Evergreen
Possibilities await.

Benefit Enrollment Guide

2026

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A message from HR at Evergreen

At Evergreen we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable. This guide will help you choose the type of plan and level of coverage that is right for you.

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www.EvergreenOshkosh.com

Eligibility

Eligible Employees:

Employees with a master schedule between 20 and 30 hours per week are eligible for all benefits **except** Health Insurance. Employees with a master schedule of 30 or more hours per week are eligible for all benefits including Health Insurance.

When Are You Eligible?
Newly Eligible Employees:
Benefits are effective the first of the month following 30 days.

Annual Open Enrollment:
You may make changes to your benefit elections during your open enrollment period.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse, and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, step-children and children obtained through court- appointed legal guardianship, as well as children of same sex state-registered domestic partners.

When Coverage Begins:

The effective date for your annual benefits is January 1, 2026. Newly hired employees and dependents will be effective in Evergreen's benefits programs the first of the month following 30 days of employment. All elections are in effect for the entire plan year and can only be changed during Open Enrollment unless you experience a family status event.

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within **30 days** of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact Erin Sanders to make these changes.

Health Insurance

	WPS Health Plan Inc. $2,000 copay Health Plan HPS Statewide Network First Health Network for outside WI	
	Preferred Providers	Non-Preferred Providers
Annual Deductible		
Individual	$2,000	$16,000
Family	$4,000	$32,000
Coinsurance	100%	50%
Maximum Out-of-Pocket*		
Individual	$6,000	$24,000
Family	$12,000	$48,000
Physician Office Visit		
Primary Care	$25 copay	Deductible then 50%
Specialty Care	$50 Copay	Deductible then 50%
Preventive Care		
Adult Periodic Exams	100% (no charge)	Deductible then 50%
Well-Child Care	100% (no charge)	Deductible then 50%
Diagnostic Services		
X-ray and Lab Tests	$50 copay for x-ray & bloodwork	Deductible then 50%
Complex Radiology (CT/PET Scans, MRIs)	$500 copay	Deductible then 50%
Urgent Care Facility	$100 copay	Deductible then 50%
Emergency Room Facility Charges*	$500 copay, waived if admitted	Deductible then 50%
Emergency medical Transportation	$100 copay	Deductible then 50%
Inpatient Facility Charges	$1,500 copay	Deductible then 50%
Outpatient Facility and Surgical Charges	Office Visit/Physician and Surgeon fee: No charge Facility: $900 copay after deductible	Deductible then 50%
Mental Health		
Inpatient	$1,500 copay	Deductible then 50%
Outpatient	Office Visit: $25 copay Facility: $900 copay after deductible	Deductible then 50%
Substance Abuse		
Inpatient	$1,500 copay	Deductible then 50%

	WPS Health Plan Inc. $2,000 copay Health Plan HPS Statewide Network First Health Network for outside WI	
	Preferred Providers	Non-Preferred Providers
Outpatient	Office Visit: $25 copay Facility: $900 copay after deductible	Deductible then 50%
Other Services		
Chiropractic	$50 copay	Deductible then 50%
Retail Pharmacy (30 Day Supply)		
Generic (Tier 1)	$10 Copay	Not covered
Preferred (Tier 2)	$40 Copay	Not covered
Non-Preferred (Tier 3)	$80 Copay	Not covered
Preferred Specialty (Tier 4)	Not covered*	Not covered*
Mail Order Pharmacy (90 Day Supply)		
Generic (Tier 1)	$20 copay	N/A
Preferred (Tier 2)	$80 copay	N/A
Non-Preferred (Tier 3)	$160 copay	N/A
Preferred Specialty (Tier 4)	N/A*	N/A*

*Please contact SmithRx for more information on obtaining specialty drugs through the Connect360 program

Health Benefits

The charts above are a brief outline of what is offered. Please refer to the summary plan description for complete plan details. The summary plan descriptions can be found on the Employee Resources page of Evergreen's website.

