earnings	Max% of Income covered	Max monthly benefit available (if the amount exceeds the plan max of $7,500, enter $7,500).

2. Calculate your cost per paycheck.

$_____ ÷ 100 = $_____ X $0.430 = $_____ ÷ 26 = $_____

Your annual Earnings	Your rate	Your annual cost	Number of paychecks per year	Total cost Per paycheck

Your coverage effective date or any increase in coverage may be delayed if you are disabled on the date coverage is scheduled to take effect. For more detailed descriptions of coverage, limitations, and exclusions, please refer to the Unum benefit booklet. You can find these on our website at: **OHM Advisors - Home (sharepoint.com)**

VOLUNTARY CRITICAL ILLNESS

New for 2024!

Voluntary Critical Illness Insurance can pay money directly to you when you're diagnosed with certain serious illnesses. If you are diagnosed with a covered illness, you can receive a lump sum benefit payment. You can use the money however you want. It can be used to help you pay your medical out-of-pocket costs, or you can use it to pay for non-medical items as well. The money is there for you to help you during a difficult time. This coverage can be used more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

Rates are based on age.

- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You'll be billed directly.

Who is eligible?

- You, Your Spouse, Your Children (Dependent children newborn to age 26,regardless of marital or student status). Employee must purchase coverage in order to purchase spouse coverage.
- Choose $10,000, $20,000 or $30,000 of coverage with no medical underwriting to qualify if you apply during this enrollment.
- Spouses can only get 50% of the employee coverage amount as long as you have purchased coverage for yourself.
- Children from birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of your election.

The charts on the following page shows some highlights of what's covered under this plan.

ATTAINED AGE	EMPLOYEE & CHILD			SPOUSE		
Rates are based on Attained Age. Premiums increase as insured ages. Spouse rate based on Spouse age						
	$10,000	$20,000	$30,000	$5,000	$10,000	$15,000
Under 25	$1.50	$3.00	$4.50	$0.75	$1.50	$2.25
25-29	$2.20	$4.40	$6.60	$1.10	$2.20	$3.30
30-34	$3.20	$6.40	$9.60	$1.60	$3.20	$4.80
35-39	$4.50	$9.00	$13.50	$2.25	$4.50	$6.75
40-44	$6.60	$13.20	$19.80	$3.30	$6.60	$9.90
45-49	$9.90	$19.80	$29.70	$4.95	$9.90	$14.85
50-54	$15.40	$30.80	$46.20	$7.70	$15.40	$23.10
55-59	$22.20	$44.40	$66.60	$11.10	$22.20	$33.30
60-64	$32.70	$65.40	$98.10	$16.35	$32.70	$49.05
65-69	$49.00	$98.00	$147.00	$24.50	$49.00	$73.50
70-74	$74.20	$148.40	$222.60	$37.10	$74.20	$111.30
75-79	$104.60	$209.20	$313.80	$52.30	$104.60	$156.90
80-84	$145.20	$290.20	$435.30	$72.55	$145.10	$217.65
85+	$229.00	$458.00	$687.00	$114.50	$229.00	$343.50

VOLUNTARY CRITICAL ILLNESS—Continued

CANCER	
Invasive Cancer	100%
Non-Invasive Cancer	25%
Skin Cancer	$500
CRITICAL ILLNESSES	
Heart Attack (Myocardial Infarction)	100%
End Stage Renal (Kidney) Failure	**100%**
Major Organ Failure Requiring Transplant	100%
Stroke	100%
Coronary Artery Disease (Major)	50%
Coronary Artery Disease (Minor)	10%
PROGRESSIVE DISEASES	
Dementia (including Alzheimer's Disease)	100%
Functional Loss	100%
Multiple Sclerosis	100%
Parkinson's Disease	$100%
SUPPLEMENTAL CRITICAL ILLNESSES	
Benign Brain Tumor	100%
Coma	100%
Loss of Hearing	100%
Loss of Sight	100%
Loss of Speech	100%
HIV or Hepatitis	100%
Permanent Paralysis	100%
Infection Disease	25%
Infectious Disease Hospital Consecutive Days	14 Days
ADDITIONAL CRITICAL ILLNESSES FOR YOUR CHILDREN	
Cerebral Palsy	100% (50% of coverage amount)
Cleft Lip or Palate	100% (50% of coverage amount)
Cystic Fibrosis	100% (50% of coverage amount)
Down Syndrome	100% (50% of coverage amount)
Spina Bifida	100% (50% of coverage amount)

For more detailed descriptions of coverage, limitations, and exclusions, please refer to the Unum benefit booklet. You can find these on our website at: **OHM Advisors - Home (sharepoint.com)**

VOLUNTARY HOSPITAL INDEMNITY INSURANCE

OHM Advisors offers a voluntary Hospital Indemnity plan through Unum. Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness, or childbirth.

