2025 TEAMMATE Benefits Guide

ActiveDay

FULL 1 | FULL 2 | FTACA (B)

Welcome!

At Active Day, we believe the benefits we offer are an essential part of your overall rewards as a valued Teammate. After carefully reviewing the benefits package options for the upcoming plan year, we've made enhancements to the rewards available to our Active Day family.

We're thrilled to announce that there will be no increases to Teammate contributions for any of the benefits provided by Active Day, along with several exciting benefit enhancements.

We want to ensure that we illustrate our commitment to you by providing you with valuable benefit options and the tools and resources you need to stay committed to your health.

The benefits in this guide are effective June 1, 2025 through May 31, 2026.

Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualifying life event (see page 2 of this guide for more information).

If you have any questions about Open Enrollment or the benefits outlined in this guide, please contact Member Advocacy at 800-563-9929.

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Important Enrollment Information

Who is Eligible to Elect Benefits?*

Teammate Eligibility

All full-time Teammates working **30 or more hours per week** are eligible for the following benefits on the first of the month following 60 days of employment*:

- Medical, Prescription, Dental, and Vision
- Basic Life and AD&D
- Voluntary Teammate, Spouse, and Child Life
- Voluntary Short-Term Disability (STD)

Teammates must be actively at work doing all their regular full-time duties to be eligible for Voluntary Benefits coverage (listed on page 16 of this guide).

Dependent Eligibility

- **Medical, Prescription, Vision, Dental, and Voluntary Benefits:** Dependents are covered until the end of the month in which they turn 26
- **Voluntary Spouse Life:** Eligible until age 70
- **Voluntary Child Life:** Dependents are covered until the day in which they turn 26

* For employment classification below full-time status, a 12-month look-back measurement period applies to determine eligibility.

Who can I cover? (Available Coverage Tiers)

- Teammate
- Teammate + Child(ren) up to age 26, including:
  - Birth child(ren) or spouse's birth child(ren)
  - Child(ren) legally adopted or placed for adoption.
  - Child(ren) under a Qualified Medical Support Order (QMSCO)
  - Eligible disabled child(ren)
- Teammate + Legal Spouse
- Teammate + Family

Qualifying Life Events

Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualifying life event (QLE).

Qualifying Life Events include:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Change in child's dependent status
- Death of a spouse, child, or other qualified dependent
- Change in employment status or a change in coverage under another employer-sponsored plan
- Change in residence due to an employment transfer for you or your spouse

IMPORTANT:

You must notify your manager within 30 days of experiencing a qualifying life event.

Please note: it is the Teammate's responsibility to notify their manager at the time their dependent is no longer eligible under an Active Day benefits plan so that Active Day can issue a timely COBRA notification and adjust their payroll deduction if necessary.

Wellness Initiatives

wellnessworks

Healthy living isn't always easy. It is important to keep it simple, set realistic goals, and remember that even small choices can add up to significant health benefits. Active Day is committed to helping Teammates achieve their healthy lifestyle goals.

SAVE $650 PER YEAR!

To promote our commitment to wellness, we offer an annual discount of **$650 per year** for Teammate contributions by completing the wellness program activities outlined below.

Wellness Program

Active Day's wellness program requirements include the following wellness activities:

- Certifying that you are tobacco-free (Non-Tobacco User Affidavit) or by completing the Tobacco Cessation Program
- Obtaining annual physical and biometric screening
- Completing a health risk assessment through Personify Health

If you enroll in medical benefits, please look out for additional details coming from Active Day when Personify Health launches on June 1st!

To be eligible to continue to receive the wellness discount for the next plan year (June 1, 2026 - May 31, 2027) these items must be completed between June 1, 2025, and March 31, 2026.

The annual physical and screening are fully covered under preventive care with no cost sharing from the Teammate. When you schedule your exam, please be sure to schedule it as "**Annual Preventive Exam.**"

Non-Tobacco User Affidavit

If you participate in the Active Day health plan with Independence Blue Cross, you are eligible for the Payroll Deduction Reward with your enrollment. By signing the Non-Tobacco User affidavit, you are attesting that you have not used tobacco for 90 days prior to your effective date of coverage.

Earning the Wellness Discount as a Tobacco User: Quit for Life Tobacco Cessation

Active Day offers the Quit for Life Tobacco Cessation program to Teammates who enroll in the Active Day health plan with Independence Blue Cross. There is no cost to you to participate in this program that provides coaching, nicotine replacement therapy and so much more.

For more details on this program, please visit the **BenePortal**. You can also go to **www.quitnow.net** or call **1-866-QUIT-4-LIFE** (TTY: 711) to get started.

Medical Plan Options

INDEPENDENCE BLUE CROSS

Below is a summary of IBX medical plan options. If you need help finding an in-network provider or viewing a claim status, visit **www.ibx.com**, scan the QR code, or download the **IBX mobile app**. Each plan includes prescription benefits.

Scan to visit IBX online

IBX IN-NETWORK BENEFITS*

BENEFIT DESCRIPTION	CATASTROPHIC HDHP	CORE HDHP	ENHANCED PPO
Deductible (Individual/Family)	$6,750 / $13,500	$2,500 / $5,000	$1,500 / $3,000
Coinsurance	Plan pays 100%	Plan pays 80%	Plan pays 80%
Active Day HSA Contribution* (Funded Quarterly – see page 6 for more details)	Up to $400 annually	Up to $400 annually	N/A
Out-of-Pocket Maximum (Individual/Family)	$6,750 / $13,500	$6,350 / $12,700	$4,500 / $9,000
Primary Care Physician Office Visit	Plan pays 100% after deductible	Plan pays 80% after deductible	$10 copay
Specialist Office Visit	Plan pays 100% after deductible	Plan pays 80% after deductible	$30 copay
Urgent Care Center	Plan pays 100% after deductible	Plan pays 80% after deductible	$30 copay
Emergency Room (waived if admitted)	Plan pays 100% after deductible	Plan pays 80% after deductible	$200 copay then plan pays 80%
Outpatient Surgery	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible
Inpatient Hospital Stay	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 80% after deductible

* For full plan details, including out-of-network benefits, please refer to the full plan summaries located on the TBX portal.