Employee Contributions (Bi Weekly 26 per yr)	
	Bi-weekly contribution
Employee	$75
Employee & Spouse	$175
Employee & Child(ren)	$155
Employee & Spouse & Child(ren) (Family)	$235

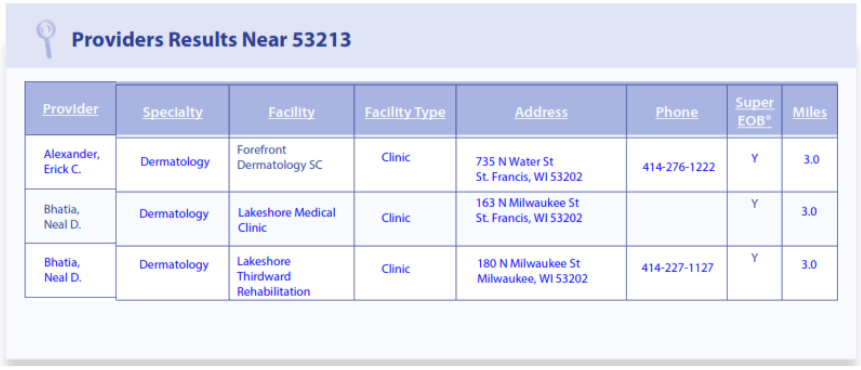
Finding a Provider

Choose your doctor

View the extensive HPS Provider Directory to find a doctor for your healthcare need(s). No copay is necessary upon arrival to your appointment.

Follow these steps to find your in-network providers:

1. Go to onlineaccess.hps.md
2. On the homepage click on Icon - **Find a Provider**
3. Enter the **Type of Provider, Provider Name and Location**
4. Review the results



Providers Results Near 53213

Provider	Specialty	Facility	Facility Type	Address	Phone	Super EOB®	Miles
Alexander, Erick C.	Dermatology	Forefront Dermatology SC	Clinic	735 N Water St St. Francis, WI 53202	414-276-1222	Y	3.0
Bhatia, Neal D.	Dermatology	Lakeshore Medical Clinic	Clinic	163 N Milwaukee St St. Francis, WI 53202		Y	3.0
Bhatia, Neal D.	Dermatology	Lakeshore Thirdward Rehabilitation	Clinic	180 N Milwaukee St Milwaukee, WI 53202	414-227-1127	Y	3.0

Choose a provider from the HPS Provider Directory to receive in-network benefits. Claims from out-of-network providers will not be included on the SuperEOB, therefore, mailed and billed separately.

The HPS Network

HPS is contracted with two-thirds of Wisconsin counties, covering 96 hospital facilities and 22,600 individual providers. Below is a sample list of some of our many contracted providers:

- Affinity Health System
- Agnesian Health Care
- Aurora Health System – All locations
- BayCare Clinic
- Beaver Dam Community Hospital
- Bellin Health Systems
- Children's Hospital of Wisconsin
- Columbia St. Mary's – All locations
- Community Memorial Hospital
- Door County Memorial Hospital
- Froedtert Health – All locations
- Gundersen Lutheran Health System
- Holy Family Memorial
- Independent Physicians Network (IPN)
- Medical College of Wisconsin
- Mercy Medical Center (Oshkosh)
- Meriter Hospital and Affiliated Physicians
- Ministry Health Care – All locations
- Oconomowoc Memorial Hospital
- Physician's Health Network of Sheboygan (PHN)
- Prevea Clinic
- ProHealth Care Medical Associates
- Ripon Medical Center
- Rogers Memorial Hospital
- St. Elizabeth Hospital
- St. Joseph's West Bend
- St. Mary's Hospital – Green Bay
- St. Nicholas Hospital
- St. Vincent Hospital
- The Sleep Wellness Institute
- ThedaCare – All locations
- UW Hospital & Clinics
- Waukesha Memorial Hospital
- Wheaton Franciscan Healthcare

HPS Customer Care:
Phone: 888-477-7968
Monday-Thursday 7am-8pm, Friday 7am-5pm, Saturday 9am-1pm
Portal: onlineaccess.hps.md

Teladoc Health

Teladoc HEALTH | WPS | WPS/Auxiant

Virtual care that makes healthier possible

Access your healthcare by phone, video or app.

