2026 Benefits Options

Encompass Health

At Encompass Health, we continually strive to provide a high-quality, comprehensive benefits package to our valued employees. That includes determining benefits offerings that fit your evolving needs.

You are dedicated to setting the standard through providing quality care our patients can trust. In turn, Encompass Health is committed to caring for you and your future. Our focus is to provide you with the tools and resources that will allow you to make informed choices, selecting the benefits most right for you and your family.

This booklet includes the relevant information you'll need to do just that.

Encompass Health®

Contents

This booklet is intended to be a summary of the benefit plans. It does not include all provisions, exclusions and limitations of each plan. If there is a discrepancy between this document and the contract or policy issued by the carrier, then the terms of the contract or policy will govern.

Summary Plan Description (SPD)

A Summary Plan Description, or SPD, outlines the eligibility, schedule of benefits and items that are covered or excluded by the benefit plan. The SPDs for all benefit plans are located on the Encompass Health intranet on the Benefits home page at: http://insidenew.encompasshealth.com/corporate/benefits.

Eligibility and enrollment

Generally, the benefit plan eligibility includes full-time employees and part-time benefit-eligible employees. There are other plans described herein that other employee designations may elect.

New employees or those just becoming eligible must enroll immediately upon becoming eligible. Changes to the enrollment may be made within the first 31 days. Any enrollments or changes beyond the initial 31 days will not be accepted. If you have not elected coverage, you will have no coverage for the remainder of the year and the next available time to elect or update your benefits will be during Annual Enrollment with a January 1, effective date.

When coverage begins

Coverage will be effective on the date of eligibility (hire date/change of status date). Changes to the initial enrollment can be made within the first 31 days of eligibility. The effective date for coverage changes made within the first 31 days of eligibility is the date the form is signed by the employee.

When coverage ends

Coverage will end at midnight: on the last date of employment, the date an employee changes to a non-benefit eligible class, when an employee goes out on a non-FMLA OR worker's compensation leave of absence and is no longer receiving a paycheck.

Eligible members

Eligible members that you may include in your health insurance coverage are listed below. You must provide proper documentation for each member within two weeks of the coverage effective date (see the Dependent Eligibility Verification section in this booklet). Without proper documentation, your eligible members will not be covered.

- Your legal spouse
- Your same or opposite sex domestic partner, provided he or she meets the domestic partner requirements
- An unmarried or married child* up to age 26
- An unmarried, incapacitated child* who is age 26 and over; is not able to support themself; and depends on you for support, if the incapacity occurred before age 26

*A child is defined as your natural child; stepchild; legally adopted child; child placed for adoption; or, other child for whom the employee has permanent legal custody.

Domestic partners

For your domestic partner to be covered under the medical plan (including the Prescription Drug Program) and the dental and vision programs, you and your domestic partner must:

- Consider each other life partners
- Both be age 18 or older
- Not be blood related
- Have lived together for at least 12 months
- Share the same permanent address and provide your driver's licenses listing the common address
- Have joint responsibility for each other's welfare and be mentally competent
- Not be legally married to or in a domestic partnership with anyone else
- Not have had another domestic partner within the past six months
- Share necessities of life and financial interdependence

Domestic partners must complete the "Affidavit Declaring Domestic Partnership Status" and submit at least two of the following documents:

- A joint bank account, credit account or loan
- Joint vehicle ownership
- Joint ownership, mortgage or lease of a residence
- Evidence of common household expenses, such as utilities or phone
- Wills naming each other as executor and/or beneficiary
- Granting each other power of attorney
- Designating each other as a beneficiary under a retirement benefit account or evidence of other joint financial responsibility

You must submit a Domestic Partner Affidavit with the specified documentation above to obtain coverage.

Unless your domestic partner qualifies as a "tax dependent" under the Internal Revenue Code, you may be treated as receiving "imputed income" for federal income tax purposes with respect to the benefits provided to your domestic partner. Imputed income is the difference between the fair market value of the benefit provided to your domestic partner and the amount that you have paid for that benefit. You must pay federal income taxes (including Social Security tax and Medicare tax) on your imputed income. Similar treatment may apply for state and local income-tax purposes, to the extent applicable. For more information on federal, state or local taxation, please contact your tax advisor.

Qualified event changes

Changes to benefit elections during the year are permitted only with a "qualifying event." A qualifying event includes:

- Marriage
- Divorce/legal separation or termination of domestic partner status
- Addition of newborn
- Death of dependent
- Court-ordered coverage for dependent child only
- Dependent child has lost coverage
- Significant change in health coverage offered to employee and dependent
- Spouse/domestic partner commencement or termination of employment
- Change in eligibility of employee or spouse
- Unpaid leave of absence by employee or spouse

A change in coverage based on one of the reasons above must be made within 31 days of the event. Documentation must be submitted to support the qualifying event (ex. marriage license, finalized divorce decree, etc). The form needed to complete the change is provided on the Benefits home page.

If approved, when the qualifying event change is effective

The effective date of the coverage change will be the date the employee requests the change (based on the date the form is signed). Changes due to marriage, divorce, birth or adoption are effective the date of the actual qualifying event.

Medical and prescription drug plans

There are two traditional PPO medical plans and a High Deductible Health Plan (HDHP) option to choose from through Blue Cross Blue Shield of Texas. The Core and Plus traditional PPO medical plans and the HDHP include prescription drug coverage and require an annual deductible be met before the coinsurance coverage is applied. The premium for the medical plan and prescription drug coverage appear as one deduction amount on the paycheck. The rates are listed in the table below.

Some important differences between the traditional PPO plans and the HDHP are as follows:

What you should know: health plan comparison	**CORE**	**PLUS**	**CHOICE**
Insurance Plans	The **Core PPO** Plan allows the employee to have copays and lower deductibles with a Nationwide BCBS PPO Network.	The **Plus PPO** Plan allows the employee to have copays and lower deductibles with a Nationwide BCBS PPO Network.	The Choice Plan is commonly referred to as a **High Deductible Health Plan (HDHP)** with lower premiums and higher deductibles with a Nationwide BCBS PPO Network.
Copay	Primary Care Provider: **$30** Specialist Care Provider: **$45** Urgent Care Center: **$50** (Annual deductible is not required)	Primary Care Provider: **$30** Specialist Care Provider: **$45** Urgent Care Center: **$50** (Annual deductible is not required)	Employee is responsible for the **FULL cost** of their healthcare expenses, until the annual deductible is met.
Prescription Drug	Rx expenses have a **separate** annual deductible of $150 (doesn't apply to generic).	Rx expenses have a **separate** annual deductible of $100 (doesn't apply to generic).	Rx expenses are counted **towards** the annual deductible.

<table>
<tr><th>What you should know: health plan comparison</th><th>CORE</th><th>PLUS</th><th>CHOICE</th></tr>
<tr><td>Hospital Admission</td><td>$500 copay; 70% in-network after deductible and copay.</td><td>$300 copay; 80% in-network after deductible and copay.</td><td>80% after calendar year deductible is met.</td></tr>
<tr><td>Annual Deductible</td><td>The CORE PPO Plan has a lower deductible and the member pays a higher premium per check.
<table><tr><th>Deductible</th><th>In-Network</th><th>Out-of-Network</th></tr><tr><td>Single</td><td>$1,500</td><td>$2,000</td></tr><tr><td>Family</td><td>$3,000</td><td>$4,000</td></tr></table></td><td>The PLUS PPO Plan has the lowest deductible and the member pays the highest premium per check.
<table><tr><th>Deductible</th><th>In-Network</th><th>Out-of-Network</th></tr><tr><td>Single</td><td>$750</td><td>$2,000</td></tr><tr><td>Family</td><td>$1,500</td><td>$4,000</td></tr></table></td><td>The HDHP has the highest deductible and the member pays the lowest premium per check. Employees are responsible for the full cost of healthcare expenses, until the annual deductible is met (including Rx drugs).
<table><tr><th>Deductible</th><th>In-Network</th><th>Out-of-Network</th></tr><tr><td>Single</td><td>$3,400</td><td>$6,600</td></tr><tr><td>Family</td><td>$6,600</td><td>$12,000</td></tr></table></td></tr>
<tr><td>Annual Out-of-Pocket</td><td>Once the OOP has been met, the plan pays at 100%.
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<tr><td>Health Savings Account (HSA)</td><td>N/A</td><td>N/A</td><td>An HSA can be used for current and future medical expenses. If elected with a minimum $1 contribution, the company will contribute up to $500 for employee only and up to $1,000 for dependent coverage each year to participating employees. Employer contributions will be reflected on each check. Employees own this account and all unused funds will roll over each year.</td></tr>
<tr><td>(FSA) Medical, Dental & Vision</td><td>The Medical FSA is used to set aside up to $2,000 in pre-tax deductions to pay for eligible healthcare expenses. The IRS requires you to re-enroll each year in this plan. Unused funds do not roll over each year.</td><td>The Medical FSA is used to set aside up to $2,000 in pre-tax deductions to pay for eligible healthcare expenses. The IRS requires you to re-enroll each year in this plan. Unused funds do not roll over each year.</td><td>N/A</td></tr>
<tr><td>(FSA) Dependent Care</td><td>The Dependent FSA is used to set aside up to $5,000 in pre-tax deductions to pay for eligible dependent care expenses. The IRS requires you to re-enroll each year in this plan. Unused funds do not roll over each year.</td><td>The Dependent FSA is used to set aside up to $5,000 in pre-tax deductions to pay for eligible dependent care expenses. The IRS requires you to re-enroll each year in this plan. Unused funds do not roll over each year.</td><td>The Dependent FSA is used to set aside up to $5,000 in pre-tax deductions to pay for eligible dependent care expenses. The IRS requires you to re-enroll each year in this plan. Unused funds do not roll over each year.</td></tr>
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*The comparison does not include all provisions, exclusions and limitations of each plan. If there is a discrepancy between this document and the contract or policy issued by the carrier, then the terms of the contract or policy will govern.

Medical/prescription drug plan summary of in-network benefits

Service	CORE	PLUS	CHOICE
Annual Deductible Individual/Family	$1,500/$3,000	$750/$1,500	$3,400/$6,600
Coinsurance	70%	80%	80% after calendar year deductible is met
Out-of-Pocket Annual Maximum Individual/Family	$5,000/$10,000	$4,000/$8,000	$4,000/$8,000
Physician Office Visit/consultant for Primary Care Providers	$30 (no deductible)	$30 (no deductible)	80% after calendar year deductible is met
Preventive Care	100% no deductible or copay	100% no deductible or copay	100% no deductible or copay
Physician Office Visits/consultant for Specialty Care Providers	$45 copay	$45 copay	80% after calendar year deductible is met
Urgent Care Center Visit	$50 copay	$50 copay	80% after calendar year deductible is met
Hospital Admission	$500 copay; 70% after deductible and copay	$300 copay; 80% after deductible and copay	80% after calendar year deductible is met
Emergency Room Charges	**CORE**	**PLUS**	**CHOICE**
Emergency Treatment (includes accidental injury and ER visits after 5 p.m. or on weekends)	70% after $250 copay	80% after $200 copay	80% after calendar year deductible is met
ER Physician Visit	70% after $100 copay	80% after $100 copay	80% after calendar year deductible is met

Out-of-Network benefits are available in the Plus and Core plans, with a higher individual annual deductible and a 50% coinsurance.

Medical/Rx employee cost per paycheck* (24 deductions/year)

Coverage Tier	CORE	PLUS	CHOICE
Employee Only	$75.59	$140.02	$57.26
Employee + Spouse/Domestic Partner	$223.08	$345.14	$177.44
Employee + Child(ren)	$211.19	$330.02	$167.98
Employee + Family**	$260.63	$415.21	$201.31

*Paycheck deductions are on a before-tax basis and cover benefits in arrears.
**Includes employee + spouse/domestic partner and child/children.

Blue Cross Blue Shield's Access for Members℠ (BAM℠)

Participants in the Blue Cross Blue Shield Medical Plans are encouraged to register on the website at www.bcbstx.com/member to get information about your health benefits, anytime and anywhere. You can use your computer, phone or tablet to access the Blue Cross and Blue Shield of Texas (BCBSTX) secure member website, Blue Access for Members (BAM). The services available include accessing your claim statements, locating a provider and requesting ID cards.

Participants also have access to Blue Cross resources such as: Member Rewards administered by Vitals, Virtual Visits powered by MDLIVE and Well onTarget.

Member Rewards: Minimize your out-of-pocket costs and get cash rewards when a lower cost, quality provider is selected from several possibilities.

Virtual Visits: Access board-certified doctors around the clock for non-emergency health issues. Connect by **mobile app**, online video or telephone.

Well onTarget: Set personal health and wellness goals and track your progress, access self-directed health courses or connect with a wellness coach.

The **mobile app** is available on the App Store and Google Play

Rx summary

Purchased at Participating Pharmacy	CORE	PLUS	CHOICE
Annual Rx Deductible (Maximum of 2 per family)	$150 Core Medical Plan (does not apply to generics)	$100 Plus Medical Plan (does not apply to generics)	80% after calendar year deductible is met
Generic Drugs	$10 copay with no deductible	$10 copay with no deductible	80% after calendar year deductible is met
Brand Name Drugs on Preferred List	$45	$45	80% after calendar year deductible is met
Brand Name Drugs on Non-Preferred List	$60	$60	80% after calendar year deductible is met
Specialty Drugs	30% co-insurance for all specialty medications included in the PrudentRx Program list*. For medications not included in the Prudent Solution, you will be responsible for the cost share noted above.	30% co-insurance for all specialty medications included in the PrudentRx Program list*. For medications not included in the Prudent Solution, you will be responsible for the cost share noted above.	30% co-insurance for all specialty medications included in the PrudentRx Program list*. For medications not included in the Prudent Solution, you will be responsible for the cost share noted above.
Purchased Using Mail Order (90-Day Supply)	**CORE**	**PLUS**	**CHOICE**
Annual Rx Deductible	None	None	80% after calendar year deductible is met
Generic Drugs	$30 copay	$30 copay	80% after calendar year deductible is met
Brand Name Drugs on Preferred/Non-Preferred List	$135/$180	$135/$180	80% after calendar year deductible is met

**Your plan includes the PrudentRx solution for specialty medications. This program is designed to lower your out-of-pocket costs by assisting you with enrollment in drug manufacturers discount copay cards/assistance programs. Once enrolled in the PrudentRx solution, your out-of-pocket cost will be $0 for eligible medications. If you opt out, you will be responsible for the 30% coinsurance (only the amount you pay out of pocket will apply toward your MOOP for essential health benefit medications – non-essential health benefit medications do not apply toward MOOP).*

Prescription drug coverage

Prescription drug coverage is included with the medical plan election. More than 68,000 pharmacies (most major chain and independent drug stores) participate nationwide. Your prescription coverage is through CVS Caremark.