- The money is paid directly to you — not to a hospital or care provider.
- The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as coinsurance, copays and deductibles.
- You get affordable rates when you buy this coverage at work.
- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You'll be billed directly.

Who is eligible?

- You, Your Spouse (ages 17 and up), Your Children (Dependent children newborn until their 26th birthday, regardless of marital or student status). Employee must purchase coverage in order to purchase spouse or child coverage.

HOSPITAL		
Covered Benefits		
Admission	Payable for a maximum of 1 day per year	$1,000
ICU Admission	Payable for a maximum of 1 day per year	$1,500
Hospital Daily Stay	Payable per day up to 365 days	$200
ICU Daily Stay	Payable per day up to 30 days	$150
Short Stay	Payable for a maximum of 1 day per year	$250

RATES: BI-WEEKLY / PER PAYCHECK	
Employee Only	$8.18
Employee + Spouse	$18.09
Employee + Children	$12.66
Family	$22.57

For more detailed descriptions of coverage, limitations, and exclusions, please refer to the Unum benefit booklet. You can find these on our website at: **OHM Advisors - Home (sharepoint.com)**

VOLUNTARY ACCIDENT INSURANCE

OHM Advisors offers voluntary Accident Insurance through Unum. Accident Insurance can pay a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. It includes a range of incidents, from common injuries to more serious events.

Accident insurance is valuable because:

- It provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident.
- These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and child care.
- You're guaranteed base coverage, without answering health questions.
- The cost is conveniently deducted from your paycheck.
- You can keep your coverage if you change jobs or retire. You'll be billed directly.
- Voluntary accident insurance provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident, or for accidental death and dismemberment. These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and child care.

Benefit schedule specifies payment amounts for events like:

- Burns
- Coma
- Dislocations
- Emergency Room treatments
- Fractures
- Hospitalizations
- Major diagnostic tests
- Paralysis
- Physical Therapy
- Surgery

Be Well Benefit

Every year, each family member who has Accident coverage can also receive **$75** for getting a covered Be Well Benefit screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

BI-WEEKLY RATES	
Employee Only	$6.79
Employee + Spouse	$12.11
Employee + Children	$14.70
Family	$20.02

For more detailed descriptions of coverage, limitations, and exclusions, please refer to the Unum benefit booklet. You can find these on our website at: **OHM Advisors - Home (sharepoint.com)**

24-HOUR EMERGENCY TRAVEL ASSISTANCE

OHM Advisors employees are also automatically covered by Unum's worldwide emergency travel assistance.
It is available to you and your family members who are travelling 100 miles or more away from home.
Emergency medical assistance for employees, spouses, and dependent children.
Assistance is available 24 hours a day, 7 days a week.

Access to Assist America is as close as your smart phone! Download the Assist America free App for iPhone and Android, which will give you instant access to a wide range of assistance, including:

- One-touch call to our 24/7 Emergency Operations Center
- Pre-trip information, such as:
  - Country-specific visa requirements
  - Immunization regulations
  - Security advisories
  - and more
- Global Embassy Locator
- Information about all our member services
- U.S. Pharmacy Locator
- Travel alerts

Services include:

- Medical consultation, evaluation and referral
- Hospital admission assistance
- Emergency medical evacuation
- Critical care monitoring
- Medical repatriation
- Prescription assistance
- Emergency message service
- Transportation for a friend or family member to join the hospitalized patient
- Care and transport of minor children
- Emergency trauma counseling
- Assistance in return of vehicle
- Legal and interpreter referrals
- Return of mortal remains

MY PET PROTECTION

Voluntary Pet Insurance

My Pet Protection® through Nationwide is offered exclusively to employees and gives your pet superior protection at an unbeatable price.

- 90% back on vet bills
- Visit any vet, anywhere
- Exclusive to employees, not available to the general public
- One price, regardless of the pet's age
- Best deal: average savings of 40% over similar plans from other pet insurers

Sign up multiple pets with individual plans and receive a discount[3] for even more savings.

- **Accidents,** including poisonings and allergic reactions
- **Injuries,** including cuts, sprains and broken bones
- **Common illnesses,** including ear infections, vomiting and diarrhea
- **Serious/chronic illnesses,** including cancer and diabetes
- **Hereditary** and congenital conditions
- **Surgeries** and hospitalization
- **X-rays,** MRIs and CT scans
- **Prescription medications** and therapeutic diets

My Pet Protection with Wellness® is also available for preventive care coverage, including checkups, shots and more.

