2026 Employee Benefits Guide

BENEFITS EFFECTIVE: JANUARY 1 – DECEMBER 31, 2026

IMPORTANT CONTACTS

You'll find many details about the benefit plans on the **ADP Workforce Now website**. However, you can use this table if you need to contact a benefit provider directly. Please note that some websites and phone numbers may not be accessible until your benefits are effective.

PLAN TYPE	CARRIER/ PROVIDER	PHONE NUMBER	WEB / EMAIL
Medical, Prescription Drugs and Vision	HMSA	800-776-4672	**www.hmsa.com** Policy #80242-1
Medical, Prescription Drugs and Vision	Kaiser	800-966-5955	**www.kaiserpermanente.org** Policy #408
Dental	Hawaii Dental Service	844-829-3256	**www.hawaiidentalservice.com** Policy #9021
Life/AD&D and Disability	Guardian	866-551-0315	**www.guardianlife.com** Policy #517044, #901990
Supplemental Medical: Accident, Critical Care, Hospital Indemnity	Prudential	General Services: 800-475-6021 Claims: 800-475-4052	**www.prudential.com/mybenefits** Policy # 72955
Flexible Spending Accounts (FSAs)	WEX Health	866-451-3399	**customerservice@wexhealth.com** GPID #39845
Employee Assistance Program (EAP)	Guardian (Uprise Health)	800-386-7055	**worklife.uprisehealth.com** Access Code: worklife
Legal & Identity Theft	Legal Shield	800-654-7757	**www.sheildbenefits.com/allenmedia**
Pet Insurance	Nationwide	877-738-7874	**benefits.petinsurance.com/allenmediabroadcasting**
Employee Concierge and Leave of Absence	TouchCare	866-486-8242	**assist@touchcare.com** **www.touchcare.com**
Medicare Navigation	SmartConnect	833-460-6174	**http://smartmatch.com/connect/allenmedia/**
Employee Discounts	LifeMart	N/A	ADP Portal and click Myself > Benefits > Employee Discounts > LifeMart **adpwfnhelpdesk@lifecare.com**
ADP Employee Solution Center	ADP	855-547-8508	**www.workforcenow.adp.com**

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WHAT'S INSIDE

QUESTIONS

Did you know you have a free personal health assistant? TouchCare takes care of all the health and benefit things you don't like or don't know how to deal with: fixing billing mistakes, finding and coordinating with providers, cost estimates, care coordination, and more. We save you time to worry about the important things in life, like what new show to binge.

Get in touch with your TouchCare Team!

touchcare.com/ask
866-486-8242

assist@touchcare.com or
Download the TouchCare Mobile App!

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Creditable Prescription Drug Coverage and Medicare Notice in the Legal Notices at the back of this booklet for more details.

HOW TO ENROLL

LOG IN

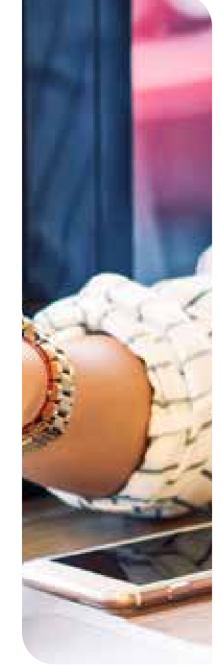
- To enroll, go to: Myself > Benefits > Enrollments. On the Enrollments page, you'll find various benefit-related cards, including Your Benefits (where you can view your current benefits), and Dependents & Beneficiaries (where you can review and edit your dependent/beneficiary information).
- On the Surveys screen, confirm your tobacco attestation for yourself and any dependents over the age of 18. Simply answer Yes or No and agree to the disclosure before proceeding.
- The Select Benefits screen will group your benefits into different sections and categorize them by plan type (such as Medical, Dental, Vision, etc.). When viewing all available plans, you can choose whom you want to cover and which plan you'd like to enroll in. As you select or deselect your dependents, the plan costs will automatically update. To view plan details, select plan comparison or additional details to compare coverage differences. Once you've decided on a plan, click "select plan" followed by "confirm details."
- If applicable, upload any requested documents. Choose a file to upload and click "Upload Document."
- Review all your elections and plan costs. When you're ready to finalize your selections, click "Submit Enrollment."

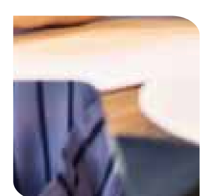
LIFE EVENTS

Following the enrollment deadline, it may be possible for you to make changes to certain benefits in the event of a personal circumstance change, such as marriage or the birth of a child. To modify your benefits based on a qualifying life event, you must make the change within 30 days of the event in ADP.

WHAT HAPPENS IF I DON'T ENROLL?

Please make sure to log in and actively enroll in the benefits that you require for the year 2026. If you do not make any updates you will not be automatically enrolled in your current coverage, except for company-paid Basic Life/ AD&D, STD, LTD, EAP, and TouchCare.





WHAT YOU NEED TO KNOW

ELIGIBILITY

You are eligible to participate in the Allen Media Broadcasting benefit plans if you are a regular full-time employee scheduled to work 20 hours or more per week. You and your eligible dependents can enroll in benefits that will be effective on the 1st of the month following four continuous weeks of employment.

DEPENDENT ELIGIBILITY

Eligible dependents include spouse or domestic partner, dependent children up to age 26, unmarried dependent children beyond age 26 incapable of self-support due to mental or physical handicap.

SPOUSE PREMIUM SURCHARGE

If your spouse has access to medical benefits through his or her employer and you choose to cover your spouse under an Allen Media Broadcasting medical plan, a monthly surcharge of $100 will be added to your medical contribution.

QUALIFYING LIFE EVENTS (QLE)

No changes are allowed to your medical, dental, vision, or Flexible Spending Account (FSA) elections during the plan year, except if you experience a "qualifying life event" which includes:

- Marriage or divorce
- Birth or adoption of a child
- Death of a dependent
- Medicare entitlement
- End of a dependent's eligibility
- Termination of your spouse or domestic partner's employment that affects benefits or constitutes a loss of other group coverage

If you have a QLE, you must report the life event in the ADP system, provide the necessary documentation and make your election changes within 30 days of the change (60 days for adding a newborn).

MEDICAL AND PRESCRIPTION DRUG COVERAGE

HMSA AND KAISER

Medical coverage offers valuable benefits to help you stay healthy and pay for care if you or your covered family members become sick or injured.

WHICH MEDICAL PLAN IS RIGHT FOR YOU?

Before you choose your benefits, think about:

- How much health care and what type of care did you need this year?
- Do you expect your needs to be similar next year?
- Do you prefer to pay less from your paycheck or less out of your pocket when you need care?

USING IN-NETWORK PROVIDERS

Allen Media Broadcasting will offer a choice between two HMOs and one PPO medical plan option through Kaiser and HMSA. You need to choose a Primary Care Physician (PCP) if enrolled in the HMO plan. To help you stay healthy, preventive care, for nationally recommended services, is covered at 100%, as long as you receive care from an in-network provider. To maximize benefits, always select an in-network provider. On the PPO plan, in-network care is covered at a higher percentage than out-of-network care. You can access the HMSA HMO and PPO provider directory at **www.hmsa.com/search/providers**. You can access the Kaiser HMO provider directory at **www.kp.org**. Please refer to the charts for a brief summary of each of the medical plans' major features

PRESCRIPTION DRUG COVERAGE

Your prescription drug coverage is included in your medical plan. Medications are grouped into tiers, which determine your portion of the drug cost.

