WellHaven
Pet Health

Well People | Well Pets | Well Practice | Well Community

2025 EMPLOYEE BENEFITS GUIDE

January 1, 2025 through December 31, 2025

Welcome to WellHaven

WellHaven has a reputation for being “best in class”. We work hard every day to make a difference – a difference in the lives of our pets and pet families. We exist to strengthen the positive ripple effect that derives from happy, successful vet hospital leaders and teams, care that truly addresses the needs of pet parents, and, by extension, healthy pets. When the animals feel the love, everyone feels the difference.

Well Community

Well Practice

Well Pets

Well People

Table of Contents

Eligibility

You may be and/or become eligible to enroll in our benefits plan if one of the following apply:

- At the time of hire, if you are classified as Full Time Regular and scheduled to work 30 or more hours per week.
- You are reclassified, due to an Employee Classification Change, as Full Time Regular and scheduled to work 30 or more hours per week.
- You meet the minimum number of hours required for medical insurance eligibility during one of our annual measurement periods.

You may also enroll your eligible dependent(s) in the same plans you enroll yourself. Eligible dependents include:

- Legally married spouse
- Qualified domestic partner*
- Dependent child(ren) up to age 26

*To enroll a domestic partner, you must complete the appropriate Domestic Partner Affidavit Form and/or provide a copy of your state approved registration. There are tax implications when enrolling a domestic partner.

Eligible employees may participate in the benefit plans on the first day of the month following or coinciding with 30 days of employment (hire) or status change.
****Acquisition new hires and campus employees are eligible 1st of month following date of hire.**

Enrollment

You will enroll in the benefit plans through the Benefit Portal within the Paycom system. Please watch for an email, from "Paycom Self Service". Follow the Paycom Benefits Portal Guide which provides instructions for completing your enrollment. You will want to enroll at least 15 days prior to your benefits start date. You must enroll within 30 days of your eligibility date. You will also enroll during our annual Open Enrollment period.

Please note! If you do not complete your enrollment during your designated window, you will not be able to enroll or make changes unless you experience a Qualifying Life Event, or until the next open enrollment period.

Mid-Year Changes

Unless you have a Qualifying Life Event (QLE), you cannot make mid-year benefit changes. Within 30 days of a QLE, you must make a change. QLE examples include:

- Marital or domestic partnership status change
- Birth or adoption of an eligible child(ren)
- Death of a spouse, domestic partner, child(ren) or other qualified dependent
- Change in your employment status that affects your eligibility for benefits
- Change in your spouse or domestic partner's employment status that affects his/her/their eligibility for benefits
- Change in your child(ren)'s dependent status or eligibility for benefits
- Change in coverage under another employer-sponsored plan
- Directive from a Qualified Medical Child Support Order

Please contact Human Resources if you have any questions or believe you may qualify for an election change.

Please note! To make changes to your benefit elections, you MUST notify HR within 30 days of the Qualifying Life Event (including newborns). Be prepared to show documentation supporting the QLE such as a marriage license, birth certificate, or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to make your election changes.

QLE changes are processed through the Benefit Portal within the Paycom system.

What's new this year?

- Touchcare Healthcare concierge and caring advocacy, personal health assistant
- Health insurance carrier is changing from Regence to BRMS /Cigna Network
- Medical Deductibles have changes

2024 HDHP Deductible	2024 PPO PLAN Deductible
$2,500 Ind/$5,000 Family	$4,500 Ind/$9,000 Family
Aggregate Deductible	Embedded Deductible
2025 Cigna HDHP	2025 Cigna PPO Plan
$3,300 Ind/**$6,600** Family	**$3,500** Ind / **$7,000** Family
Embedded Deductible	Embedded Deductible

- Emergency Room copay has changed on 2025 Cigna PPO Plan

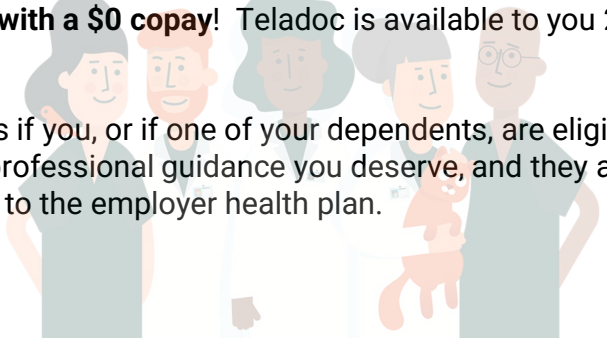
2024 HDHP	2024 PPO PLAN
Deductible then 20%	$100 Copay then Deductible then 20%
2025 Cigna HDHP	2025 Cigna PPO Plan
Deductible then 20%	**$300 Copay** then Deductible then 20%

- Prescription vendor is changing to FairosRx

2024 HDHP & 2024 PPO Plan
Regence BlueCross BlueShield of Oregon: Regence HSA Healthplan 3.0SM
2025 Cigna HDHP & 2025 Cigna PPO Plan
FAIROSRx

- Teladoc Virtual care is a separate benefit offered to you with **$0 copay** regardless of the medical plan you are enrolled. Whether you or an eligible dependent is at work, school, home, or on vacation, if you need a doctor's visit, use **Teladoc with a $0 copay**! Teladoc is available to you 24 hours a day and 7 days per week.

- Medicare Transition Services if you, or if one of your dependents, are eligible for Medicare due to age or a disability, we now have the professional guidance you deserve, and they are here to help you explore your Medicare options compared to the employer health plan.



Healthcare concierge and caring advocacy

Confidential, expert assistance, *at no cost to you*

Who is TouchCare?

TouchCare is your personal health assistant. TouchCare is here to provide free, confidential assistance to help take the stress out of healthcare. Let TouchCare help find in-network doctors, get cost estimates, deal with billing issues and explain your benefits...*all at no cost to you.*

How can I get help?

It's easy to open a case. You can call **866-486-8242**
(M-F, 8 am - 9 pm EST), visit www.touchcare.com and log into our member portal, email assist@touchcare.com, or download our TouchCare app on your mobile device.

You'll need to register with TouchCare:

1. Get Started

Visit www.touchcare.com and click on **member login** or **download our mobile app**. Click 'new member' on the sign-up page.

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**.

Confidential, compassionate support to help you save time, stress, and money.

Stay up-to-date with Touchcare on Instagram. Follow us: @touchcarehealth

1. How can TouchCare help me?

TouchCare is here to help you get the most out of your benefits, which translates to you saving money and using your benefits smarter. As your advocate and expert Health Assistant, TouchCare can assist with:

- Benefits navigation for health insurance & voluntary benefits
- Billing & claims negotiation
- Provider searches & appointment scheduling Cost comparisons
- Procedure preparation assistance RxCare
- and more!

2. How do I schedule a consultation?

After you are registered, you can schedule a visit for a Benefit Refresher or Rx Consult, visit: https://www.touchcare.com/get-scheduled/.

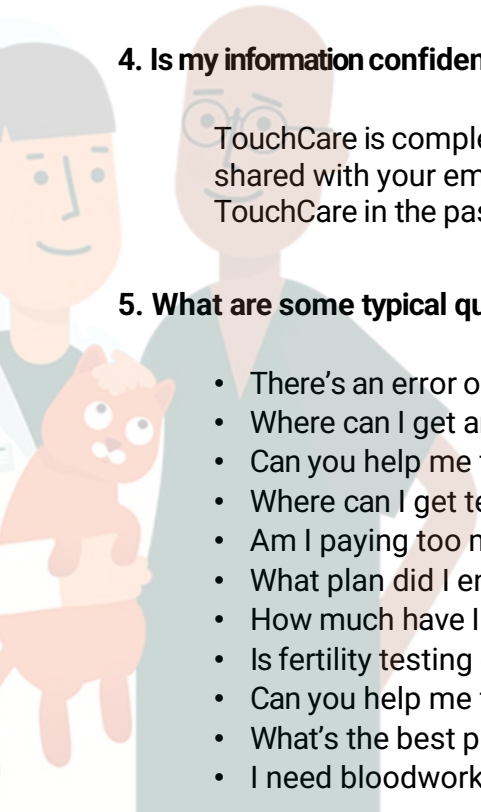
3. How much does TouchCare cost?

TouchCare is completely free for members. In many instances, TouchCare can save money for our members — so it pays you to use TouchCare!

4. Is my information confidential?

TouchCare is completely HIPAA compliant, which means all your information is securely stored and never shared with your employer. TouchCare reports general statistics (like how many employees have used TouchCare in the past year), but TouchCare never shares personally identifiable information.

5. What are some typical questions members ask?



- There's an error on my bill, can you help me fix this?
- Where can I get an MRI?
- Can you help me find an in-network dentist near me? What's an FSA?
- Where can I get tested for COVID-19?
- Am I paying too much for my prescription drugs?
- What plan did I enroll in again?
- How much have I met toward my deductible?
- Is fertility testing covered in my plan?
- Can you help me find an in-network therapist?
- What's the best plan for my family and me?
- I need bloodwork, what's the cheapest option?

6. Can my dependents use TouchCare?

Absolutely! TouchCare is completely free to use for you and your dependents.

My Benefits through BRMS

1. Who is BRMS?
A Third-Party Administrator (TPA) who will be assisting your employer in managing your benefits plan. We provide comprehensive claims administration and customer support for your medical plan through Cigna.
2. When you need support, call TouchCare our healthcare concierge for the following information:

- How to find a provider
- ID Cards
- Claim Status
- Medical and Pharmacy Benefits
- Plan Documents such as SBCs, SPDs, etc
- And much more

3. Who can I contact regarding my claim status and information?

- You can access your claims information by visiting www.myhealthbenefits.com.

4. Who can my doctor/providers contact for information about my plan or to check my eligibility?
Your doctor/providers can contact BRMS for any benefit and plan-related questions through one of two methods•

- Contact Provider Services through the Number listed on your ID card
- Visit brmsprovidergateway.com

MyHealthBenefits.com

New User Registration

With MyHealthBenefits®, you have access to an all-inclusive resource library, current benefit information, digital ID cards, our pricing comparison tool, and much more! Log into myhealthbenefits.com to take advantage of these tools.

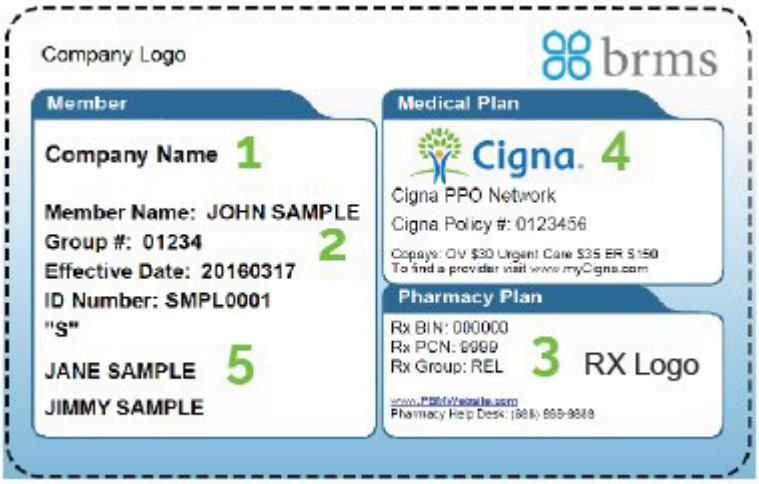
Registering for your new MyHealthBenefits account is required to view and manage your benefits.