#

Easy Enrollment	**1. Select the species (dog or cat)**	**2. Provide your zip code**	**3. Pick your plan**
	To enroll your bird, rabbit, reptile or other exotic pet, please call 888-899-4874.		

vethelpline® Available to all pet insurance members. Unlimited, 24/7 access to a veterinary professional ($150 value). Only from Nationwide®.

My Pet Protection® is available exclusively through your employer.

Get a quote today. **https://benefits.petinsurance.com/ohm-advisors**

Nationwide® is on your side

[1]Some exclusions may apply. Certain coverages may be subject to pre-existing exclusion. See policy documents for a complete list of exclusions. [2]Average based on similar plans from top competitors' websites for a 4-year old Labrador retriever in California, 94550. Data provided using information available as of March 2016. [3]Pet owners receive a 5% multiple pet discount by insuring two to three pets or a 10% discount on each policy for four or more pets.

LEGAL SHIELD | ID SHIELD

HAVE YOU EVER...

Associate: ALI C. SANDERS
Email: alisanders@legalshieldassociate.com
Phone: 248-991-5065
Website: www.shieldbenefits.com/ohmi

- ❑ Needed your will prepared or updated?
- ❑ Signed a contract?
- ❑ Received a moving traffic violation?
- ❑ Worried about being a victim of identity theft?
- ❑ Been concerned about your child's identity?
- ❑ Had social media accounts? (Facebook, Instagram, Twitter, LinkedIn, YouTube)

The LegalShield Membership Includes:

- Dedicated Law Firm Direct access, no call center
- Legal Advice/Consultation on unlimited personal issues
- Letters/Calls made on your behalf
- Contracts/Documents Reviewed Up to 15 pages
- Residential Loan Document Assistance for the purchase of your primary residence
- Will Preparation—Living Will, Health Care Power of Attorney, Financial Power of Attorney
- Speeding Ticket Assistance
- IRS Audit Assistance (Begins with the tax return due April 15th of the year you enroll)
- Trial Defense (If named defendant/respondent in a Covered civil action suit)
- Uncontested Divorce, Separation, Adoption and/or Name Change Representation (Available 90 days after enrollment)
- 25% Preferred Member Discount (Bankruptcy, criminal charges, DUI, personal injury, etc.).
- 24/7 Emergency Access for covered situations

The IDShield Membership Includes:

- Credit Monitoring Continuous credit monitoring through TransUnion
- Online Privacy Management IDShield provides consultation and guidance on ways participants can protect their privacy and personally identifiable information across the internet and on their smart devices
- Reputation Management & Score - Scans social media accounts for existing content that could be damaging to a participants' online reputation and ranks your online risk
- Financial Account Monitoring Accounts monitored include checking, savings, employer 401k accounts, loans and more
- $1 Million Protection Policy Coverage for lost wages, legal defense fees, stolen funds and more
- Unlimited Service Guarantee ensures that we won't give up until your identity is restored!
- Identity Restoration Performed by Licensed Private Investigators to restore your identity to its pre-theft status
- 24/7 Emergency Access with an identity theft emergency

Plan Prices are Per Pay Period Deduction	Family Price	Individual Price
LegalShield Legal Plan Only	**$8.75 / every two weeks**	**$8.75 / every two weeks**
IDShield Identity Theft Plan Only	**$8.75 / every two weeks**	**$4.13 / every two weeks**
Combined Plans	**$15.65 / every two weeks**	**$12.88 / every two weeks**

The secure website to enroll is www.shieldbenefits.com/ohmi

PLEASE NOTE: Member's spouse coverage can be a married spouse OR boyfriend/girlfriend; domestic partner; same sex partner

Put your law firm and identity theft protection in the palm of your hand with the LegalShield and IDShield mobile apps!