Retail program

Under the Prescription Program, you will need to present your ID card when visiting a participating pharmacy. You will also be required to pay a copay for each drug purchase. After the appropriate copay has been paid, your pharmacy will electronically file your claim for you and your prescription drug coverage will pay the remaining balance.

You can find important information to help you manage your pharmacy benefits on the CVS website, www.caremark.com. In addition to helping you find a participating pharmacy, you can look up drugs covered by your plan, find Preferred Brand Drugs, learn about generic drugs and find other important information about your prescription drug coverage.

Specialty drug program

CVS Specialty will be your exclusive specialty pharmacy. You must fill your specialty prescriptions using CVS Specialty services or your medications won't be covered and you will have to pay the entire cost*.

CVS Specialty does much more than just provide your medication – we help you manage your condition as well as your health. You'll get the support of a dedicated CareTeam led by pharmacists and nurses who are specially trained in your condition. You'll also have the choice to have your medications delivered anywhere nationwide or pick them up at any CVS Pharmacy® location.** And we'll help you with insurance, handle your claims, and find ways to keep your out-of-pocket costs low, too.

Specialty drug contact information
Customer Service: 800.237.2767
Website: www.CVSspecialty.com

*Your out-of-pocket cost may vary depending on your prescribed medication, prescription benefit coverage, or grace fills.

**Where allowed by law. In-store pick up is currently not available in Oklahoma. Puerto Rico requires first-fill prescriptions to be transmitted directly to the dispensing specialty pharmacy. Products are dispensed by CVS Specialty and certain services are only accessed by calling CVS Specialty directly. Certain specialty medication may not qualify. Services are also available at Long's Drugs locations.

CVS Maintenance Choice® Voluntary Program

The CVS Maintenance Choice® Program is a voluntary benefit that offers employees a convenient and cost-effective way to manage long-term (maintenance) medications—those taken regularly for chronic conditions such as high blood pressure, diabetes, asthma or high cholesterol.

Flexible Fulfillment Options: You can choose to receive a 90-day supply of your maintenance medications either:

- Through **CVS Caremark Mail Service Pharmacy**, with home delivery in secure, trackable packaging.
- Or by picking up at a **CVS Pharmacy retail location**, with same-day availability and face-to-face pharmacist support

Convenience:

- Refill prescriptions online, by phone, or email.
- Access 24/7 pharmacist support.
- Manage prescriptions and track orders online at Caremark.com.

Participating Pharmacies include CVS, Costco, Kroger-affiliated pharmacies and select independents. Use the Pharmacy Locator to find eligible locations

Why Choose Maintenance Choice?

- **Save money** with fewer copays.
- **Simplify your routine** with fewer pharmacy visits.
- **Enjoy flexibility** in how and where you receive your medications.

Mail Order Contact Information

Customer Service: 833.956.1260

Website: www.caremark.com

Women's and Family Health

Women's & Family Health is an innovative approach for the journey into parenthood, from pre-pregnancy through delivery and ongoing parenting support, for you or your spouse/domestic partner:

Well onTarget – Self-guided courses about pregnancy that you can take online, covering topics such as healthy foods, body changes and labor.

Ovia Health –The apps are included in your health plan benefits offered through Blue Cross and Blue Shield of Texas (BCBSTX). They provide support through your entire parenthood journey:

- **Ovia Fertility** – Track your cycle and predict when you are more likely to get pregnant
- **Ovia Pregnancy** – Monitor your pregnancy and baby's growth week by week leading up to your baby's due date
- **Ovia Parenting** – Keep up with your child's growth and milestones from birth through three years old
- **High-Risk Maternity Management** – If your pregnancy is high-risk, BCBSTX will provide support from Maternity Specialists to help you care for yourself and your baby
- **Behavioral Health** – Provides access to an extensive network of mental health clinicians who are there to help with post-partum depression

Dependent eligibility verification

It is Encompass Health's fiduciary responsibility to ensure the claims paid by the medical, dental, and vision plans are for dependents who meet the dependent definitions outlined by the plans. You must provide certain documentation on each member you wish to cover in the medical, dental and vision plans. The required documentation for your spouse, domestic partner, and/or children must be submitted to your local HR within two weeks of enrollment. Members without proper documentation will not be covered.

The Benefit Enrollment Form lists the acceptable documents for each member type.

Dependent Eligibility Verification	
Relationship	**Acceptable Documentation**
Legal Spouse	• Copy of top half of the front page of the employees' most recently filed federal tax return that includes this spouse (black out all financial information); or • If married and filing separately, provide a copy of both spouses' federal tax returns that reflects the same address; or • If unable to provide tax returns, a copy of the marriage certificate and one of the following: - Documentation of joint ownership of residence - Documentation of joint tenants on lease of residence - Copy of both driver's licenses reflecting same address - Current bank/credit card statement (within the past 12 months) with both spouses names
Children (under the age of 26)	• Natural Child – Copy of birth certificate showing employee's name • Stepchild – Copy of birth certificate showing employee's spouse's name; and a copy of marriage certificate showing the employee and parent's name • Legal Guardian, Adoption – Copy of Affidavits of Dependency, Final Court Order with presiding judge's signature and seal, or Adoption Final Decree with presiding judge's signature and seal
Domestic Partner (see Encompass Health Domestic Partner Guidelines for qualifi-cations)	• Completed Encompass Health Affidavit declaring domestic partner status; and • Copy of driver's license listing same residence as employee; and • Demonstrate financial interdependency by providing copies of at least two of the following documents: - Ownership of a joint bank account, credit account or loan obligation - Common ownership of a motor vehicle - Joint ownership of a residence or lease agreement - Evidence of common household utilities - Execution of wills naming each other as executor and/or beneficiary - Granting each other durable powers of attorney - Designation of each other as beneficiary under a retirement account

Enrolling

New employees or those just becoming eligible must enroll immediately upon becoming eligible. Changes to the enrollment may be made within the first 31 days.

Enrolling late or discontinuing coverage

A request to newly enroll, or to drop coverage once in the plan, must be made within 31 days of a documented qualifying event (see the Qualified Event Changes section in the front of this booklet). Complete the Encompass Health Benefits Enrollment Change Form located on the Benefits home page and return to your human resources department with documentation to support the qualifying event. Once enrolled in a medical and prescription plan option, this election cannot be changed until the next annual enrollment period.

ID cards

Blue Cross will mail ID cards to homes of participants within two weeks of enrollment.

For more information

Refer to the Blue Cross Blue Shield Medical Plan Booklet or Prescription Drug Plan located on the Benefits home page on the Encompass Health intranet for specific benefit coverage, copayments for Encompass Health and non-Encompass Health facilities, deductibles and provider networks.

Glossary of health coverage and medical terms

Please see pages 45-47 for a full glossary of many commonly used health coverage and medical terms.

Medical and Pharmacy contact information

Blue Cross Blue Shield Customer Service: 800.521.2227

Medical Preauthorization: 800.441.9188

Provider Network: 800.810.2583

Website: Medical - www.bcbstx.com

The BCBS of Texas App is available on Google Play or the App Store or text BCBSTX to 33633.

Website: Pharmacy - www.caremark.com

To download our mobile app, visit www.caremark.com/mobile.

Lantern®

Need Surgery? Call your new Lantern™ Benefit.

The Lantern™ benefit is a supplemental benefit offered by Encompass Health for planned, non-emergency surgeries that provides a personalized concierge experience through a dedicated Care Advocate as well as access to quality care through a network of credentialed health care providers. By using the Lantern benefit, you may save money through reduced financial responsibility like waived deductible and/or coinsurance. By enrolling in one of the Encompass Health medical plans, you and your covered dependents are automatically enrolled in the Lantern™ benefit.

When you call Lantern, a Care Advocate will help you choose a surgeon that meets the rigorous Lantern credentialing standards, coordinate your appointments, coordinate logistics such as medical record transfers and any necessary travel arrangements, and ensure you have access to the best information as you make decisions about your care. Covered procedure categories include (but are not limited to) orthopedics, spine, general surgery, gynecology, bariatric, ear nose and throat, GI, cardiac and interventional pain management.

ID cards

You will receive a Lantern™ Member ID card in the mail. If you do not receive a card or need a replacement, please visit Lantern™ at my.lanternca re.com or call 833.227.7577.

For more information

For additional information and for the full list of available surgeries offered under the Lantern benefit, visit my.lanternca re.com to chat, or call 833.227.7577 to speak with a Care Advocate today.

Lantern contact information

Customer Service: 833.227.7577

Website: my.lanternca re.com

Quantify®

Quantify – Specialty Infusion Care

Quantify is a national provider of specialty infusion therapies, focused on delivering personalized, patient-centered care for individuals with complex medical conditions. These therapies are often high-cost and long-term, and Quantify works to make them more accessible and affordable. Coverage is available to employees and/or dependents enrolled in Encompass Health's health insurance plan.

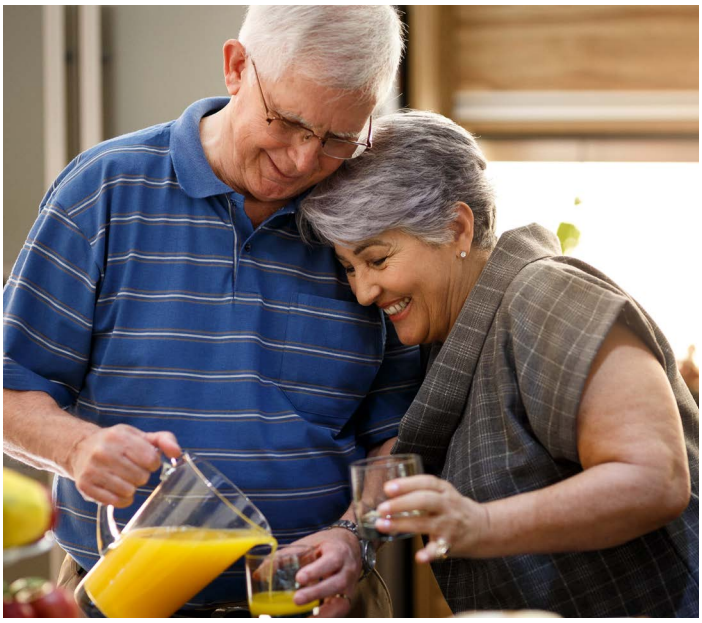
Key features

- Personalized Treatment Plans: Customized to each patient's diagnosis and health goals.
- Home-Based Infusion Services: More than 80% of therapies can be administered at home, offering convenience and comfort.
- 24/7 Clinical Support: Patients receive around-the-clock access to remote monitoring and a dedicated care team.

How to get started

If you qualify, a member of Quantify's dedicated care team will contact you to review your personalized treatment plan and schedule your first appointment—either at home or at one of Quantify's 65+ locations nationwide.

For more information, visit quantifyspecialtycare.com



Tria Health – pharmacy advocate program

Tria Health provides one-on-one, confidential telephonic counseling with a pharmacist to make sure your medications are working as intended and that you can afford them. Tria Health's pharmacists are your personal medication experts and will work with you and your doctor(s) to make sure your conditions are properly controlled without the risk of medication-related problems.

For more information

Who should participate? Tria Health's Pharmacy Advocate Program is available for employees and/or dependents on Encompass Health's health insurance. Tria Health is recommended for members who have any of the following conditions and/or take multiple medications:

Diabetes	Mental health
Heart disease	Asthma/COPD
High Cholesterol	Osteoporosis
High blood pressure	Migraines
Pain management	Specialty medicine

Participating members can save money on their medications: By attending your consultation(s), you will receive a $50 Tria Health Rewards VISA gift card.

Members can qualify to receive up to $150 by attending three consultations within a 12-month period.

Active members with diabetes will also have access to a free wireless blood glucose meter, testing strips, and **mobile app** designed to help you better manage your diabetes.

How to schedule

Schedule an appointment to meet with a medication expert over the phone at a time that is convenient for you. Your Tria Health pharmacist will make sure the medications you take are safe, affordable and effective.

Tria Health contact information

Customer Service: 888.799.8742

Website: www.triahealth.com/schedule

Dental plan

Encompass Health's dental benefits are offered to full-time and part-time benefit-eligible employees and are administered by MetLife. The plan includes a core dental plan and several buy-up options.

- Additional $500 in annual benefits payable (total payable equal $1,500 annually)
- Add orthodontic coverage for your children – $1,500 lifetime maximum benefit
- Or you may add both buy-up options to your Core Dental Plan.

Orthodontic coverage

Orthodontic benefits for your children up to age 19 are available to you as a buy-up option. The benefit is 20% of your orthodontic lifetime maximum and 50% of each monthly payment, up to a $1,500 lifetime maximum per child as long as you are actively covered on the plan.

For more information

The MetLife Plan booklet and summary detailing covered procedures and rates are located on the Benefits home page on the Encompass Health intranet. This plan coordinates benefits with other group dental plans.

Dental Summary	
Annual Deductible	$50 per individual ($100 maximum per family)
Preventive Care	100% with no deductible
Basic Restorative	80% after annual deductible
Major Restorative	50% after annual deductible
Annual Maximum Benefit	$1,000/per person

Employee cost per paycheck*

Coverage Tier	Employee Only	Employee + Family**
Core	$3.61	$18.05
Core + $500	$5.36	$21.71
Core + Child Orthodontics	N/A	$52.97
Core + $500 + Child Orthodontics	N/A	$56.63

*Paycheck deductions are on a before-tax basis and cover benefits in arrears.