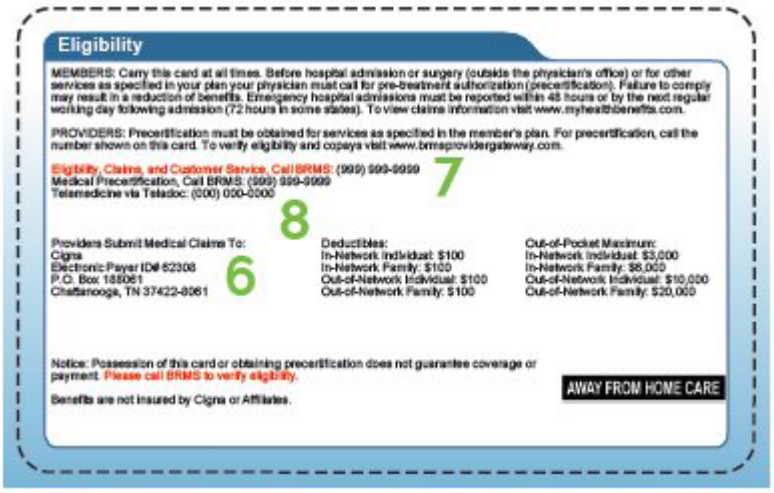
Follow the steps below to complete your registration.

1. In your web browser, enter www.myhealthbenefits.com .
2. You will be directed to the benefits system login page. All users will be required to go through the registration process to create a new username and password.
3. To register for an account, click **Create New Account.**
4. Complete the registration process. You will be required to validate your account with an active email address.
5. Once your email address has been validated, your account will be successfully verified.
6. Click **Log In** to enter your account credentials.
7. Enter your username and password, and the system will prompt you to validate your identity by entering a code. (sent via phone call, text message or email). Note: This second step in the authentication process will be required every time an attempt to access your account is made from a device the system does not recognize.
8. Upon completing the multi-factor verification, you will be taken to your MyHealthBenefits dashboard.

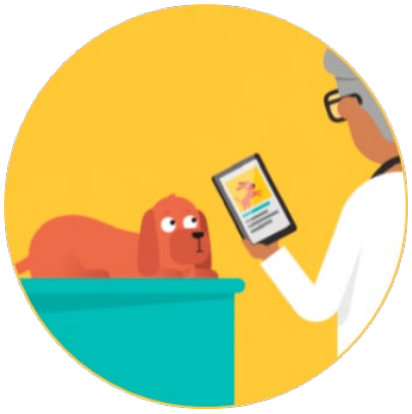
Benefit & Risk Management Services “BRMS”

Understanding Your ID Card





1. Eligibility Information
2. Medical Plan Group Number
3. Pharmacy Information
   - Fairos Rx
4. Coverage/Network
5. Dependents
6. Claims Submission
7. Member Customer Service (TouchCare’s Number)
8. Teladoc

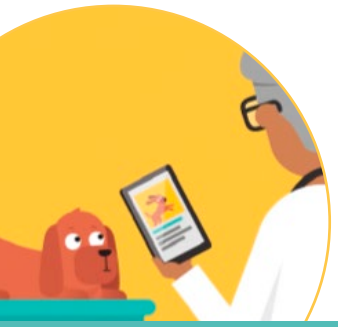


PROVIDER INFORMATION
- Please verify eligibility through www.MyHealthBenefits.com.
- Do NOT verify with Cigna.
- Providers will need to submit all claims to Cigna.
- Do NOT send claims to BRMS.

Medical Plan Summary

WellHaven has partnered with BRMS/Cigna to offer you both a competitive Qualified High Deductible Health Plan (QHDHP) with the coordination of a Health Savings Account (HSA), as well as a Preferred Provider (PPO) Plan.

Both plans allow you the freedom to visit either In-Network or Out-of-Network providers; however, staying within the Cigna network of providers (in-network) will provide you with least out-of-pocket costs.



The following chart outlines highlights of both plans. Please refer to the Summary of Benefits Coverage (SBC), available in Paycom for a full listing of covered services and "Which Plan is Right for Me and My Family?" in this guide.

With an QHDHP, you will need to meet the calendar year deductible before medical and prescription drug benefits begin. Once the deductible is met, you will pay the coinsurance up to the out-of-pocket maximum as outlined below. Use the Health Savings Account (HSA) to pay for these costs.

With the PPO, you will pay a copay for Primary Care, Urgent Care, Specialist, prescription drug benefits, without needing to meet the medical plan deductible.

Plan	Cigna High Deductible Health Plan		Cigna PPO Plan	
Services	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Deductible	$3,300 Individual / $6,600 Family		$3,500 per person / $7,000 Family	
Out-of-Pocket Maximum	$5,000 per person/ $10,000 Family		$6,700 per person / $13,500 Family	
Preventive Care	Covered in full	After Deductible, you pay 40%	Covered in full	After Deductible, you pay 40%
Primary Care Visit	After Deductible, you pay 20%	After Deductible, you pay 40%	$40 Copay	After Deductible, you pay 40%
Specialist Visit	After Deductible, you pay 20%	After Deductible, you pay 40%	$60 Copay	After Deductible, you pay 40%
Diagnostic Lab and X-Ray	After Deductible, you pay 20%	After Deductible, you pay 40%	After Deductible, you pay 20%	After Deductible, you pay 40%
Urgent Care	After Deductible, you pay 20%	After Deductible, you pay 40%	Same as Office Visit	After Deductible, you pay 40%
Emergency Room	After Deductible, you pay 20%	Paid at in-network level	Deducible applies and a $300 copay, after deductible you pay 20%	Paid at in-network level
Inpatient Hospital/Outpatient Hospital	After Deductible, you pay 20%	After Deductible, you pay 40%	After Deductible, you pay 20%	After Deductible, you pay 40%
Chiropractic Care – 12 visit max/year	After Deductible, you pay 20%	After Deductible, you pay 40%	$40 Copay	After Deductible, you pay 40%
Acupuncture – 12 visit max/year	After Deductible, you pay 20%	After Deductible, you pay 40%	$40 Copay	After Deductible, you pay 40%
Prescription Drugs[1] – Retail and Mail Order – Fairos Rx Generic/Pref-Brand/Brand/Specialty	After Deductible, you pay 20%	After Deductible, you pay 20%	$20 Copay / $40 Copay / $60 Copay / 50% up to $300 max Mail Order: 3x Retail Specialty drugs – 30-day supply only	

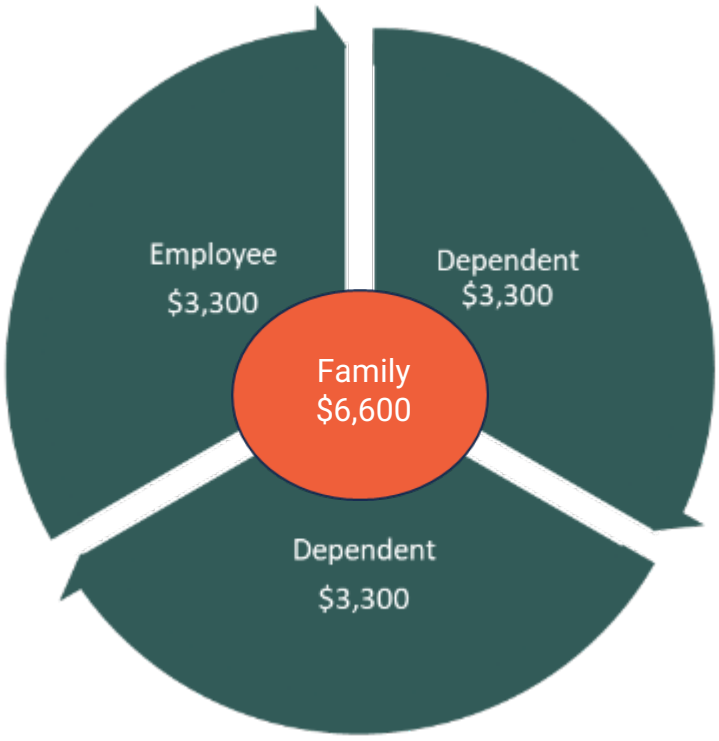
1. Compound drugs covered at 50% coinsurance

*Disclaimer – If you visit an Out-of-Network provider, you are responsible for charges above usual, customary, and reasonable (UCR) limits.

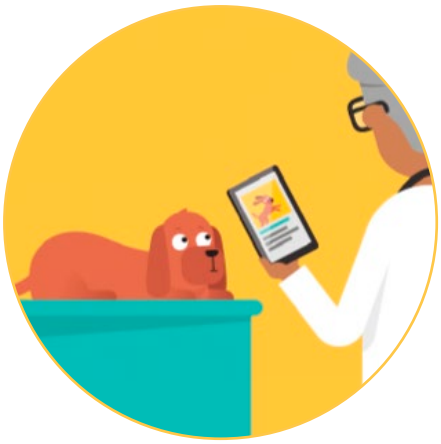
Understanding your Plan Deductible and Out-of-Pocket Maximum.

Embedded Deductible & OOPM

- Each covered family member meets their own individual deductible/OOPM.
- Once any one family member meets the individual deductible, the plan's benefits will begin to pay for that member.
- Other family members will still have to meet their individual deductibles until the family deductible has been meet; if the family deductible has been met by any combination of family members, the plan's benefits will pay for all family members for the rest of the plan year.
- Similarly, once any one family member meets the individual OOPM, the plan will cover 100% of services for that member; once the family OOPM is met by any combination of family members, the plan will cover 100% for all members for the rest of the year.



Cigna QHDHP $3,300/ $6,600



CHOOSING THE RIGHT HEALTHCARE PROVIDER

A trip to the ER can easily cost three times as much as a visit to an urgent care, convenience clinic, and your wait time will likely be considerably longer. Follow the guidelines shown here to help you determine where to go first to get care.

Teladoc	• Diarrhea and constipation • Headaches and migraines • Rash and skin problems • Sore throat and stuffy nose • Sprains and strains • Urinary tract infections • Allergies • Back problems • Bronchitis • Cold and flu symptoms • Ear infections
Doctor's Office	• Annual exams and general health issues • Cold and flu symptoms (e.g., stuffy nose, cough, fever) • Minor aches and pains • Vaccinations
Retail Health Clinic (e.g., Walgreens Health Care Clinic or CVS MinuteClinic)	• Common conditions such as pink eye and strep throat • Minor wounds, abrasions and skin conditions (e.g., rash from poison ivy)
Urgent Care	• Diagnostic X-rays and laboratory tests • Minor broken bones (e.g., fingers, toes) • Minor infections and rashes • Sprains, strains and cuts • Stomach pain
Emergency Room	• Chest pain, shortness of breath and other symptoms of heart attack or stroke • Heavy bleeding • Major broken bones (e.g., arms, legs) • Major lacerations and burns

SAVE MONEY USING IN-NETWORK PROVIDERS

Your insurance company develops networks by contracting with doctors, hospitals, labs and other providers that have agreed to provide health care services to members at negotiated—or discounted—rates. You'll generally pay less out of pocket when you use providers in your plan's network, usually referred to as in-network providers.