PER-PAY (26 PAYS) TEAMMATE MEDICAL COST-SHARE *(See page 19 for full cost breakdown)*

TIER	CATASTROPHIC PLAN		CORE PLAN		ENHANCED PPO PLAN	
	WELLNESS	NON-WELLNESS	WELLNESS	NON-WELLNESS	WELLNESS	NON-WELLNESS
Teammate-Only	$30.93	$55.93	$69.24	$94.24	$98.83	$123.83
Teammate+ Spouse	$260.60	$285.60	$342.56	$367.56	$434.45	$459.45
Teammate + Child(ren)	$157.44	$182.44	$222.47	$247.47	$289.61	$314.61
Family	$329.91	$354.91	$435.45	$460.45	$555.00	$580.00

About the Medical Plans

The IBX medical plans give you the freedom to see any provider in or out-of-network without a referral. Members also receive in-network coverage across the country through BlueCard PPO and around the world through BlueCard Worldwide. Plan features include:

- More than 750,000 physicians and 5,500 hospitals nationwide.
- Emergency care is covered anywhere, anytime; out-of-pocket max protects you from catastrophic expenses.
- Preventive care is covered 100% in-network and is not subject to the deductible (first dollar coverage).

Prescription Drug Plan

INDEPENDENCE BLUE CROSS

If you are enrolled in the medical plans, you are automatically enrolled in the prescription drug plan through Independence Blue Cross, outlined below. For more information, visit **www.ibx.com** or scan the QR code.

Scan to visit IBX online

IBX PRESCRIPTION BENEFITS

PLAN	CATASTROPHIC HDHP	CORE HDHP	ENHANCED PPO
RETAIL PHARMACY: UP TO A 30-DAY SUPPLY			
Generic	Plan pays 100% after deductible	Plan pays 80% after deductible	$10 copay
Preferred Brand	Plan pays 100% after deductible	Plan pays 80% after deductible	$30 copay
Non-Preferred Brand	Plan pays 100% after deductible	Plan pays 80% after deductible	$50 copay
MAIL-ORDER PHARMACY: UP TO A 90-DAY SUPPLY			
Generic	Plan pays 100% after deductible	Plan pays 80% after deductible	$20 copay
Preferred Brand	Plan pays 100% after deductible	Plan pays 80% after deductible	$60 copay
Non-Preferred Brand	Plan pays 100% after deductible	Plan pays 80% after deductible	$100 copay

Important Note for the Core/ Catastrophic HDHP Plans:

If you are enrolled in the **Core** HDHP or **Catastrophic** HDHP plan, and you fill a retail pharmacy or mail-order prescription, you will pay the full cost until the deductible is met. After the deductible is met, you will pay 20% of the cost of the prescription in the Core HDHP plan and 0% in the Catastrophic HDHP plan.

Note that the prescription drug benefit is subject to the HDHP deductible with the exception of certain preventive medications such as:

- Advair
- Actos
- Prozac
- Benicar
- Effexor XR
- Lipitor
- Diovan
- Wellbutrin
- Crestor

For a complete list of covered medications, visit the BenePortal at **www.activedaybenefits.com**.

Using Mail-Order

It's easy to set up mail-order service through Optum. Most doctors use e-prescribing which transmits your prescription electronically. Once you have set up your online account, ask your doctor to send your prescriptions to Optum.

If you haven't yet established an online account with Optum, please visit **www.optum.com**.

Health Savings Account

INDEPENDENCE BLUE CROSS (IBX)

*If you elect the **Catastrophic** or **Core** High-Deductible Health Plans (HDHP), you may be eligible to make pre-tax contributions toward a Health Savings Account (HSA). An HSA allows you to save money for qualified healthcare expenses you're expecting, such as contact lenses or prescriptions, as well as the unexpected ones.*

HSA Triple-Tax Advantages

- The money you deposit and withdraw is tax-free. Unused funds roll over year after year.
- An HSA is portable; if you leave Active Day or retire, you can take your HSA funds with you.
- Once you meet the required amount balance minimum, you will have the option to begin investing your money.

Employer HSA Funding

Active Day will fund $100 per quarter (up to $400 annually)* to your IBX-affiliated HSA. Everyone that elects HSA deductions during Open Enrollment will have an IBX HSA established.

Teammates with existing HSAs can roll over their funds to their IBX HSA. Further guidance on the rollover process will be provided separately.

Contribution Limits

HSA contribution limits are set by the Internal Revenue Service (IRS) and adjusted annually. 2025 limits are:

- $4,300 for individual
- $8,550 for family coverage
- $1,000 catch-up contribution for those age 55+

When deciding how much to contribute to your HSA, make sure to factor in any employer contribution amounts. The IRS annual maximum is the total combined employer and Teammate funding (i.e., Teammates cannot elect a deduction at the maximum if they are receiving company funds).

HSA Eligibility

In order to qualify for an HSA, you must be an adult who meets the following qualifications:

- You have coverage under an HSA-qualified, high deductible health plan (HDHP)
- You (or your spouse, if applicable) have no other health coverage (excluding other types of insurance, such as dental, vision, disability or long-term care coverage)
- Are not enrolled in Medicare
- You cannot be claimed as a dependent on someone else's tax return

Qualified Medical Expenses

You can use the funds in your HSA to pay for qualified healthcare expenses, such as:

- Doctor visits
- Dental care, including extractions and braces
- Vision care, including contact lenses, prescription sunglasses and LASIK surgery
- Prescription medications
- Chiropractic services and acupuncture

A full list of eligible expenses can be found at **www.irs.gov/publications/p969**.