LegalShield legal plans cover the member; member's spouse; never married dependent children under 26 living at home; dependent children under the age 18 for whom the member is the legal guardian; never married dependent children up to age 26 if a full-time college student; or physically or mentally disabled dependent children. IDShield is a product of Pre-Paid Legal Services, Inc. d/b/a LegalShield ("LegalShield"). LegalShield provides access to identity theft protection and restoration services. For complete terms, coverage and conditions, please see www.idshield.com. All Licensed Private Investigators are licensed in the state of Oklahoma. A $1 million insurance policy is issued through a nationally recognized carrier. LegalShield/IDShield is not an insurance carrier. Certain limitations apply. IDShield is a product of Pre-Paid Legal Services, Inc. d/b/a LegalShield ("LegalShield"). LegalShield provides access to identity theft protection and restoration services. IDShield plans are available at individual or family rates. For complete terms, coverage and conditions, please see an identity theft plan. All Licensed Private Investigators are licensed in the state of Oklahoma. An Identity Fraud Reimbursement Policy ("Policy") is issued through a nationally recognized carrier. LegalShield/IDShield is not an insurance carrier. This covers certain identity fraud expense reimbursement and legal costs as a result of a covered identity fraud. The amount of coverage is dependent on the type of identity theft plan. See a Policy for complete terms, coverage, conditions and limitations related to family members who are eligible for coverage under the Policy. For a summary description of benefits for the Policy coverage see https://idshield.cloud/summary-of-benefits. We do not monitor all transactions at all businesses and the monitoring network is limited only to institutions participating in the financial monitoring feature.

LEGAL SHIELD | ID SHIELD ▪ **MEMBER**PERKS

Save with these incredible **MEMBER**PERKS

Your LegalShield and IDShield Memberships are simply amazing. In addition to the privileges that are already yours, we have added these MEMBERPERKS with hundreds of merchants and thousands of discounts. Members can access savings at both national and local companies on everyday purchases such as tickets, electronics, apparel, travel and more. Members have the opportunity to save, on average, over $2,000 per year. MEMBERPERKS can save you enough to pay for your membership for years to come!

RECEIVE EXCLUSIVE DISCOUNTS

Access your members-only discounts in categories such as:

- APPAREL
- AUTOMOTIVE
- BOOKS, MOVIES & MUSIC
- CELL PHONES
- ELECTRONICS
- FINANCE
- FLOWERS & GIFTS
- FOOD
- HEALTH & WELLNESS
- HOME SERVICES
- INSURANCE & PROTECTION SERVICES
- OFFICE & BUSINESS
- REAL ESTATE & MOVING SERVICES
- SPORTS & OUTDOORS
- TICKETS & ENTERTAINMENT
- TRAVEL

WHAT MEMBERS ARE SAYING:

MEMBERPerks pays for my membership!

- Martha S.

"I saved 20% at Advance Auto and I also saved 30% on movie tickets on date night with my wife. This membership is it!"

- Andre E.

"I am receiving 8% off my Verizon cell phone monthly charge!"

- Paulette M.

Enjoy preferred member pricing on some of your favorite brands and services.

Office DEPOT OfficeMax · Harry & David · Skechers Direct More Than Just Work Shoes · VIVIDSEATS · verizon · Postmates · AMC Theatres · Holiday Inn Club Vacations · HOME CHEF · MAJOR LEAGUE BASEBALL · AND MANY MORE!

Getting Started

To sign up, simply log in at legalshield.perkspot.com. If you don't already have an account, follow the simple on-screen instructions to make an account with your personal or work email and LegalShield Membership number.

These benefits are for LegalShield and IDShield Members. All offers or promotions are subject to change without notice.

SHEET_MEMBERPerks_060420

SECURE WEBSITE TO ENROLL: www.shieldbenefits.com/ohmi

PTO / HOLIDAY

Number of Years	Total PTO Days	Total Hours*
1 through 5	15	120 hours
6	16	128
7	17	136
8	18	144
9	19	152
10 through 19	20	160
20 through 25	25	200

*Hours shown are for FT staff. For FTE and PT, see Proration Chart in your employee handbook.
The maximum PTO accumulation carryover shall be five days (40 hours).

NEW EMPLOYEES

New eligible employees will accrue PTO at the rate of 1.25 days per month (or pro-ration of) from date of hire until January 1 following date of hire. New employees are subject to 90-day waiting period before accredited PTO may be used. PTO accrued during the 90-day waiting period will be available on the 91st day of employment.

HOLIDAY

Employees receive a total of 9 paid holidays: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving, the day after Thanksgiving, Christmas Eve, Christmas Day and a Floating holiday. Other holiday time off is at the discretion of the Corporate Officers.

401(k) PLAN / ROTH 401(k)

The OHM Advisors 401(k) Plans and Profit-Sharing will assist employees in reaching financial goals for retirement. Employees age 21 & up are eligible to participate in the 401k plan immediately in accordance with plan and complete 90 days of service to participate in the profit-sharing plan. Employer match and profit-sharing will be paid the following year provided the employee works a minimum of 1,000 hours.

OHM will match 50 cents for each dollar deposited through automatic payroll deductions by the employee up to a maximum contribution of $1,500 per plan year. Contribution can only be made in whole percentages between 1% and 90% of your eligible pay on a pre-tax basis, up to the annual IRS dollar limit.