Bottom Line: Use in-network providers whenever possible to get the lowest rate. To find in-network providers in your area or to find out whether your current provider is in your plan's network, visit your insurance company's website or TouchCare for support in finding a provider.

WellHaven Pet Health

Preventive Care

No Cost to You!

Did you know that our medical plans cover In-Network preventive care at no cost to you? No deductible, no copays – the plan covers preventive services in full.

Preventive care includes the following:

- Annual checkups for adults, including routine screenings, immunizations and routine gynecological exams
- Routine checkups for children, including routine screenings, assessments, and immunizations
- Breastfeeding support and one new non-Hospital grade breast pump including its accompanying supplies
- Depression screening for all adults, including screening for maternal depression
- Women's contraception – IUD, contraceptive patch and ring, diaphragm, and the Pill (not all brands covered in full)
- Provider counseling and Tobacco cessation medications

Key Definitions

- The deductible is the amount you need to pay before the plan begins to pay benefits.
- Coinsurance is the percentage of the allowable charges that the Plan/you will pay after the deductible is met.
- The out-of-pocket maximum is the maximum amount you will pay for covered services in a given calendar year. Deductibles, copayments, and coinsurance all count toward the out-of-pocket maximum.

Please note! Premiums do not count toward the out-of-pocket maximum.

Please note! Not all brands of medications are covered in full, and limitations do apply. Contact TouchCare for additional details on what is covered under the Plan.

Telehealth

No Cost to You!

Telehealth through Teladoc doctors are available 24/7 for virtual appointments — from diagnosis and treatment to prescriptions, all in one call that you can make any time and from anywhere. Appointments are typically available in less than 15 minutes. No co-payment.

Conditions covered include allergies, back pain, common cold, pink eye, rashes, sore throat, flu/covid assessment and more. **Teladoc** makes it easy to get quality care for every member of your family.

Teladoc board-certified doctors can diagnose and treat non-emergency medical conditions, prescribe medications, and send prescriptions to your pharmacy!

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

Health Savings Account Summary

We understand how important it is to have the freedom to make your own decisions regarding your health care dollars. A Health Savings Account (HSA), combined with the Qualified High Deductible Health Plan (QHDHP), can keep your health care spending choices in your hands. Enrolling in the QHDHP, which is governed by the IRS, may allow you to participate in a Health Savings Account (HSA).

In addition to your individual HSA contributions, WellHaven will contribute $625 for the individual plan / $1,250 for the dependent plan annually to your account.

What is an HSA?

A Health Savings Account (HSA) is a personal health care bank account that you can use to pay out-of-pocket qualified expenses with pre-tax dollars. It is designed to give employees more accountability and control of their health care decisions. An HSA allows you to:

- Be prepared for unexpected health care expenses not accounted for in your personal finances
- Increase tax savings
- Save and "roll over money" if you do not spend it in the calendar year
- Carry it with you. The money in your account is always yours, even if you change health plans or jobs
- Create health care savings for retirement

Benefits of an HSA

There are many benefits of using an HSA, including the following:

- It is portable. The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.
- It is a tax-saver. An HSA provides a triple tax advantage:
  - Your contributions to the HSA are made with pre-tax dollars
  - Funds within the HSA accrue tax-free
  - You can withdraw funds tax-free (if used for eligible medical expenses)

HSA Enrollment at a Glance

Enrolling is easy! Follow these steps to set up your HSA Account.

1. Enroll in WellHaven's Medical Plan (QHDHP)
2. Enroll in WellHaven's HSA through Wex Health Benefits
3. Receive an HSA New Enrollment Packet from Wex Health Benefits
4. Contribute $ to your HSA on a pre-tax basis through payroll deductions
5. Use your HSA debit Card to pay for eligible expenses

Please note! Follow all instructions directed by Wex Health Benefits to finalize your HSA account set up.

HSA Frequently Asked Questions

Who is eligible for an HSA?

In order to qualify to participate in an HSA you must be enrolled in a QHDHP and cannot:

- Be covered under another non-qualified health plan such as your spouse's PPO Plan;
- Be covered by a traditional Flexible Spending Account (FSA) such as your spouse's FSA through his/her/their work;
- Be enrolled in Medicare or Tricare ; if you collect Social Security, you are automatically enrolled in Medicare part A, making you ineligible to contribute to the HSA
- Have received Veterans Administration (VA) services within the past 3 months (care for service-related injury or illness is exempt);
- Be claimed as a dependent on someone else's tax return.

What are eligible qualified expenses?

Expenses for the treatment or prevention of a physical or mental condition. As long as you have a balance in your HSA, you may use the funds to pay or reimburse yourself for:

- Deductibles, copays, and coinsurance
- Eligible prescription fees
- Dental care costs (non-cosmetic)
- Contact lenses and other vision expenses
- Certain over-the-counter pharmacy items

IRS Publication 502 provides a complete list of eligible expenses and can be found at www.irs.gov.

How do I use my HSA dollars?

You use your Wex Health Benefits (HSA) debit card for eligible purchases and to pay doctor/hospital bills online. If you pay for a service with a different credit card, cash, or check, you can still get reimbursed through your HSA.

What if I use my HSA dollars for an ineligible expense?

If you are under the age of 65, you will be subject to applicable taxes and an excise tax penalty of 20% - please consult Wex Health Benefits to complete a mistaken contribution form before April 15th to avoid penalties and taxes.

Can I use my HSA dollars to pay for expenses incurred by my domestic partner?

Yes, but only if you claim your domestic partner as a federal tax dependent when you file your taxes.

What happens to my HSA if I leave WellHaven? Or if I retire?

The HSA is always yours to keep, including the company's $625 / $1,250 annual contribution. If you retire, an HSA is a great retirement savings account. The HSA dollars you save for retirement will help you continue to pay medical expenses well into your retirement. After age 65, you can use these dollars for reasons other than paying medical expense. You will be required to pay the monthly administration fee.

I have enrolled in WellHaven's QHDHP for myself only. Can I use my WellHaven HSA to pay for medical costs incurred by my family members not enrolled in the QHDHP?

Yes, you can use your HSA for eligible expenses incurred by your legal spouse and tax dependents, whether they are enrolled on your Medical Plan through WellHaven.

Do I need to keep my receipts for HSA qualified expenses?

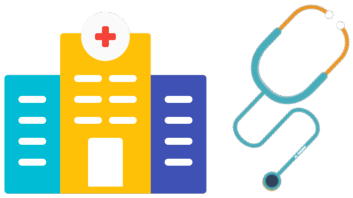
Yes, keep your HSA receipts for each year with your income tax return. Speak with a tax advisor before purging records.

Health Savings Account Contributions

For 2025 WellHaven will contribute $625 towards your HSA account for Employee-Only coverage and $1,250 if you elect dependent coverage, to offset the annual deductible limit.

Contribute to your HSA and take advantage of:

- Pre-tax contributions
- Tax free payment of qualified medical expenses
- Tax free earnings
- HSA account growth as funds rollover year-to-year



The following chart outlines current contribution amount annual limits. This may change year to year.

Please note! You can change/start/stop your contribution amount at any time throughout the year, provided you do not exceed the annual maximum.

The 2025 HSA maximum employee contribution amount is $4,300 for individual coverage and $8,550 for family coverage, this includes the employer contributions. Additionally, if you are 55+ years of age, you can make an additional "catch-up" contribution of $1,000.

2025 WellHaven Medical Plan Enrollment	2025 HSA Plan Enrollment Eligibility	2025 HSA Maximum Contribution Limit	2025 WellHaven HSA Contribution	2025 Total Employee Contribution Limit–Annual	2025 Total Employee Contribution Limit–Per Pay Period
Employee Only	Individual < Age 55	$4,300	$625	$3,675	**$153.13**
	Individual > Age 55	$5,300	$625	$4,675	**$194.79**
Employee + Spouse/ DP	Family < Age 55	$8,550	$1,250	$7,300	**$304.17**
	Family > Age 55	$9,550	$1,250	$8,300	**$345.83**
Employee + Child(ren)	Family < Age 55	$8,550	$1,250	$7,300	**$304.17**
	Family > Age 55	$9,550	$1,250	$8,300	**$345.83**
Employee + Family	Family < Age 55	$8,550	$1,250	$7,300	**$304.17**
	Family > Age 55	**$9,550**	**$1,250**	**$8,300**	**$345.83**

Flexible Spending Accounts (FSAs)

An FSA allows you to set aside money before it is taxed and use it to pay for **eligible medical, dental, and vision expenses**, plus there is a dependent care account to help pay for **daycare expenses**.

- You choose how much to contribute based on your personal needs – up to the maximum annual allotment
- It's like getting a 25%-40% discount since all qualified expenses are paid for on a pre-tax basis!

Health Care FSA - you are not required to be enrolled in the WellHaven medical plan to participate.

Dependent Care FSA – eligible dependents include:

- Child(ren) up to age 12
- Disabled Dependent or Spouse
- Elder Care – tax dependent

The following chart outlines the types of FSAs, current contribution maximums, and rollover rules.

See the Wex website for a full list of eligible expenses.

Locked-in – your annual contribution election is "locked in" for the year = you cannot make changes, except for qualifying life events (QLEs).

When are FSA funds available?

Limited Purpose & General Purpose Health Care FSA funds are available on the first day of the Plan year.

- Plan Year for 2025 = 1/1/2025–12/31/2025

Dependent Care FSA funds are available once your payroll contribution(s) has been deposited into your FSA account.

Medical Insurance Enrollment	WellHaven Regence Plan	Medical Plan Outside of WellHaven	Eligible Health Care FSA	Type of Health Care Eligible Expenses	Maximum Employee Contribution in 2025	Last Day to Incur Expenses	Last Day to Submit Expenses	FSA Balance on 3/31/2025	Rollover Balance 1st Day to Use $ in 2026
QHDHP	✓	✓	**Limited Purpose**	• Dental • Vision	$3,200	12/31/2025	3/31/2026	• Up to $640 can rollover to 2026 • Balances over $640 are Forfeited by Employee	4/1/2026
PPO	✓	✓	**General Purpose**	• Dental • Vision • Medical	$3,200	12/31/2025	3/31/2026	• Up to $640 can rollover to 2026 • Balances over $640 are Forfeited by Employee	4/1/2026
			Eligible FSA						
N/A	N/A	N/A	**Dependent Care**	N/A	$5,000	12/31/2025	3/31/2026	• Balances of any amount are forfeited by Employee	N/A

Which Medical Plan is Right for Me and My Family?