Online and Mobile Access

You can get instant access to your account by logging in at **ibx.com** or by using the **IBX mobile app**. With this virtual access, you can do things like view account balance and activity, submit qualified expenses for reimbursement and more!

* You will receive $100 if you are enrolled for June coverage and are actively employed on July 1st. From there, you will receive $100 if you are: Enrolled for September coverage and actively employed on Oct 1st; Enrolled for December coverage and are actively employed on Jan 1st; Enrolled for March coverage and are actively employed on April 1st.

Additional Medical & Prescription Resources

Here are some other great benefits provided to those who enroll in one of the Independence Blue Cross medical plans. Take advantage of these programs to stay on track with your health goals – all at $0 out-of-pocket cost!

Wellness Reimbursements

- You can receive up to $150 of reimbursement towards Weight Watchers, Weight Watchers Online, or an approved weight management program at any network hospital.
- You can receive up to $150 of reimbursement towards membership fees after 120 visits to an approved fitness center.
- You can receive up to $150 of reimbursement towards an approved and completed tobacco cessation program.

To find out more about these great programs, please visit **www.ibx.com/stay-healthy/health-and-wellness/discounts-and-reimbursements**.

IBX Wire and Email

Stay up to date, save money, and maximize your benefits by signing up for email or text alerts with IBX Wire. You can get personalized reminders about your health, notifications about plan information, and more. To get connected, go to **www.ibx.com/getconnected**.

Connect to Care Providers

Independence Blue Cross has relationships with Connect to Care providers to ensure members have timely access to high-quality behavioral health care. Visit **www.ibx.com/providerfinder** to look for additional in-network behavioral health providers and resources.

Behavioral Health Navigation — Personalized Connection to Care

Call IBX's Behavioral Health Care Navigation team on **1-800-688-1911** to help with finding in-network behavioral health providers and scheduling services.

- The Behavioral Health Care Navigation team can directly schedule your appointment or connect you to an in-network behavioral health provider to ensure quick access to care.
- The team also offers clinical assessments to connect you with the appropriate treatment and in-the-moment support when needed.

Shatterproof Treatment Atlas

With Atlas, you can access a free online tool that connects you and your loved ones with **trustworthy, in-network addiction treatment**.

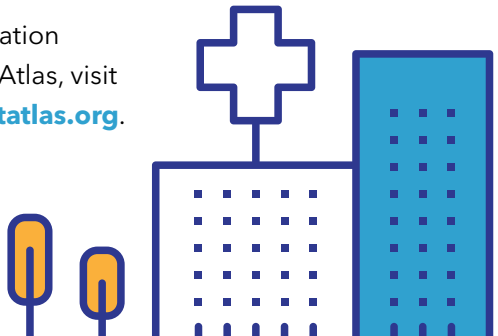
Shatterproof's Treatment Atlas can help you find and compare treatment facilities to ensure you are finding the best care for your needs.

How Atlas Works

First, complete a brief and anonymous set of questions which offer initial guidance on the most appropriate level of care and recommendations for additional treatment services. Then, utilize the Atlas tool to find and compare treatment providers.

Atlas not only contains a comprehensive list of addiction treatment providers, but it also has filters which allow you to find the best options based on things like location, specific treatment services offered, languages, and more.

For more information or to start using Atlas, visit **www.treatmentatlas.org**.



Hypertension & Diabetes Management

Independence Blue Cross, in partnership with Teladoc Health, offers free tools and personalized support to help members manage high blood pressure and diabetes effectively.

Hypertension Management

If you have high blood pressure, Teladoc provides:

- An advanced blood pressure monitor at no cost.
- Personalized insights and trend analysis via a secure account and mobile app.
- Live one-on-one coaching and guidance to develop healthy habits.

Diabetes Management

For those managing diabetes, Teladoc offers:

- A free advanced blood glucose meter, strips, and lancets.
- Real-time, one-on-one live support for out-of-range readings.
- Automatic uploads, health summary reports, and optional emergency contact alerts.

How to Enroll

To get started, visit **teladochealth.com/register/INDEPENDENCE** or call **1-800-835-2362** using registration code **INDEPENDENCE**.

Preventive Care Services

One important way to stay healthy is getting the preventive care your doctor recommends – and you'll pay $0.

Preventive care is the care and counseling you receive to prevent health problems. It's one of the best ways to keep you and your family in good health. It can include:

- Check-ups (annual physicals, pediatric well-visits, gynecology well-visits)
- Cancer and other health screenings
- Immunizations

Why should I receive preventive care?

We want to be sure you get the preventive care recommended for you based on your personal risk factors, age, and gender. Doing so helps you identify health problems or minor issues before they become major health concerns, like diabetes or colon cancer. Plus, you save money on health care costs!

What Preventive Care Services are Right for You?

Preventive care needs can differ based on personal risk factors, age, and gender. However, taking the steps to find the right preventive care will help you to identify health issues before they become major concerns.

To find which preventive services are right for you and covered under the IBX health plan, visit **ibx.com/preventive** or scan the QR code.

Then reach out to your doctor or contact a Registered Nurse Health Coach (**800-275-2583**) to ensure the appropriate services and schedule an appointment.

Additional Benefit Resources

HUSK Wellness (GlobalFit)

Achieving optimal health and wellness doesn't have to be complicated or expensive. Access exclusive best-in-class pricing with some of the biggest brands in fitness, nutrition, and wellness with HUSK Marketplace.

Gyms & Fitness Centers

HUSK Marketplace members can access exclusive savings and flexible membership options to a variety of facilities. From national chains to specialty studios, HUSK has something for every workout.