**Includes employee + spouse/domestic partner and child/children.

ID cards

MetLife does not produce identification cards. Your dentist will verify and access your dental coverage through MetLife for you.

Enrolling

New employees or those just becoming eligible must enroll immediately upon becoming eligible. Changes to the enrollment may be made within the first 31 days. Any enrollments or changes beyond the initial 31 days will not be accepted – if you have not elected coverage, then you will have no coverage for the remainder of the year.

Enrolling late or discontinuing coverage

A request to newly enroll, or to drop coverage once in the plan, must be made within 31 days of a documented qualifying event (see the Qualified Event Changes section in the front of this booklet). Complete the Benefits Change Request Form located on the Benefits home page and return to your human resources department with documentation to support the qualifying event. You may not add or drop a buy-up option for any reason during a plan year. Your next opportunity to make this change will be during the next annual enrollment period.

Dependent eligibility verification

It is Encompass Health's fiduciary responsibility to ensure the claims paid by the medical, dental and vision plans are for dependents who meet the dependent definitions outlined by the plans. You must provide certain documentation on each member you wish to cover in the medical, dental, and vision plans. The required documentation for your spouse, domestic partner, and/or children must be submitted to your local HR within two weeks of enrollment. Members without proper documentation will not be covered.

The Benefit Enrollment Form lists the acceptable documents for each member type.

MetLife contact information

Customer Service: 800.942.0854

Website: http://mybenefits.metlife.com

The **mobile app** is available on the App Store and Google Play.

Vision plans

Encompass Health's vision benefits are offered to full- and part-time benefits-eligible employees and are administered by Vision Service Plan (VSP).

For more information

VSP has a nationwide network of providers and includes benefits for annual exams, contact lenses and glasses. The carrier offers a base plan and an enhanced buy-up option that provides greater allowance for frames and contacts. Refer to the plan's brochure located on the Benefits home page for benefit coverage, frequency of use and copays.

You may visit the carrier's website to see a listing of the eye care providers in your area. The website address for the VSP plan is listed in the contact section below.

Vision plans cost per paycheck*

Coverage Tier	VSP	
	Base	Buy-Up
Employee Only	$4.15	$5.26
Employee + Family**	$10.15	$12.85

*Paycheck deductions are on a before-tax basis and cover benefits in arrears.
**Includes employee + spouse/domestic partner and child/children.

Service	Frequency	VSP	
		Base	Buy-Up
		Copays	
Eye Exam	12 months	$10	$10
Frames	24 months	$10	$10
Lenses	12 months	$10	$10
Contacts	12 months	$0	$0
Frames/Contacts Allowance		$160	$210
Provider Networks		Mostly opthamologists and optometrists	

Enrolling

New employees or those just becoming eligible must enroll immediately upon becoming eligible. Changes to the enrollment may be made within the first 31 days. Any enrollments or changes beyond the initial 31 days will not be accepted – if you have not elected coverage, then you will have no coverage for the remainder of the plan year.

Enrolling late or discontinuing coverage

A request to newly enroll, or to drop coverage once in the plan, must be made within 31 days of a documented qualifying event (see the Qualified Event Changes section in the front of this booklet). Complete the Benefits Change Request Form located on the Benefits home page and return to your human resources department with documentation to support the qualifying event. You may not change the vision plan for any reason during a plan year. Your next opportunity to make this change will be during the next annual enrollment period.

Dependent eligibility verification

It is Encompass Health's fiduciary responsibility to ensure the claims paid by the medical, dental, and vision plans are for dependents who meet the dependent definitions outlined by the plans. You must provide certain documentation on each member you wish to cover in the medical, dental, and vision plans. The required documentation for your spouse, domestic partner, and/or children must be submitted to your local HR within two weeks of enrollment. Members without proper documentation will not be covered.

The Benefits Enrollment Form lists the acceptable documents for each member type.

How to use your plan

Once enrolled in a vision plan, you may call a provider within the vision plan carrier's network you elected to make your eye appointment. The provider will contact your vision carrier to verify coverage. No paperwork is required by you. At your appointment, pay the provider directly the copays and cost of any non-covered items.

Vision Service Plan

- 24,000+ providers in network nationwide
- Network consists of ophthalmologists and optometrists
- Provider search on website
- Affiliate providers (i.e. Visionworks, Pearle Vision, Costco Optical)
- No ID cards or claim forms needed — network doctor will verify benefits with VSP

VSP contact information

Customer Service: 800.877.7195

Website: www.vsp.com

The **mobile app** is available on the App Store and Google Play.

Flexible Spending Accounts (FSA)

Flexible Spending Accounts (FSA) are tax-advantaged accounts that allow eligible employees to set aside pre-tax deductions to build up cash for eligible expenses (day care or healthcare expenses). These plans allow you to reduce your taxable income by the amount you contribute. Money deposited into your FSA must be used during the plan year for appropriate expenses.

(FSA) Medical, dental and vision

The Medical (FSA) allows full-time and part-time benefit-eligible employees to set aside up to $2,000 in pre-tax payroll deductions to pay for eligible healthcare expenses. The Medical FSA allows you to reduce your taxable income by the amount you contribute.

The Medical FSA allows reimbursement for most health, dental and vision care expenses not reimbursed by any other insurance plan. You do not have to participate in a Encompass Health sponsored medical plan to participate in the Medical FSA. The Medical FSA plan contains a grace period, which allows you to use money left in your account at the end of 2026 to pay expenses incurred in 2027 through March 15, 2027. Claims reimbursement for the 2026 plan year must be submitted by March 31, 2027. In other words, the grace period allows you to access funds from the prior plan year to pay for expenses incurred in the current plan year for up to two and a half months after the previous plan year ends.

Examples of covered expenses

- Copays and deductibles
- Orthodontics
- Glasses/contact lenses
- For a comprehensive list of expenses covered by the Medical FSA, visit www.healthequity.com/fsa-qme

Examples of non-covered expenses

- Healthcare expenses covered by other plans
- Cosmetic services or surgery
- Insurance premiums

(FSA) Dependent care

The Dependent Care Spending Account allows full- and part-time employees to set aside up to $5,000 in pre-tax payroll deductions to build up cash for eligible dependent childcare expenses. This plan allows you to reduce your taxable income by the amount of the Dependent Care Spending Account contributions.

The Dependent Care Spending Account allows a family to receive reimbursement for expenses associated with the care of a dependent child under age 13. In addition, reimbursement may be received for a disabled spouse, or an older parent in eldercare, while you are at work.

Examples of covered expenses

- Licensed nursery
- Day care facilities
- After school day care program
- Childcare inside or outside of your home
- For a comprehensive list of expenses covered by the Dependent Care FSA, visit www.healthequity.com/dcfsa-qme

Examples of non-covered expenses

- Child support payments
- School tuition
- Food, clothing or entertainment
- Overnight camp expenses

Enrolling

- After an election is made, it cannot be changed during the plan year without a qualifying family status change.
- The Medical FSA cannot be decreased for any reason, unless within 31 days of enrollment.
- Re-enrollment into the spending account plan(s) is required each calendar year.
- Enrollees new to the HealthEquity FSA plan will receive a new FSA debit card and a FSA welcome letter. Current FSA member's' cards will be reloaded with the new election amount for the 2026 plan year.

Enrolling late or discontinuing participation

Enrollment into any of the spending accounts must be made within 31 days of hire, or within 31 days of a documented qualifying event (see the Qualified Event Changes section in the front of this booklet). Employees can review their benefits elections and report a life event through the Benefits module in Fusion.

Participation in Medical FSA cannot be cancelled, or contributions decreased/increased during the plan year, unless within 31 days of enrolling or within 31 days of a qualified change.

Participation in the Dependent Care Spending Account cannot be cancelled or changed unless requested within 31 days of a documented qualifying event.

FSA debit card and FSA/DCFSA claims reimbursement

1. Your FSA plan offers a debit card to use for qualified medical expenses including RX, dental and vision services.
2. When you use your FSA Debit card, HealthEquity may request you submit needed documentation to substantiate the debit card transaction as dictated by the IRS.
3. Claims may be available on your HealthEquity account portal that could be used to match the debit card transaction with a claim on file. See steps below under the Claim reimbursement details on how to match the transaction.

To request FSA or DCFSA claim reimbursement, simply:

- Log in to your HealthEquity online account at https://my.healthequity.com.
- Click on “View Claims” Link and then select the applicable FSA claim by clicking “Details.”
- Here, you will choose whether to

  Pay Provider - Submit payment directly to the provider tied to your claim.

  Reimburse yourself - Request to be reimbursed for the claim via EFT or check (check fee applies).

  Close Expense - No action needing to be taken on claim but you want it to show as Resolved.

  Match Transaction - Match the claim to a pending substantiation debit card swipe transaction.
- To file for an FSA or Dependent Care FSA claim reimbursement when a claim is not listed on your account portal click on “Reimburse Me” or “Pay Provider.”
- When selecting “Reimburse Me” you will click on “Add a New Expense” and provide all required information to add the expense and attach supporting documentation.
- When selecting “Pay Provider,” select the account in which you wish to file for reimbursement from and select “Enter Claim” record and send payment option, click next. You will select who to pay and click next. Then continue the steps to request payment be issued as well as provide back up documentation as prompted through the steps.

For more information

IRS regulations govern the spending accounts. Refer to the IRS Publication 969 https://www.irs.gov/forms-pubs/about-publication-969.

HealthEquity contact information

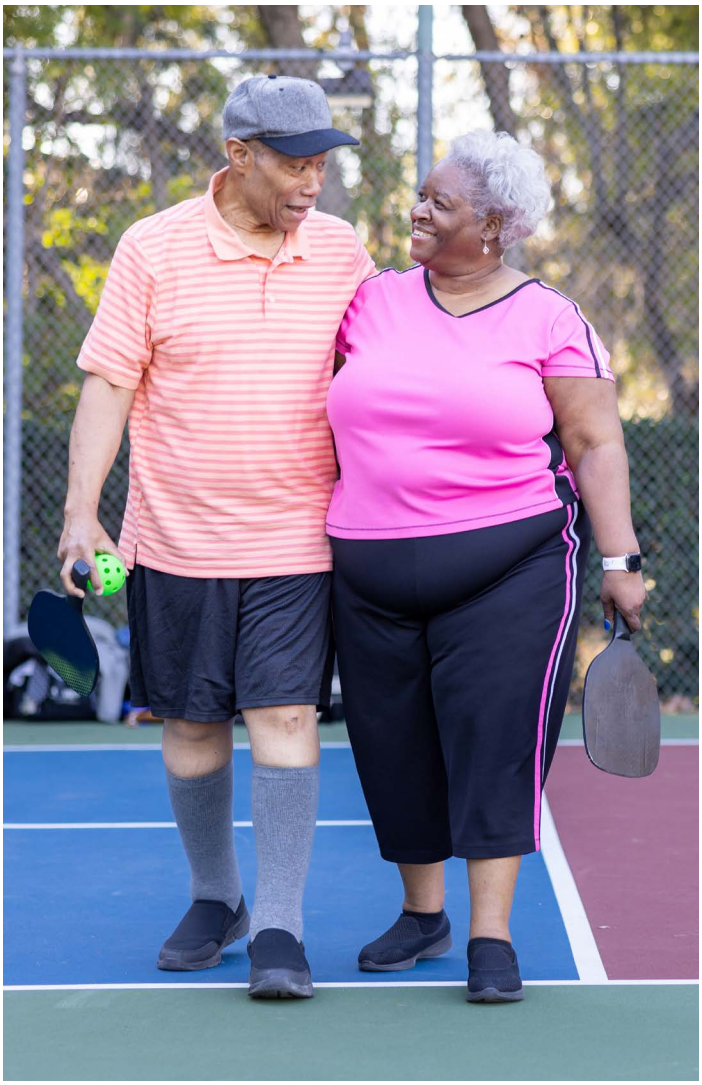
Customer Service: 844.396.0226

Education Center: https://learn.healthequity.com/EncompassHealth/fsa

Help Center website: https://help.healthequity.com/en/

Website to file claims: https://my.healthequity.com

The **HealthEquity Mobile app** is available on the App Store and Google Play.



HealthEquity® (HSA)

A Health Savings Account (HSA) is an individually owned, tax-advantaged account that you can use to pay for current or future IRS-qualified medical expenses.

How to enroll

Enrollments are completed through the benefits self-service module in Fusion. Once enrollment is processed, HealthEquity will mail a welcome kit including your HSA debit card.

How an HSA works

You can contribute to your HSA via payroll deduction, online banking transfer, or by sending a personal check to HealthEquity. Your employer or third parties, such as a spouse or parent, may contribute to your account as well.

- You can pay for qualified medical expenses with your HealthEquity HSA debit card directly to your medical provider or pay out of pocket. You can either choose to reimburse yourself or keep the funds in your HSA to grow your savings.
- Unused funds will roll over year to year. After age 65, funds can be withdrawn for any purpose without penalty (subject to ordinary income taxes).
- Check balances and account information via HealthEquity's member website, mobile device or by calling customer service 24/7.

Are you eligible for an HSA?

If you have a qualified high deductible health plan (HDHP) –either through your employer, spouse or one you've purchased on your own–chances are you can open an HSA. Additionally:

- New HSA account holders are required to have a valid U.S. residential address to open an HSA – members cannot use a P.O. Box address to open an HSA.
- You must be covered on an IRS qualified High Deductible Health Plan (HDHP) on the first of the month.
- You cannot be covered under any other non-HSA compatible health plan, including Medicare (Parts A & B) and TRICARE.
- You or your spouse don't have a Flexible Spending Account (FSA) or Health Reimbursement Account (HRA).
- Current FSA members with unused funds in their account on January 1, 2026, will be prohibited from participating in the HSA until April 1, 2026.

What are the annual IRS contribution limits?