This is a unique opportunity for you. Fidelity and OHM Advisors Profit Sharing / 401(k) Plans are committed to helping you make the most of it. You'll get the information you need to make sound choices, the tools you need to manage effectively, and the continuing guidance and support you need to pursue your goals with confidence.

The 401(k) *total* contribution limit for the 2024 plan year is: **$23,000.** Persons over age 50 are entitled to an additional catch-up contribution of **$7,500** in 2024. All excess contributions are considered *taxable* income.

Visit **www.401k.com** to complete your enrollment or call (800) 835-5097 with questions.

IMPORTANT NOTICES

The Federal Government has outlined several notices as Important Notices for our plan participants, as listed below and included on the following pages:

- Certificate of Creditable Coverage
- Children's Health Insurance Program (CHIPRA)
- Genetic Information Nondiscrimination Act (GINA)
- HIPAA Privacy Practices (instructions of how to obtain)
- Medicare Eligibility—Communicate with Human Resources
- Medicare Part D Creditable Coverage Notices
- Mental Health Parity and Addiction Equity Act (MHPAEA)
- Michelle's Law
- Newborns' and Mothers' Health Protection Act
- Nondiscrimination Statement
- Qualified Changes in Status/Changing your Pre-Tax Contribution Amount Mid-Year and HIPAA Special Enrollment
- Summary of Benefits and Coverage
- Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
- Wellness Program Notice
- Women's Health & Cancer Rights Act
- Your Rights & Protections Against Surprise Medical Bills

IMPORTANT NOTICES

Qualified Changes in Status / Changing your Pre-Tax Contribution Amount Mid-Year

We sponsor a program that allows you to pay for certain benefits using pre-tax dollars. With this program, contributions are deducted from your paycheck before federal, state, and Social Security taxes are withheld. As a result, you reduce your taxable income and take home more money. How much you save in taxes will vary depending on where you live and on your own personal tax situation.

These programs are regulated by the Internal Revenue Service (IRS). The IRS requires you to make your pre-tax elections before the start of the plan year January 1— December 31. The IRS permits you to change your pre-tax contribution amount mid-year only if you experience a change in status, which includes the following:

- Birth, placement for adoption, or adoption of a child, or being subject to a Qualified Medical Child Support Order which orders you to provide medical coverage for a child.
- Marriage, legal separation, annulment or divorce.
- Death of a dependent.
- A change in employment status that affects eligibility under the plan.
- A change in election that is on account of, and corresponds with, a change made under another employer plan.
- A dependent satisfying, or ceasing to satisfy, eligibility requirements under the health care plan.
- Electing coverage under your state's Marketplace (also known as the Exchange) during the annual enrollment or as a result of a special enrollment.

The change you make must be consistent with the change in status. For example, if you get married, you may add your new spouse to your coverage. If your spouse's employment terminates and he/she loses employer-sponsored coverage, you may elect coverage for yourself and your spouse under our program. However, the change must be requested within 30 days of the change in status. If you do not notify Human Resources within 30 days, you must wait until the next annual enrollment period to make a change.

These rules relate to the program allowing you to pay for certain benefits using pre-tax dollars. Please review the medical booklet and other vendor documents for information about when those programs allow you to add or drop coverage, add or drop dependents, and make other changes to your benefit coverage, as the rules for those programs may differ from the pre-tax program.

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 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). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact Human Resources. The Children's Health Insurance Program Reauthorization Act of 2009 added the following two special enrollment opportunities:

- The employee's or dependent's Medicaid or CHIP (Children's Health Insurance Program) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

It is your responsibility to notify Human Resources within 60 days of the loss of Medicaid or CHIP coverage, or within 60 days of when eligibility for premium assistance under Medicaid or CHIP is determined. More information on CHIP is Provided later in this guide.

IMPORTANT NOTICES

Certificate of Creditable Coverage
You can request a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to COBRA, when COBRA coverage ceases, if you request it before you lose coverage, or if you request it up to 24 months after losing coverage.

Children's Health Insurance Program (CHIPRA)
The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") requires employers that maintain group health plans in certain states to notify their employees of potential opportunities for premium assistance available in their state.
If you are an employee residing in one of the following states, please see the attached notice (please note these states are subject to change): AL, AK, AZ, AR, CO, FL, GA, ID, IN, IA, KS, KY, LA, ME, MA, MN, MO, MT, NE, NV, NH, NJ, NY, NC, ND, OK, OR, PA, RI, SC, SD, TX, UT, VT, VA, WA, WV, WI, and WY.