HUSK Nutrition

HUSK Nutrition provides evidence-based virtual health and nutrition programs. You will meet with a Registered Dietitian who will implement a complete 1-on-1 nutrition program specifically designed to answer your nutrition related questions, accommodate your individual needs, and fit your busy lifestyle.

Home Equipment & Tech

Whatever your fitness level is, HUSK has exclusive equipment and wearable technology to help support you on your wellness journey. Whether you want to monitor an everyday activity or start a new fitness routine, you can find the best products and deals here.

On-Demand Fitness

Take advantage of all the benefits of group exercise classes in the comfort of your own home. HUSK's streaming membership options will take your wellness and workouts to the next level.

Mental Health

We all need help sometimes. HUSK Mental Health connects you with licensed therapists through technology. Our therapists empower you through guidance and support using evidence-based practices.

Visit **marketplace.huskwellness.com/connerstrong** to get started with HUSK today!

GoodRx

This service offers an easy way to compare prices for all FDA-approved prescription drugs at virtually every pharmacy in America.

You can find pharmacy coupons, manufacturer discounts, generics, comparable drug choices, and savings tips all in one place. GoodRx can often beat the copay amount or help with drugs that are not covered by the plan.

For more information, visit **www.goodrx.com** or download the GoodRx mobile app.

Note: Out-of-pocket expenses through GoodRx do not apply to your Independence Blue Cross medical deductible or out-of-pocket maximum.

NEW BENEFIT! Utopia WellCare

Utopia WellCare's goal is to help you develop a better overall relationship with your health via comprehensive Functional Nutrition services provided by Board-Certified Registered Dietitians.

How it works

Utopia WellCare provides one-on-one virtual consultations with dietitians at no cost to you. Consultations are covered under preventive care through your insurance carrier and offer **6 FREE visits**.

Scan to visit Utopia Wellcare

Have Questions?

- Email **info@utopiawellcare.com**
- Visit **utopiawellcare.com** or scan the QR code above
- Download the Utopia Wellcare Mobile App

Vision Plan

DAVIS VISION

When you enroll any of the medical plans, **you automatically have vision plan benefits administered through Davis Vision**. Our vision plan gives you the freedom to see any provider in or out-of-network without a referral. To find a provider, please go to **www.davisvision.com**.

Scan to visit Davis Vision online

DAVIS VISION PLAN

BENEFIT DESCRIPTION	IN-NETWORK	OUT-OF-NETWORK REIMBURSEMENT
Exam	$0 Copay	Up to $35 reimbursement to member*
Frames (two options)	Choose from participating provider's own frame collection and member receives allowance of $65** Choose from the Davis Collection of frames (available at most participating providers) and frames are covered in full	Eyeglasses are available up to a $100 reimbursement to the member*
Lenses & Spectacle Lenses	**Covered at no extra cost and includes:** all range of prescriptions, oversize lenses, glass or plastic lenses, single vision, bifocal, trifocal, or lenticular lenses	Spectacle lenses are available up to a $100 reimbursement to the member*
Additional Lens Options	**Additional options covered at no cost include:** glass grey #3 prescription sunglass lenses, tinting and polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/- 6.00 diopters	
Contact Lenses* ** (in lieu of eyeglasses)	Member receives an allowance up to $100**	Up to $100 reimbursement to member*
Frequency of Services	Once every two calendar years	N/A

* In lieu of participating provider benefit, member is responsible for balance

** Member is responsible for balance & allowance is for evaluation and lenses separately.

*** Please note Medically Necessary Contact lenses are covered with no charge with prior approval

Dental Plan

DELTA DENTAL

Your Delta Dental PPO dental plan benefits run on the plan year (June 1 through May 31). Below is a summary of the dental plan available to you. Teammates can access dental coverage by calling Delta Dental at **800-452-9310** or by visiting **www.deltadentalins.com**. A full benefit description can be found on **BenePortal**.

Scan to visit Delta Dental online

DPPO DENTAL PLAN

BENEFIT DESCRIPTION	DELTA DENTAL PPO DENTISTS**	DELTA DENTAL PREMIER DENTISTS**	NON-DELTA DENTAL DENTISTS
Plan Year (6/1 to 5/31) Deductible (Individual/Family)	No deductible	No deductible	$50 / $150
Plan Year (6/1 to 5/31) Maximum (Per member, per plan year)	$1,000	$1,000	$1,000
Preventive & Diagnostic Services Exams, Cleanings, X-Rays, Sealants and Space Maintainers	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Services Fillings, Simple Extractions, Endodontics (root canal), Periodontics, Oral Surgery	Plan pays 80%	Plan pays 80%	Plan pays 80%
Major Services Crowns/Inlays/Onlays, Bridges and Dentures, Repairs, Implant Services	Plan pays 50%	Plan pays 50%	Plan pays 50%
Orthodontia Benefits	Not covered	Not covered	Not covered

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.

Set up an account online!

Get information about your plan, check benefits and eligibility information, find a network dentist and more. Sign up for an online account at **www.deltadentalins.com**.

PER-PAY (26 PAYS) DENTAL COST-SHARE

(See page 19 for full cost breakdown

COVERAGE TIER	TEAMMATE PER-PAY (26 PAYS)
Teammate-Only	$9.44
Teammate+ Spouse	$20.61
Teammate + Child(ren)	$22.91
Family	$32.84

Dependent Care Flexible Spending Account

FLORES

The Dependent Care Flexible Spending Account (FSA) provides you with an important tax advantage that can help you pay for dependent care expenses on a pre-tax basis. By anticipating dependent care costs for the next plan year, you can lower your taxable income.