Scenario: Employee only enrolled

LOW USAGE SCENARIO

Summary usage of this employee:

- Received their annual preventive exam
- Had a sickness/injury that required two trips to urgent care

Summary of Examples	Actual Cost	QHDHP	PPO (Most Savings)
Preventive Exam	$120	$0	$0
Urgent Care Visit (2)	$250	$250	$80
Specialist Visit	$160	$160	$60
Total Plan Cost	**$530**	**$410**	**$140**
Employer HSA Contributions	n/a	(-$625)	$0
Employee Annual Premiums	n/a	$2,292	$1,566
Total Cost	**$530**	**$2,077**	**$1,706**
Employee HSA tax savings assuming $3,525 Contribution*	n/a	$881	n/a
Employee FSA tax savings assuming $3,050 Contribution*	n/a	n/a	$763

Scenario: Employee enrolled with spouse

MEDIUM USAGE SCENARIO

Summary usage of this employee and spouse:

- They each had their preventive exam (2)
- Two specialist visits total (one each)
- A CT Scan (Employee)
- A healthy pregnancy with no complications (spouse)
- Tier 1 medication (12 fills – employee)

Summary of Examples	Actual Cost	QHDHP (Most Savings)	PPO
Preventive Exam (2)	$240	$0	$0
Specialist Visit (2)	$320	$320	$120
CT Scan	$1,200	$1,200	$1,200
Pregnancy	$12,000	$4,840	$6,000
Tier 1 Rx (12 Fills)	$336	$336	$240
Total Plan Cost	**$14,096**	**$6,696**	**$7,560**
Employer HSA Contributions	n/a	(-$1,250)	$0
Employee Annual Premiums	n/a	$6,509	$5,473
Total Cost	**$14,096**	**$11,955**	**$13,033**
Employee HSA tax savings assuming $7,050 Contribution*	**n/a**	**$1,763**	**n/a**
Employee FSA tax savings assuming $3,050 Contribution*	**n/a**	**n/a**	**$763**

Scenario: Employee enrolled with family

HIGH USAGE SCENARIO

Summary usage of this family:

- They each had their preventive exam (4)
- Four primary care visits total
- Lab work (1 each)
- A visit to the ER (2)
- Tier 3 medications (12 fills)

Summary of Examples	Actual Cost	QHDHP (Most Savings)	PPO
Preventive Exam (4)	$480	$0	$0
Primary Care Visit (10)	$1,250	$1,250	$400
Specialist Visit (4)	$640	$640	$240
Lab Work	$300	$300	$300
ER Visit (2)	$4,400	$3,128	$4,600
Tier 3 Rx (12 Fills)	$1,200	$240	$720
Total Plan Cost	**$8,270**	**$5,558**	**$6,260**
Employer HSA Contributions	$0	(-$1,250)	$0
Employee Annual Premiums	n/a	$10,628	$9,625
Total Cost	**$8,270**	**$14,936**	**$15,885**
Employee HSA tax savings assuming $7,050 Contribution*	n/a	$1,763	n/a
Employee FSA tax savings assuming $3,050 Contribution*	n/a	n/a	$763

Please note! Total QHDHP costs do NOT take into consideration employee contributions to their HSA accounts. Actual costs are estimates for the specified services, costs may vary depending on doctor, office, and hospital.

**Assumes a 25% tax bracket*

Dental Plan Summary

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays. Several studies suggest that oral diseases, such as periodontitis (gum disease), can affect other areas of your body—including your heart. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery.

WellHaven has partnered with MetLife to bring you two Dental PPO Plans. Both Dental PPO plans allow you the freedom to see a dentist of your choice or access the PPO network of dentists. If you use a dentist participating in the PPO network, your out-of-pocket expenses will be reduced, as fees are subject to a negotiated rate. If you use a non-network provider, you are responsible to pay the difference in cost between the non-network provider's charges and the allowed amount.

Please note! You can use your HSA and FSA dollars to pay for qualified dental costs including orthodontia.

Plan	Buy Up Plan		Base Plan	
Services	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$50 Individual / $150 Family		$75 Individual / $225 Family	
Annual Benefit Maximum	$1,500 Per Person		$1,000 Per Person	
Preventive Care	Deductible Waived Paid at 100%	Deductible Waived Paid at 100% of allowed amount	Deductible Waived Paid at 100%	Deductible Waived Paid at 100% of allowed amount
Exams				
X-Rays				
Cleanings				
Basic Restorative	After Deductible, you pay 20%	After Deductible, you pay 20% of allowed amount	After Deductible, you pay 20%	After Deductible, you pay 20% of allowed amount
Major Restorative	After Deductible, you pay 50%	After Deductible, you pay 50% of allowed amount	After Deductible, you pay 50%	After Deductible, you pay 50% of allowed amount
Orthodontia (Children and Adults)	You pay 50%, deductible does not apply	You pay 50% of allowed amount, deductible does not apply	Not Covered	
	Up to $1,000 lifetime maximum benefit	Up to $1,000 lifetime maximum benefit		

Which Dental Plan is Right for Me and My Family?

Scenario: Employee only enrolled

LOW USAGE SCENARIO	Recommended Option
Summary usage of this employee: • Received their annual cleaning Employee does NOT have a need for orthodontia coverage.	**Base Plan** – the employee does not have a need for additional dental services or orthodontia coverage and therefore, should consider paying the lower premium for the Base Plan.

Scenario: Employee enrolled with family

HIGH USAGE SCENARIO	Recommended Option
Summary usage of this family: • Received their annual cleanings • Has a child utilizing orthodontia coverage • Has a need for fillings	**Buy Up Plan** – the employee and his/her/their family have a need for additional dental services and orthodontia coverage and therefore, should consider paying the higher premium for the Buy Up Plan.

Vision Plan Summary

Driving to work, reading a news article and watching TV are all activities you perform every day. Your ability to do these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems. The WellHaven Vision Plan is offered through Vision Service Plan (VSP).

WellHaven's vision plan entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures, and provides specified dollar amount or discounts for the purchase of eyeglasses and contact lenses. See the chart below for a brief summary of these benefits. Please refer to the Summary of Benefits, available in Paycom Self Service, for a full listing of covered services.

The Vision Plan provides you with the freedom to see an eye doctor of your choice or access the VSP vision network of providers. If you use a provider participating in the network, your out-of-pocket expenses will be reduced. If you use a non-network provider, in-network benefits and discounts will not apply and benefits will be paid according to a set benefit reimbursement schedule.

Please note! Look to using your HSA or FSA dollars to pay for qualified vision costs including purchasing glasses, contacts, and even contact lens solution.

Services	In-Network	Out-of-Network
Exams	$10 Copay, then covered in full	$10 Copay, then covered up to $45
Hardware (Materials) Copay	$25 Copay	$25 Copay
Lenses		
Single Vision	Covered in full after Copay	After Copay, covered up to $30
Lined Bifocal	Covered in full after Copay	After Copay, covered up to $50
Lined Trifocal	Covered in full after Copay	After Copay, covered up to $65
Lenticular	Covered in full after Copay	After Copay, covered up to $100
Progressive	$0 to $175 Copay	After Copay, covered up to $50
Frames	After Copay, covered up to $130	After Copay, covered up to $70
Contact Lenses		
Elective	Covered up to $130	Covered up to $105
Medically Necessary	Covered in full	Covered up to $210
Fit & Follow-Up	Up to $60 Copay	Not covered
Coverage Frequency		
Exams	Covered every 12 months	
Lenses	Covered every 12 months	
Frames	Covered every 24 months	

Life and AD&D Insurance

Basic Life and Accidental Death & Dismemberment (AD&D) Insurance: Life insurance can help provide for your loved ones if something were to happen to you. WellHaven provides benefit eligible employees with $25,000 in Basic Life and AD&D insurance through MetLife. There is no charge to you for this benefit.

Voluntary Supplemental Life and Accidental Death & Dismemberment (AD&D) Insurance: While WellHaven provides you with Basic Life and AD&D insurance, some employees may want to purchase additional coverage. Through MetLife, you have the option of purchasing additional coverage at attractive rates and the convenience of payroll deductions.

You can purchase coverage for yourself, and your dependents. Your cost is based on your insurance age and amount of coverage you select. Age-related cost adjustments will occur on January 1 of each year. You must elect coverage for yourself first, in order to enroll your spouse/domestic partner or child(ren). Spouse/Domestic Partner premium is based on the employee's age. Below is a summary of the coverage you can purchase.

Please note: you can elect to increase your employee coverage $5,000 each year during open enrollment without submitting evidence of insurability (as long as you are not already over the maximum benefit).

Please note! When initially eligible, you are eligible to receive up to the guaranteed issue without submitting any Evidence of Insurability (EOI) or proof of good health, as long as you enroll within 31 days of your initial eligibility date. Any life insurance coverage over the Guarantee Issue Amount(s) will be subject to EOI (insurance underwriting approval). It is your responsibility to complete and submit the required EOI forms, to obtain the amount in excess of the guaranteed issue amount, within 31 days of the date you apply for coverage. If you choose not to participate at the time you are initially eligible and elect to enroll at a later time, you may be required to go through the EOI process for coverage, regardless of amount.

Coverage	Benefit Amounts	Guaranteed Issue Amount
Employee	Increments of $5,000 with a minimum of $10,000, up to the lesser of 5x annual earnings or $300,000	**$100,000**
Spouse or Domestic Partner	Increments of $5,000, up to the lesser of $100,000 or 50% of the employee's supplemental life insurance amount	**$25,000**
Child(ren)	15 days to 6 months: Flat $1,000 Over age 6 months: Flat amount: $1,000, $2,000, $4,000, $5,000, or $10,000	**$10,000**

Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental life insurance. If you purchase supplemental life insurance, you will receive an equal amount of AD&D coverage. AD&D pays an additional benefit if you die as the result of an accident, as well as a benefit payable if you survive but lose a limb or your eyesight as the result of an accident.

Disability Insurance - Voluntary

In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. This coverage is provided through MetLife and paid by the employee. Disability benefits must be approved by a physician and the disability provider.

Short-Term Disability: Short-Term Disability (STD) is an employee paid benefit that provides partial income protection if you are unable to work due to an illness or injury. Your benefit covers a portion of your weekly salary up to 12 weeks.

Long-Term Disability: Long-Term Disability (LTD) is an employee paid benefit that provides partial income protection if you are unable to work for more than 90 days. The benefit provides you with 60% of your monthly earnings during your approved disability period on a tax-free basis, up to a maximum of $15,000/$8,000 per month.