Genetic Information Nondiscrimination Act (GINA)
The Genetic Information Nondiscrimination Act of 2008 protects employees against discrimination based on their genetic information. Unless otherwise permitted, your employer may not request or require any genetic information from you or your family members.
GINA prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.
To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.
"Genetic Information" as defined by GINA, includes an individual's family medical history, the results of genetic tests, the fact that a member sought or received genetic services, and genetic information of a fetus carried by a member or an embryo lawfully held by a member receive assistive reproductive services.

How to Obtain a Notice of HIPAA Privacy Practices
To obtain a notice of privacy practices, please contact your Human Resources Department or your insurance carrier at the telephone listed in this booklet.

Medicare Eligible? Notify HR!
Please notify your Human Resource Department when you or your dependents become eligible for Medicare. We are required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the health plan pays primary. You must also contact Medicare directly to notify them that you have health care coverage through an employer group. Privacy laws prohibit anyone other than the Medicare beneficiary, or their legal guardian, to update or change Medicare records.

Mental Health Parity and Addiction Equity Act (MHPAEA)
The Mental Health Parity and Addiction Act of 2008 general requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For more Information regarding the criteria for medical necessity determinations made under your employer's plan with respect to mental health or substance use disorder benefits, please contact your human resources department.

Michelle's Law
When a dependent child loses student status for purposes of the group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier. For additional information contact your plan administrator.

IMPORTANT NOTICES

Newborns' and Mothers' Health Protection Act

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

Nondiscrimination Statement: Discrimination is Against the Law

Our company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Summary of Benefits and Coverage

In addition, health plans are required to provide members with a Summary of Benefits and Coverage (SBC). The SBC is different from the standard summary, in that it provides members with improved standardized information designed to help better understand your coverage and compare the options available to you. The SBCs are provided for you on the company intranet, Spark.

Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA)

The Uniformed and Services Employment and Re-Employment rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and re-employment in regard to an Employee's military leave of absence. These requirements apply to medical and dental coverage for you and your Dependents. They do not apply to any Life, Short Term or Long Term Disability or Accidental Death & Dismemberment coverage you may have. A full explanation of USERRA and your rights is beyond the scope of this document. If you want to know more, please see the Summary Plan Description (SPD) for any of our group insurance coverage or go to this site: http://www.dol.gov/vets/programs/userra/main.htm

An alternative source is VETS. You can contact them at 1-866-4-USA-DOL or visit this site: http;//www.dol.gov/vets

An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm

Women's Health & Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistent with those established for other benefits under the plan.

IMPORTANT NOTICES

Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

You're protected from balance billing for:

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

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

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

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

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

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

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

If you think you've been wrongly billed, contact the plan or insurance carrier listed on the carrier contacts page in your Employee Benefit Guide. The federal phone number for information and complaints is: **1-800-985-3059**. For more information about your rights under federal law, visit **www.cms.gov/nosurprises/consumers.**

PREMIUM ASSISTANCE UNDER MEDICAID AND CHIP

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of **July 31, 2022**. Contact your State for more information on eligibility.

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

PREMIUM ASSISTANCE UNDER MEDICAID AND CHIP

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	KANSAS – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884
FLORIDA - Medicaid	**KENTUCKY – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 ▪ Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
GEORGIA – Medicaid	**LOUISIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 / GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
INDIANA – Medicaid	**MAINE – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740 TTY: Maine relay 711
IOWA – Medicaid and CHIP (Hawki)	**MASSACHUSETTS – Medicaid and CHIP**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840

PREMIUM ASSISTANCE UNDER MEDICAID AND CHIP

MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MONTANA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
NEBRASKA – Medicaid	**OREGON – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 / Omaha: 402-595-1178	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
NEVADA – Medicaid	**PENNSYLVANIA – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462
NEW HAMPSHIRE – Medicaid	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, X-5218	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
NEW JERSEY – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW YORK – Medicaid	**SOUTH DAKOTA**
Website: https://www.health.ny.gov/health_care/medicaid/ ▪ Phone: 1-800-541-2831	Website: http://dss.sd.gov Phone: 1-888-828-0059

PREMIUM ASSISTANCE UNDER MEDICAID AND CHIP

TEXAS – Medicaid	WASHINGTON – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
UTAH – Medicaid and CHIP	**WEST VIRGINIA – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Websites: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
VERMONT– Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm ▪ Phone: 1-800-362-3002
VIRGINIA – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since **July 31, 2022**, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with our 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. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

- 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.
- Our Company has determined that the prescription drug coverage offered by its employer sponsored health plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is creditable you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current coverage with our company may be affected. You may keep your prescription drug coverage under the group health plan if you select Medicare Part D prescription drug coverage. If you do select Medicare Part D prescription drug coverage, the group health plan prescription drug coverage will coordinate with the Medicare Part D prescription drug coverage. If you do decide to join a Medicare drug plan and drop your current coverage with our company, be aware that you and your dependents may not be able to get this coverage back until the next open enrollment or if you experience a qualifying life event.