About the Dependent Care FSA

The Dependent Care FSA lets you use pre-tax dollars toward qualified dependent care expenses for children up to the age of 13 or individuals 13 or older if they are unable to care for themselves and reside with you at least 8 hours per day. The DCFSA can be used for:

- Au Pair or nanny
- Before- and after-school programs, day camps, preschool
- Baby-sitting/dependent care to allow you to work
- Adult/eldercare for adult dependents

Contribution Limits

The annual maximum amount you may contribute for 2025 is $5,000 (or $2,500 if married and filing separately) per calendar year.

Use-it-or-Lose-It!

Dependent Care FSA funds do not roll over. Money not used by the end of the plan year (May 31, 2026) will be forfeited.

2.5 Month Grace Period

The IRS permits employers to offer a grace period of up to 2.5 months following the end of the plan year. During this time, you can continue to use any leftover funds from the previous plan year for eligible dependent care expenses. The grace period ends on August 15th.

To file a claim for reimbursement:

- Incur an eligible expense and obtain an invoice or receipt from your dependent care provider.
- Download and fill out the Dependent Care claim form, available on the portal.
- Submit the invoice with a claim form via fax, mail, Mobile app, or upload at **www.flores247.com**
- You will be paid via check or direct deposit.

Note: Dependent Care FSAs are not pre-funded with the full annual election amount. Claims are processed weekly and reimbursed with the pre-tax fund balance that have been payroll deducted at the time the claim is filed.

For more information:

For more information visit **flores247.com**, scan the QR code, or call **800-532-3327**.

Scan to visit Flores online

Term Life and AD&D

NEW YORK LIFE

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Underwritten and administered by New York Life, Active Day provides all active benefits-eligible Teammates with a Basic Life/AD&D benefit. **This coverage is provided to you at no cost.**

Voluntary Life Insurance

Underwritten and administered by New York Life, all benefit-eligible Teammates are eligible to participate in the Voluntary Teammate, Spouse & Child Life Insurance Plans. **Since this plan is voluntary, the Teammate is responsible for 100% of the premium.** If you waive this coverage during this open enrollment and would like to purchase coverage at a later time, you will be required to complete a New York Life Enrollment & Statement of Health Form.

Please note if you elect over the guaranteed issue amount, you are not guaranteed coverage until approved by New York Life; therefore no payroll deduction will be taken until approved.

Voluntary Life Calculation

(Election amount/1,000)*Rate = Monthly Premium

Example:

If a 38-year-old Teammate elects $50,000 in Voluntary Life Insurance, an amount of $6.00 would be deducted on a **monthly** basis.

(Election amount of $50,000 divided by $1,000 = 50. Multiply 50 times the rate of $.12 – and that equals $6.00 as the monthly premium)

To calculate your **bi-weekly payroll deduction** – Take monthly premium, multiply by 12, then divide by 26. The bi-weekly premium would be $2.77.

Reminder:

During this Open Enrollment period, if you would like to elect or change your Voluntary Life, you can elect up to the guaranteed issue amount without completing the New York Life Enrollment & Statement of Health Form.

Voluntary Teammate Life

COVERAGE AMOUNT	GUARANTEED ISSUE AMOUNT
$10,000 increments up to a maximum of $500,000	$150,000 up to age 64 $10,000 for age 65+

Voluntary Spouse Life

COVERAGE AMOUNT	GUARANTEED ISSUE AMOUNT
50% of Teammate life coverage up to a maximum of $250,000	$10,000

Voluntary Child Life

COVERAGE AMOUNT (AGE 14 DAYS TO 26 YEARS OLD)
10% of Teammate life insurance coverage up to a maximum of $10,000 (coverage limits based on child(ren)'s age)

Monthly Voluntary Life Costs

TEAMMATE & SPOUSE*	
AGE BAND	**RATE PER $1,000**
<20	$0.070
20-24	$0.070
25-29	$0.070
30-34	$0.080
35-39	$0.120
40-44	$0.200
45-49	$0.320
50-54	$0.490
55-59	$0.860
60-64	$1.420
65+	$2.280
CHILD RATE PER $1,000	
$0.170	

* Spouse rates based on Teammate's age

Voluntary Short-Term Disability

NEW YORK LIFE

Underwritten and administered by New York Life, Active Day offers full-time Teammates the opportunity to elect Voluntary Short-Term Disability (STD) income benefits. Because this benefit is voluntary, the **Teammate is responsible for the cost**.

In the event you become disabled from a non-work-related injury or sickness, disability income benefits provide a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

VOLUNTARY SHORT-TERM DISABILITY BENEFIT	
Benefits Begin	After 14 days of disability for injury/sickness
Benefits Payable	Up to 11 weeks
Percentage of Income Replaced	60% of first $1,667 of your pre-disability earnings
Weekly Maximum Benefit	$1,000

Reminder:

Reminder! During this Open Enrollment period, you will have the opportunity to elect Voluntary STD without needing to provide a Statement of Health Form (EOI).

If you choose to waive coverage during this open enrollment and elect to purchase coverage at a later time, you will be required to complete a New York Life Enrollment & Statement of Health Form. Please note that coverage is not guaranteed until approved by New York Life, and no payroll deductions will be taken until approval is granted.

Monthly Voluntary STD Costs

TEAMMATE & SPOUSE*	
AGE BAND	**RATE PER $1,000**
<20	$0.623
20-24	$0.623
25-29	$0.706
30-34	$0.573
35-39	$0.473
40-44	$0.432
45-49	$0.415
50-54	$0.482
55-59	$0.623
60-64	$0.756
65+	$0.847

Voluntary Short-Term Disability Calculation

- Take annual salary and multiply by .60.
- Take that total and divide by 52. This equals your weekly benefit amount.
- Take the weekly benefit amount and divide by 100.
- Then take that total and multiply by that monthly age banded rate. This equals your **MONTHLY** premium.