Contributions made by all parties to an HSA cannot exceed the annual HSA limit set by the Internal Revenue Service (IRS). Anyone can contribute to your HSA, but only the account holder and employer can receive tax deductions on those contributions. Combined annual contributions for the account holder, employer and third parties (i.e., parent, spouse or anyone else) must not exceed these limits.[2]

2026 Annual HSA Contribution Limits		
Individual	Family	Catch-Up Contributions*
$4,400	$8,750	$1,000

How can you benefit from tax savings?

An HSA provides triple tax savings.[3]

- Contributions to your HSA can be made with pre/post tax dollars. Any post-tax contributions made up to the IRS Limit can be tax deductible.
- HSA funds earn interest and investment earnings are tax free.
- When used for IRS-qualified medical expenses, distributions are free from tax.
- For a comprehensive list of expenses covered by the Dependent Care FSA, visit www.healthequity.com/hsa-qme

IRS-qualified medical expenses

You can use your HSA to pay for a wide range of IRS-qualified medical expenses for yourself, your spouse or tax dependents. An IRS-qualified medical expense is defined as an expense that pays for healthcare services, equipment or medications. Funds used to pay for IRS-qualified medical expenses are always tax free. HSA funds can be used to reimburse yourself for past medical expenses if the expense was incurred after your HSA was established. While you do not need to submit any receipts to HealthEquity, you must save your bills and receipts for tax purposes.

The **mobile app** is available on the App Store and Google Play.

1) HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax-free with very few exceptions. Please consult a tax adviser regarding your state's specific rules

HealthEquity does not provide legal, tax or financial advice. Always consult a professional when making life-changing decisions.

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Commuter (COM)

Only available in New Jersey and Libertyville, IL

Commuter is a pre-tax benefit account used to pay for qualified parking and public transit - including train, subway, bus, ferry and eligible vanpool - as part of your daily commute to work. Commuter is a great way to put extra money in your pocket each month and make your commute more convenient and affordable.

HealthEquity Commuter Benefits

HealthEquity is our transit and parking commuter service provider. Enroll for a welcome email with order and account information. Changes to your Commuter election must be submitted the month prior to be effective on the first of the following month.

Why you need it

- Save an average of 30% on public transit and parking as part of your daily commute to and from work. (Assumes a combined tax rate of 30%, including FICA, state and federal income taxes. Actual amounts may vary.)
- No waiting. Sign up anytime to start saving, with no "use it or lose it" as long as you're enrolled.

How you manage it

Simply decide how much to contribute up to the allowed monthly limit as set by the IRS. Funds are withdrawn from your paycheck for deposit to your account before taxes are deducted. Pause or cancel contributions to your account at any time. There is no "use it or lose it" as long as your're enrolled the program.

How much you can contribute

Monthly contribution maximum amounts are as follows:

- Transit (eligible transit and vanpool): Pre-Tax up to $325
- Parking (eligible parking): Pre-Tax up to $325

Program features

- You can make your elections online directly through the HealthEquity website.
- You will be able to choose from several different transit pass options, including but not limited to: HealthEquity® Visa® Commuter Card, MBTA, Amtrak, Martz Lines Passes, Amtrak Tickets/Passes, etc.
- Transit passes will be delivered directly to your home address.
- Changes can be made at any time. Changes must be

submitted by the 10th of the month prior to be effective on the first of the following month.
- Pre-tax contribution amounts will run through payroll.
- You can make one-time orders or set your ordeer as recurring monthly.

How to enroll

Using the Commuter Benefits Program is easy, quick and hassle-free. And unlike other pre-tax savings programs, it works from month to month with no annual election required - you can sign up, make changes or cancel at any time. HealthEquity makes ordering your monthly transit or parking benefit a snap.

To register online, visit www.HealthEquity.com/wageworks select “LOG IN/REGISTER” and then “Employee Registration”. You’ll need to answer a few simple questions and create a username and password.

1 Log into your member portal and select your Commuter program.

2 Select “Enroll in Commuter.”

3 Choose the type of order you wish to make; public transit, vanpool, or your parking option and follow the instructions.

4 Select “Every Month” to repeat the same order automatically each month until you change or cancel it.

5 Select “Manage Calendar” to select benefit months you wish to receive your order.

6 Select “One Time” if you prefer to log in again whenever you’d like to order more. Then complete your order.

7 Don’t forget to enter your email address to receive confirmations electronically.

That’s it! If you provided your email address, check your inbox after you enroll for a welcome email with order and account information.

HealthEquity contact information

Customer Service: 844.396.0226
Education Center: https://www.healthequity.com/learn
Help Center website: https://help.healthequity.com/en/
Website to file claims: https://my.healthequity.com
The HealthEquity Mobile app is available on the App Store and Google Play.

COBRA

Continuation of coverage through COBRA

Certain status changes will cause an employee to become ineligible to remain on the Encompass Health group health insurance plans. Once we are notified of a change in status, you will automatically receive a COBRA notification from the COBRA administrator. These changes in status include termination of employment, change to an ineligible class or going on a leave of absence. Employees may elect to continue their current coverage at the full cost of the plan for up to a period of 18 months.

COBRA notification letters are also sent to the dependent of an employee if we have been notified to remove a spouse from the plan due to divorce, or if BCBS has determined that a child is over the age of 26. Dependents may elect to continue their current coverage at the full cost of the plan for up to a period of 36 months.

McGriff COBRA Services

Customer service: 888.888.3442
Email: cobraadmin@mcgriffinsurance.com
Website: https://cobralogin.mcgriffinsurance.com/
Fax: 252.293.9048

Life insurance coverage

Basic Life Insurance

Encompass Health provides basic term life insurance benefits to full-time employees in an amount equal to one times your annual base pay at no cost to you; with a $500,000 maximum. Refer to the Encompass Health Basic Life Insurance Booklet for full details of coverage and limitations.

Enrolling

Employees are required to name a beneficiary for the basic life insurance benefits. Without a beneficiary, your life insurance may not be distributed as you intend. The beneficiary information is to be retained at Lincoln Financial Group (Life & Disability). Beneficiary changes can be made at any time by contacting Lincoln Financial.

Log on to MyLincolnPortal.com to register and update your beneficiary.

Optional group term life insurance

Additional insurance is available for purchase to full-time employees. The additional insurance plans are group term life insurance and dependent life insurance. Refer to the plan booklets for full details of coverage and limitations.

Employee group term life insurance

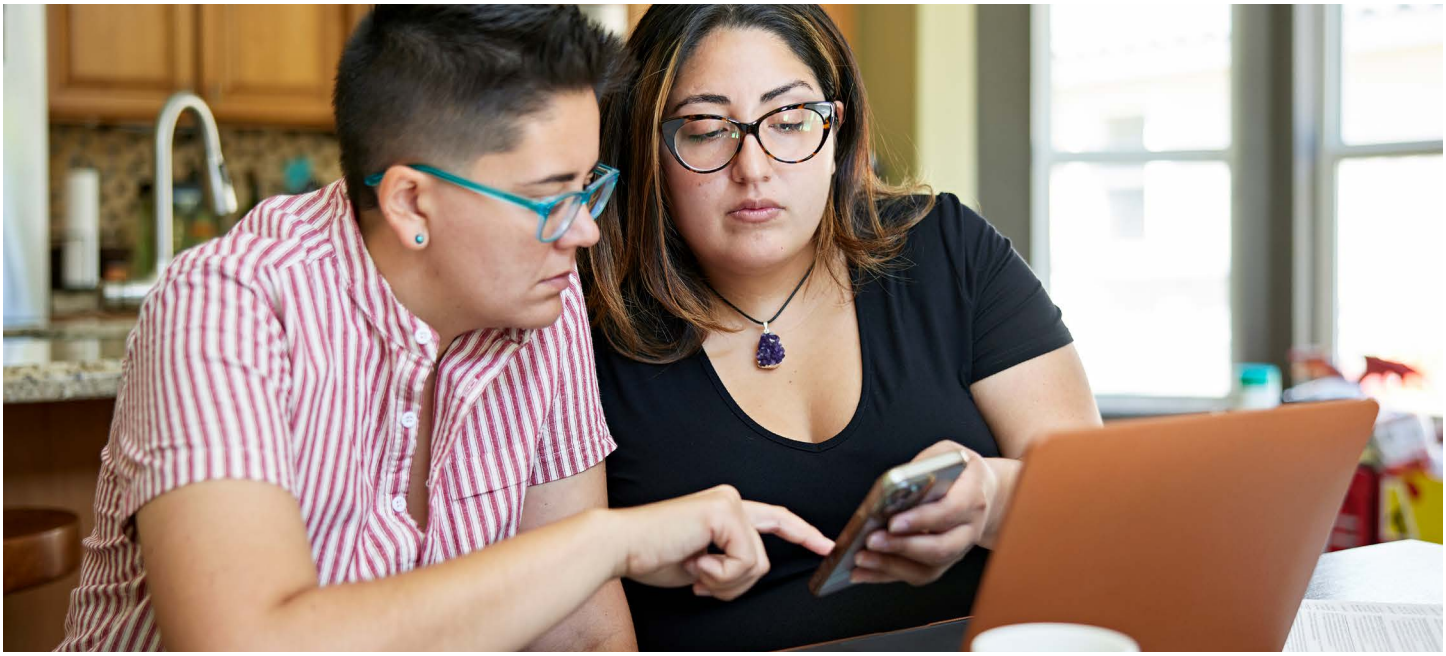
You may purchase group term life insurance on yourself from one to five times your base annual pay. Coverage up to two times your annual base pay (maximum of $500,000) is guaranteed without providing medical evidence of good health, if coverage is elected during the first 31 days of eligibility. You may apply for benefit levels over the guaranteed coverage amount by providing medical evidence of good health satisfactory to Lincoln Financial. The cost for this life insurance is based on your age and the approved coverage amount (see age chart in this section).

Spouse/domestic partner group term life insurance

You may purchase group term life Insurance for your spouse/domestic partner in $10,000 increments up to $200,000. Coverage for your spouse/domestic partner cannot exceed 100% of your benefits amount (basic + optional term life). You can select spouse coverage up to $50,000 without providing medical evidence of good health, if coverage is elected during the first 31 days of eligibility. Coverage over $50,000 may be purchased by providing medical evidence of good health to Lincoln Financial. The cost for this life insurance is based on your age and the approved coverage amount (see age chart in this section). Rates change as the insured enters a higher age category. You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.

Employee and Spouse/Domestic Partner Group Term Life Insurance Rates	
Age	Monthly Rates per $1,000 of Coverage
Less than 30	$0.060
30-34	$0.080
35-39	$0.091
40-44	$0.116
45-49	$0.175
50-54	$0.275
55-59	$0.443
60-64	$0.709
65-69	$1.270
70-74	$2.060
75+	$3.075

Child Term Life Insurance Rates	
Coverage Amount	Monthly Cost
$5,000	$0.65
$10,000	$1.30
$15,000	$1.95
$20,000	$2.60
$25,000	$3.25



Child term life insurance

You may purchase term life insurance for your dependent child (from birth up to age 26) in $5,000 increments up to $25,000. Coverage for your child cannot exceed 100% of your benefit amount (basic + optional term life). The cost for this life insurance is determined by the elected coverage amount (see rate table in this section).

Waiting period for totally disabled

If your eligible dependent is totally disabled or confined, any increase or addition to your dependent's coverage that is elected after your initial enrollment period will begin on the date your eligible dependent is no longer confined. In addition, if you are not actively at work, your initial, increase or added coverage is not effective until you return to active employment. This provision does not apply to a newborn child while dependent insurance is in effect.

TOTALLY DISABLED means that, as a result of an injury, a sickness or a disorder:

Your dependent spouse:
- is confined in a hospital or similar institution;
- is cognitively impaired; or
- is confined at home under the care of a physician for a sickness or injury.

Your dependent children:
- are confined in a hospital or similar institution; or
- are confined at home under the care of a physician for a sickness or injury.

*If your dependent is confined to a hospital, skilled nursing facility or rehabilitation facility on the date the enrollment or increase is to be effective, coverage will begin when the confinement ends.

Enrolling

Enrollment into the optional term life insurance plans must be made within 31 days of hire date or a change to full-time status. Lincoln Financial does not require proof of insurability on amounts elected during this period up to the guaranteed coverage amount. Coverage amounts elected which are over the guaranteed coverage amount require the insured to provide medical evidence of good health satisfactory to Lincoln Financial. Enrollments are completed through the benefits self-service module in Fusion.

Enrolling late or discontinuing coverage

Enrollment into the optional term life insurance plans beyond the initial 31 days will not be accepted. The next opportunity to apply for this coverage is during annual enrollment typically held at year-end and may require medical evidence of good health satisfactory to Lincoln Financial. You may cancel coverage at any time through the benefits self-service module in Fusion.

Lincoln Financial Group Life Insurance contact information

Customer service: 1.888.964.2178, option 2

Voluntary accidental death and dismemberment insurance

Voluntary accidental death and dismemberment insurance (AD&D) is available to full-time employees. AD&D insurance provides around-the-clock protection in the event of a loss due to an accident. Refer to the plan booklet for full details of coverage and limitations.

Employee accidental death and dismemberment insurance

You may purchase AD&D insurance in benefit amounts from $25,000 to $300,000. Medical evidence of insurability is not required. The cost for this insurance is based on the coverage amount elected (see rate table in this section). You may not cover your spouse as a dependent if your spouse is enrolled for coverage as an employee.

Spouse/domestic partner accidental death and dismemberment insurance

You may purchase AD&D insurance on your spouse/domestic partner in benefit amounts from $25,000 to $300,000. Coverage for your spouse/domestic partner cannot exceed 100% of your elected AD&D benefits amount. Medical evidence of insurability is not required. The cost for this insurance is based on the coverage amount elected (see rate table in this section).

Child accidental death and dismemberment insurance

You may purchase AD&D insurance on a dependent child (from birth up to age 26) in benefit amounts from $5,000 to $30,000. Coverage for your child cannot exceed 100% of your elected AD&D benefits amount. Medical evidence of insurability is not required. The cost for this insurance is based on the coverage amount elected (see rate table in this section).