REVIEW YOUR MEDICAL PLAN OPTIONS

You will have the option to choose from three medical plans — two HMOs and one PPO.

MEDICAL BENEFITS	KAISER HMO	HMSA HMO	HMSA PPO	
	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible – Individual	None	None	None	$100
Calendar Year Deductible – Family	None	None	None	$300
Calendar Year Out-of-Pocket Limit – Individual	$2,500	$2,500 ($3,600 Rx)	$2,500 ($3,600 Rx)	
Calendar Year Out-of-Pocket Limit – Family	$7,500	$7,500 ($4,200 Rx)	$7,500 ($4,200 Rx)	
Coinsurance	10%	10%	20%	30%
Preventive Services	Covered at 100%	Covered at 100%	Covered at 100%	30%
PCP Office Visit	$15 Copay (Adult) $0 (Child age 0–17)	$20 copay	$12 copay	30% after ded
Specialist Office Visit	$15 copay	$20 copay	$12 copay	30% after ded
Inpatient Hospitalization	10%	10%	10%	30% after ded
Emergency Room	$100 copay	$100 copay	20%	20%
Urgent Care Facility	$15 copay 20% out of area	$20 copay	$12	30% after ded
PHARMACY BENEFITS	RETAIL / MAIL ORDER	RETAIL / MAIL ORDER	RETAIL / MAIL ORDER	OUT-OF-NETWORK (RETAIL)
Tier 1 Generic	$3 maintenance $10 / $20 other generics	$7 / $11	$7 / $11	$7 + 20% coinsurance
Tier 2 Preferred Formulary	$45 / $90	$30 / $65	$30 / $65	$30 + 20% coinsurance
Tier 3 Non-Preferred Formulary	N/A	$30+$45 member cost share / $65+135 member cost share	$30+$45 member cost share / $65+ $135 member cost share	$30 + 20% coinsurance
Tier 4 Preferred Formulary Specialty	$200 copay	$100 / Not covered	$100 / Not covered	Not covered
Tier 5 Non-Preferred Specialty	N/A	$200 / Not covered	$200 / Not covered	Not covered

KEY WORDS TO KNOW

Deductible: The amount **you pay** before the plan begins to pay.

Out-of-Pocket Costs: Expenses **you pay** yourself, such as deductibles, copays, and the remaining amounts after plan coinsurance is paid.

Out-of-Pocket Maximum: The maximum amount **you pay** for covered services in a year (you may need to pay additional amounts if coverage is received from an out-of-network provider).

Copay: An amount **you pay** for a covered service each time you use that service, which usually does not apply toward the deductible.

Coinsurance: Percentage of the charge that **you will pay**, typically after you have met the deductible.

MEDICAL CONTRIBUTIONS

Your 2026 medical employee contributions are listed below. Your portion will be withheld bi-weekly (26 pay periods) from your paycheck on a pretax basis.

MEDICAL EMPLOYEE CONTRIBUTIONS

The amount you are deducted for your medical insurance coverage is dependent on:

1. Your Union vs. Non-Union status,
2. Your monthly salary, and
3. The number of dependents enrolled.

The law requires employers to contribute at least half of the premium cost for single coverage. The employee must contribute the rest as long as their share is not more than 1.5% of their wages. Certain exceptions apply for Union employees.

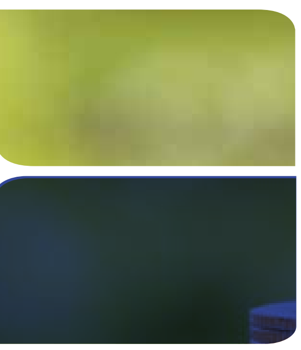
Example: Malia works 40 hours a week. Her monthly paycheck is $1,733. Her health insurance costs $300 a month, half which is $150, 1.5% of her net salary is $26. According to the law, Malia pays the lesser of the two amounts — $26. Her employer pays the rest.

Below are the total monthly premiums for each medical insurance plan option. For details about the exact cost you pay for medical insurance, please contact Human Resources.

KAISER HMO	
Employee Only	$694.91
Employee + 1 Dependent	$1,389.82
Employee + Family	$2,084.73

HMSA HMO	
Employee Only	$918.44
Employee + 1 Dependent	$1,836.88
Employee + Family	$2,755.32

HMSA PPO	
Employee Only	$931.36
Employee + 1 Dependent	$1,862.72
Employee + Family	$2,794.08



SPENDING ACCOUNTS

You can save money on your health care and dependent care costs through the use of tax-advantaged accounts that allow you to use before-tax dollars to pay for eligible expenses. For additional details about the following accounts, contact **customerservice@wexhealth.com**.

FLEXIBLE SPENDING ACCOUNTS: WEX

	HEALTH CARE FLEXIBLE SPENDING ACCOUNT	DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT
Eligible Expenses	Eligible medical, dental, and vision expenses.	Expenses for child/elder care for eligible tax dependents that allow you and/or your spouse or domestic partner to work (medical, dental and vision expenses are not eligible for reimbursement with this account).
How It's Funded	• You can make paycheck contributions up to **$3,400** per year • Your annual election amount is made during your enrollment period. You cannot change it unless you have a qualifying life event during the year (such as getting married or having a baby) • Your entire annual contribution is available to you at the beginning of the plan year	• You can make paycheck contributions up to $5,000 per year ($2,500 if married and filing separately), pretax, to use for qualified dependent care or elder care expenses • Your election is made during your enrollment period. You cannot change it unless you have a qualifying life event during the year (such as having a baby or a change in dependent care expenses) • Your funds are only available to you after they have been deposited into your account each pay period
Unused Funds	Up to **$680** of unused money can be carried over to the next plan year, as long as you re-enroll in the benefit. Amounts above $680 will be forfeited.	You should estimate your expenses carefully before enrolling because unused funds in your account do not carry over at the end of the year and are forfeited.
How to Access	You will receive a benefits debit card that you can use to pay for eligible expenses. Or, you can submit claims for reimbursement of eligible expenses. NOTE: You'll receive only one debit card to use for all of your WEX Health-supported accounts.	

DENTAL INSURANCE

HAWAII DENTAL SERVICE

Research shows there may be a connection between poor dental health and serious health conditions. Regular dental check-ups and good oral hygiene are an essential part of your general health and well-being. Dental benefits are available to you and your eligible family members to cover routine care such as exams, X-rays and cleanings, as well as fillings, dentures, bridgework and periodontal care.

HAWAII DENTAL SERVICE (HDS) SUMMARY AND RATES

The Allen Media Broadcasting dental plan benefits have been designed to allow employees and their dependents to use the dental provider of their choice, regardless of their network status. In-Network dentists are reimbursed a percentage of a fee that has been negotiated with HDS. Out-of-Network dentists are reimbursed a percentage based on the Usual Customary and Reasonable (UCR) for their area. If you choose to see an Out-of-Network provider your out of pocket costs may be higher.