Example

If a 38-year-old Teammate has an annual salary of $25,000, an amount of $7.58 would be deducted on a bi-weekly basis for Voluntary STD coverage. (Salary of $25,000*0.60 = $15,000. Take $15,000/52 = $288.46; this is the weekly benefit amount. $288.46/100 = $2.88 times the rate of $5.70 = $16.42 as the monthly premium.)

To calculate your **bi-weekly payroll deduction** – Take monthly premium, multiply by 12, then divide by 26 (bi-weekly). 16.42*12 = $197.04/26 = $7.57 bi-weekly payroll contribution amount.

Employee Assistance Program (EAP)

CAREBRIDGE

Make Emotional Wellbeing a Priority

Real help, when and where you or a loved one needs it

- **Confidential Mental Health Assistance:** Access to 24/7 guidance and counseling with licensed clinicians to assist with concerns such as stress, anxiety, depression, grief, substance abuse, and relationship conflicts. Support options include three in-person or telehealth referrals, text, and chat.
- **Work-Life Solutions:** Experienced work-life specialists can provide qualified referrals and resources for everyday concerns including child and eldercare, education planning, legal, wellness support groups, transportation, relocation, and pet care.
- **Financial Wellness:** Improve your ability to feel good about your financial life now and in the future. Learn skills to assist with retirement planning, debt management, budgeting, establishing savings, and preparing for a crisis.
- **Stress Management:** Learn to eliminate the chronic negative effects of stress and enhance personal life satisfaction with actionable tools and coaching.
- **Digital Tools and Support:** The Carebridge EAP App and **CarebridgeNow.com** make it easy for you to access a wide array of mental health and life management resources including articles, training, calculators, self-care tips, mindfulness practices, discount shopping programs, and more.

Scan to visit Carebridge online

To Contact Carebridge

Carebridge services are available 24/7 and are free and confidential.

- Email: **clientservice@carebridge.com**
- Website: **CarebridgeNow.com**
- Call: **800-437-0911**

Use code **SH7M3** to use your benefits.

Additional Voluntary Benefits

Payroll contributions for these plans are specific to age and coverage level. Your costs can be determined by visiting ***my.tbx360.com/activeday****.*

Whole Life Insurance

Administered by Banker's Worksite

Whole Life Insurance provides guaranteed life insurance coverage and access to living benefits that can assist you or your family with large expenditures that can arise during critical medical events or in event of death.

Additionally, a portion of premium paid accrues as a cash value that grows over time can be used for loans, drawn for retirement, or to fund the policy premiums.

Critical Illness & Accident Insurance

Administered by MetLife

Critical Illness & Accident Insurance covers accidental injuries and illnesses that include, but are not limited to, cancer, heart attack, stroke and paralysis. These two benefits have been bundled together to provide you with the coverage to prepare for the unexpected.

Hospital Indemnity Insurance

Administered by MetLife

Hospital Indemnity Insurance can supplement existing medical coverage and help provide financial support to pay for out-of-pocket expenses such as deductibles, copayments, and non-covered medical services in the event of a covered hospitalization.

Benefits are paid regardless of what is covered by medical insurance and payments are made directly to you.

IMPORTANT NOTE
About the MetLife Plans:

THIS IS A FIXED INDEMNITY POLICY, NOT HEALTH INSURANCE. This fixed Indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit **HealthCare.gov** or call **800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Pet Insurance

NATIONWIDE

With Nationwide pet insurance, owners can focus on their pet's wellbeing without worrying about the cost for care.

Nationwide offers two plans for Teammates to choose from: **My Pet Protection** and **My Pet Protection with Wellness500**. Both plans are guaranteed issuance, have a $250 annual deductible and include medical coverage with the choice of 50% or 70% reimbursement levels.

About the My Pet Protection Plan

My Pet Protection is a medical plan that offers an annual benefit of $7,500 for eligible veterinary bills related to accidents, injuries and illnesses, including emergency clinics and specialists.

About the My Pet Protection with Wellness500 Plan

My Pet Protection with Wellness500 offers the same protection as our medical plan, but includes coverage for preventive care. With this plan, up to $500 of the annual $7,500 benefit can be used for wellness, including checkups, flea and heart worm preventives, vaccinations, spay and neuter and more.

Scan to visit Nationwide online

What makes My Pet Protection different?

My Pet Protection is available through workplace benefits programs and is guaranteed issuance. It also includes additional benefits like lost pet advertising, emergency boarding and more. It's no surprise that My Pet Protection is the most paw-pular coverage plan from America's #1 pet insurer.

Signing up is easy!

Simply visit **benefits.petinsurance.com/activeday** or call **877-738-7874.** Please have your Paycom ID available and reference "Active Day" as your employer when applying.

Understanding Your Pet Insurance Options

COVERAGE	MY PET PROTECTION	MY PET PROTECTION WITH WELLNESS 360
Accidents	✓	✓
Injuries	✓	✓
Illness	✓	✓
Hereditary and congenital conditions	✓	✓
Diagnostics and imaging	✓	✓
Procedures and surgeries	✓	✓
Wellness exams		✓
Vaccinations		✓
Flea prevention		✓
Spray or neuter		✓
And more!	✓	✓

401(k) Retirement Plan

EMPOWER

Eligibility

You are eligible to contribute to the plan and receive employer contributions after you meet the following requirements:

- Attain age 21
- Complete 6 months of service and work 500 hours

Teammates may enroll in the plan on the first of the month after meeting the eligibility requirements.

Teammate Contributions

- Once you meet the eligibility requirements, you may begin Pre-Tax and/or Roth (after-tax) contributions to the plan.
- For 2025 you can contribute up to $23,500 to the plan in combined pre-tax and Roth contributions. If you are 50 or over, you can make an additional catch-up contribution up to $7,500 for 2025.
- Eligible Teammates may roll over balances from other qualified accounts to the plan.