General Medical (24/7 Care)

Need care for non-urgent and common conditions? Get same-day appointments with a certified provider from wherever you are. Teladoc Health providers diagnose, treat and even prescribe medicine if needed.

- Allergies
- Bronchitis
- Flu
- COVID-19
- Pink eye
- Rashes
- Sinus infections
- Sore throats
- And more

free/visit

Mental Health

Have real conversations and see progress with a therapist of your choice. Available 7 days a week from the privacy of your own home.

- Anxiety and depression
- Sleep issues
- Relationship conflicts
- Trauma and PTSD
- Medication management

Therapy free/visit
Psychiatry free/first visit
Psychiatry free/ongoing visits

Dermatology

Dealing with a skin issue? Start an online skin review with a dermatologist by uploading images and details of your concern. Get a treatment plan and prescription if needed in 24 hours or less.

- Acne
- Eczema
- Psoriasis
- Skin infections
- Rashes
- Rosacea

free/online review

HDHP members may have a fee depending on your plan.

Set up your account or log in to schedule a visit

Visit Teladoc.com | Call 1-800-TELADOC (800-835-2362) | Download the app

Active & Fit


Get Fit for Fall
STANDARD FITNESS MEMBERSHIP
$28/mo.
12,700+ FITNESS CENTERS
Active&Fit DIRECT™
TM
Thousands of Fitness Options
• Choose from 12,700+ standard gyms for just $28/mo.[1]
• Plus, 8,800+ premium exercise studios with 20% - 70% discounts at most locations.[1]
Flexible & Affordable
• No long-term contracts. Switch gyms or cancel with ease.
• Join multiple gyms and get a discount.[2]
Go Beyond the Gym
• 1:1 well-being coaching to help you reach your health goals at no additional cost.
• Get Fit at Home™ for free with 12,000+ on-demand workout videos before you enroll.
Standard Fitness Network
24 FITNESS
EOS FITNESS
the Y
CHUZE FITNESS
ANYTIME FITNESS
+ More
Premium Fitness Network
STRETCH LAB
YOGASIX
CLUB PILATES
F45
pure barre
+ More
Get Started: Enroll now through your WPS Customer Account

Vision Discount Program

WPS customers receive FREE access to the EyeMed Vision Care discount program. EyeMed offers substantial savings on eye care and eyewear at thousands of provider locations nationwide.

EyeMed's provider network includes many familiar optical retailers, including LensCrafters, Pearle Vision, Target Optical, and more.

To find a vision care provider in your area, contact EyeMed toll-free at **866-559-5252** or **eyemed.com**. On the website, click **Find an eye doctor**, enter your ZIP code, and select **Access Network** in the **Choose Network** drop-down menu.

WPS customers receive access to the EyeMed Vision Care discount program at no additional cost.

Vision Care Services	EyeMed Network Provider
Eye Exam (with dilation, as necessary)	$5 off routine exam $5 off contact lens exam
Complete Pair Eyeglass Purchase*	
Frames	
Any Available Frame at Provider Location	35% off retail price
Standard Plastic Lenses	
Single Vision	$50 member responsibility
Bifocal	$70 member responsibility
Trifocal	$105 member responsibility
Progressive-Standard	$135 member responsibility
Progressive-Premium	20% off retail price
Lens Options	
UV Coating	$15 member responsibility
Tint (solid and gradient)	$15 member responsibility
Standard Scratch-Resistant Coating	$15 member responsibility
Standard Polycarbonate	$40 member responsibility
Standard Anti-Reflective Coating	$45 member responsibility
Premium Anti-Reflective Coating	20% off retail price
Other Add-Ons and Services	20% off retail price
Contact Lenses (discount applies to materials only)	
Conventional	15% off retail price
Disposable	100% of retail price
Laser Vision Correction	
LASIK or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price
Frequency of use for examination, frames, lenses, or contact lenses unlimited	

WPS™ Powered By Auxiant®

WPS™ A HEALTH SOLUTIONS COMPANY

*Frame, lens, and lens option discounts apply only when purchasing a complete pair of eyeglasses. If purchased separately, customers receive 20% off the retail price. Benefits may not be combined with any discount, promotional offering, or other group benefit plans, except as indicated. Discount plan is effective July. 1, 2024 through June, 30 2026. Vision program is not insurance, is not part of the insurance policy, is offered at no additional charge, and can be changed or discontinued at any time.