KEY WORDS TO KNOW

Service examples below are not guarantees of coverage; refer to Plan Documents to confirm covered services.

Deductible: The amount you pay before the plan begins to pay.

Annual Maximum Benefit: Maximum total amount the plan will pay during the plan year.

Preventive Services: Services designed to prevent or diagnose dental conditions including oral evaluations, routine cleanings, X-rays, fluoride treatments and sealants.

Basic Services: Services such as basic restorations, some oral surgery, endodontics and periodontics.

Major Services: Services such as crowns, dentures, implants.

ANNUAL DEDUCTIBLE	
Individual / Family	None
BENEFITS MAXIMUM	
Annual Maximum	None
DENTAL COVERAGE	
Diagnostic, Cleanings	Plan pays 100%
Preventive Services *Fluoride, sealants, space maintainers*	Plan pays 70%
Basic Services *Fillings, root canals, oral surgeries*	Plan pays 70%
Major Services *Crowns, bridges, dentures, implants*	Plan pays 70%

The Total Health Plus program allows members with certain chronic conditions (e.g., diabetes, cancer, stroke) or expectant mothers to receive additional cleanings/gum maintenance and/or fluoride treatments per year. Contact the plan for more details.

To find an In-Network provider please visit **www.hawaiidentalservice.com/findadentist**

The amount you are deducted for your medical and dental insurance coverage is dependent on:

1. Your Union vs. Non-Union status,
2. Your monthly salary, and
3. The number of dependents enrolled.

DENTAL INSURANCE DEDUCTIONS

Non-Union employees pay 35% of the total premium, or $9.23 per pay period (bi-weekly).

Union employees pay 25% of the total premium, or $6.59 per pay period (bi-weekly).

VISION INSURANCE

Having an annual eye exam is one of the best ways to make sure, you're keeping your eyes healthy. Eye exams can help prevent and treat easily correctable vision problems, which can cause permanent vision impairment.

VISION PLAN HIGHLIGHTS

The following vision benefits are included in your medical HMSA plan.

HMSA	PREFERRED PROVIDER PLAN	HEALTH PLAN HAWAII PLUS
Annual eye exam	$10 copayment	$20 copayment
Basic lenses	$10 copayment	$10 copayment
Basic frames	$15 copayment / 24 months	$15 copayment / 24 months
Contact lenses	$25 copayment up to $130 maximum	$25 copayment up to $130 maximum

Member resources:

- **hmsa.com/eyemed**
- EyeMed microsite
- EyeMed provider locator

KEY WORDS TO KNOW

Copay: An amount you pay for a covered service each time you use that service.

Retail Allowance: Maximum allowance paid toward the cost of vision materials; you are required to pay any amounts in excess of the retail allowance.

eyemed	LensCrafters	OPTICAL	GLASSES.COM	contactsdirect	Ray-Ban
eyemed.com	lenscrafters.com	targetoptical.com	glasses.com	contactsdirect.com	ray-ban.com/insurance

The following "Optical 150" vision benefits are included in your Kaiser medical plan. You will receive $150 annual allowance to use for eyeglass frames, eyeglass lenses, a complete pair of eyeglasses, contacts lens exam and fitting or contact lenses. Enrolled dependents (up to 18 years of age) will receive an eye exam one pair of polycarbonate single vision, lined bifocal or lined trifocal lenses, one frame per year from Kaiser's value collection frames, one pair of non-disposable contact lenses or an initial supply of disposable contact lenses (in lieu of glasses) once per year at no charge. Additional member discounts available for second pair of eyeglasses, non prescription sunglasses, 6–12 month supply of contact lenses.

LIFE AND AD&D INSURANCE

GUARDIAN

The loss of income that results from an unexpected death can create significant strain for your family at an already difficult time. Life and accident insurance provide important financial protection for your family.

EMPLOYER-PAID TERM LIFE AND AD&D INSURANCE

Allen Media Broadcasting provides you with a base level of employee term life and AD&D insurance at no cost to you. This coverage provides a benefit of 1.5 times your annual base salary up to $200,000. Your Basic Life and AD&D coverage will reduce to 65% upon attainment of age 65, 40% upon attainment of age 70, 25% upon attainment of age 75.

VOLUNTARY TERM LIFE AND AD&D INSURANCE

EMPLOYEE	SPOUSE/DOMESTIC PARTNER	CHILD(REN)
You can elect voluntary employee life and AD&D* coverage in increments of $10,000 up to $250,000 (guaranteed issue of $100,000, $50,000 if 65–69 or $10,000 if 70+).	You can elect voluntary spouse life and AD&D*coverage in increments of $5,000 up to $250,000 (guaranteed issue of $25,000, $10,000 if 65–69)	You can elect voluntary child(ren) life and AD&D* coverage in increments of $5,000 not exceed $10,000 (guaranteed issue of $10,000).

*Voluntary Life and Voluntary AD&D products must be purchased together.

SELECT A BENEFICIARY

It's important to choose a beneficiary to receive the policy's benefit payment in the event of the insured person's death. Be prepared with your beneficiary information as you enroll in your 2026 benefits via ADP.

EVIDENCE OF INSURABILITY (EOI)

Life insurance amounts over guaranteed issue may require approval from Guardian. After electing coverage, you will receive more information.

KEY WORDS TO KNOW

Life Insurance: Pays a benefit upon the death of an insured person.

Accidental Death & Dismemberment (AD&D) Insurance: Pays a benefit upon the accidental death of an insured person; also provides benefits for certain covered accidental dismemberments.

Beneficiary: Person or legal entity designated as the recipient of benefits from life or AD&D insurance.

Guaranteed Issue Coverage: An amount of insurance that does not require evidence of insurability.

Evidence of Insurability: Statement of health proving a person's eligibility for certain amounts of coverage.

VOLUNTARY LIFE/AD&D INSURANCE PLAN RATES (PER MONTH)

VOLUNTARY TERM LIFE	
LIFE AGE	EMPLOYEE/SPOUSE PER $1,000
Under 30	$0.081
30–34	$0.085
35–39	$0.110
40–44	$0.163
45–49	$0.260
50–54	$0.425
55–59	$0.679
60–64	$1.026
65–69	$1.903
70+	$3.704

CHILD(REN) LIFE RATE PER $1,000	$0.163 (covers all dependent children)

VOLUNTARY AD&D	
	PER $1,000
Employee	$0.03
Spouse	$0.03
Child(ren)	$0.03

To assign or change your beneficiary log on to **workforcenow.adp.com**. More information about this plan is available on **workforcenow.adp.com**.

DISABILITY INSURANCE

GUARDIAN

A disability can be one of the biggest financial risks you face. Your work income will end, but your living expenses will continue. When you need to miss work for an extended period of time, disability insurance, paid for by Allen Media Broadcasting, can replace a percentage of your lost income for a certain period of time.