Employee and Spouse/Domestic Partner AD&D Insurance	
Coverage Amount	Monthly Cost
$25,000	$0.50

Employee and Spouse/Domestic Partner AD&D Insurance	
$50,000	$1.00
$75,000	$1.50
$100,000	$2.00
$125,000	$2.50
$150,000	$3.00
$175,000	$3.50
$200,000	$4.00
$225,000	$4.50
$250,000	$5.00
$275,000	$5.50
$300,000	$6.00

Child AD&D Insurance	
Coverage Amount	Monthly Cost
$5,000	$0.10
$10,000	$0.20
$15,000	$0.30
$20,000	$0.40
$25,000	$0.50
$30,000	$0.60

Waiting period for totally disabled

If your eligible dependent is totally disabled or confined, any increase or addition to your dependent's coverage that is elected after your initial enrollment period will begin on the date your eligible dependent is no longer confined. In addition, if you are not actively at work, your initial, increase or added coverage is not effective until you return to active employment. This provision does not apply to a newborn child while dependent insurance is in effect.

TOTALLY DISABLED means that, as a result of an injury, a sickness or a disorder:

Your dependent spouse:
- is confined in a hospital or similar institution;
- is cognitively impaired; or
- is confined at home under the care of a physician for a sickness or injury.

Your dependent children:
- are confined in a hospital or similar institution; or
- are confined at home under the care of a physician for a

TOTALLY DISABLED means that, as a result of an injury, a sickness or a disorder:

Your dependent spouse:
- is confined in a hospital or similar institution;
- is cognitively impaired; or
- is confined at home under the care of a physician for a sickness or injury.

Your dependent children:
- are confined in a hospital or similar institution; or
- are confined at home under the care of a physician for a sickness or injury.

*If your dependent is confined to a hospital, skilled nursing facility or rehabilitation facility on the date the enrollment or increase is to be effective, coverage will begin when the confinement ends.

Enrolling

Enrollment into the voluntary AD&D insurance plans must be made within 31 days of hire date or a change to full-time status. These plans do not require proof of insurability. Enrollments are completed through the benefits self-service module in Fusion.

Enrolling late or discontinuing coverage

Enrollment into the voluntary AD&D insurance plans beyond the initial 31 days from benefits eligibility will not be accepted. The next opportunity to apply for this coverage is during annual enrollment typically held at year-end. You may cancel coverage at any time through the benefits self-service module in Fusion.

Lincoln Life Insurance contact information

Customer service: 1.888.964.2178, option 2

Income protection

Short-term disability plan

The short-term disability (STD) plan is a voluntary plan which provides partial income replacement for full time employees who are unable to work due to illness, pregnancy or injury. This plan is not offered to employees in states where disability coverage is provided or mandated by the state. (CA, HI, MA, NJ, NY, PR, RI). Disclaimer: If you work in a state with a statutory disability plan, your short-term disability benefit may be offset by the state benefit.

Pre-existing conditions

During the first 12 months of coverage, no short-term disability benefits will be paid for a disability that is due to a pre-existing condition. A pre-existing condition is an injury or sickness (including pregnancy) for which you received medical treatment, consultation or diagnostic measures, prescribed drugs or medications, or for which you followed treatment recommendations during the three months prior to your effective date of coverage.

60% STD benefit plan - 14-day waiting period

This plan provides you with a weekly benefit amount equal to 60% of your base weekly earnings up to a maximum of $1500 per week. The benefit waiting period is 14 calendar days and the maximum benefit duration is 24 weeks. The premiums are calculated based on your age and base monthly salary. Please refer to the premium chart on the next page for the approximate monthly cost.

2026 Monthly Cost											
60% Plan		Rate per $10 of Benefit	$0.837	$0.726	$0.600	$0.600	$0.667	$0.799	$0.957	$1.151	$1.394
Annual Salary	Weekly Salary	60% STD Weekly Benefit	18-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
$20,000	$385	$231	$19.32	$16.75	$13.85	$13.85	$15.39	$18.44	$22.08	$26.56	$32.17
$25,000	$481	$288	$24.14	$20.94	$17.31	$17.31	$19.24	$23.05	$27.61	$33.20	$40.21
$30,000	$577	$346	$28.97	$25.13	$20.77	$20.77	$23.09	$27.66	$33.13	$39.84	$48.25
$35,000	$673	$404	$33.80	$29.32	$24.23	$24.23	$26.94	$32.27	$38.65	$46.48	$56.30
$40,000	$769	$462	$38.63	$33.51	$27.69	$27.69	$30.78	$36.88	$44.17	$53.12	$64.34
$45,000	$865	$519	$43.46	$37.70	$31.15	$31.15	$34.63	$41.49	$49.69	$59.76	$72.38
$50,000	$962	$577	$48.29	$41.88	$34.62	$34.62	$38.48	$46.10	$55.21	$66.40	$80.42
$55,000	$1,058	$635	$53.12	$46.07	$38.08	$38.08	$42.33	$50.71	$60.73	$73.04	$88.47
$60,000	$1,154	$692	$57.95	$50.26	$41.54	$41.54	$46.18	$55.32	$66.25	$79.68	$96.51
$70,000	$1,346	$808	$67.60	$58.64	$48.46	$48.46	$53.87	$64.53	$77.30	$92.97	$112.59
$80,000	$1,538	$923	$77.26	$67.02	$55.38	$55.38	$61.57	$73.75	$88.34	$106.25	$128.68
$90,000	$1,731	$1,038	$86.92	$75.39	$62.31	$62.31	$69.27	$82.97	$99.38	$119.53	$144.76
$100,000	$1,923	$1,154	$96.58	$83.77	$69.23	$69.23	$76.96	$92.19	$110.42	$132.81	$160.85
$120,000	$2,308	$1,385	$115.89	$100.52	$83.08	$83.08	$92.35	$110.63	$132.51	$159.37	$193.02
$130,000 and above	$2,500	$1,500	$125.55	$108.90	$90.00	$90.00	$100.05	$119.85	$143.55	$172.65	$209.10

$1500 / Week Maximum Benefit

Enrolling

Enrollment must be completed through the benefits self-service module in Fusion within 31 days of your hire date or change of status to full-time.

Enrolling late or discontinuing coverage

Enrollment into the short-term disability plans beyond the initial 31 days will not be accepted. The next opportunity to apply for this coverage will be during annual enrollment typically held at year end and may require medical evidence of insurability satisfactory to Lincoln Financial. Claims approval will be subject to the pre-existing condition limitation described in this section. You may cancel coverage at any time through the benefits self-service module in Fusion.

Reporting a disability claim

The benefit waiting or elimination period to receive disability benefits is 14 days.

Call Encompass Health's dedicated claim intake number at Lincoln Financial Group at 888.964.2178, option 1 to file a disability claim.

For a scheduled or planned disability (due to surgery or pregnancy), you may call up to two weeks in advance of your disability. The Encompass Health policy number is 09-LF0216.

Paid time off (PTO) may be used during the applicable 14-calendar day waiting period. However, you cannot receive both PTO and disability payments at the same time during the disability benefit period.

Long-term disability plans

The long-term disability (LTD) plans provide partial income replacement for full-time employees who are unable to work due to illness or injury. Coverage in the company provided plan is effective the date of your six-month anniversary if you have continued to meet the eligibility requirements.

Pre-existing conditions

During the first 12 months of coverage, no long-term disability benefits will be paid for a disability that is due to a pre-existing condition. A pre-existing condition is an injury or illness for which you received medical treatment, consultation or diagnostic measures, prescribed drugs or medications, or for which you followed treatment recommendations during the three months prior to your effective date of coverage. See the plan booklet for additional information on coverage, limitations and exclusions.

Company paid benefit: 50% LTD benefit plan - $10,000 monthly max

Encompass Health provides full-time employees, at no cost, long-term disability coverage in the amount of 50% of your base monthly earnings, up to a maximum of $10,000/month.

Buy-up option: 60% LTD benefit plan - $10,000 monthly max (additional 10%)

Full-time employees may purchase an additional 10% of long-term disability coverage up to a maximum of $10,000 in monthly benefits.

Enrolling

Once eligible, enrollment in the 50% plan is automatic and requires no forms.

To purchase the additional 10% buy-up plan, select this plan on your Benefits Enrollment Form. The premiums for this plan will not be deducted from your check until you have met the six-month eligibility waiting period.

Coverage for either of these plans will become effective the date of your six-month anniversary, if you have continued to meet the eligibility requirements during this period.

60% Long-Term Disability Buy-Up Rates	
Age	Per $100 of Your Monthly Base Salary
Less than 25	$0.066
25-29	$0.066
30-34	$0.132
35-39	$0.231
40-44	$0.341
45-49	$0.473
50-54	$0.550
55-59	$0.594
60-64	$0.572
65+	$0.440

Enrolling late or discontinuing coverage - buy-up option

Enrollment into the buy-up plan beyond the initial 31 days will not be accepted. The next opportunity to apply for this coverage will be during annual enrollment typically held at year end and may require medical evidence of insurability satisfactory to Lincoln Financial. Claims approval will be subject to the pre-existing condition limitation described in this section. You may cancel coverage at any time through the benefits self-service module in Fusion..

Reporting a disability claim

The benefit waiting or elimination period to receive long-term disability benefits is 180 calendar days.

Call the Encompass Healthcare dedicated claims intake number at Lincoln Financial Group at 888.964.2178, option 1 to file a claim. You may also file online or check your claim status at MyLincolnPortal.com. Use code **“Encompass”** to register.

Paid time off

Encompass Health offers full-time and benefit-eligible part-time employees paid time-off benefits ("PTO"). Paid time-off benefits are a combination of the traditional vacation and sick time benefits. Benefit-eligible employees accrue PTO hours each time they receive a paycheck, beginning with their first paycheck. In addition, full-time employees receive 56 hours of holiday time each calendar year. Eligible part-time employees receive 28 hours of holiday time each calendar year. Holiday time is in addition to accrued PTO.

Paid time-off hours are accrued based on the actual hours paid up to 80 hours, during a pay cycle, multiplied by the applicable hourly accrual rate. An employee's accrual rate is based on the applicable PTO schedule and the employee's eligible service. The eligible service date may be adjusted for break in service or periods of ineligibility.

Employees will continue to accrue PTO up to a maximum of one times the annual amount. Once this maximum amount is reached, the employee will stop accruing until PTO time is used and the balance is reduced to less than the maximum amount.

Schedule 1 – Exempt positions*

Years of Eligible Service	Hourly Accrual Rate	Hours Earned Per Pay Period**	Maximum Accrual	Annual Number of Days
0-2.999	0.0692	5.54	144	18
3-4.999	0.0885	7.08	184	23
5-9.999	0.1038	8.30	216	27
10+	0.1192	9.54	248	31

Schedule 2 – Non-exempt positions

Years of Eligible Service	Hourly Accrual Rate	Hours Earned Per Pay Period**	Maximum Accrual	Annual Number of Days
0-2.999	0.0500	4.00	104	13
3-4.999	0.0692	5.54	144	18
5-9.999	0.0846	6.77	176	22
10+	0.1000	8.00	208	26

*Plus the following clinical positions: RN, LPN, LVN, PT, LPTA, OT, COTA, RRT, CRT, SLP, SLPA, Pharmacist, Sleep Lab Technologist, Rad Technologist
**(Based on 80 hours)

Retirement savings plan - 401(k)

Take full advantage of the company matching contribution for your 401(k). Encompass Health's match is 50% of the first 6% of pay contributed to the plan.

The Encompass Health Retirement Investment Plan is a plan qualified by the IRS and operating under Department of Labor regulations. The plan allows employees to contribute up to 100% of their pay on a pre-tax basis into their individual retirement account subject to the normal maximum limits set by the IRS. If you will be age 50 or older by December 31, you may be able to make additional catch-up contributions to the Plan. The IRS limits are set annually and can be found at workplace.schwab.com. Catch-up contributions may be made on a pre-tax and/or Roth 401(k) basis.

How the plan works

Employees direct the investment of their contributions and the company matching amounts. Participants receive quarterly statements outlining account activity and balances. Online access is also available for account review and changes using the workplace.schwab.com website. The earnings in the plan accumulate tax-deferred until retirement or withdrawal. The Encompass Health plan also features a loan provision, which allows participants to borrow their own money without an IRS penalty and repay themselves through payroll deduction.

Roth option

Your plan includes a Roth option. If you decide to make Roth contributions, they will be deducted from your paycheck after taxes. Your contributions and earnings will grow tax-free, and you will not pay taxes on the money when it's withdrawn—provided that any distribution from the plan account occurs at least five years following the year you make your first Roth contribution, and you have reached age 59½ or have become disabled. If you die, your beneficiary will not owe taxes on the plan account balance. Federal law limits the dollars you can contribute every year.

Company match

A 50% matching contribution is applied to the first 6% of salary deferred into the plan. You will receive 50 cents on every dollar that you contribute up to 6% of your compensation each payday. Any contributions greater than 6% of an employee's salary are not matched. Any money you contribute into the plan is always 100% vested. However, a vesting schedule does apply to the Encompass Health company match. The vesting schedule for ownership of the company match is three years in which you work 1,000 hours each year. Specific plan information is available in the Summary Plan Description (SPD).

Investment advice

Retirement plan advice is provided by Morningstar Investment Management LLC, at no additional cost to you. Let the investment advisors help you get started saving for retirement, or fine tune your investment selections to meet your retirement goals. You can access the service via your online account or by calling Schwab Participant Services at 800.724.7526

Who is eligible?

Full- and part-time employees at least 21 years of age.

Rollovers

The plan accepts rollovers from other qualified plans at any time.

Enrolling

Eligible employees can enroll into the plan, make changes to your salary deferral percentage and investments at any time by going to the Schwab website at workplace.schwab.com (your ID is your social security number and your pin number is your four-digit month and birth date), or by calling Participant Services at 800.724.7526.

Manage your account - go paperless – it's easy!

Save time and resources by viewing your retirement statements, reports, regulatory notices and transaction confirmations online by signing up to receive your 401(k) plan communications electronically. It makes it easy to organize and stay on top of your account details and activity.