TruHearing

WPS | TruHearing

1-844-203-4870 | TTY: 711

Addressing hearing loss is important.

Your hearing is essential to your overall well-being. You have a comprehensive hearing program through TruHearing® that gives you access to hearing aids at low prices. Take the first step toward a healthier, happier you.

Get the latest technology.

Choose from a wide selection of hearing aids from the **top hearing aid manufacturers** when you purchase through TruHearing.

signia WIDEX PHONAK

oticon ReSound Starkey

Exam fee: $0. *Exam must be performed by a TruHearing network provider.*

Your hearing aid purchase includes

- **60-day,** risk-free trial
- **1 year** of follow-up visits at no charge
- **3-year supply** of batteries per non-rechargeable hearing aid
- **3-year** full manufacturer warranty

Start by calling TruHearing.

1-844-203-4870 | TTY: 711

Hours: 7 am - 7 pm CT, Monday–Friday

Flexible Spending Accounts

FSAs are pre-tax accounts allowed under the IRS code that allow you to pay for out-of-pocket qualified health care, dental, vision and dependent care expenses with pre-tax dollars. You elect the dollar amount you want to contribute and the money is deducted in equal installments from your paychecks before taxes are withheld. You will be reimbursed once you show proof that the service was received and that it was for a qualified expense. Participants in the plan will save approximately 30% in taxes on out of pocket expenses.
In addition to the tax savings, you have the benefit of having access to your entire election amount as soon as the plan year begins. It is like receiving an advance payment to pay for your expenses, meaning if you incur an expense early in the plan year, you can use up to your entire election amount to pay your bill. The money will be deducted from your paycheck over the course of the entire year, easing your financial burden.

Health Flexible Spending Accounts:

Some common qualified expenses for a Health flexible spending account include health insurance deductibles, co-pays, co-insurance, dental expenses, vision expenses, prescription drugs and OTC medications such as pain relievers or allergy medications.

Dependent Care Flexible Spending Accounts:

The Dependent Care FSA is used for expenses incurred for the care of children under the age of 13 and for certain dependent adult care expenses. You (and your spouse, if married) must work or attend school full-time in order for the expenses to qualify.
With dependent care expenses, you can be reimbursed up to the amount that has already been deducted from your paycheck. Reimbursements cannot be made for future dates of service.
When using the Dependent Care FSA, you will need to file Form 2441 with your income tax returns and you cannot apply the Federal Tax Credit for dependent care expenses.

2026 Annual IRS Contribution Limits	
Health FSA	$3,400
Dependent Care FSA	$7,500

The Health FSA and Dependent Care FSA are separate accounts. You can make contributions to both accounts, but they are not interchangeable. Both accounts are “use it or lose it” accounts and any unused funds are forfeited at the end of the plan year.