DISABILITY BENEFIT SUMMARY

EMPLOYER-PAID SHORT TERM DISABILITY		
60% of your pre-disability weekly earnings up to a maximum weekly benefit of $2,000. (Benefits are taxable and reduced by other group disability benefits, state TDI, and dependent social security benefits)	Maximum payout period: 22 weeks	Elimination Period: 14 days

EMPLOYER PAID LONG TERM DISABILITY

EMPLOYER-PAID LONG TERM DISABILITY			
60% of your pre-disability monthly earnings up to a maximum monthly benefit of $12,000. (Benefits are taxable)	Maximum benefit period: Until you are no longer considered disabled, or you reach Social Security Normal Retirement Age (SSNRA)	Elimination Period: 180 days or the end of the STD maximum benefit period	Pre-existing Condition Limit: 3 months lookback / 12 months after exclusion

When you are ill or injured for a long time, Guardian provides return-to-work services (i.e., nurse consultant, case manager, vocational analysis, job retraining, etc.) and assistance in obtaining Social Security Disability Benefits to help you get the maximum benefits from your coverage.

KEY WORDS TO KNOW

Short Term Disability: When you need to miss work for an extended period of time due to an illness or accident, short term disability insurance can replace a percentage of your lost income (up to a maximum weekly benefit) for a certain number of weeks.

Long Term Disability: If you experience a disabling illness or injury that lasts longer than your short term disability benefit, long term disability insurance can replace a percentage of your lost income (up to a maximum monthly benefit) for an extended period of time.

LEAVE OF ABSENCE SUPPORT

TOUCHCARE'S ENHANCED LOA SERVICES

TouchCare's Leave of Absence service goes beyond the standard approach, offering seamless, personalized support to help you navigate through personal challenges with ease and confidence. With our LOA support, you'll have a dedicated team by your side, ensuring that your needs are met while keeping everything aligned with your company's leave policies and return-to-work procedures.

EXPERIENCE EXCEPTIONAL SUPPORT WITH TOUCHCARE'S ENHANCED LOA SERVICES

Personalized Support

Our team is here to support you throughout your leave, providing clear communication and guidance to ensure your experience is as smooth and stress-free as possible.

Confidential & Secure

We handle all your personal information with the utmost care, managing communication with your healthcare providers and insurance companies to ensure your privacy.

Seamless Integration

Our support aligns with your company's internal leave policies and procedures, ensuring that everything is handled efficiently and in to your specific needs.

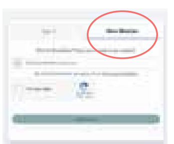
Simplified Process

We make it easy to start your leave of absence. Our simple intake questionnaire and one-on-one consultations are designed to reduce confusion and stress.

HOW TO SCHEDULE YOUR LOA CONSULTATION WITH TOUCHCARE:

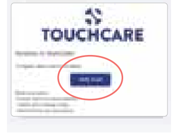
1 Create an account

Visit **www.touchcare.com** and click on member login or download our mobile app. Click 'new member' on the sign-up page. (Already have an account? Skip to step 4.)



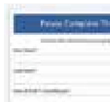
2 Verify your email

Upon creating your account, you will be asked to verify your email address. Find the verification email in your inbox and click 'verify email'.



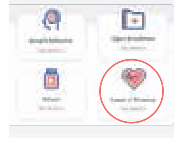
3 Complete our form

Click the link in our email to finish registration by completing our quick intake form and release form. Finally, enter a password to create your account and open your first case.



4 Log in to our portal

Once registered, log in to your TouchCare account via our member portal (**touchcare.com/ask**) or app. Then click on the 'Get Scheduled' tab or 'Schedule' tab in the app.

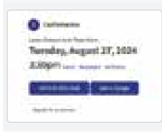


5 Get scheduled

Click on 'Leave of Absence' button to be taken to our scheduler page. Here you'll be able to choose a date and time that works best for you. You'll also answer a few quick questions.

6 Confirm your consult

You'll receive a confirmation email and a reminder text on the day of your consultation. We'll call you at the date and time you selected at the number you provided.



How else can TouchCare help you?

- Advise on eligible leave
- Provide salary and state benefits info
- Follow-ups in TouchCare portal
- Assist with leave application
- Provide leave dates to Manager and HR
- Find healthcare providers
- Help with medical bills and claims
- Find lower-cost medications
- Support with any challenges
- Remind of key leave dates
- Answer questions
- Assist with a smooth return to work

Get the App
TOUCHCARE

HOSPITAL INDEMNITY INSURANCE

PRUDENTIAL

When you're in the hospital or undergoing outpatient surgery, the last thing you need to worry about is how much it will cost to get better. Even when you have health insurance, premiums don't cover everything.

If you're admitted to the hospital for a covered accident or sickness, hospital indemnity insurance plans provide benefits that can help pay for hospital expenses that aren't covered by your health insurance, such as costs related to hospital stay copays and coinsurance, and other inpatient services.

With this added financial protection, you can dedicate energy toward getting well instead of worrying about bills.

BENEFIT HIGHLIGHTS

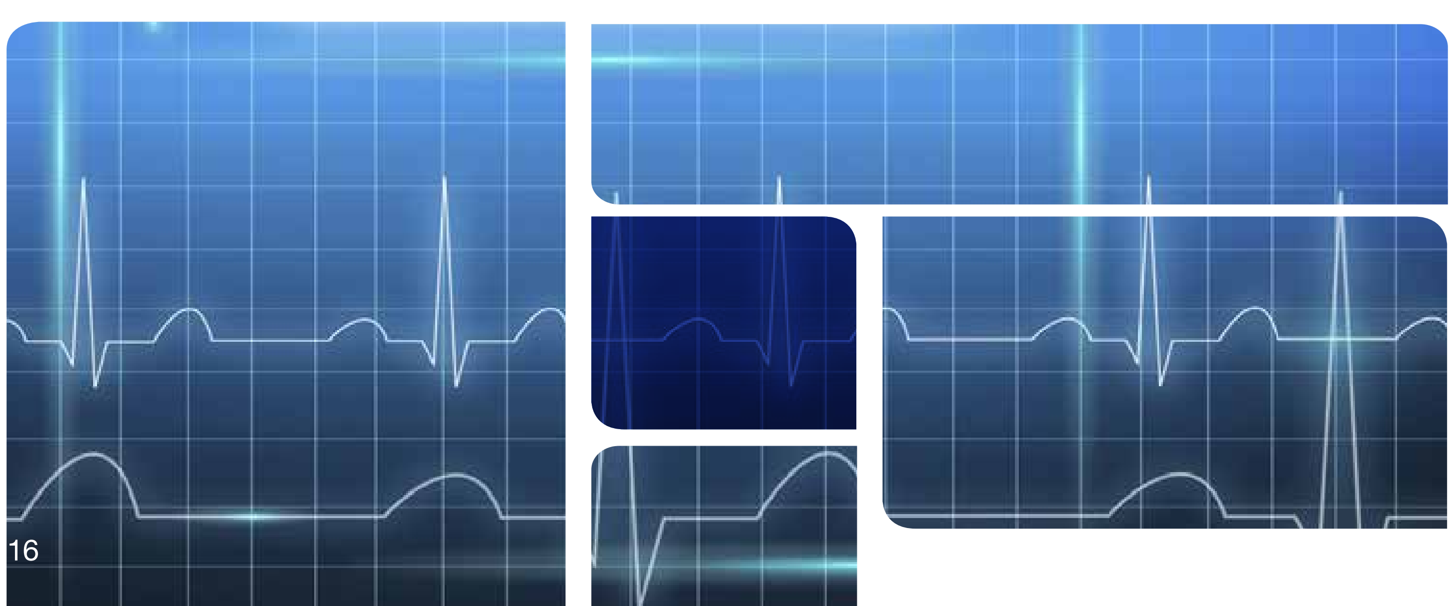
- Pays $1,500 for Hospital admission
- Pays $3,000 for ICU admission
- $100 daily benefit for hospital confinement up to 365 days
- $50 annual health screening benefit for each covered member; includes a wide variety of screenings including dental and vision exams