Once you enroll at workplace.schwab.com, go to My Profile > Communications Preferences > Edit Delivery Options > Click Save Changes > Confirm or update your current email address.

Don't forget to designate your beneficiary when you enroll

It only takes a minute to go online and designate a beneficiary for your account. In the event of your death, your vested plan account balance will be paid to your designated beneficiary (ies), so be sure to make your designations when you enroll. Once you enroll at workplace.schwab.com, go to My Profile from the top right of the home page, Click Beneficiaries, then select Elect or Update Beneficiary.

For more information

Details can be found on the Encompass Health intranet under the Benefits home page, or you may visit the Schwab website at workplace.schwab.com.

Schwab customer service center

Call Participant Services at 800.724.7526 to enroll, change your salary deferral percentage, change your investment allocations, obtain a loan, process a rollover from another qualified plan or to inquire about account balances.

The **mobile app** is available on the App Store or Google Play.

Encompass Health Employee Stock Purchase Plan

The Encompass Health Employee Stock Purchase Plan (ESPP), administered by UBS Financial Services, allows employees to purchase Encompass Health common stock through payroll deduction. This is a voluntary plan. Encompass Health pays the brokerage fees associated with the purchase of the stock.

How the plan works

You decide how much you would like to contribute from your paycheck each pay period. Enroll into the plan by visiting the UBS One Source website or by calling customer service at 844.402.1854. Your authorized deductions will be deducted after tax from your paycheck each pay period during the offering period (calendar month) and deposited into your UBS Financial Services brokerage account. At the close of each offering period, or calendar month, UBS Financial Services will deliver your Encompass Health shares to your brokerage account. You can view the number of shares purchased for you by accessing your account on the UBS One Source website, or by calling customer service. You may sell your shares at any time provided the company is not in a blackout period. Any fees associated with the sale of your stock are your responsibility.

Who is eligible?

Full-time and part-time employees at least 21 years of age.

How to enroll

Contributions must be a whole dollar amount and a minimum of $20 per pay period is required to participate (no maximum applies). To enroll, go to the UBS One Source website, or contact customer service at 844.402.1854.

Follow these instructions to enroll online:

- Go to the UBS One Source website (www.ubs.com/onesource/ehc)
- Click the link, “first time at UBS OneSource” to create an account
- Enter your six-digit Encompass Health employee ID number as your user name
- Click YES to confirm your employee ID number
- Create a password following the online instructions
- Enter your contribution elections
- Check the “Carry Forward Your Contribution Election” box, Click NEXT
- Print “Confirmation of Elections”

How to make changes to an existing election

Once you are enrolled, you can change your contribution amount anytime by logging into the UBS One Source website www.ubs.com/onesource/ehc with your Encompass Health employee ID number or custom user name and password you created. On the OneSource website, under the “Activity” tab, click the “View/Update Elections link located under the “Actions” icon. Click this link to go to the Contribution Election page. Enter your contribution change. UBS will send confirmation of your change.

UBS contact information

Customer Service: 844.402.1854
Website: www.ubs.com/onesource/ehc

Employee Assistance Program

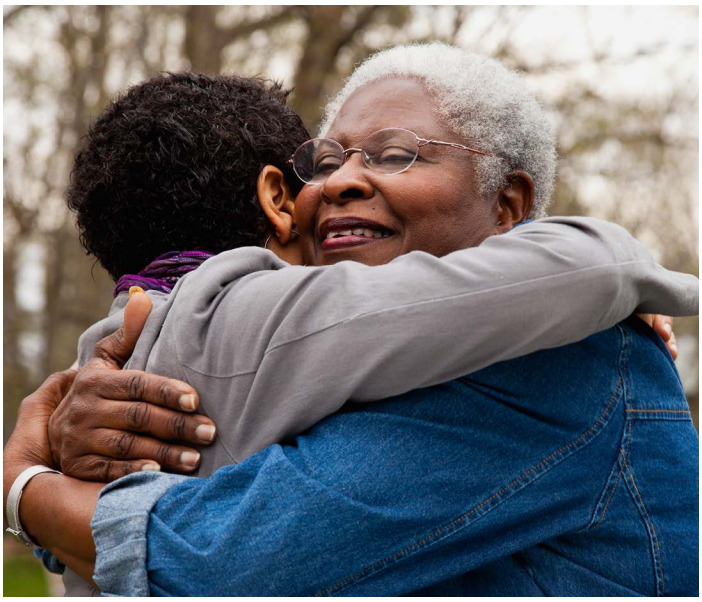
Encompass Health partners with Spring Health to ensure that employees and their family members can easily get mental health support whenever and wherever it's needed. This program provides you with access to diverse therapists, crisis intervention, coaching, medication management, wellness exercises and community resource referrals at no cost to you.

Employees and their dependents may voluntarily choose to take advantage of these ***confidential*** services, available at ***no cost***:

- **6 free therapy sessions** per member, per year
- **6 free coaching sessions** per member, per year
- Unlimited guidance and support from a Care Navigator (licensed clinician)
- Private and confidential care

Easy access to high-quality care and resources also includes:

- 5 minutes to take a short assessment and get started
- 2-day average wait for therapy appointments
- Virtual and in-person therapy options
- Schedule appointments directly through mobile app or website
- Self-guided mental wellbeing exercises available on-demand
- 24/7 crisis support via phone
- Work-life resources available



For more information

Details of benefit coverage and frequency of use of benefits are located on the Benefits home page of the Encompass Health 360 site.

Enrolling

This plan is provided by Encompass Health at no cost to employees.

Visit encompasshealth.springhealth.com or download the Spring Health mobile app. [*No authorization code is needed to register]

SpringHealth contact information:

Visit springhealth.com/support
or call 855.629.0554, M-F, 8am-11pm ET
• Press 1 for support in Spanish
• Press 2 for crisis support (24/7)
• Press 3 for member support

The mobile app is available on the App Store or Google Play.

Step Up to Excellence program

Encompass Health believes that employees who strengthen our reputation and goals for excellence deserve recognition. The Step Up to Excellence program provides employees with the opportunity to recognize their colleagues, and in turn, they can be recognized as well. Staff can be recognized for going above and beyond their regular duties via awards for categories such as Stepping Up to Excellence, On the Spot Recognition, Comfort, Professionalism & Respect, Hospital CEO Award or Non-Nursing Preceptor.

Employees can let leadership know when colleagues go above and beyond by submitting a reward nomination at stepuptoexcellence.com.

The website also allows employees to recognize fellow employees with non-point valued e-certificates to celebrate a birthday, wedding, new baby or professional accomplishment. Points earned may be redeemed for merchandise, travel, event tickets and more. Visit stepuptoexcellence.com to review the Rewards Gallery. Any points you earn roll over from year to year, allowing

you to accumulate points towards items on your wish list.

The IRS considers employee recognition awards as income. As such, you will be taxed on the recognition points as they are entered and once awarded. The taxes will be reflected on your next paystub following your reward.

If you terminate employment with Encompass Health, you will not be able to redeem your points after your last day of service. Instead, you will receive a Mastercard gift card equivalent to the point value in your account. If you do not have enough points for a Mastercard gift card, you will receive an Amazon gift card instead. The gift card will be mailed to your home address.

The **mobile app** for the Step Up To Excellence program, titled "WeRecognize", is available on the App Store and Google Play.

Service Recognition Awards program

Encompass Health recognizes employees celebrating milestone anniversaries through the Service Recognition Awards Program. Beginning with the fifth-year anniversary, and again every five years of service, employees receive a gift catalog from which to make a selection. Staff will receive a physical catalog in the mail and an email containing instructions for ordering their gift. The gift selections increase in value with every five-year milestone.

Retirement awards are also available for employees with 10 years of continuous service or who are at least 62 years of age. Retirees will receive a gift in a keepsake box with an engraved crystal memento. Retirement Awards are ordered and sent to the HR director at the hospital for presentation.

Tuition reimbursement

Reimbursement of tuition is available upon completion of pre-approved, job-related courses that are offered through an accredited institution and scheduled outside normal working hours. In addition, the employee must be working toward a degree. Tuition reimbursement is subject to budgeting considerations.

Eligible expenses

Reimbursement is limited to tuition and associated mandatory fees for up to two courses per academic term. The annual maximum amount that any individual may receive for tuition reimbursement in a single calendar year is $3,500 for full-time employees and $1,750 for part-time employees.

Eligible employees

Active full-time and part-time employees (working at least 24 hours/week) in good standing that have been employed six months in an eligible class may take advantage of this benefit.

Advising

As an Encompass Health employee, you are also eligible to participate in an Advising Session with one of change to Bright Horizons' Education Experts. Expert advisors will help you find the right school, program, degree or course to meet your educational and career objectives. They can also compare different programs, majors or degrees to help save you time and money toward your degree and assist with admissions and college financing processes.

There is no cost to you to participate in advising. To schedule an appointment, access the advising page within the Bright Horizons website.

Continuing education

Payment reimbursements may be available to employees who participate in job-related courses, seminars and conferences, etc. that enhance the employee's professional development. Continuing education is subject to home office departments and hospital budgeting considerations.

Eligible expenses

Subject to approval, necessary tuition, room, meals and transportation costs associated with enrollment and attendance may be included. The annual maximum is $2,500 for full-time employees and $1,250 for part-time employees.

Eligible employees

All active full-time and part-time employees (working at least 24 hours/week) in good standing that have been employed six months in an eligible class may take advantage of this benefit.

Work commitment time frames

Employees must sign a Continuing Education Reimbursement Form if they reach the cumulative maximum listed below.

Cumulative Maximums for Full- & Part-time Employees	Commitment Time Frame
Full-time employees $2,500	1 year
Part-time employees $1,250	1 year

Allstate® - identity & cyber protection

It's your digital identity. Own it.

Overall losses from identity fraud reached nearly $23 billion in 2023. We're more online than ever at work and at home, but that means we're also more vulnerable to scams, fraud, and cybercrime. If your identity is stolen, or if a loved one is defrauded, the mental stress can be as debilitating as the financial strain.

We're offering Allstate Identity Protection Pro+ Cyber because it delivers comprehensive identity and financial protection along with powerful personal computer and mobile cybersecurity tools. The unique tools and proactive monitoring they provide help you manage and protect your personal data. You can use your plan to monitor your identity with rapid alerts, see where your personal data lives online, and safeguard your digital devices. If fraud does occur, they provide up to **$1 million expense reimbursement** — $2 million for family plan subscribers— for many out-of-pocket expenses, including lost wages, legal fees, even cyber and ransomware. Identity theft insurance underwritten by insurance company subsidiaries or affiliates of Assurant.

The description herein is a summary and intended for informational purposes only and does not include all terms, conditions and exclusions of the policies described. Please refer to the actual policies for terms, conditions, and exclusions of coverage. Coverage may not be available in all jurisdictions.

Allstate Identity Protection Pro+ Cyber provides best-in-class features:

- Cyber protection with network security, military-grade VPN and password manager plus device protection tools for up to 5 devices
- Privacy and data monitoring with Allstate Digital Footprint®, data breach notifications, solicitation reduction and more
- Family protection for your whole household and senior family age 65+ (with family coverage)
- Identity and financial monitoring with Identity Health Status, Allstate Security Pro®, high-risk transaction monitoring and more
- Comprehensive credit monitoring with annual credit report, credit lock credit freeze assistance and more
- Identity restoration with U.S.-based support and up to $1 million reimbursement for identity theft expenses, stolen funds and ransomware* expenses.

Opt for a family plan and also get:

- Family mobile and desktop device protection for up to 10 devices plus up to $2 million in identity theft expense reimbursement

Bi-weekly Rates	
Employee	Family
$3.67	$6.90

How to enroll

Please complete enrollment at www.myaip.com. Once enrollment is processed, Allstate will send you a welcome email for activation.

Allstate contact information

Customer Service: 800.789.2720

Website: www.myaip.com

The **mobile app** is available on the App Store and Google Play.

Farmers GroupSelect℠ - auto and home insurance

The search is over for special savings on your auto and home insurance. Farmers GroupSelect Auto and Home's group insurance program is available to you as a voluntary benefit made available by your employer.

How to enroll

For premium quotes and to enroll, participate/apply, simply call 800.438.6381. You can also visit the website any time at Farmers.com/groupselect (BJY-company code).

Farmers GroupSelect auto and home insurance

Farmers GroupSelect product offers special group discount rates for various combinations of plans that can be payroll deducted. As part of the program, you have access to unique savings on auto and home insurance services, as well as a variety of other insurance policies. Even if you don't own your home, you should still protect it. Farmers GroupSelect renter's insurance provides coverage for theft and damage. You can save money when you choose us for your renters and auto coverage.

Services offered are listed below. These plans can be customized/individualized to your needs.

- Renter's insurance
- Condo insurance
- Mobile home
- Motorcycle
- Auto insurance
- Home insurance
- Boat insurance
- Recreational vehicle (RV)
- Personal excess liability
- Luxury items
- Recreational/sports equipment
- Musical instruments

Note that the availability of products varies by state.

*** The Deductible Savings Benefit is not available in all states. In New York State, drivers must pay a state-required minimum deductible before using this benefit. Not available in all states, such as MA. Identity Theft Resolution Service is not available in NC, nor to auto customers in NH, and is not available in all policy forms. Advertisement produced on behalf of the following specific insurers and seeking to obtain business for insurance underwritten by Farmers Property and Casualty Insurance (a MA & MN licensee) and certain of its affiliates: Economy Fire & Casualty Company, Economy Premier Assurance Company, Economy Preferred Insurance Company, Farmers Casualty Insurance Company (a MN licensee), Farmers Direct Property and Casualty Insurance Company (CA Certificate of Authority: 6730; Warwick, RI), Farmers Group Property and Casualty Insurance Company (CA COA: 6393; Warwick, RI), or Farmers Lloyds Insurance Company of Texas, all with administrative home offices at 700 Quaker Lane, Warwick, RI 02886. Company names approved in domiciliary states; approval pending non-domiciliary states. Coverage, rates, discounts, and policy features vary by state and product and are available in most states to those who qualify. Policies have exclusions, limitations, and terms under which the policy may be continued in force or discontinued. For costs and complete details of coverage, contact your local representative or the company.