Contact Erin Sanders for an FSA enrollment packet

DIVERSIFIED
BENEFIT SERVICES

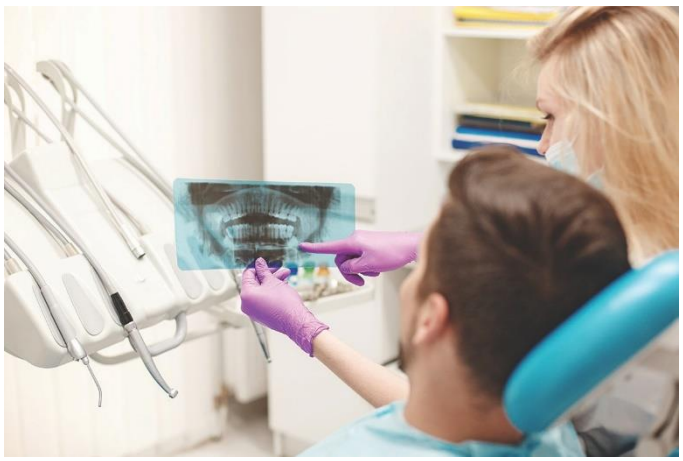
Dental Insurance

	Humana Insurance Company Inc Dental Plan 809584	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$50	$50
Family	$150	$150
Waived for Preventive Care?	Yes	Yes
Annual Maximum		
Per Person / Family	$1,500 *After you reach the annual max, you are only responsible for 70% of preventive, basic, and major services for rest of year (excludes orthodontia)*	$1,500 *After you reach the annual max, you are only responsible for 70% of preventive, basic, and major services for rest of year (excludes orthodontia)*
Preventive	100%	100%
Basic	80%	80%
Major	50%	50%
Orthodontia		
Benefit Percentage	50%	50%
Adults	not covered	not covered
Dependent Child(ren)	covered to age 18	covered to age 18
Lifetime Maximum	$1,000 *(plan pays 50%, no deductible)*	$1,000 *(plan pays 50%, no deductible)*
Benefit Waiting Periods	N/A	N/A

Employee Contributions (Bi Weekly 26 per yr)	
Employee	$5.00
Employee & Dep(s)	$14.00

Dental Benefits

Members are required to pay the difference between the plan payment and the provider's actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a participating provider. Please refer to the summary plan description for complete plan details. The summary plan descriptions can be found on the Employee Resources page of Evergreen's website. To find a participating provider, you can go to Humana.com and choose "Dental", "Find Care" under Dental, click "find a dentist", enter zip code and search radius, under "Select a lookup method" choose "All Dental Networks", then "PPO/Traditional Preferred".



Vision Insurance

	Humana Insurance Company Inc Vision Plan 809584
Copay	
Routine Exams (Annual)	$10 Standard Exam Retinal imaging up to $39
Vision Materials	
Materials Copay	$15 Copay
Lenses	Benefit varies by type of lens. Covered every 12 months
Contacts Covered in lieu of frames. Medically necessary contacts may be covered at a higher benefit level	Elective contacts covered $130 allowance then 15% off balance over $130, covered every 12 months
Frames	Covered at $130 allowance, 20% off balance over $130, covered every 24 months

Employee Contributions (Monthly)	
Employee	$7.69
Employee & Spouse	$15.38
Employee & Child(ren)	$14.61
Employee & Spouse & Child(ren) (Family)	$20.28

Vision Benefits

Please refer to the summary plan description for complete plan details. The summary plan descriptions can be found on the Employee Resources page of Evergreen's website.

To find a participating provider:

1. go to Humana.com and login to your account or create an account
2. "Find a doctor", "purchased through my employer"
3. "Already a Humana Member" select "my vision coverage is provided by my employer", and then "Vision care"
4. select "Humana Vision PLUS (Humana Insight Network)"

Life and AD&D

Evergreen provides Basic Life and AD&D benefits to eligible employees. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

Unum Life Insurance Company of America Life and AD&D All Others	
You	
Benefit Maximum	$25,000
Guaranteed Issue	$25,000

Important Reminder!

Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes.
Beneficiaries can be changed at ANY time throughout the year.

The above benefits will begin to decrease at age 65.
For questions on additional coverage, please contact Erin Sanders.

*Beneficiaries can be changed at any time through the year! Please be sure to update your beneficiaries!

Mental Health and Wellness Support

Evergreen's value of wellness means that we are providing choices to grow oneself in mind, body and spirit. This does not happen without an investment in options and opportunities for our employees to be the best versions of themselves.

We start with offering counseling at no cost to our employees and their immediate family members. We partner with Jill Schabow and her team at Vital Traction, LLC. Employees and their family members can make appointments to see her at her office in Neenah or during hours she is available onsite at Evergreen. To contact Jill, call 920.915.3263 or email jill.traction@gmail.com.

We also recognize the importance of individuals maintaining a relationship with their Primary Care Physician and offer a $50 bonus once per calendar year to all employees who complete their annual wellness/physical appointment. You can find the PCP Visit Verification form in the Perks section of the Employee Resources page of Evergreen's website.