	Short-Term Disability
Eligibility	All active full-time employees working at least 30 hours per week
Benefits Begin	On 8th Day - Elimination Period
Benefit Duration	12 Weeks – including Elimination Period
Weekly Benefit %	60% of Avg. Weekly Salary
Maximum Weekly Benefit	$1,500

	Long-Term Disability
Eligibility	All active full-time employees working at least 30 hours per week
Benefits Begin	90 Day Elimination Period
Monthly Benefit %	60% of Avg. Basic Monthly Earnings
Maximum Monthly Benefit	$15,000 – DVM/Sr. Leadership $8,000 – all other

*DVM own occupation until age 65

Short and Long Term Disability Premium Calculations

Short Term Disability	Long Term Disability
60% of Avg. Weekly Salary	60% of Avg. Basic Monthly Earnings
$1,500 Max Avg. Weekly Benefit	$8,000 Max Avg. Monthly Benefit

STD Calculation

Hourly Rate	x Hours Per Week	= Weekly Payroll	x %	= Benefit	x Rate	Sub-Total	/10 = Monthly Premium	/2 = Per Pay Period
$15.00	40.00	$600.00	.60	$360.00	0.607	$168.120	$16.18	$8.41

LTD Calculation

Hourly Rate	x Hours Per Week	= Weekly Payroll	x 52 Weeks	Monthly Payroll	x Rate	Sub-Total	/100 = Monthly Premium	/2 = Per Pay Period
$15.00	40.00	$600.00	$31,200	$2,600	0.633	$1,645.800	$16.46	$8.23

Things To Consider

- If your state provides a Paid Leave Program, you may want to reach out to MetLife to discuss how the State Program and this employer-sponsored STD Program would coordinate benefits.
- If you are expecting a long-term loss of income, purchasing the WellHaven sponsored LTD Plan may be appropriate.
- If you are expecting a short-term loss income (i.e. pregnancy), purchasing the WellHaven sponsored STD Plan may be appropriate.

Please note! When initially eligible, you are eligible to enroll in disability coverage without submitting any Evidence of Insurability (EOI) or proof of good health, as long as you enroll within 31 days of your initial eligibility date. Any disability coverage elected outside of your initial eligibility date will be subject to EOI (insurance underwriting approval). It is the employee's responsibility to complete and submit the required EOI forms, to obtain the coverage, within 31 days of the date you apply for coverage. If you choose not to participate at the time you are initially eligible and elect to enroll at a later time, you will be required to go through the EOI process for coverage.

Voluntary Critical Illness

Severe illnesses often have out-of-pocket expenses that medical insurance doesn't cover. This coverage pays you a lump sum if you are diagnosed with a covered condition. It can help you worry less about expenses so you can focus on your recovery.

- Employees can choose $15,000 or $30,000 in coverage to cover conditions including Heart Attack, Cancer, End State Renal Failure, Paralysis, loss of vision and many others
- Spouses/Domestic partners/dependent children will be offered 50% of the employee amount
- Pre-Existing Condition Limitation not included. Benefits payable for a covered condition, so long as it occurs on or after the coverage effective date, even if it results from a pre-existing condition. "Pre-existing condition" refers to a sickness or injury for which medical advice or care was sought prior to the coverage effective date.

Age	EE Only	EE+SP	EE+ Children	EE+ Family
18-24	$0.140	$0.225	$0.250	$0.335
25-29	$0.170	$0.270	$0.280	$0.380
30-34	$0.220	$0.345	$0.330	$0.455
35-39	$0.285	$0.440	$0.395	$0.550
40-44	$0.405	$0.615	$0.515	$0.725
45-49	$0.580	$0.885	$0.690	$1.000
50-54	$0.810	$1.280	$0.920	$1.390
55-59	$1.100	$1.785	$1.210	$1.900
60-64	$1.635	$2.640	$1.750	$2.755
65-69	$2.305	$3.815	$2.415	$3.925
70-74	$3.505	$5.560	$3.615	$5.670
75-84	$4.905	$7.655	$5.015	$7.765

- Rates are per $1,000 of coverage per pay period
- Spouse/domestic partner/dependent children rates based on the employee age
- **Rate Example:**
- Family purchases $30,000 of coverage and EE is age 30
- $30,000*0.455/1,000 = $13.65 semi-monthly

Voluntary Hospital Indemnity

A hospital stay or medical procedure can cost thousands of dollars. You can use this coverage to help pay for the out-of-pocket expenses medical insurance doesn't cover, such as co-insurance, co-pays and deductibles.

Employees can choose between a low or high option depending on the level of coverage you would like

Benefit	High Plan	Low Plan
First Day Hospital Admission - 4 times per year	$1,000	$500
Hospital Confinement - Daily Benefit up to 15 days	$200	$100
Annual Max	$4,000	$2,000

Per Paycheck Rates

Tier	High Plan	Low Plan
EE	$11.51	$5.76
EE + Spouse	$19.13	$9.56
EE + Children	$17.04	$8.52
EE + Family	$24.65	$12.33

- If a covered person is readmitted within 180 days for the same or related sickness/injury for which MetLife paid an Admission Benefit, an additional Admission Benefit is not payable.

NOTES:

- *These benefits are paid through payroll deduction on a post-tax basis. You may also cancel these benefits at any time as they do not require a Qualifying Event*
- Proof of Good Health - Critical Illness benefit does not require medical questioning for any amounts; all elected coverage is guaranteed. Additionally, Hospital Indemnity pay out based on a schedule of events / services.
- The above illustration is intended as a brief overview of benefits. Benefit maximums, plan provisions and State mandates may apply.

MetLife Value Add Benefits

Will Preparation

With Will Preparation, you can have a Will prepared, easily and economically. If you're enrolled in **MetLife's Supplemental Life Insurance** coverage, you and your spouse may take advantage of Will Preparation Services.

Services are offered through MetLife Legal Plans*, a MetLife company and include:

- Access to attorneys who participate in MetLife Legal Plans' network for preparing for updating Wills, Living Wills and Powers of Attorney.
- Employees may use a non-participating attorney and receive reimbursement for covered services according to a set fee schedule. You will be responsible for any of the attorney fees that exceed the reimbursed amount if you choose the out-of-network option.

* Will Preparation is offered by MetLife Legal Plans, Inc., Cleveland, Ohio. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company and Affiliates, Warwick, Rhode Island. For New York sitused cases, the Will Preparation service is an expanded offering that includes office consultations and telephone advice for certain other legal matters beyond Will Preparation. Tax Planning and preparation of Living Trusts are not covered by the Will Preparation Service.

People procrastinate for many reasons, but thanks to the Will Preparation service, you can prepare or update your important documents easily and economically. And, you'll add to your peace of mind knowing that you're helping to protect your family's financial future.

Estate Resolution Services

If you are enrolled in MetLife's Voluntary Supplemental Life and AD&D Plan you have access to Estate Resolution services that fully covers attorney's fees by a Network Attorney to settle an estate. You will receive:

- Unlimited in-person or telephone consultations with an attorney to discuss matters or general questions relating to probating an estate.
- Preparation of estate documents.
- Preparation of correspondence needed to transfer non-probate assets, as well as associated tax filing.

Employee Assistance Program (EAP)

We all need help every now and then. Problems are just a part of everyday life. In addition to the benefits outlined in this Guide, WellHaven also provides you access to an Employee Assistance Program (EAP) through LifeWorks US Inc., under an agreement with MetLife.

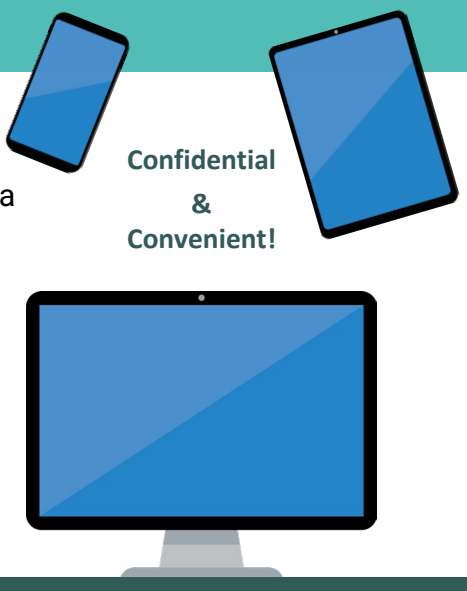
As a **benefit-eligible employee**, you are automatically enrolled in this Program and this benefit is provided at no cost to you.

What can the EAP help me with?

The EAP offers confidential support to help you with life's challenges and locate resources and services. A simple phone call connects you with a team of experienced professionals ready to assist you with a wide range of personal, family, and work issues including:

- Family: Caring for an elderly family member, returning to work after having a baby, going through a divorce
- Work: Job relocation, building relationships with co-workers and managers, navigating through reorganization
- Money: Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues
- Legal Services: Issues relating to civil, personal and family law, financial matters, real estate and estate planning
- Identity Theft Recovery: ID theft prevention tips and help from a financial counselor if you are victimized
- Health: Coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking
- Everyday Life: Moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, training a new pet

How does it work?



The EAP is **confidential** and available to you and your household 24 hours a day, 7 days a week. You and your household are entitled to up to 5 consultations per issue, per individual, per calendar year. You choose between face-to-face sessions or convenient and easy telephonic consultations. The program also offers easy to use educational tools and resources, online and through a mobile app. There's a chat feature so you can talk with a consultant to guide you or help you schedule an appointment with a counselor.

Introducing Student Loan Refinancing

- We have partnered with Peanut Butter to help our employees tackle student debt.
- Our student loan assistance program includes:
  - Curated advice and insights to help you restructure you loans and save money
  - Access to refinancing marketplace designed to get you the best terms possible
  - Free counseling services
- Student loan refinancing options
  - $200 rebate put towards student loan

Paid Time Off (PTO)

WellHaven offers a generous PTO program designed to support your wellbeing, and the flexibility to use time accrued to meet your needs.

PTO includes the following:

- Sick Pay
- Vacation Time Off
- Personal Time Off

PTO Eligibility

- Employees classified as Full Time (working 30+ hours per week)
- Eligible employees will accrue PTO starting on the first day of hire or status change
- PTO is available for use after ninety (90) days of hire or status change
- Prior acquisition seniority counts

Employee Classification	PTO Accrual Per Pay Period	Annual PTO Accrual	Maximum PTO Accrual CAP	Annual PTO Maximum Carryover
Salaried Exempt *Includes: Doctors, Hospital leadership, and certain Campus positions*	5.00 hours	120.00 hours	160.00 hours	Full amount accrued
Hourly Non-Exempt (<3 yos) *Includes: Hospital para staff and certain Campus positions*	3.33 hours	80.00 hours	120.00 hours	Full amount accrued
Hourly Non-Exempt (3+ yos) *Includes: Hospital para staff and certain Campus positions*	3.50 hours	84.00 hours	124.00 hours	Full amount accrued

Paid Holidays

WellHaven recognizes the following **seven (7) annual Holidays**:

- New Year's Day
- Memorial Day
- 4th of July
- Labor Day
- Thanksgiving Day
- Christmas Day
- Personal Floating Holiday

Paid Holiday Eligibility

- Employees classified as Full Time (working 30+ hours per week)
- Eligible employees will be eligible for Holiday Pay on the first day of hire or status change

Paid Holiday Benefit

- Paid Holidays are an 8.00-hour benefit for all eligible employees

Working on a Company-Recognized Holiday

- Employees working on a Company-recognized Holiday will be paid for the hours worked as well as the 8.00 hours of Holiday

Maternity/Paternity/Adoption/Foster Paid Leave (MPAFL)

MPAFL entitles eligible employees to receive 2 weeks of paid Leave.