Employer Contributions

- Effective June 1, 2025, Active Day will match $0.50 for every dollar that you contribute, up to a total match of $1,000.00 annually.
- Matching contributions are made each pay period.

Vesting

- You are always 100% vested in your salary deferral and rollover contributions.
- Company contributions are vested 20% per year after 1 year of service. You are fully vested in the company match after 5 years of service.

Loans and Withdrawals

- You are permitted to take a loan from the plan for up to 50% of your vested account balance ($50,000 max). The maximum loan term is 5 years for a general-purpose loan.
- You can take a distribution from the plan for any of the following reasons. You must request a distribution of rollover balances at any time . Distributions made prior to attaining age 59.5 may be subject to a 10% excise penalty.
  - Separation from Service
  - Attainment of 59.5
  - Financial Hardship
  - Disability

Getting Started

If you would like to enroll in the plan, make changes to your savings elections, or view your account, please log on to the Empower website by visiting **empowermyretirement.com** or scanning the QR code, or download the Empower app. You can also contact the Empower participant service center at **855-756-4738**.

Teammate Payroll Contributions

& ACTIVE DAY COST SHARE

Below are the per-pay period costs/payroll deductions for each level of benefit we offer.

BI-WEEKLY RATES – MEDICAL/PRESCRIPTION/VISION COVERAGE

PLAN	COVERAGE TIER	TOTAL MONTHLY	ACTIVE DAY MONTHLY	TEAMMATE PER-PAY (26 PAYS)
WELLNESS PROGRAM REQUIREMENTS MET ($650 DISCOUNT PER YEAR)				
IBX Catastrophic Medical Plan	Teammate-Only	$657.00	$589.98	$30.93
	Teammate + Spouse	$1,511.77	$947.14	$260.60
	Teammate + Child(ren)	$1,171.45	$830.32	$157.44
	Family	$1,927.64	$1,212.84	$329.91
IBX Core Medical Plan	Teammate-Only	$733.90	$583.89	$69.24
	Teammate + Spouse	$1,688.71	$946.49	$342.56
	Teammate + Child(ren)	$1,308.53	$826.52	$222.47
	Family	$2,153.25	$1,209.78	$435.45
IBX Enhanced Medical Plan	Teammate-Only	$831.13	$617.01	$98.83
	Teammate + Spouse	$1,912.48	$971.16	$434.45
	Teammate + Child(ren)	$1,481.92	$854.44	$289.61
	Family	$2,438.59	$1,236.10	$555.00
NON-WELLNESS RATES				
IBX Catastrophic Medical Plan	Teammate-Only	$657.00	$535.81	$55.93
	Teammate + Spouse	$1,511.77	$892.97	$285.60
	Teammate + Child(ren)	$1,171.45	$776.15	$182.44
	Family	$1,927.64	$1,158.67	$354.91
IBX Core Medical Plan	Teammate-Only	$733.90	$529.72	$94.24
	Teammate + Spouse	$1,688.71	$892.32	$367.56
	Teammate + Child(ren)	$1,308.53	$772.36	$247.47
	Family	$2,153.25	$1,155.62	$460.45
IBX Enhanced Medical Plan	Teammate-Only	$831.13	$562.84	$123.83
	Teammate + Spouse	$1,912.48	$916.99	$459.45
	Teammate + Child(ren)	$1,481.92	$800.27	$314.61
	Family	$2,438.59	$1,181.93	$580.00

BI-WEEKLY RATES – DENTAL PLAN

COVERAGE TIER	TOTAL MONTHLY	ACTIVE DAY MONTHLY	TEAMMATE PER-PAY (26 PAYS)
Teammate-Only	$20.45	$0.00	$9.44
Teammate + Spouse	$44.66	$0.00	$20.61
Teammate + Child(ren)	$49.63	$0.00	$22.91
Family	$71.16	$0.00	$32.84

Enrollment Instructions

THE BENEFITS EXPERT (TBX)

Enrolling in Benefits

STEP 1: Create an Account

- Register for an account on the MyTBX360 portal at **my.tbx360.com/activeday** and follow the prompts to complete the process.

STEP 2: Enroll into your Benefits

- **User ID:** Enter your social security number (no dashes) or use the last 4 characters of your Paycom Self Service username
  - (E.g. Your Paycom ESS username is 0X417AG13; use AG13 as your TBX user ID**)**
- **PIN:** Enter the last 4 digits of your SS# and the last 2 digits of your birth year, no dashes required.
  - **Social Security Number:** 12345**6789**
  - **Date of Birth:** June 1st, 19**80**
  - **PIN is 678980**

TIP: Have the names, birth dates, and social security numbers of all eligible dependents you wish to enroll.

Questions?

For any assistance, you can call the TBX call center at **855-482-9669** from 7AM to 7PM CST (Monday – Friday) or by emailing **requestbenefits@activeday.com**

Scan to visit TBX 360

Benefits MAC & BenePortal

CONNER STRONG & BUCKELEW

Benefits Member Advocacy Center (Benefits MAC)

The Benefits MAC, provided by Conner Strong & Buckelew, can help you and your covered family members navigate your benefits.

Contact the Benefits MAC to:

- Find answers to your benefits questions
- Search for participating network providers
- Clarify information received from a provide or your insurance company, such as a bill, claim, or explanation of benefits (EOB)
- Guide you through the enrollment process or how you can add or delete coverage for a dependent
- Rescue you from a benefits problem you've been working on
- Discover all that your benefits have to offer!

You can contact Benefits MAC in any of the following ways:

- Via phone: **800-563-9929**, Monday through Friday, 8:30 am to 5:00 pm EST
- Via the web: **www.connerstrong.com/memberadvocacy**
- Via e-mail: **cssteam@connerstrong.com**
- Via fax: **856-685-2253**

Member Advocates are available Monday through Friday, 8:30 am to 5:00 pm (Eastern Time). After hours, you will be able to leave a message with a live representative and receive a response by phone or email during business hours within 24 to 48 hours of your inquiry.