MetLife® Legal Plans

Protection at every step.

MetLife Legal Plans offers a legal service benefit made available to you by Encompass Health. To learn more about the legal plan, visit www.legalplans.com/whyenroll or call the MetLife Client Service Center at 800.821.6400 (Access Code: 1500288).

How to enroll

Enrollments are completed through the benefits self-service module in Fusion.

Plan to stay protected

For only $7.88 per paycheck, MetLife Legal Plans give you access to a network of more than 18,000 vetted attorneys to help navigate life's big milestones and unexpected events for you, your partner and dependent children up to age 26. MetLife provides online tools to complete your estate planning documents or download self-help legal forms, in addition to telephone and office consultations for an unlimited number of personal legal matters with a network attorney of your choice. During the consultation, the attorney will review the law, discuss your rights and responsibilities, explore your options and recommend a course of action. You can receive legal advice and fully-covered legal services for a wide range of personal legal matters including:

- Wills and estate planning
- Real estate matters
- Debt collection/ID theft defense
- Traffic tickets
- Family law
- Consumer protection
- Document preparation
- Advice and consultation
- Immigration assistance

The **mobile app** is available on the App Store and Google Play.

Purchasing Power®

Life is about more than just making ends meet. The Purchasing Power program gives you convenient buying options—so you can make great financial choices and get the most out of life.

How to enroll

To enroll log onto https://www.purchasingpower.com (Group number HSO2248) or contact 888.923.6236.

Purchasing power

Welcome to payments you can live with and products you can't live without. Welcome to giving better circumstances to your finances. Welcome to Purchasing Power, a purchase program sponsored by your employer that makes it easy to get the products you need and pay for them over time. Zero interest. No credit check. No hidden fees. To participate in Purchasing Power, you must meet a few eligibility requirements including minimum age of 18, salary of $16,000 per year and a six-month tenure.

Purchasing Power contact information

Customer Service: 888.923.6236

Website: https://www.purchasingpower.com (Group number HSO2248)

The **mobile app** is available on the App Store and Google Play.

Group legal plans are administered by MetLife Legal Plans, Inc., Cleveland, Ohio. In California, this entity operates under the name MetLife Legal Insurance Services. In certain states, group legal plans are provided through insurance coverage underwritten by Metropolitan General Insurance Company, Warwick, RI. Some services not available in all states. No service, including consultations, will be provided for: 1) employment-related matters, including company or statutory benefits; 2) matters involving the employer, MetLife and affiliates and plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) costs and fines; 8) frivolous or unethical matters; 9) matters for which an attorney client relationship exists prior to the participant becoming eligible for plan benefits. Coverage for defense of criminal matters is excluded from insurance coverage for individuals located in New York. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters. Please see your plan description for details.

Lincoln Financial Group® - Voluntary plans

You work hard for your paycheck. But, it can be difficult to budget for life's unexpected emergencies. That's why Encompass Health is giving you the option to purchase the Lincoln Financial Group coverage shown below. It can help protect your finances and give you some comfort when you need it the most.

For our voluntary worksite benefits, you can call 800.423.2765 to file your benefit and wellness claim or visit our website any time at www.mylincolnportal.com.

How to enroll

Enrollments are completed through the benefits self-service module in Fusion.

Group accident insurance*

With the high cost of medical care today, a trip down the stairs can hurt your bank account as much as your body. Accident insurance can pay you money based on the injury and the treatment you receive, whether it's a simple sprain or something more serious like a broken bone. Your plan can pay benefits for emergency room treatment, stitches, crutches, injury-related surgery and a list of other accident-related expenses. The money is paid directly to you and you decide how to spend it. You can also purchase coverage for your spous e and dependent children.

Accident Biweekly Rates with Wellness			
Employee	Employee & Spouse	Employee & Children	Family
$3.89	$6.59	$7.38	$10.00

Group hospital indemnity insurance*

An unexpected hospital stay, even for a routine procedure, could force you to dip into your hard-earned savings. Hospital indemnity insurance can pay you a lump-sum benefit to help cover the costs associated with a hospital stay. It can complement your health plan to help with the out-of-pocket expenses medical insurance may not cover, such as coinsurance, copays and deductibles. You decide how to spend the money. Coverage is also available for your spouse and children.

Hospital Indemnity Biweekly Rates			
Employee	Employee & Spouse	Employee & Children	Family
$7.26	$14.68	$11.50	$18.92

Group Critical illness insurance*

What's a critical illness? Heart attack and stroke are a couple of common examples. This coverage also includes serious conditions like permanent paralysis, and some policies can provide coverage for cancer. Treatment for these conditions can be very expensive, so critical illness insurance can help–by paying a lump sum directly to you at the first diagnosis of a covered condition. You decide how to spend the money, and you can also purchase coverage for your spouse. Dependent children are automatically covered at 50% of your benefit amount, to a max amount of $10,000.

Critical Illness Biweekly Rates with Wellness			
Employee Only	$10,000	$20,000	$30,000
Age Band			
< 25	$1.71	$3.42	$5.14
25-29	$1.71	$3.42	$5.14
30-34	$2.40	$4.80	$7.20
35-39	$2.40	$4.80	$7.20
40-44	$3.74	$7.48	$11.22
45-49	$3.74	$7.48	$11.22
50-54	$6.65	$13.30	$19.95
55-59	$6.65	$13.30	$19.95
60-64	$11.12	$22.24	$33.36
65-69	$11.12	$22.24	$33.36
70+	$21.89	$43.78	$65.67

Critical Illness Biweekly Rates with Wellness			
Spouse Only	$5,000	$10,000	$15,000
Age Band			
< 25	$0.86	$1.71	$2.57
25-29	$0.86	$1.71	$2.57
30-34	$1.20	$2.40	$3.60
35-39	$1.20	$2.40	$3.60
40-44	$1.87	$3.74	$5.61
45-49	$1.87	$3.74	$5.61
50-54	$3.33	$6.65	$9.98
55-59	$3.33	$6.65	$9.98
60-64	$5.56	$11.12	$16.68
65-69	$5.56	$11.12	$16.68
70+	$10.95	$21.89	$32.84

*I understand the group insurance requested will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners. A delayed effective date will apply if you are not Actively at Work/an Active Member. A delayed effective date may apply to your dependent, if he or she is confined in a hospital or health care facility or is in a period of limited activity on the date insurance would otherwise take effect.

I understand the information provided is for enrollment in group insurance as offered by my Employer and will not be used for underwriting purposes.

Lincoln Financial Group contact information

Customer Service: 888.964.2178, option 3
Group Number: BLUELF0216

Website: www.mylincolnportal.com

The **mobile app** is available on the App Store and Google Play.

AFLAC® - Voluntary plan

Whole life insurance

Whole life insurance can pay money to your loved ones if you die. But, it also offers additional value: “one or more Qualifying events, you can request up to one half of the death benefit.” Whole life insurance premiums won’t increase with age, and your policy can build cash value over time.

How to enroll

Enrollments can be completed by calling 844.349.0782.

Whole Life Biweekly Rates - Sample Approximation by Age Employee & Spouse Volume Purchase					
Whole Life-Non Tobacco Employee Bi-weekly					
Age	$20,000	$40,000	$50,000	$75,000	$100,000
25	$7.95	$14.52	$17.81	$26.02	$34.23
35	$10.75	$20.12	$24.81	$36.52	$48.23
45	$18.20	$35.01	$43.43	$64.44	$85.46
55	$35.14	$68.89	$85.77	$127.97	$170.16
Whole Life Tobacco Employee Bi-weekly					
Age	$20,000	$40,000	$50,000	$75,000	$100,000
25	$11.21	$21.03	$25.94	$38.22	$50.50
35	$16.19	$31.00	$38.40	$56.92	$75.42
45	$27.32	$53.26	$66.23	$98.65	$131.08
55	$48.54	$95.69	$119.27	$178.21	$237.15
Whole Life-Non Tobacco Spouse Bi-weekly					
Age	$5,000	$10,000	$20,000	$25,000	
25	$3.03	$4.67	$7.95	$9.60	
35	$3.72	$6.07	$10.75	$13.10	
45	$5.59	$9.79	$18.20	$22.40	
55	$9.83	$18.26	$35.14	$43.58	
Whole Life Tobacco Spouse Bi-weekly					
Age	$5,000	$10,000	$20,000	$25,000	
25	$3.84	$6.30	$11.21	$13.66	
35	$5.09	$8.79	$16.19	$19.89	
45	$7.87	$14.35	$27.32	$33.81	
55	$13.18	$24.96	$48.54	$60.33	

Aflac contact information

Customer Service: 800.433.3036 Group Number: 27098
Website: http://aflacgroupinsurance.com/

The mobile app is available on the App Store and Google Play.

BenefitHub

BenefitHub is an all-in-one platform designed to make it easier for you to access and manage your workplace discounts. It offers a wide range of benefits and discounts, including health and wellness programs, financial services, travel and leisure deals, and more. With BenefitHub, you can conveniently explore and take advantage of these perks, improving your work-life balance and overall job satisfaction. It's a user-friendly platform that centralizes all your discounts in one place, making it simple to navigate and enjoy the perks available to you as part of our organization.

BenefitHub contact information

Customer Service: 813.675.2210
Website: https://encompasshealth.benefithub.com/app/home

The mobile app is available on the App Store and Google Play.

Glossary of health coverage and medical terms

This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

Blue text indicates a term defined in this Glossary.

See page 48 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

Allowed amount
Maximum amount on which payment is based for covered healthcare services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See balance billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Coinsurance
Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Complications of pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Copayment
A fixed amount (for example, $15) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Deductible
The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

Durable medical equipment (DME)
Equipment and supplies ordered by a healthcare provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency medical condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency medical transportation
Ambulance services for an emergency medical condition.

Emergency room care
Emergency services you get in an emergency room.

Emergency services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded services
Healthcare services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation services
Healthcare services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health insurance
A contract that requires your health insurer to pay some or all of your healthcare costs in exchange for a premium.

Home health care
Healthcare services a person receives at home.

Hospice services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital outpatient care
Care in a hospital that usually doesn't require an overnight stay.

In-network coinsurance
The percent (for example, 20%) you pay of the allowed amount for covered healthcare services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

In-network copayment
A fixed amount (for example, $15) you pay for covered healthcare services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Medically necessary
Healthcare services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.

Non-preferred provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network coinsurance
The percent (for example, 40%) you pay of the allowed amount for covered healthcare services to providers who do not contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-network copayment
A fixed amount (for example, $30) you pay for covered healthcare services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-pocket limit
The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

Physician services
Healthcare services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your healthcare services.

Preauthorization
A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription drug coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription drugs
Drugs and medications that by law require a prescription.

Primary care physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of healthcare services for a patient.

Primary care provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of healthcare services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), healthcare professional or healthcare facility licensed, certified or accredited as required by state law.

Reconstructive surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation services
Healthcare services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled nursing care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

UCR (usual, customary and reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How you and your insurer share costs - example

Jane's Plan Deductible: $1,500

Coinsurance: 20%

Out-of-Pocket Limit: $5,000

Jane hasn't reached her $1,500 deductible yet.

Her plan doesn't pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible; coinsurance begins.

Jane has seen a doctor several times and paid $1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: $75
Jane pays: 20% of $75 = $15
Her plan pays: 80% of $75 = $60

Jane reaches her $5,000 out-of-pocket limit.

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered healthcare services for the rest of the year.

Office visit costs: $200
Jane pays: $0
Her plan pays: $200

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-521-2227 or at www.bcbstx.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Encompass Hospital providers: $0 Individual / $0 Family In-Network: $1,500 Individual / $3,000 Family Out-of-Network: $2,000 Individual / $4,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services that charge a copayment, prescription drugs, emergency room services, and In-Network preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Prescription drug deductible: $150 Individual / $300 Family. Prescription deductible applies only to brand drugs. Per occurrence: $500 In-Network inpatient admission. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Encompass Hospital providers: $0 Individual / $0 Family In-Network: $5,000 Individual / $10,000 Family Out-of-Network: $6,000 Individual / $12,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, preauthorization penalties, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of network providers.	You pay the least if you use a provider in Encompass provider network. You pay more if you use a provider in-network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Encompass Hospital Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	N/A	$30 copayment/visit; deductible does not apply	50% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	N/A	$45 copayment/visit; deductible does not apply	50% coinsurance	Chiropractic services limited to 26 visits per calendar year.
	Preventive care/screening/ immunization	N/A	No Charge; deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	N/A	30% coinsurance	50% coinsurance	No Charge after office visit copayment. Coinsurance may vary if services rendered in an outpatient hospital setting.
	Imaging (CT/PET scans, MRIs)	N/A	30% coinsurance	50% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Encompass Hospital Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-833-956-1260 www.caremark.com	Generic drugs	N/A	$10 retail / $30 mail order copay/prescription; deductible does not apply	Not Covered	Prescription drug deductible: $150 Individual / $300 Family Retail covers 30 day supply. With appropriate prescription, up to a 90 day supply is available. Mail order covers a 90 day supply. Specialty drugs must be obtained from In-Network specialty pharmacy provider. Mail order is not covered. *See Benefit Booklet of CVS Benefits Summary for more information
	Preferred brand drugs	N/A	$45 retail / $135 mail order copay/prescription	Not Covered	
	Non-preferred brand drugs	N/A	$60 retail / $180 mail order copay/prescription	Not Covered	
	Specialty drugs	N/A	30% coinsurance for all specialty medications included in the PrudentRX Program List. For medications not included in the Prudent Solution, you will be responsible for the cost share noted above.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge; deductible does not apply	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	N/A	30% coinsurance	50% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Encompass Hospital Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Emergency room: No Charge; deductible does not apply Physician's fee Not Covered	Emergency room $250 copayment/visit; deductible does not apply Emergency room services 30% coinsurance	Emergency room $250 copayment/visit; deductible does not apply Emergency room services 30% coinsurance	Emergency room copayment waived if admitted.
	Emergency medical transportation	N/A	30% coinsurance	30% coinsurance	Ground and air transportation covered.
	Urgent care	N/A	$50 copayment/visit; deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge; deductible does not apply	30% coinsurance	50% coinsurance	$500 inpatient admission deductible for In-Network providers. All services must be preauthorized; 50% penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	N/A	30% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Encompass Hospital Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	N/A	$30 copayment/office visit; deductible does not apply 30% coinsurance for other outpatient services	50% coinsurance	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your plan policy for more details.
	Inpatient services	No Charge; deductible does not apply	30% coinsurance	50% coinsurance	$500 inpatient admission deductible for In-Network providers. All services must be preauthorized; 50% penalty if not preauthorized Out-of-Network.
If you are pregnant	Office visits	N/A	$30 PCP/$45 SPC copayment/visit; deductible does not apply	50% coinsurance	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	N/A	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	No Charge; deductible does not apply	30% coinsurance	50% coinsurance	$500 inpatient admission deductible for In-Network providers. Preauthorization is not required.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Encompass Hospital Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge; deductible does not apply	30% coinsurance	50% coinsurance	Preauthorization is required.
	Rehabilitation services	No Charge; deductible does not apply	30% coinsurance	50% coinsurance	None
	Habilitation services	No Charge; deductible does not apply	30% coinsurance	50% coinsurance	
	Skilled nursing care	No Charge; deductible does not apply	30% coinsurance	50% coinsurance	Limited to 90 days per calendar year. Preauthorization is required.
	Durable medical equipment	N/A	30% coinsurance	50% coinsurance	None
	Hospice services	No Charge; deductible does not apply	30% coinsurance	50% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult, only for accidents)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care (limited to 26 visits per calendar year)
- Hearing aids (1 per ear per 36-month period)
- Infertility treatment (assisted reproductive technology lifetime max: $5,000 medical)
- Non-emergency care when traveling outside the U.S.
- Routine foot care