- Full-Time Classified Employees receive 80.00 hours paid at regular base rate.*
- Part-Time Classified Employees receive an average (based on working hours) of 2 weeks paid at regular base rate.*

* Note for Doctors: MPAFL based on base rate + production over 6-month lookback.

Bereavement Leave

Full-Time Classified Employees that have been with WellHaven for at least six (6) months are eligible to receive Bereavement leave.

Bereavement Leave may be taken for immediate family members:

- Spouse
- Domestic Partner
- First Line Relatives – including those directly related to employee or Spouse/Domestic Partner
    - Parents – step/half/adopted/legal guardians
    - Siblings – step/half/adopted
    - Children – step/half/adopted
    - Grandparents – step/half/adopted
    - Grandchildren -step/half/adopted

Taken at the time of death for:

- Making funeral arrangements
- Attending the funeral and burial
- Paying respects to the family at a wake or memorial

Paid Benefit

- Three (3) days = 24 hours
- Paid at the employee's current base rate

Unpaid Benefit

- Additional two (2) days

Professional License

Professional License Eligibility

The following employees are eligible to receive reimbursement for Professional License renewal costs:

- Employees classified as Full Time and working in an eligible position *
- Employees classified as Part Time, working 20+ hours per week and in an eligible position *

Employees are eligible upon hire.

* Eligible positions are outlined in the table below.

Professional License Renewal Benefit by Position

Position	DVM License	DVM DEA License	Renewal Cycle
DVM *(DEA and DVM License)* (Full Time: 30+ hours per week)	Yes	TBD, as needed	Per regulatory body renewal cycle
DVM *(DEA and DVM License)* (Part time: 20-29.99 hours per week)	Yes	TBD, as needed	Per regulatory body renewal cycle

Position	CVT/LVT/RVT License	Renewal Cycle
CVT/LVT/RVT (Full Time: 30+ hours per week)	Yes	Per regulatory body renewal cycle
CVT/LVT/RVT (Part time: 20-29.99 hours per week)	Yes	Per regulatory body renewal cycle
Practice Manager with CVT/LVT/RVT (Full Time: 30+ hours per week)	Yes	Per regulatory body renewal cycle
Practice Manager with CVT/LVT/RVT (Part time: 20-29.99 hours per week)	Yes	Per regulatory body renewal cycle

Other license/certifications may apply. Please see your Practice Manager for details.

Professional Liability Insurance

WellHaven will carry and pay the premiums on professional liability insurance (DVM).

Continuing Education (CE)

Continuing Education (CE) Eligibility

The following employees are eligible to participate in the Continuing Education Program:

- Employees classified as Full Time and working in an eligible position *
- Employees classified as Part Time, working 20+ hours per week and in an eligible position *

Employees are eligible upon hire.

If an employee has submitted their notice of resignation, they are no longer eligible to use CE hours or make CE – related purchases.

* Eligible positions are outlined in the table below.

CE Benefit by Position

Eligible Position	Annual Maximum Reimbursement for CE Tuition/Costs	Annual Maximum Paid Hours (aka. Paid Time) for attending CE Events
DVM (Full Time: 30+ hours per week)	$1,500.00	24 hours
DVM (Part time: 20-29.99 hours per week)	$750.00	16 hours
Practice Manager – Credentialed CVT/LVT/RVT (Full Time)	$750.00	16 hours
Practice Manager – Non-Credentialed (Full Time)	$500.00	16 hours
CVT/LVT/RVT (Full Time)	$500.00	16 hours
Veterinary Assistant or Non-Credentialed Technician (Full Time)	$125.00	8 hours

Those eligible for CE benefits have the option to combine two years' benefit (current year + following year) to use in the same calendar year:

- To attend a CE conference, etc.

DVM – CE may be used for:

- AVMA Annual Membership Dues
- One Local or State Veterinary Annual Membership
- Continuing Education Classes
- Any Expenses Related to Traveling to/from CE Classes

Wellness Plans

Eligible employees may receive a maximum of two (2) wellness plans at any given time period.

- Plans are for your personal pet(s).
- Employees enrolled in a plan receive 20% off services and products not covered under the plan.

Note: For pet food, employees are also eligible for a 50% discount through the Hill's VIP Market program when ordering through their hospital account.

Wellness Plan Benefit Eligibility

- Employee is working for a hospital that uses the eVet system and the hospital offers wellness plans.
- Employees must select from the currently available plans at their hospital.
- Employees are eligible on the first of the month following thirty (30) days of employment.
- Employees classified as Full Time (working 30+ hours per week) are eligible for up to two (2) plans.
- Employees classified as Part Time (regularly scheduled, not temp or per diem) are eligible for one (1) plan.
- Wellness Plans will expire on the last day of employment with WellHaven.

Scrubs & WellHaven Branded Clothing

Scrubs and Clothing Eligibility and Benefit:

- **Hospital-based employees that are both Full Time and Part Time are eligible for an annual scrubs/clothing allowance.**

Allotment Amount:

- Para Full-Time Allotment - $120
- Para Part-Time Allotment - $60
- Doctor Full Time Allotment - $170
- Doctor Part Time Allotment - $110

New Hires: The allotted amount will be added to the paycheck following 60 days of employment.
Annual allotment: The amount will be included in the January 25th paycheck for that year's scrub purchases.

Usage: The scrub allotment is a taxable benefit and is included in the employee's paychecks to make scrub purchases for the calendar year. Please adhere to your hospital's uniform guidelines when purchasing your scrubs.

Additional Employee Discounts

Hill’s VIP Market Program

- Employees are eligible for a 50% discount on pet food when ordering through their hospital account via the Hill's VIP Market program.
- Food can be shipped directly to your home.

IDEXX Lab Reference Discounts

- Eligible staff receive a courtesy discount through the IDEXX US program, applicable to doctors and staff IDEXX Discount

Elanco Flea, Tick, and Heartworm Preventatives

- Your hospital leaders will partner with local Elanco representatives to schedule bi-annual lunch and learns. Elanco provides free heartworm and flea/tick prevention for up to two (2) pets.

Benefits Premium Cost

Medical Plan PER PAYCHECK Pre-Tax Contributions

Coverage Level	Cigna QHDHP $3,300	Cigna PPO $3,500
Employee Only	$ 84.81	$ 88.81
Employee + Spouse	$ 271.87	$ 228.62
Employee Only + Child(ren)	$ 212.33	$ 178.56
Employee + Family (Spouse + Children)	$ 443.92	$ 402.01

Dental Plan PER PAYCHECK Pre-Tax Contributions

Coverage Level	Buy Up Plan	Base Plan
Employee Only	$ 11.26	$ 8.18
Employee + Spouse	$ 22.08	$ 16.05
Employee Only + Child(ren)	$ 24.84	$ 18.05
Employee + Family (Spouse + Children)	$ 38.18	$ 27.74

Vision Plan PER PAYCHECK Pre-Tax Contributions

Coverage Level	Employee Pays
Employee Only	$ .48
Employee + Spouse	$ 1.19
Employee Only + Child(ren)	$ 1.23
Employee + Family (Spouse + Children)	$ 2.42

Please note! Premiums are automatically deducted from your paycheck on a pre-tax basis per our Pre-Tax Section 125 Premium Only Plan. Refer to Human Resources if you have questions.

*DOMESTIC PARTNER PREMIUMS – Domestic Partner (who does not qualify as a dependent of the employee, under Section 152 of the Internal Revenue Code) premiums will be paid post-tax. Employer contributions made on behalf of a domestic partner will be considered imputed income and taxed accordingly.

Benefits Premium Cost

Supplemental Life Insurance and AD&D

MONTHLY Post-Tax Rates per $1,000 of Benefit

Age Band	Rate - Employee	Rate – Spouse*
Under 25	$0.112	$0.112
25 - 29	$0.112	$0.112
30 - 34	$0.122	$0.122
35 - 39	$0.151	$0.151
40 - 44	$0.201	$0.201
45 - 49	$0.289	$0.289
50 - 54	$0.433	$0.433
55 - 59	$0.656	$0.656
60 - 64	$0.903	$0.903
65 - 69	$1.435	$1.435
70+	$2.808	$2.808

***Spouse rates based on employee's age.**

Child Rate – Monthly per $1,000 Benefit

Coverage Level	Employee Pays
All Ages (up to 26)	$0.290

Benefits Premium Cost

Supplemental Life Insurance and AD&D

MONTHLY Payroll Deduction Chart –

Age From	Age To	$5,000 Requested	$10,000 Requested	$15,000 Requested	$20,000 Requested	$25,000 Requested	$30,000 Requested	$35,000 Requested	$40,000 Requested	$45,000 Requested
0	**29**	$0.56	$1.12	$1.68	$2.24	$2.80	$3.36	$3.92	$4.48	$5.04
30	**34**	$0.61	$1.22	$1.83	$2.44	$3.05	$3.66	$4.27	$4.88	$5.49
35	**39**	$0.76	$1.51	$2.27	$3.02	$3.78	$4.53	$5.29	$6.04	$6.80
40	**44**	$1.01	$2.01	$3.02	$4.02	$5.03	$6.03	$7.04	$8.04	$9.05
45	**49**	$1.45	$2.89	$4.34	$5.78	$7.23	$8.67	$10.12	$11.56	$13.01
50	**54**	$2.17	$4.33	$6.50	$8.66	$10.83	$12.99	$15.16	$17.32	$19.49
55	**59**	$3.28	$6.56	$9.84	$13.12	$16.40	$19.68	$22.96	$26.24	$29.52
60	**64**	$4.52	$9.03	$13.55	$18.06	$22.58	$27.09	$31.61	$36.12	$40.64
65	**69**	$7.18	$14.35	$21.53	$28.70	$35.88	$43.05	$50.23	$57.40	$64.58
70	**99**	$14.04	$28.08	$42.12	$56.16	$70.20	$84.24	$98.28	$112.32	$126.36

Age From	Age To	$50,000 Requested	$55,000 Requested	$60,000 Requested	$65,000 Requested	$70,000 Requested	$75,000 Requested	$80,000 Requested	$85,000 Requested	$90,000 Requested
0	**29**	$5.60	$6.16	$6.72	$7.28	$7.84	$8.40	$8.96	$9.52	$10.08
30	**34**	$6.10	$6.71	$7.32	$7.93	$8.54	$9.15	$9.76	$10.37	$10.98
35	**39**	$7.55	$8.31	$9.06	$9.82	$10.57	$11.33	$12.08	$12.84	$13.59
40	**44**	$10.05	$11.06	$12.06	$13.07	$14.07	$15.08	$16.08	$17.09	$18.09
45	**49**	$14.45	$15.90	$17.34	$18.79	$20.23	$21.68	$23.12	$24.57	$26.01
50	**54**	$21.65	$23.82	$25.98	$28.15	$30.31	$32.48	$34.64	$36.81	$38.97
55	**59**	$32.80	$36.08	$39.36	$42.64	$45.92	$49.20	$52.48	$55.76	$59.04
60	**64**	$45.15	$49.67	$54.18	$58.70	$63.21	$67.73	$72.24	$76.76	$81.27
65	**69**	$71.75	$78.93	$86.10	$93.28	$100.45	$107.63	$114.80	$121.98	$129.15
70	**99**	$140.40	$154.44	$168.48	$182.52	$196.56	$210.60	$224.64	$238.68	$252.72