ALL POLICIES INCLUDE

- Benefits payable directly to the policyholder (unless specified otherwise) that can be used for any purpose
- Availability for you, your spouse and eligible dependent children

PLAN RATES

PRUDENTIAL HOSPITAL INDEMNITY PLAN	
TIER	MONTHLY
Employee Only	$15.21
Employee & Spouse	$32.76
Employee & Child(ren)	$26.18
Employee & Family	$42.23



CRITICAL ILLNESS INSURANCE

PRUDENTIAL

Critical illnesses, such as heart attack, stroke, cancer or organ failure, are usually unexpected and may not be preventable. Recovering from a serious illness often brings significant expenses other than medical costs, which can amount to thousands of dollars.

Critical Illness insurance can help with the treatment costs of covered critical illnesses and enhance your medical plan, giving you the flexibility to pay bills related to treatment or to help with everyday living expenses.

BENEFIT HIGHLIGHTS

- Pays a lump-sum cash benefit of $10,000 or $20,000 directly to you to help cover out-of-pocket expenses associated with a covered critical illness
- Pays in addition to existing medical insurance benefits
- Includes a $50 annual health screening benefit and a 50 annual mental health screening benefit per covered member
- Pays upon diagnosis of a covered condition
- Examples of covered conditions include: cancer, heart attack, stroke, major organ failure, end stage renal failure*

PLAN RATES

Rates are age-banded for both employees and spouses. Children are included at no additional charge with the benefit not to exceed 50% of the employee election.

For additional plan details, visit **workforcenow.adp.com**

*Not a guarantee of coverage. Benefits vary by state. Review plan documents to verify covered benefits.

ACCIDENT INSURANCE

PRUDENTIAL

An accident can require a variety of treatments, testing, therapies and other care to assist in recovery. Even the best medical plans may leave you with extra costs to pay out of your own pocket. Everyday expenses like your mortgage, car payment or child care may be harder to cover due to lost or reduced income.

Accident Insurance can help you bounce back by providing cash benefits if you experience a covered accident. These benefits help with expenses and protect your savings, letting you focus more on recovering.

BENEFIT HIGHLIGHTS

- Receive cash benefits to help cover out-of-pocket expenses associated with a covered accident
- $50 annual health screening benefit for each covered member; includes a wide variety of screenings including dental and vision exams
- Pays benefits for each covered occurrence
- Examples of covered services include: emergency room, hospitalization, doctor's visits, physical therapy*
- Additional benefits available for certain injuries, such as dislocations, fractures, burns, and lacerations

*Not a guarantee of coverage. Benefits vary by state. Review plan documents to verify covered benefits.

BENEFIT EXAMPLE

Accident Insurance coverage is selected

You are injured in a covered accident

You visit a physician

You are treated for your injuries

Submit a claim and receive cash benefits from your plan to help cover your expenses.

For additional plan details, visit **workforcenow.adp.com**

PLAN RATES

PRUDENTIAL ACCIDENT PLAN	
TIER	MONTHLY
Employee Only	$6.11
Employee & Spouse	$10.75
Employee & Child(ren)	$11.24
Employee & Family	$15.75

ADDITIONAL BENEFITS

As part of your benefits package offered, you have access to a variety of additional programs that can help save you money and provide important assistance with everyday needs. For detailed benefits information, log on to **workforcenow.adp.com** or **TouchCare.com**. Benefit materials can also be found on **ambemployeebenefits.com**.

LEGAL PLAN: LEGALSHIELD

The legal plan, administered by LegalShield, provides you, your spouse or domestic partner, and eligible, unmarried dependent children up to age 26 with direct access to an experienced provider law firm for advice and consultation on a wide range of personal legal matters including, but not limited to:

- Letters or calls made on your behalf
- Contract and document review (up to 10 pages per document)
- Will preparation
- Moving traffic violations (15 day waiting period)
- IRS audit assistance
- 24/7 emergency access for covered situations
- And more!

You'll have access to experienced attorneys nationwide. The plan is easy to use – no copayments or deductibles. No one can predict the future, but LegalShield can help you prepare whatever legal needs may arise.

Visit **www.shieldbenefits.com/allenmedia** to learn more and enroll.

IDENTITY THEFT PROTECTION: LEGALSHIELD

LegalShield's identity protection plan, administered by IDShield, includes proactive identity and credit monitoring - offering a comprehensive solution to help safeguard against today's identity fraud threats. Benefits include, but are not limited to:

- Auto-monitoring of your personal information
- Dark web monitoring
- Continuous credit monitoring
- Username and password monitoring
- Social media reputation monitoring to protect against cyber bullying and reputational damage
- Unlimited consultation
- Full-service identity restoration by Licensed Private Investigators
- 24/7 emergency assistance for covered ID theft situations
- And more!

Visit **www.shieldbenefits.com/allenmedia** to learn more and enroll.

LEGAL ASSISTANCE PLAN AND IDENTITY THEFT PROTECTION RATES (PER MONTH)

LEGALSHIELD ID PROTECTION	EMPLOYEE MONTHLY	FAMILY MONTHLY
LegalShield + ID Shield	$24.90	$30.90
ID Shield	$8.95	$18.95
LegalShield	$15.95	$15.95

EMPLOYEE ASSISTANCE PROGRAM (EAP): GUARDIAN

Guardian Uprise Health Employee Assistance program is an employer sponsored program, available at no cost to you and your family.

Services are confidential and available 24 hours a day, 7 days a week. Your Employee Assistance Program (EAP) includes:

- Referrals to local counselors with up to 3 sessions at no charge
- Unlimited telephonic support with an EAP Counselor
- State-of-the-art website featuring planning tools
- A complimentary consultation with financial and legal professionals plus discounts on legal services

HOW TO ACCESS

- To access the Uprise Health Employee Assistance Program, you'll need a few personal details
- Visit **worklife.uprisehealth.com**
- Access Code worklife

For more information or support, you can reach out by phoning 1-800-386-7055 or emailing **eapcounselor@uprisehealth.com**. The team is available 24 hours a day, 7 days a week.

MEDICARE NAVIGATION: SMARTCONNECT

SmartConnect is an exclusive program created specifically for working or retiring adults (and family member who are Medicare-eligible and may not have fully explored the benefits of Medicare coverage. Staying on Allen Media Broadcasting's health coverage may be easy, but it's not always the best option. Medicare plans could provide more coverage at a lower cost than Allen Media Broadcasting's plan.