All employees are able use Evergreen's Fitness and/or Aquatics Centers at no cost. The Aquatic Center schedule is posted on Evergreen's website. The Fitness Center is open 24/7/365.

Massage therapy has been proven to work wonders for your mind, body and spirit. Evergreen partners with Rachel Anna Massage in Oshkosh to allow employees to pay for massage therapy services via payroll deduction. To schedule massage therapy services, contact Rachel Anna at 920.203.6564 or email rachelannamassage@gmail.com.

Evergreen partners with Work Well Hypnosis to offer the benefits of hypnosis to employees and their family members. call 920-521-8366 or email info@workwellhypnosis.com to schedule an appointment. Payroll deduction is available.

For a complete list of other perks that Evergreen has to support our employees, please see the Perks Section of the Employee Resources page of Evergreen's website.

Changes in Benefit Elections

Open Enrollment:

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefits plan. All elections and changes take effect on the first day of the plan year. During Open Enrollment, you can:

- Add, change, or delete coverage
- Add, or drop dependents from coverage
- Enroll, or re-enroll in dependent or health care flexible spending accounts. To continue your FSA benefits, you must re-enroll each plan year.

If you do not make your 2026 benefit elections, you will automatically be defaulted to your prior year elections, except for the FSA, which will default to zero ($0) elections.

Note: Some states (currently, California, Massachusetts, New Jersey, Rhode Island, Washington D.C., and Vermont) may impose a tax on residents who do not have health insurance coverage, subject to limited exceptions.

Retirement Plan

Evergreen 403 (b) Retirement Plan

Take the first step to a secure retirement lifestyle and participate in the Evergreen

Retirement Plan! The plan offers: A Variety of Ways to Save:

- Pre-tax: When you contribute to your pre-tax 403(b) account, you receive an immediate tax savings. Your pre-tax 403(b) contributions are deducted from your pay before federal income taxes and income taxes of most states, so the amount of your salary subject to taxation is lower.
- Roth 403(b): When you contribute to a Roth 403(b) account, there is no initial tax savings since your contributions are taken out after taxes. However, you may benefit from tax savings later on when you withdraw your funds.

Evergreen offers a matching contribution, which provides you with the opportunity to receive free money into your retirement plan. The combined result is a retirement savings plan you cannot afford to pass up! The current formula is a 100% match up to the first 4% compensation.

Please contact Erin Sanders at 920-237-2132 or email esanders@evergreenoshkosh.com with questions or to enroll in the 403(b)-retirement plan.

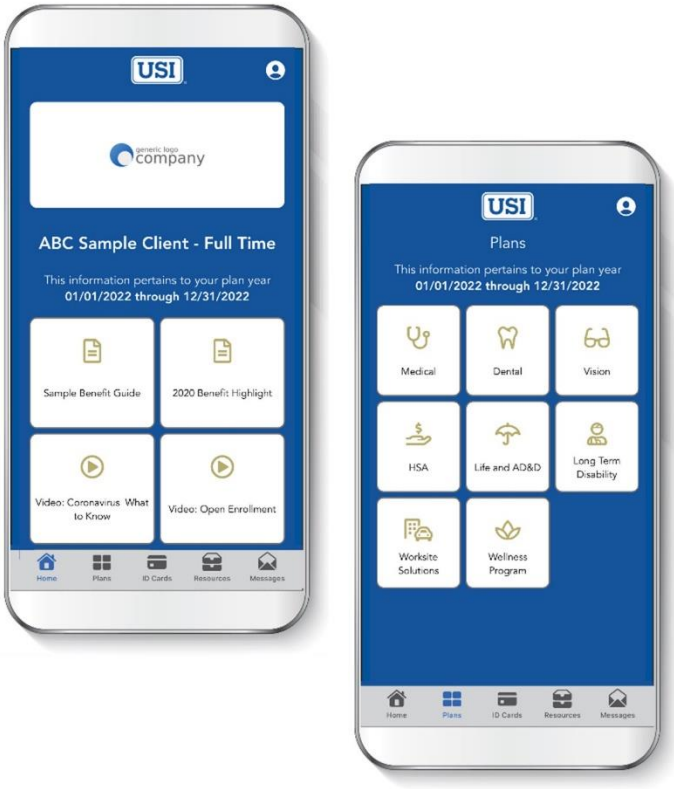
Contact Information

USI Mobile App – MyBenefits2GO

Evergreen is pleased to offer on-the-go access to key benefit information through the USI Mobile App, MyBenefits2GO. Search for "MyBenefits2GO" and download the free app in your smartphone. Add your name and email then enter the code **W52147** when prompted.