BenePortal

Your Benefits Information – All in One Place!

At Active Day, Teammates have access to a full-range of valuable benefit programs. With BenePortal, you and your dependents can review your current Teammate benefit plan options online, 24/7!

Use BenePortal to access benefit plan documents, insurance carrier contacts, forms, guides, links, and other applicable benefit materials. BenePortal is mobile-optimized, making it easy to view your benefits on-the-go. Simply bookmark the site in your phone's browser or save it to your home screen for quick access.

BenePortal features include:

- Secure online access – with NO login required!
- Direct links to benefits enrollment sites
- Plan summaries
- Wellness resources
- Carrier contacts
- Downloadable forms
- GoodRx
- Benefit Perks Discount Program
- And more!

Simply go to **www.activedaybenefits.com** to access your benefits information today!

Carrier Contacts

Have questions about enrolling? Please contact **requestbenefits@activeday.com**.
Have questions about your benefits or need assistance? The below contacts are available:

BENEFIT	CARRIER	WEBSITE	PHONE/EMAIL
Member Advocacy	Conner Strong & Buckelew	www.connerstrong.com/memberadvocacy	800-563-9929 cssteam@connerstrong.com
Benefits Enrollment	TBX	my.tbx360.com/activeday	855-482-9669
Medical Benefits	Independence Blue Cross (IBX)	www.ibx.com	800-275-2583 (1-800-ASK-BLUE)
Prescription Benefits	Independence Blue Cross (IBX) and Optum	www.ibx.com www.optum.com	800-275-2583 (1-800-ASK-BLUE)
Health Savings Account (HSA)	Independence Blue Cross (IBX)	www.ibx.com	800-275-2583 (1-800-ASK-BLUE)
Vision Benefits	Davis Vision	www.davisvison.com	800-999-5431
401(k) Retirement Plan	Empower	www.empowermyretirement.com	855-756-4738
Addiction Treatment/Support	Shatterproof Treatment Atlas	www.treatmentatlas.org	800-597-2557
Dependent Care Flexible Spending Account (FSA)	Flores	www.flores247.com	800-532-3327
Dental Benefits	Delta Dental	www.deltadentalins.com	800-452-9310
Employee Assistance Program (EAP)	Carebridge	www.carebridgenow.com	800-437-0911 clientservice@carebridge.com
Life & Disability Insurance	New York Life	www.newyorklife.com	800-225-5695
Voluntary Whole Life Insurance	Bankers Worksite	mycoverage.bankersworksite.com	866-458-7500
Voluntary Critical Illness, Accident, and Hospital Indemnity Insurance	MetLife	mybenefits.metlife.com	800-438-6388
Voluntary Pet Insurance	Nationwide	benefits.petinsurance.com/activeday	877-738-7874

Legal Notices

Special Enrollment Notice

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 (including COBRA 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 Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within [30 days or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage.

Loss of eligibility 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 (CHIP) 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 CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

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 [30 days or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

Eligibility for 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 (CHIP) 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. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

To request special enrollment or obtain more information, contact Human Resources.

Newborns' and Mothers' Health Protection Act Notice

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

Women's Health and Cancer Rights Act Notice

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 benefits. If you have any questions, please speak with Human Resources.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447
ALASKA – Medicaid
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
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
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+)
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

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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
I
NDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
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
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/

Legal Notices

Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

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

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

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

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

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – 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: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

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

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

UTAH – Medicaid and CHIP
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
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select and https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924
WISCONSIN – Medicaid and CHIP
Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
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 March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

Availability of Summary Health Information

As a Teammate, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

A paper copy is available, free of charge, by emailing Christina Speck at cspeck@activedaycom.

Model General Notice of COBRA Continuation Coverage Rights

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

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

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

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

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

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

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

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

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

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

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

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

For all other qualifying events (divorce or legal separation of the Teammate and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days

Legal Notices

after the qualifying event occurs. You must provide this notice to Christina Speck.

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

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

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

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

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

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

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

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

Plan contact information
Christina Speck, Director of Benefits
6 Neshaminy Interplex Suite 401 Trevose, PA 19053,
888-505-1088

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

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

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Active Day, has determined that the prescription drug coverage offered by Independence Blue Cross 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 Active Day coverage will not be affected. [See pages 9 - 11 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.] If you decide to join a Medicare drug plan and drop your current Active Day, medical and prescription coverage, be aware that you and your dependents will no longer be eligible to receive benefits under this plan.

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 Active Day, and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Active Day, 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:	April 2025
Name of Entity/Sender:	Active Day
Contact--Position/Office:	Human Resources/Benefits
Address:	6 Neshaminy Interplex Suite 401 Trevose, PA 19053
Phone Number:	Christina Speck, 215.847.5797

Legal Notices

PART A: General Information

When key parts of the health care law took effect in 2014, there was a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets our needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace began in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your Teammate contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the insurance carrier's customer service number located on your ID card. 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. To get information about the Marketplace coverage, you can call the government's 24/7 Help-Line at 1-800-318-2596 or go to https://www.healthcare.gov/marketplace/individual/.

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.

[1] 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.

3. Employer Name ADSC Holdings Inc d/b/a/ Active Day	**4. Employer Identification Number** 47-4866784	
5. Employer Address 6 Neshaminy Interplex Suite 401	**6. Employer phone number** 888-505-1088	
7. City Trevose	**8. State** PA	**9. Zip Code** 19053
10. Who can we contact about Teammate health coverage at this job? Christina Speck, Director of Benefits	**11. Phone** 888-505-1088	12. Email address cspeck@activeday.com