SmartConnect puts your specific needs first and matches you with the education and the experienced advisor you need to make the best decision for you. SmartConnect gives you access to plans from national insurance carriers. Whether you're planning to continue working or looking to retire, SmartConnect has expert listeners who can guide you to a tailored solution. SmartConnect knows this is a big decision. Their mission is to inspire confidence and help you find your balance in Medicare.

Visit **https://smartmatch.com/connect/allenmedia/** to view a variety of Medicare options and prices available to you. Or call 833-460-6174, Monday – Friday, 7:30 a.m. – 5 p.m. CT and speak to a Medicare specialist who can answer questions, conduct policy reviews, and even help you work with the carrier when necessary.

PET INSURANCE: NATIONWIDE

Don't forget your pets! Just like any other family member, pets can get sick & hurt too. Nationwide's My Pet Protection Choice plan offers new features & more customizable insurance options than ever before! You now have multiple deductible options ($100 - $500/yr), your choice of 3 coinsurance options (50%, 70%, 80%), and 2 new Wellness options ($450 - $800/yr), with reimbursement limits up to $15,800/yr! This exclusive new plan is designed specifically for employees (not available outside of work) and includes improved, employee-only pricing. Get a quote for your pet and enroll them today via the custom link above! Available to all FT & PT employees anytime throughout the year!

THERE ARE THREE SIMPLE WAYS FOR EMPLOYEES TO SIGN UP FOR THEIR NEW PET INSURANCE VOLUNTARY BENEFIT:

Go directly to the dedicated URL we've created for your company: **benefits.petinsurance.com/allenmediabroadcasting**

Visit **PetsNationwide.com** and enter your company name "Allen Media Broadcasting, LLC"

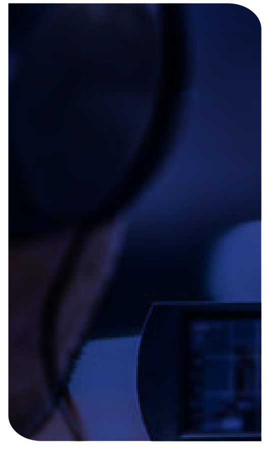
Call 877-738-7874 and mention that you are an employee of Allen Media Broadcasting, LLC to receive preferred pricing.

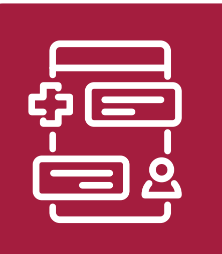
EMPLOYEE DISCOUNTS: LIFEMART

LifeMart has partnered with Allen Media Broadcasting via ADP to offer employees and family members special savings on personal insurance products, hotels, theme parks, electronics and much more.

Access LifeMart discounts anywhere, anytime, with the LifeMart mobile app. Simply download the app and you can browse major savings on the go. Available for download in the Google Play Store and iTunes Store. Need help? Contact: **adpwfnhelpdesk@lifecare.com** Save on brands you know and love with LifeMart. Find exclusive discounts on products and services.

You can visit ADP Portal and click on Myself > Benefits > Employee Discounts, to learn more.





HEALTH ADVOCACY

TOUCHCARE

Have you needed help finding the right doctor or navigating your benefits? Can you locate a convenient, lower-cost provider for medical services that you need? Have you ever had a claim issue with your insurance that you couldn't resolve?

Now you can get personalized support with all of this and more by registering with and contacting TouchCare. A personal health assistant who is ready to guide you and your family through insurance-related questions or concerns!

TAKE ADVANTAGE OF ALL OF YOUR HEALTH CARE BENEFITS

By simply being an Allen Media Broadcasting employee, you'll have access to tools and resources online or can call, email or schedule an appointment to talk to a dedicated Personal Health Assistant.

There is no cost to you for this service.

GET HELP FINDING DOCTORS AND COST COMPARISONS

With TouchCare, you will be navigated to highly-rated providers that are in-network and conveniently located. TouchCare helps you to obtain costs for services in your area, and compare with other facilities close by.

FIND THE BEST PRICE FOR YOUR HEALTH CARE SERVICES

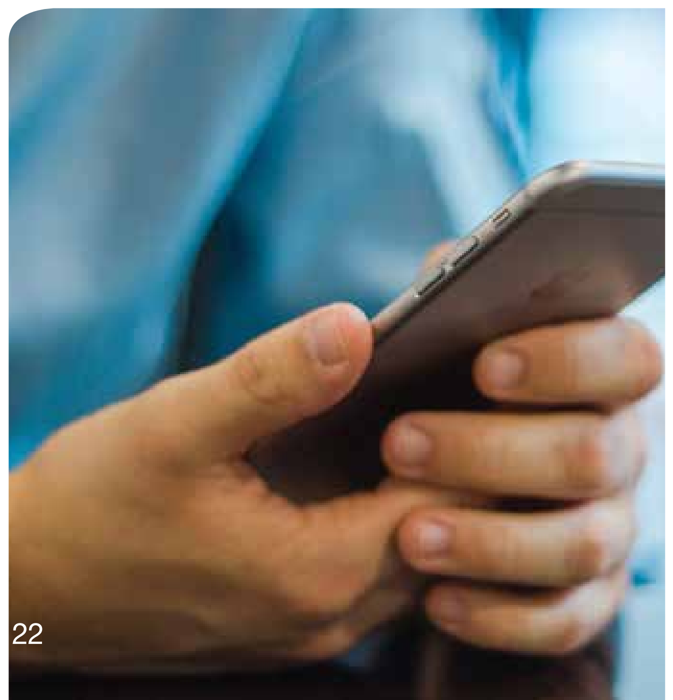
TouchCare Health Assistants ensure you never overpay for care by carefully researching all options and costs.