Highlights of the MyBenefits2GO App

- Access benefits information on the go
- Convenient contact information for Carriers and HR
- Organized plan information in one place
- View the most updated plan information
- Store your ID cards in the app



Benefit Resources

USI Benefit Resource Center

Have Questions? Need Help?

Evergreen is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

BRCMidwest@usi.com
Monday - Friday
Monday through Friday
8:00am to 5:00pm Eastern
& Central Standard Time

855-874-0829
24 hours a day, 7 days a week

Carrier Contacts

Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

	CARRIER	PHONE NUMBER	WEBSITE
WPS Powered by Auxiant	WPS (copay up front)	888-915-2493	www.wpshealth.com
	WPS Prior Auth	800-333-5003	
	First Health Network (non-WI, out of area)	800-226-5116	
HPS	HPS (no copay up front)	888-477-7968	www.hps-findcare.com
Telehealth / Teladoc	Teladoc	800-835-2362	www.Teladoc.com
Pharmacy	SmithRx	844-454-5201	www.smithrx.com
Dental PPO	Humana Insurance Company Inc	877-877-1051	www.Humana.com
Vision	Humana Insurance Company Inc	877-877-1051	www.Humana.com
Life and AD&D	Unum Life Insurance Company of America	800-275-8686	www.Unum.com
Long Term Disability (LTD)	Unum Life Insurance Company of America	866-679-3054	www.Unum.com

This brochure summarizes the benefit plans that are available to Evergreen Retirement Community eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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 this plan. Therefore, the following deductibles and coinsurance apply: $2000 deductible +20%

NEWBORNS ACT DISCLOSURE – FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Erin Sanders
1130 N Westfield St
Oshkosh, Wisconsin United States 54902
920-237-2132
esanders@evergreenoshkosh.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Uses and Disclosures of Substance Use Disorder (SUD) Treatment Information
- If we receive or maintain records about you from a SUD treatment program subject to 42 CFR part 2 (a "Part 2 Program") through consent you provide the Part 2 Program to use or disclose the records, or testimony relaying the content of such records, they are given extra protection. These records shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless you provide written consent, or a court order is issued after notice and an opportunity to be heard is provided by you or the holder of the records.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

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

Other Instructions for Notice

- 1/1/2026
- Erin Sanders, VP Human Resources
  920.237.2132
  esanders@evergreenoshkosh.com

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 July 31, 2024. 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

INDIANA – 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:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
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: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsphttps://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

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
Medicaid 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: Children's Health Insurance Program (CHIP) (pa.gov)
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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
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: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
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
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 July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

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.[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 these factors in determining whether to purchase a health plan through the Marketplace.

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, 2026, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated

[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.

the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2026. 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, 2026. 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, 2026, 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, 2026, 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, 2026, and July 10, 2026, you can request this special enrollment in the employment-based health plan through September 8, 2026. 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:

Name of Entity/Sender:	Erin Sanders
Contact--Position/Office:	VP Human Resources
Address:	1130 N. Westfield St.
Phone Number:	920-237-2132

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 Evergreen Retirement Community		4. Employer Identification Number (EIN) 39-1081800
5. Employer address 1130 N Westfield St		6. Employer phone number
7. City Oshkosh	8. State WI	9. ZIP code 54902
10. Who can we contact about employee health coverage at this job? Erin Sanders		
11. Phone number (if different from above) 920-237-2132	12. Email address esanders@evergreenoshkosh.com	

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:

    Employees with a master schedule of 30 or more hours per week are eligible for all benefits.

- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:

    Dependents of eligible employees until the dependents reach the age of 26.
  - ☐ 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