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

You should also know that if you drop or lose your current coverage with Our Company and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

MEDICARE PART D CREDITABLE COVERAGE NOTICE

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

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

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

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

Date: January 1, 2024
Name of Entity/Sender: OHM Advisors
Contact Position/Office: Kelly Jackson
Address: 34000 Plymouth Road, Livonia, MI 48150
Phone Number: (734) 522-6711

NOTICE REGARDING WELLNESS PROGRAM

OHM Wellness is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete an annual physical with your primary care physician and participate in a variety of wellness activities throughout the year. You are not required to complete the HRA, to complete your annual physical, or to participate in wellness activities

However, employees who choose to participate in the wellness program will receive a lower health insurance premium in 2025. Although you are not required to complete the HRA, complete your annual physical, and participate in wellness activities, only employees who do so will receive the lower medical plan premiums. Additional incentives of up to $100 in AWARDCO cash may be available for employees who participate in the wellness program. The information from your HRA will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and OHM Advisors may use aggregate information it collects to design a program based on identified health risks in the workplace, OHM Advisors will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.
You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

NOTICE REGARDING WELLNESS PROGRAM

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, you can send an email to US Wellness or to OHM Advisors Human Resources Department:

US Wellness: privacy@uswellness.com

OHM Advisors Human Resources please submit ticket to HR Service Desk

NOTICE OF PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by our company (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on **January 1, 2024.**

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Our company requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs. However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

NOTICE OF PRIVACY PRACTICES

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of OHM Advisors for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures. Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

NOTICE OF PRIVACY PRACTICES

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information. We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below. If you have any questions or complaints, please contact:

OHM Advisors
Attention: Kelly Jackson
34000 Plymouth Road, Livonia, MI 48150
(734) 522-6711

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

This form does not constitute legal advice and is provided "as is." This form is based upon current federal law and is subject to change based upon changes in federal law or subsequent interpretive guidance. This form must be modified to reflect the user's privacy practices and its state law where the state law is more stringent.

GLOSSARY OF TERMS

Below is a list of common terms used by the insurance plans. Please note that these are generic terms, that may or may not apply to your coverage. Please refer to your plan booklets for your specific plan information.

Accelerated Benefit (also referred to as Living Benefit): An optional provision under a life policy that allows the insured to receive the benefit prior to death if the insured has a terminal illness or serious injury requiring long term care.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985 which requires group health plans to provide employees and eligible family members the opportunity to continue health care coverage at their own expense, when coverage would be lost under certain circumstances. This applies to employers with 20 or more employees only.

Coinsurance: A cost sharing arrangement under a health plan where a covered person pays a specified percentage of the cost of a specified service, such as 20% of the cost of a hospital stay.

Conversion: A provision that allows insured to convert their terminated group plan to an individual plan (in most cases the benefit level and rates will change). This provision applies to life insurance only.

Copay: A fixed amount required by a health insurer to be paid by the insured for each office, urgent care, emergency room visit or drug prescription.

Creditable Coverage: Under HIPAA, the period of an individual's coverage under a Group Health Plan, health insurance, Medicare or any one of several other specified health plans or health insurance sources that is not interrupted by a significant break in coverage (generally, a 63 day period).

Deductible: The amount that a person must pay towards covered benefits before any benefits are payable from a health plan.

- **Aggregate Deductible:** All family members' out-of-pocket expenses count toward the family deductible until it is met. Then they are all covered with the health plan's usual copays or coinsurance.
- **Embedded Deductible:** where each family member has an individual deductible in addition to the overall family deductible. When a family member meets his or her deductible before the family deductible is reached, the insurance will begin paying according to the plan's coverage for that member. If only one family member meets an individual deductible, the rest of the family must still pay their deductibles.

Exchange: A health insurance marketplace that makes available Qualified Health Plans (QHPs) to qualified individuals and employers.

Formulary: A list of prescription drugs covered by the plan, and the tier that each drug falls under (e.g. generic, brand name). The formulary is based on evaluations of efficacy, safety and cost-effectiveness of drugs.

Generic Drug: A term used to describe an identical or bioequivalent medication to a brand name medication in dosage form, safety, strength, route of administration, quality, performance and intended use.