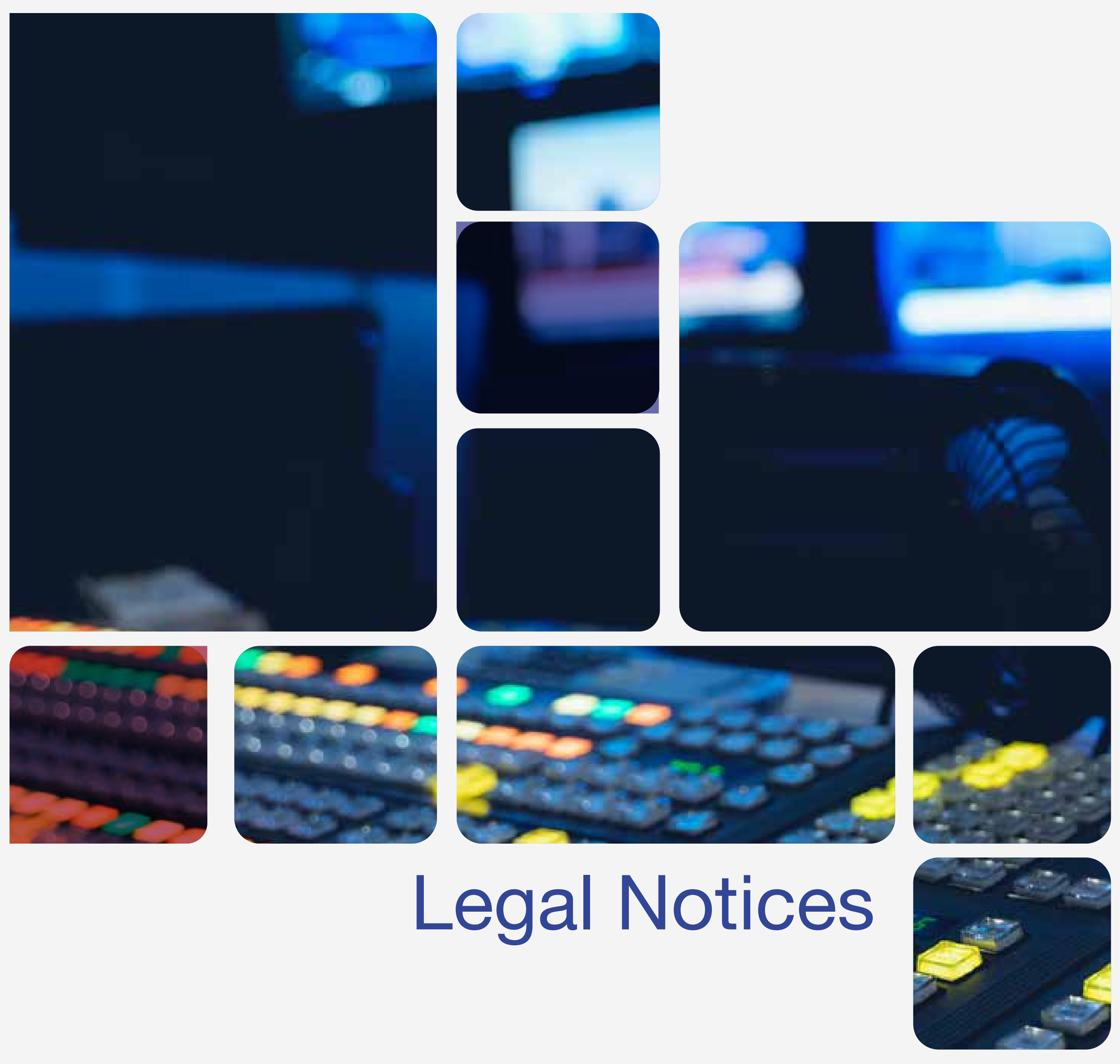
NEVER PAY MORE THAN YOU HAVE TO

Received an EOB that you think is incorrect, but don't want to deal with it? Send TouchCare your bills, advise what you feel is wrong, ask questions — and TouchCare will work on your behalf to fix any errors. Also, get assistance finding the lowest cost options for all of your prescriptions.

HOW TO GET STARTED

- Visit **www.touchcare.com**, or
- Download the app, or
- Call 866-486-8242 between 8 a.m. – 9 p.m. (ET) to speak with the concierge team





Legal Notices

HEALTH PLAN OF ALLEN MEDIA GROUP RESERVES THE RIGHT TO CHANGE, AMEND OR TERMINATE ANY BENEFITS PLAN AT ANY TIME FOR ANY REASON. PARTICIPATION IN A BENEFITS PLAN IS NOT A PROMISE OR GUARANTEE OF FUTURE EMPLOYMENT. RECEIPT OF BENEFITS DOCUMENTS DOES NOT CONSTITUTE ELIGIBILITY.

The Benefits Guide, combined with these legal notices, provides an overview of the benefits available to eligible employees and their dependents. In all cases, the official plan documents govern and the Benefit Guide is not, and should not be relied upon as a governing document. In the event of a discrepancy between the information presented in the Benefits Guide and official plan documents, the official plan documents will govern.

STATEMENT OF MATERIAL MODIFICATIONS

This enrollment guide constitutes a Summary of Material Modifications (SMM) or Summary of Material Reductions (SMR), as applicable, to the Allen Media, LLC Health and Welfare Benefit Plan summary plan description (SPD). It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

SUMMARY OF BENEFITS COVERAGE

A Summary of Benefits Coverage (SBC) for each of the employer-sponsored medical plans is available at **workforcenow.adp.com** or **amg.employeebenefits.com**

TAXATION OF BENEFITS

The taxation of certain benefits may vary at the local, state and federal level. You should consult your tax advisor if you have any questions about the proper treatment of any benefits.

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, 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

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:
https://mn.gov/dhs/health-care-coverage/

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**
ACCESS NEBRASKA
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 or (866)614-6005

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://bms.wv.gov/ 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: 1-855-294-2127

To see if any other states have added a premium assistance program since July 31, 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

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)

IMPORTANT NOTICE TO EMPLOYEES FROM ALLEN MEDIA BROADCASTING ABOUT CREDITABLE PRESCRIPTION DRUG COVERAGE AND MEDICARE

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Allen Media Broadcasting medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2026. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2026 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Allen Media Broadcasting and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

NOTICE OF CREDITABLE COVERAGE

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare.

Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by a Allen Media Broadcasting prescription drug plan, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2026. This is called creditable coverage. Coverage under these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Allen Media Broadcasting plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Allen Media Broadcasting coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment or other qualifying event, or otherwise become newly eligible to enroll in the Allen Media Broadcasting plan mid-year, assuming you remain eligible.

You should know that if you waive or leave coverage with Allen Media Broadcasting and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Allen Media Broadcasting coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- Visit **www.medicare.gov** for personalized help.
- Call your State Health Insurance Assistance Program (see a copy of the Medicare & You handbook for the telephone number) or visit the program online at **https://www.shiptacenter.org/**
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Allen Media Broadcasting Service Center
2975 Chad Drive
Eugene, OR 97408
541-225-1205

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH PLAN COVERAGE

As you know, if you have declined enrollment in Allen Media Broadcasting's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Allen Media Broadcasting will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/ CHIP eligibility change to request enrollment in the Allen Media Broadcasting health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

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 medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 541-225-1205.

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 541-225-1205.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

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 your 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.

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 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 9.96% for 2026 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 9.96% for 2026 of the employee's household income.

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

WHEN CAN I ENROLL IN HEALTH INSURANCE COVERAGE THROUGH THE MARKETPLACE?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage.

Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

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

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

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 Allen Media Broadcasting	4. Employer Identification Number (EIN) 83-4565462	
5. Employer address 2975 Chad Drive	6. Employer phone number 541-225-1205	
7. City Eugene	8. State OR	9. Zip Code 97408
10. Who can we contact about employee health coverage at this job? AMB Service Center		
11. Phone number (if different from above)	12. Email address **payroll@allenmediabroadcasting.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:
  - Active, regular employees or interns regularly scheduled to work a minimum of 30 hours per week

- With respect to dependents:

❑ We do offer coverage. Eligible dependents are:
  - Spouses and Children

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.

WHAT ABOUT ALTERNATIVES TO MARKETPLACE HEALTH INSURANCE COVERAGE?

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

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

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact 541-225-1205.

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.

NO SURPRISES ACT NOTICE
YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing.