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$1,500**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$2,000
Copayments	$30
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1,500**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$1,500**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**30%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Texas

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Forms: hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	Encompass Hospital providers: $0 Individual / $0 Family In-Network: $750 Individual / $1,500 Family Out-of-Network: $2,000 Individual / $4,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services that charge a copayment, prescription drugs, emergency room services, and In-Network preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Prescription drug deductible: $100 Individual / $200 Family. Prescription deductible applies only to brand drugs. Per occurrence: $300 In-Network inpatient admission. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Encompass Hospital providers: $0 Individual / $0 Family In-Network: $4,000 Individual / $8,000 Family Out-of-Network: $6,000 Individual / $12,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, preauthorization penalties, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of network providers.	You pay the least if you use a provider in Encompass provider network. You pay more if you use a provider in-network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Encompass Hospital Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	N/A	$30 copayment/visit; deductible does not apply	50% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	N/A	$45 copayment/visit; deductible does not apply	50% coinsurance	Chiropractic services limited to 26 visits per calendar year.
	Preventive care/screening/ immunization	N/A	No Charge; deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	N/A	20% coinsurance	50% coinsurance	No Charge after office visit copayment. Coinsurance may vary if services rendered in an outpatient hospital setting.
	Imaging (CT/PET scans, MRIs)	N/A	20% coinsurance	50% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Encompass Hospital Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-833-956-1260 www.caremark.com	Generic drugs	N/A	$10 retail / $30 mail order copay/prescription; deductible does not apply	Not Covered	Prescription drug deductible: $100 Individual / $200 Family Retail covers 30 day supply. With appropriate prescription, up to a 90 day supply is available. Mail order covers a 90 day supply. Specialty drugs must be obtained from In-Network specialty pharmacy provider. Mail order is not covered. *See Benefits Booklet of CVS Benefits Summary for more information
	Preferred brand drugs	N/A	$45 retail / $135 mail order copay/prescription	Not Covered	
	Non-preferred brand drugs	N/A	$60 retail / $180 mail order copay/precription	Not Covered	
	Specialty drugs	N/A	30% coinsurance for all specialty medications included in the PrudentRX Program list. For medications not included in Prudent Solution, you will be responsible for the cost share noted above.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge; deductible does not apply	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	N/A	20% coinsurance	50% coinsurance	None

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Encompass Hospital Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Emergency room No Charge; deductible does not apply Physician's fee Not Covered	Emergency room $200 copayment/visit; deductible does not apply Emergency room services 20% coinsurance	Emergency room $200 copayment/visit deductible does not apply Emergency room services 20% coinsurance	Emergency room copayment waived if admitted.
	Emergency medical transportation	N/A	20% coinsurance	20% coinsurance	Ground and air transportation covered.
	Urgent care	N/A	$50 copayment/visit; deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge; deductible does not apply	20% coinsurance	50% coinsurance	$300 inpatient admission deductible for In-Network providers. All services must be preauthorized; 50% penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	N/A	20% coinsurance	50% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Encompass Hospital Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	N/A	$30 copayment/office visit; deductible does not apply 20% coinsurance for other outpatient services	50% coinsurance	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your plan policy for more details.
	Inpatient services	No Charge; deductible does not apply	20% coinsurance	50% coinsurance	$300 inpatient admission deductible for In-Network providers. All services must be preauthorized; 50% penalty if not preauthorized Out-of-Network.
If you are pregnant	Office visits	N/A	$30 PCP/$45 SPC copayment/visit; deductible does not apply.	50% coinsurance	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	N/A	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	No Charge; deductible does not apply	20% coinsurance	50% coinsurance	$300 inpatient admission deductible for In-Network providers. Preauthorization is not required.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Encompass Hospital Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge; deductible does not apply	20% coinsurance	50% coinsurance	Preauthorization is required.
	Rehabilitation services	No Charge; deductible does not apply	20% coinsurance	50% coinsurance	None
	Habilitation services	No Charge; deductible does not apply	20% coinsurance	50% coinsurance	
	Skilled nursing care	No Charge; deductible does not apply	20% coinsurance	50% coinsurance	Limited to 90 days per calendar year. Preauthorization is required.
	Durable medical equipment	N/A	20% coinsurance	50% coinsurance	None
	Hospice services	No Charge; deductible does not apply	20% coinsurance	50% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult, only for accidents)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care (limited to 26 visits per calendar year)
- Hearing aids (1 per ear per 36-month period)
- Infertility treatment (assisted reproductive technology lifetime max: $5,000 medical)
- Non-emergency care when traveling outside the U.S.
- Routine foot care

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$1,050
Copayments	$40
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,450**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$850
Copayments	$1,000
Coinsurance	$30
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

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You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Forms: hhs.gov/civil-rights/filing-a-complaint/index.html	

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Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $3,400 Individual / $6,600 Family Out-of-Network: $6,000 Individual / $12,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $4,000 Individual / $8,000 Family Out-of-Network: $6,000 Individual / $12,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, preauthorization penalties, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	20% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	20% coinsurance	20% coinsurance	Chiropractic services limited to 26 visits per calendar year.
	Preventive care/screening/immunization	No Charge; deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-833-956-1260 www.caremark.com	Generic drugs	20% coinsurance	Not Covered	Retail covers 30 day supply. With appropriate prescription, up to a 90 day supply is available. Mail order covers a 90 day supply. Specialty drugs must be obtained from In-Network specialty pharmacy provider. Mail order is not covered. *See Benefit Booklet of CVS Benefits Summary for more information
	Preferred brand drugs	20% coinsurance	Not Covered	
	Non-preferred brand drugs	20% coinsurance	Not Covered	
	Specialty drugs	30% coinsurance for all specialty medications included in the PrudentRX Program List. For medications not included in the Prudent Solution, you will be responsible for the cost share noted above.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Facility Charges: 20% coinsurance ER Physician Charges: 20% coinsurance	Facility Charges: 20% coinsurance ER Physician Charges: 20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground and air transportation covered.
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Preauthorization is required; 50% penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your plan policy for more details.
	Inpatient services	20% coinsurance	20% coinsurance	Preauthorization is required; 50% penalty if not preauthorized Out-of-Network.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	20% coinsurance	None
	Habilitation services	20% coinsurance	20% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	Limited to 90 days per calendar year. Preauthorization is required.
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice services	20% coinsurance	20% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult, only for accidents)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care (limited to 26 visits per calendar year)
- Hearing aids (1 per ear per 36-month period)
- Infertility treatment (assisted reproductive technology lifetime max: $5,000 medical)
- Non-emergency care when traveling outside the U.S.
- Routine foot care

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$3,400**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,400
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$3,400**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,400
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$3,400**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

BlueCross BlueShield of Texas

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Forms: hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

bcbstx.com TX1557_ENG_20250410

Legal notices and disclosures

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 see page 41 where Notice of Creditable Coverage begins for more details.

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"). 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.

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

	Core PPO		Plus PPO		Choice HDHP	
Deductible	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Individual	$1,500	$2,000	$750	$2,000	$3,400	$6,600
Family	$3,000	$4,000	$1,500	$4,000	$6,600	$12,000
Coinsurance	30%	50%	20%	50%	20%	20%

If you would like more information on WHCRA benefits, please call your Plan Administrator at Benefits Hotline: 1-800-500-3401, 9001 Liberty Parkway Birmingham, AL 35242.

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 or 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **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, 2023. Contact your State for more information on eligibility

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1.855.692.5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1.866.251.4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1.855.MyARHIPP (855.692.7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916.445.8322 Fax: 916.440.5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1.800.221.3943 / State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1.800.359.1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1.855.692.6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1.877.357.3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid Medicaid Phone: 1-800-338-8366 Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1.573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 1-603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/Encompass Health Corporations/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 1-919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 1.401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://dvha.vermont.gov/members/medicaid/hipp-program Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select HIPP Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa

866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights.

Encompass Health Corporation is committed to the privacy of your health information. The administrators of the Encompass Health Corporation Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting the HR Help Desk: 866-275-4743, 9001 Liberty Parkway Birmingham, AL 35242.

HIPAA SPECIAL ENROLLMENT RIGHTS

Encompass Health Corporation Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Encompass Health Corporation Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program).

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.

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 new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program.

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact the HR Help Desk: 866-275-4743, 9001 Liberty Parkway Birmingham, AL 35242.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

NOTICE OF CREDITABLE COVERAGE

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

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

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

When Can You Join a Medicare Drug Plan? You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare 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 Encompass Health Corporation coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Encompass Health Corporation coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan? You should also know that if you drop or lose your current coverage with Encompass Health Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage
Contact the Benefits Hotline: 800.500.3401, 9001 Liberty Parkway Birmingham, AL 35242 for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Encompass Health Corporation changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit 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: 01/01/2026
Sender: Encompass Health Corporation
Contact: HR Help Desk
9001 Liberty Parkway Birmingham, AL 35242
866-275-4743

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact **the HR Help Desk: 866-275-4743, 9001 Liberty Parkway Birmingham, AL 35242.**

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name	4. Employer Identification Number (EIN)
Encompass Health Corporation	63-0860407
5. Employer address	**6. Employer phone number**
9001 Liberty Parkway	866-275-4743

7. City	8. State	9. ZIP code
Birmingham	AL	35242

10. Who can we contact about employee health coverage at this job?	
HR Help Desk	
11. Phone number (if different from above)	**12. Email address**

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  - ☒ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    - Legal spouse
    - Domestic partner
    - Children up to age 26
    - Children 26 or older who are mentally or physically disabled and are dependent upon you for support
  - ☐ We do not offer coverage.

☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Carrier contact

Carrier/Administrator	Website	Contact
AbsenceResources (formerly FMLASource)	www.absenceresources.com	888.228.9702
AFLAC (Group # 27098)	www.aflacgroupinsurance.com	800.433.3036
AllState	www.myaip.com	800.789.2720
BenefitHub Discount	https://encompasshelth.benefithub.com/app/home	813-675-2210
Bright Horizons	clients.brighthorizons.com/encompasshealth	844.358.1621
BCBS of Texas	www.bcbstx.com	
Medical Plan		800.521.2227
Blue Access for Members (BAM)	www.bcbstx.com/member	
Medical Preauthorization		800.441.9188
MD Live	www.mdlive.com	800.400.6354
BCBS Provider Network		800.810.2583
Well on Target	www.wellontarget.com	877.806.9380
Charles Schwab	www.workplace.schwab.com	800.724.7526
CVS Caremark	www.caremark.com	833.956.1260
CVS Specialty	www.cvsspecialty.com	800.237.2767
CVS Prior Authorization		800.294.5979
CVS Mail Order	www.caremark.com	833.956.1260
Farmer's Auto & Home Insurance	Farmers.com/groupselect	800.438.6388
Gallagher Enrollment Solutions (GES)		844.349.0782
HealthEquity (HSA, FSA, and DCFSA)	www.myhealthequity.com	844.396.0226
HealthEquity (COM - NY only)	https://participant.wageworks.com	877.924.3967
Lincoln Financial Group (Life and Disability)		
STD claims (policy #09-LF0216)	www.mylincolnportal.com	888.964.2178, option 1
LTD claims (policy #09-LF0216)	www.mylincolnportal.com	888.964.2178, option 1
Group Term Life/Personal Accident Insurance	www.mylincolnportal.com	888.964.2178 option 2
Life Claims	www.mylincolnportal.com	888.964.2178, option 2
Voluntary Plans	www.mylincolnportal.com	888.964.2178, option 3
MetLife Dental	www.mybenefits.metlife.com	800.942.0854
MetLife Legal	www.legalplans.com/whyenroll	800.821.6400
McGriff COBRA Services	https://cobralogin.mcgriffinsurance.com	888.888.3442
Purchasing Power	www.purchasingpower.com	866.923.6236
SpringHealth (EAP)	www.encompasshealth.springhealth.com	855.629.0554
Lantern	https://lanterncare.com/	833.227.7577
Tria Health	www.triahealth.com/schedule	888.799.8742
Quantify	www.quantifyspecialtycare.com	888.536.9963
UBS Financial Services	www.ubs.com/onesource/hls	844.402.1854
VSP	www.vsp.com	800.877.7195

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