Network Provider: Physicians, hospitals, or other health care providers/facilities who contract with the insurance carrier to provide services to its members.

Non-Network Provider: Physicians, hospitals, or other health care providers/facilities who DO NOT have a contract with the insurance carrier to provide services to its members. Depending on the plan, services provided by non-network providers may not be covered, or covered at a lower benefit.

Out-of-Pocket Medical Expenses: Copayments, deductibles and medical expenses that are not covered by the employer's major medical plan.

Portability: An optional provision that allows the insured to continue a group benefit directly through the carrier (in most cases at a similar benefit level and rate). This provision applies to life insurance only.

Preventive Care: Services that are for prevention, not for the treatment of active diseases or illnesses such as routine physical exams and or some screenings.

Reasonable and Customary (also referred to as UCR): Fees paid by an insurance plan for a specific procedure within a specified geographic area. If your provider is a non-network provider and charges more than the R &C you may be responsible for paying the additional amount (this is also referred to as balance billing).

Waiting Period: The period that must pass before an employee or dependent is eligible to enroll (becomes covered) under the terms of the group health plan.

QUESTIONS

Because the world of healthcare and insurance can be confusing and hard to navigate, we are pleased to introduce your Account Manager from our insurance agency, Brown & Brown. Human Resources works closely with Brown & Brown to assist you and answer any questions you may have related to the various plans offered through our benefit program.

OHM Advisors Human Resources	 **Brown & Brown** Main Number: (586) 977-6300
Submit HR Service Desk Ticket	**Sandy Birko,** Account Manager (586) 977-6300 Sandra.Birko@BBrown.com

CARRIER / VENDOR CONTACTS

CARRIER	PHONE	WEBSITE
Blue Cross Blue Shield of MI Medical and RX	(877) 790-2583	www.bcbsm.com
Blue Cross Blue Shield of MI Dental	(888) 826-8152	www.bcbsm.com
Blue Cross Blue Shield of MI Vision	(877) 790-2583	www.bcbsm.com
Crisis Text Hotline Reach out to a trained volunteer for support	Text HOME to 741741	www.crisistextline.org/together
Fidelity 401k	(800) 347-2673	www.401k.com
HealthEquity FSAs and HSAs	(877) 284-9840	www.myHealthEquity.com
LegalShield | IDShield Legal Services and Identity Protection	(248) 991-5065	Ali C. Sanders, Associate Email: alisanders@legalshieldassociate.com www.legalshield.com/info/OHM
MyBenefitsApp OHM Advisors Benefits App	https://ohmadvisors.mybenefitsapp.com/	
Nationwide Pet Insurance	(800) 540-2016	www.petinsurance.com/ohm-advisors
Unum Life, AD&D and Disability Insurance	(800) 421-0344	www.unum.com
Unum Critical Illness, Accident & Hospital Indemnity Insurance	(800) 635-5597	www.unum.com
Unum & HealthAdvocate Employee Assistance Program (EAP)	(800) 854-1446	www.unum.com/lifebalance
US Wellness / Virgin Pulse Wellness Program	(888) 671-9395	Email: support@virginpulse.com join.virginpulse.com/OHMAdvisors

OHM ADVISORS MyBenefitsApp

Access your OHM Advisors Benefits Anytime, Anywhere!

As an OHM Advisors employee, you will be able to access most of your employee benefit plan information and resources when you are “on the go” from your mobile device. Nothing needs to be installed, you can access from a computer, tablet, or smartphone.

Searchable

Quickly find service contact information and online resources

Benefit Plans

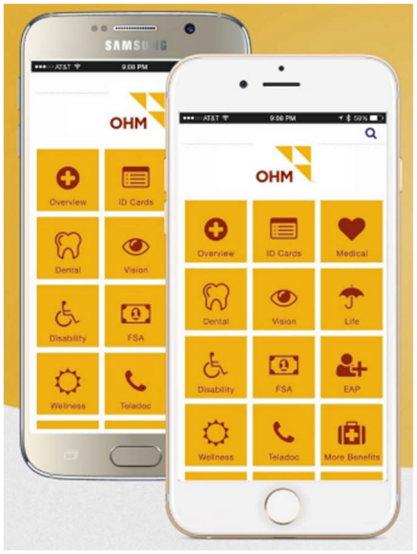
Review benefit plan information and find online provider directories

Group Information

Access and print generic ID cards with group information

Forms

Download and print benefit-related forms and information.



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iPhone

Tap the **Share icon** in Safari's lower menu bar

Add to Home Screen

Tap the Add to **home screen** icon

Android

Tap this **Icon** in the **top right** menu bar

Select: **Add to Home screen**

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