Age From	Age To	$95,000 Requested	$100,000 Requested	$105,000 Requested	$110,000 Requested	$115,000 Requested	$120,000 Requested	$125,000 Requested	$130,000 Requested	$135,000 Requested
0	**29**	$10.64	$11.20	$11.76	$12.32	$12.88	$13.44	$14.00	$14.56	$15.12
30	**34**	$11.59	$12.20	$12.81	$13.42	$14.03	$14.64	$15.25	$15.86	$16.47
35	**39**	$14.35	$15.10	$15.86	$16.61	$17.37	$18.12	$18.88	$19.63	$20.39
40	**44**	$19.10	$20.10	$21.11	$22.11	$23.12	$24.12	$25.13	$26.13	$27.14
45	**49**	$27.46	$28.90	$30.35	$31.79	$33.24	$34.68	$36.13	$37.57	$39.02
50	**54**	$41.14	$43.30	$45.47	$47.63	$49.80	$51.96	$54.13	$56.29	$58.46
55	**59**	$62.32	$65.60	$68.88	$72.16	$75.44	$78.72	$82.00	$85.28	$88.56
60	**64**	$85.79	$90.30	$94.82	$99.33	$103.85	$108.36	$112.88	$117.39	$121.91
65	**69**	$136.33	$143.50	$150.68	$157.85	$165.03	$172.20	$179.38	$186.55	$193.73
70	**99**	$266.76	$280.80	$294.84	$308.88	$322.92	$336.96	$351.00	$365.04	$379.08

Age From	Age To	$140,000 Requested	$145,000 Requested	$150,000 Requested	$155,000 Requested	$160,000 Requested	$165,000 Requested	$170,000 Requested	$175,000 Requested	$180,000 Requested
0	**29**	$15.68	$16.24	$16.80	$17.36	$17.92	$18.48	$19.04	$19.60	$20.16
30	**34**	$17.08	$17.69	$18.30	$18.91	$19.52	$20.13	$20.74	$21.35	$21.96
35	**39**	$21.14	$21.90	$22.65	$23.41	$24.16	$24.92	$25.67	$26.43	$27.18
40	**44**	$28.14	$29.15	$30.15	$31.16	$32.16	$33.17	$34.17	$35.18	$36.18
45	**49**	$40.46	$41.91	$43.35	$44.80	$46.24	$47.69	$49.13	$50.58	$52.02
50	**54**	$60.62	$62.79	$64.95	$67.12	$69.28	$71.45	$73.61	$75.78	$77.94
55	**59**	$91.84	$95.12	$98.40	$101.68	$104.96	$108.24	$111.52	$114.80	$118.08
60	**64**	$126.42	$130.94	$135.45	$139.97	$144.48	$149.00	$153.51	$158.03	$162.54
65	**69**	$200.90	$208.08	$215.25	$222.43	$229.60	$236.78	$243.95	$251.13	$258.30
70	**99**	$393.12	$407.16	$421.20	$435.24	$449.28	$463.32	$477.36	$491.40	$505.44

Benefits Premium Cost

Supplemental Life Insurance and AD&D

MONTHLY Payroll Deduction Chart

Age From	Age To	$185,000 Requested	$190,000 Requested	$195,000 Requested	$200,000 Requested	$205,000 Requested	$210,000 Requested	$215,000 Requested	$220,000 Requested	$225,000 Requested
0	**29**	$20.72	$21.28	$21.84	$22.40	$22.96	$23.52	$24.08	$24.64	$25.20
30	**34**	$22.57	$23.18	$23.79	$24.40	$25.01	$25.62	$26.23	$26.84	$27.45
35	**39**	$27.94	$28.69	$29.45	$30.20	$30.96	$31.71	$32.47	$33.22	$33.98
40	**44**	$37.19	$38.19	$39.20	$40.20	$41.21	$42.21	$43.22	$44.22	$45.23
45	**49**	$53.47	$54.91	$56.36	$57.80	$59.25	$60.69	$62.14	$63.58	$65.03
50	**54**	$80.11	$82.27	$84.44	$86.60	$88.77	$90.93	$93.10	$95.26	$97.43
55	**59**	$121.36	$124.64	$127.92	$131.20	$134.48	$137.76	$141.04	$144.32	$147.60
60	**64**	$167.06	$171.57	$176.09	$180.60	$185.12	$189.63	$194.15	$198.66	$203.18
65	**69**	$265.48	$272.65	$279.83	$287.00	$294.18	$301.35	$308.53	$315.70	$322.88
70	**99**	$519.48	$533.52	$547.56	$561.60	$575.64	$589.68	$603.72	$617.76	$631.80

Age From	Age To	$230,000 Requested	$235,000 Requested	$240,000 Requested	$245,000 Requested	$250,000 Requested	$255,000 Requested	$260,000 Requested	$265,000 Requested	$270,000 Requested
0	**29**	$25.76	$26.32	$26.88	$27.44	$28.00	$28.56	$29.12	$29.68	$30.24
30	**34**	$28.06	$28.67	$29.28	$29.89	$30.50	$31.11	$31.72	$32.33	$32.94
35	**39**	$34.73	$35.49	$36.24	$37.00	$37.75	$38.51	$39.26	$40.02	$40.77
40	**44**	$46.23	$47.24	$48.24	$49.25	$50.25	$51.26	$52.26	$53.27	$54.27
45	**49**	$66.47	$67.92	$69.36	$70.81	$72.25	$73.70	$75.14	$76.59	$78.03
50	**54**	$99.59	$101.76	$103.92	$106.09	$108.25	$110.42	$112.58	$114.75	$116.91
55	**59**	$150.88	$154.16	$157.44	$160.72	$164.00	$167.28	$170.56	$173.84	$177.12
60	**64**	$207.69	$212.21	$216.72	$221.24	$225.75	$230.27	$234.78	$239.30	$243.81
65	**69**	$330.05	$337.23	$344.40	$351.58	$358.75	$365.93	$373.10	$380.28	$387.45
70	**99**	$645.84	$659.88	$673.92	$687.96	$702.00	$716.04	$730.08	$744.12	$758.16

Age From	Age To	$275,000 Requested	$280,000 Requested	$285,000 Requested	$290,000 Requested	$295,000 Requested	$300,000 Requested
0	**29**	$30.80	$31.36	$31.92	$32.48	$33.04	$33.60
30	**34**	$33.55	$34.16	$34.77	$35.38	$35.99	$36.60
35	**39**	$41.53	$42.28	$43.04	$43.79	$44.55	$45.30
40	**44**	$55.28	$56.28	$57.29	$58.29	$59.30	$60.30
45	**49**	$79.48	$80.92	$82.37	$83.81	$85.26	$86.70
50	**54**	$119.08	$121.24	$123.41	$125.57	$127.74	$129.90
55	**59**	$180.40	$183.68	$186.96	$190.24	$193.52	$196.80
60	**64**	$248.33	$252.84	$257.36	$261.87	$266.39	$270.90
65	**69**	$394.63	$401.80	$408.98	$416.15	$423.33	$430.50
70	**99**	$772.20	$786.24	$800.28	$814.32	$828.36	$842.40

401(k)

We offer a 401(k) Plan through Voya Financial. WellHaven matches 25% of the first 6% of employee contribution deferrals. This equates to a 1.50% match!

Vesting Schedule

- 50% vested first year of employment
- 100% vested second year of employment

This 401k Plan is a qualified retirement plan that allows eligible employees to save and invest for their retirement on a tax deferred basis.

Wealth Management Education & Resources

WellCents Program

While this sounds a lot like a WellHaven branded program, it isn't.

WellCents offers educational webinars on topics like:

Have Questions? Need Assistance?

The world of health care and insurance can be confusing and hard to navigate. Below a list of contacts and resources to reach out to with benefit related questions.

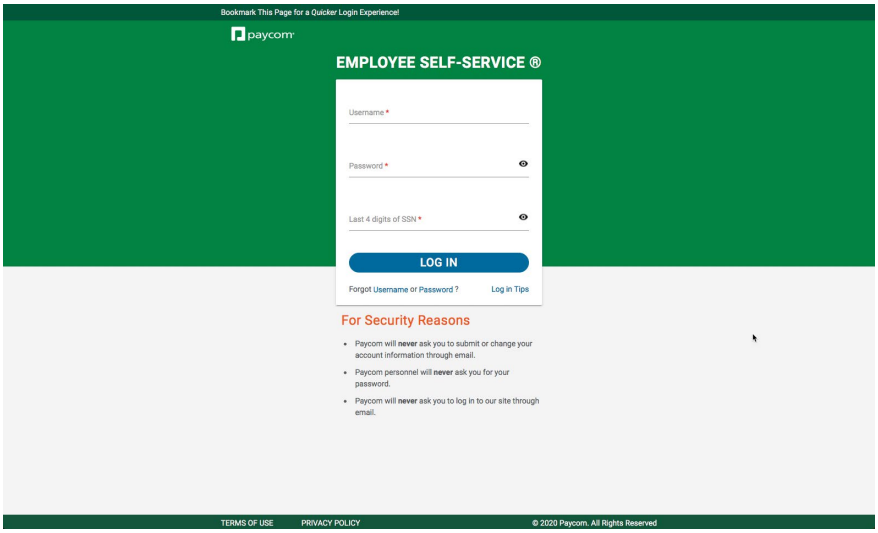
Plan	Carrier	Phone	Website
Medical **Group #31242**	BRMS/Cigna	866-486-8242	https://www.myhealthbenefits.com
Health Concierge	Touchcare Email:	866-486-8242 assist@touchcare.com	https://www.touchcare.com
Prescription Drugs	Fairos RX	866-486-8242	https://www.FairosRX.com
Telehealth	Teladoc	800-835-2362 help@teladochealth.com	https://www.teladoc.com
Health Savings Account (HSA) & FSA (Medical, Limited, & Dependent Care)	WEX Health	866-451-3399	https://wexhealth.com/
Dental Life AD & D Critical Illness & Hospital Indemnity Disability **Group # 5954159**	MetLife	800-438-6388	https://www.metlife.com/
Vision **Group #30085123**	Vision Service Plan (VSP)	800-877-7195	https://www.vsp.com/
Employee Assistance Program (EAP)	LifeWorks (MetLife)	888-319-7819	https://www.lifeworks.com User name: metlifeeap Password: eap
MetLife Legal Plan **Group # 5954159**	MetLife	800-821-6400	https://info.legalplans.com/Home/
COBRA (continuation of benefits coverage)	Paycom COBRA Admin	800-580-4505	
WellHaven Pet Health 401k Plan **Account # 81G902**	Voya Financial	800-584-6001	https://www.voyaretirementplans.com
Medicare Transition Services		844–755-5901	https://MedicareTransitionServices.com

WellHaven Contact
Email: HR@wellhaven.com

Appendix

Resources Located in the Paycom System

- Paycom Benefits Portal Guide
- Health care Forms
- Benefit Summary Plan Descriptions (SPD)
- Summary of Benefits and Coverage (SBC)
- Health Insurance Plan Booklets



Insurance Card Information

? Will I receive an insurance card?