In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

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

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

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

YOU'RE PROTECTED FROM BALANCE BILLING FOR: EMERGENCY SERVICES

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

CERTAIN SERVICES AT AN IN-NETWORK HOSPITAL OR AMBULATORY SURGICAL CENTER

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

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

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

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

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

If you think you've been wrongly billed, contact U.S. Department of Health and Human Services. The federal phone number for information and complaints is: 1-800-985-3059. Visit No Surprises Act | CMS for more information about your rights under federal law.

ALLEN MEDIA BROADCASTING HIPAA PRIVACY NOTICE

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by Allen Media Broadcasting health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of all health and welfare plans. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

THE PLAN'S DUTIES WITH RESPECT TO HEALTH INFORMATION ABOUT YOU

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not Allen Media Broadcasting as an employer — that's the way the HIPAA rules work. Different policies may apply to other Allen Media Broadcasting programs or to data unrelated to the Plan.

HOW THE PLAN MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.
- Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

HOW THE PLAN MAY SHARE YOUR HEALTH INFORMATION WITH ALLEN MEDIA BROADCASTING

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to Allen Media Broadcasting for plan administration purposes. Allen Media Broadcasting may need your health information to administer benefits under the Plan. Allen Media Broadcasting agree not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources and the Benefits team are the only Allen Media Broadcasting employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and Allen Media Broadcasting, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to Allen Media Broadcasting, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer or HMO, may disclose to Allen Media Broadcasting information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that Allen Media Broadcasting cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by Allen Media Broadcasting from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

OTHER ALLOWABLE USES OR DISCLOSURES OF YOUR HEALTH INFORMATION

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

HOW THE PLAN WILL TREAT CERTAIN SUD TREATMENT INFORMATION

The Plan is not a federally assisted substance use disorder diagnosis, treatment or referral program that is covered by 42 CFR Part 2 (a "Part 2 Program") and does not create and does not typically maintain any records that are subject to 42 CFR Part 2. If the Plan does receive any Part 2 Program records pursuant to your written consent for claim administration and payment, the records will only be used and disclosed in accordance with HIPAA and your consent. In no event will the Plan use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings against you, unless authorized by your written consent or a court order accompanied by a subpoena or other legal requirement compelling disclosure after you received notice and an opportunity to respond.

YOUR INDIVIDUAL RIGHTS

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

RIGHT TO REQUEST RESTRICTIONS ON CERTAIN USES AND DISCLOSURES OF YOUR HEALTH INFORMATION AND THE PLAN'S RIGHT TO REFUSE

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

RIGHT TO RECEIVE CONFIDENTIAL COMMUNICATIONS OF YOUR HEALTH INFORMATION

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

RIGHT TO INSPECT AND COPY YOUR HEALTH INFORMATION

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

RIGHT TO AMEND YOUR HEALTH INFORMATION THAT IS INACCURATE OR INCOMPLETE

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

RIGHT TO RECEIVE AN ACCOUNTING OF DISCLOSURES OF YOUR HEALTH INFORMATION

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM THE PLAN UPON REQUEST

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

CHANGES TO THE INFORMATION IN THIS NOTICE

The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on February 16, 2026. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice located on the benefits site.

COMPLAINTS

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan at 541-225-1205 and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint.

CONTACT

For more information on the Plan's privacy policies or your rights under HIPAA, contact 541-225-1205.

FIXED INDEMNITY PLAN NOTICE

IIMPORTANT: 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?

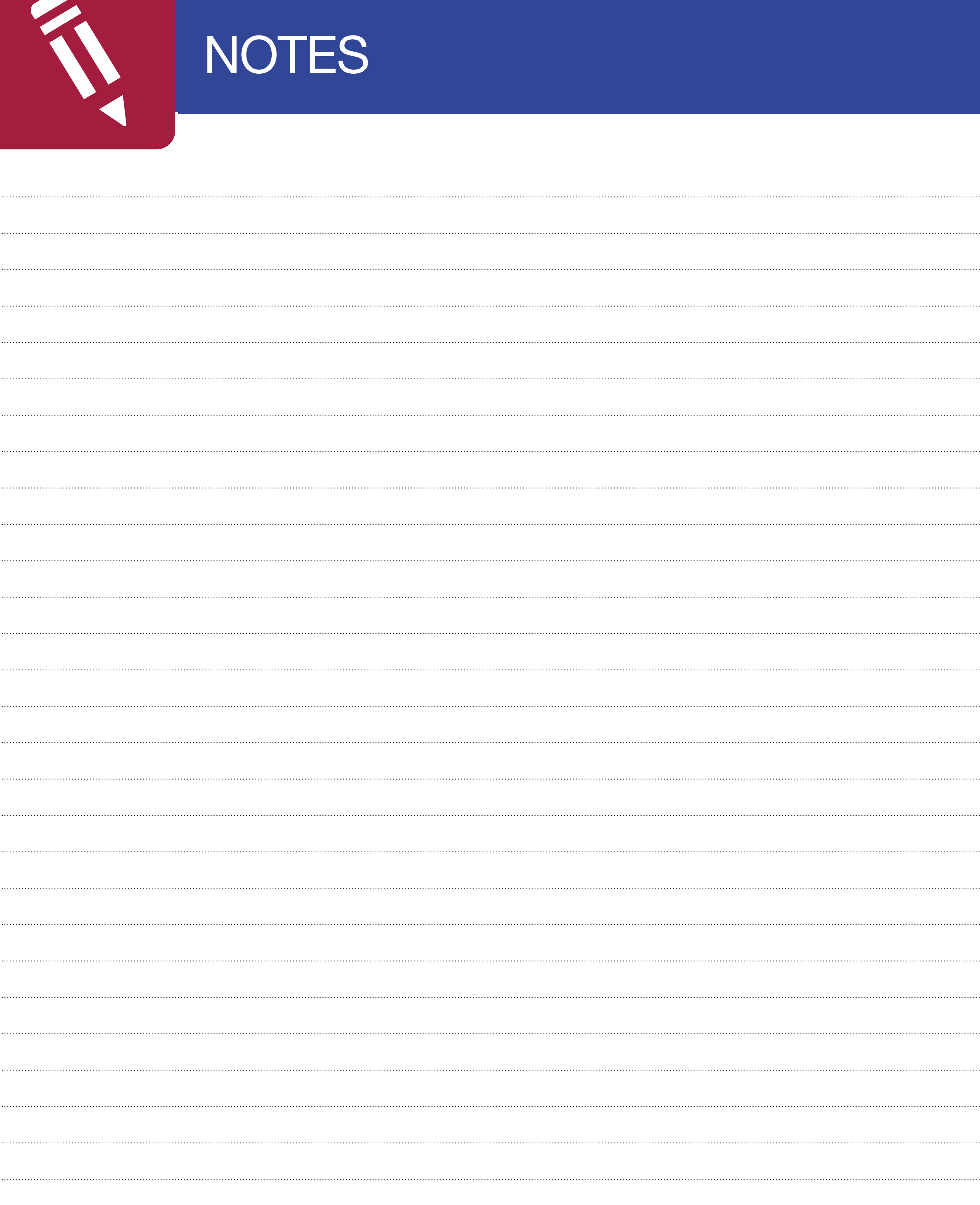
- Visit **healthcare.gov** or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

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.

NOTES



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