- Medical – YES you will receive an insurance card.
- Dental – NO insurance card (use Group No and SS# when scheduling an appointment)
- Vision – NO insurance card (use Group No and SS# when scheduling an appointment)
- HSA – YES you will receive a HSA debit card to use as you would a credit card
- FSA – YES you will receive a FSA debit card to use as you would a credit card

Appendix

Key Definitions

Coinsurance: The portion of covered health care costs the covered person is financially responsible for usually a fixed percentage. Coinsurance often is applied, according to a fixed percentage after the deductible requirement is met.

Copayment: A cost sharing arrangement in which a covered person pays a specified charge for a specified service, such $10 for an office visit.

Deductible: The amount of expenses that must be paid out of pocket before an insurer will pay any expenses.

Dependent: An individual who relies on an enrollee for financial support and/or obtains health coverage through a spouse, or parent.

Drug Formulary: A list of prescription medication preferred for use by the health plan and dispensed through participation pharmacies to covered persons.

Evidence of insurability: Proof presented through medical examination and/or through written statements about an individual's health

Generic Drug A chemically equivalent form of a brand-name drug for which the patent has expired. A generic typically is less expensive and sold under a common or "generic" name.

In-area services: Health care received within the authorized service area from a participating provider that is contracted with the health plan. *Also called in-network services*.

Inpatient An individual who has been admitted to a hospital as a registered bed patient for at least 24 hours and is receiving services under the direction of a physician.

Maximum out-of-pocket costs: The limit on total member copayments, deductibles and coinsurance under a benefit contract

Network: A system of contracted physicians, hospitals and ancillary providers that provides health care to members.

Non-participating provider: A health care provider who has not contracted with the carrier or health plan to be a participating provider of health care. Non-participating providers can bill the patient without balance billing limits typically agreed to by participating providers.

Open Enrollment Period: A time during which subscribers in a health benefit program have an opportunity to re-enroll or select an alternate health plan being offered to them, usually without evidence of insurability or waiting periods.

Out-of-area: Coverage for treatment obtained by a covered person temporarily outside the network service area.

Out-of-network: Coverage for treatment from a non-participating provider and higher copayments and coinsurance than for treatment from a participating provider.

Out-of-pocket: the total payments toward eligible expenses that a covered person funds for him/herself and/or dependents (i.e. deductibles, copays and coinsurance) as defined by the contract. Once the limit is reached benefits will increase to 100% for covered health services received during the rest of the year.

Important Notices

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, 2023. Contact your state for more information on eligibility.

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

Important Notices

ALASKA-Medicaid	COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	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
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery. com/hipp/index.html Phone: 1-877-357-3268
GEORGIA-Medicaid	**MAINE-Medicaid**
A 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	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
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

Important Notices

IOWA-Medicaid and CHIP (Hawki)	MINNESOTA-Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
LOUISIANA-Medicaid	**NEBRASKA-Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633
Phone: 1-888-342-6207 (Medicaid hotline) Or 1-855-618-5488 (LaHIPP)	Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA-Medicaid	**SOUTH CAROLINA-Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-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. 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059

Important Notices

NEW JERSEY-Medicaid and CHIP	TEXAS-Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	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
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

Important Notices

To see if any other states have added a premium assistance program since July 31, 2023, or for more in- formation 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.

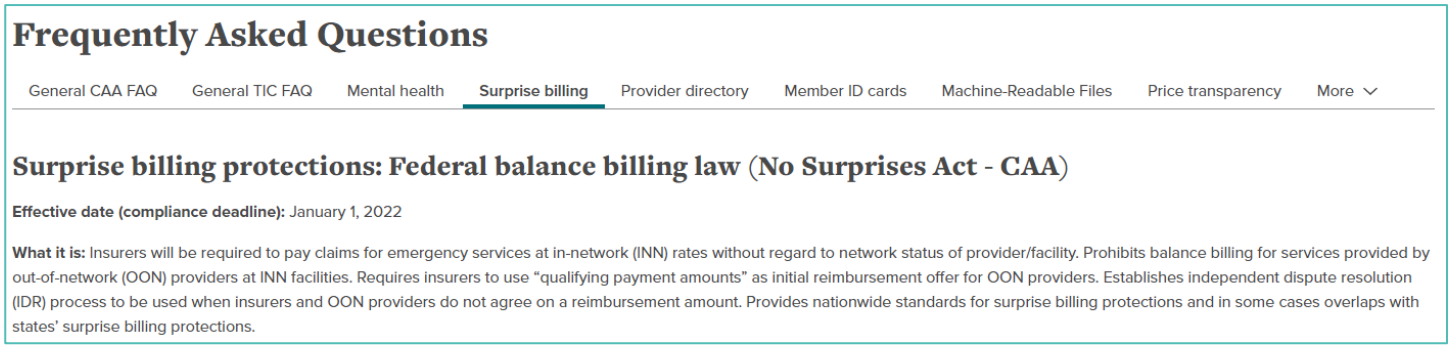
OMB Control Number 1210-0137
(expires 1/31/2026)

Important Notices

Federal No Surprises Act Bill Disclosure

Consolidated Appropriations Act of 2021 and Transparency in Coverage Rule (regence.com)

Click on the “surprise billing” tab – see below example



Frequently Asked Questions

General CAA FAQ | General TIC FAQ | Mental health | **Surprise billing** | Provider directory | Member ID cards | Machine-Readable Files | Price transparency | More

Surprise billing protections: Federal balance billing law (No Surprises Act - CAA)

Effective date (compliance deadline): January 1, 2022

What it is: Insurers will be required to pay claims for emergency services at in-network (INN) rates without regard to network status of provider/facility. Prohibits balance billing for services provided by out-of-network (OON) providers at INN facilities. Requires insurers to use “qualifying payment amounts” as initial reimbursement offer for OON providers. Establishes independent dispute resolution (IDR) process to be used when insurers and OON providers do not agree on a reimbursement amount. Provides nationwide standards for surprise billing protections and in some cases overlaps with states’ surprise billing protections.

Women’s Health and Cancer Rights Act of 1998

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 conditions related to 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.

Important Notices

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

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

To request special enrollment or obtain more information, contact Kathy Klein, Benefits & HR Specialist, Phone Number (360)-386-1348, Email: HR@Wellhaven.com

Important Notices

Notice of Privacy Practices

HIPAA privacy rules require that health plans, or their insurers, distributes a notice to participants explaining their privacy rights as group health plan participants at least every three years. HIPAA also requires that plans give the notice to new participants and to redistribute the notice if it is revised. Sending the following notice annually fulfills the requirement and might be easier than remembering to send it every three years.

Note: In 2013, HIPAA protections were expanded in important ways, including significant changes to the notice used to explain HIPAA rules governing the group health plan

HIPAA Notice of Privacy Practices

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

Wellhaven Health Plan
Notice of Privacy Practices

October 21, 2024

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), you have certain rights with respect to your Protected Health Information ("PHI"), including the right to know how your PHI may be used by a group health plan.

This Notice of Privacy Practices ("Notice") covers the following group health plans (collectively referred to as the "Plan"):

- Medical
- Health FSA

The Plan is required by law to maintain the privacy of your PHI and to provide this Notice to you pursuant to HIPAA. This Notice describes how your PHI may be used or disclosed to carry out treatment, payment, health care operations, or for any other purposes that are permitted or required by law. This Notice also provides you with the following important information:

- Your privacy rights with respect to your PHI;
- The Plan's duties with respect to your PHI;
- Your right to file a complaint with the Plan's Privacy Officer and/or to the Secretary of the Office of Civil Rights of the U.S. Department of Health and Human Services; and
- The person or office to contact for further information about the Plan's privacy practices.

Important Notices

Notice of Privacy Practices

PHI is health information (including genetic information) in any form (oral, written, electronic) that:

- Is created or received by or on behalf of the Plan;
- Relates to your past, present or future physical or mental condition, or the provision of health care services to you, or the payment for those health care services; and
- Identifies you or from which there is a reasonable basis to believe the information can be used to identify you.

Health information your employer receives during the course of performing non-Plan functions is not PHI. For example, health information you submit to your employer to document a leave of absence under the Family and Medical Leave Act is not PHI.

Section 1. USES AND DISCLOSURES OF YOUR PHI

Under HIPAA, the Plan may use or disclose your PHI under certain circumstances without your consent, authorization or opportunity to agree or object. Such uses and disclosures fall within the categories described below. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

General Uses and Disclosures

Treatment. The Plan may use and/or disclose your PHI to help you obtain treatment and/or services from providers. Treatment includes the provision, coordination or management of health care and related services. It also includes, but is not limited to, consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist. The Plan may also disclose information about your prior prescriptions to a pharmacist to determine if any medicines contraindicate a pending prescription.

Payment. The Plan may use and/or disclose your PHI in order to determine your eligibility for benefits, to facilitate payment of your health claims and to determine benefit responsibility. Payment includes, but is not limited to billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan. The Plan may also disclose your PHI to another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate payment of benefits.

Health Care Operations. The Plan may use and/or disclose your PHI for other Plan operations. These uses and disclosures are necessary to run the Plan and include, but are not limited to, conducting quality assessment and improvement activities, reviewing competence or qualifications of health care professionals, underwriting, premium and other activities relating to Plan coverage. It also includes cost management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general Plan administrative activities. For example, the Plan may use your PHI in connection with submitting claims for stop-loss coverage. The Plan may also use your PHI to refer you to a disease management program, project future costs or audit the accuracy of its claims processing functions.

However, the Plan is prohibited from using or disclosing PHI that is an individual's genetic information for underwriting purposes.

Important Notices

Notice of Privacy Practices

Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide such services, the Business Associates will receive, create, maintain, use and/or disclose your PHI. For example, the Plan may disclose your PHI to a Business Associate to administer claims or provide pharmacy benefit management services. However, Business Associates will receive, create, maintain, use and/or disclose your PHI on behalf of the Plan only after they have entered into a Business Associate agreement with the Plan and agree in writing to protect your PHI against inappropriate use or disclosure and to require that their subcontractors and agents do the same.

Plan Sponsor. For purposes of administering the Plan, the Plan may disclose your PHI to certain employees of the Wellhaven Pet **Health Plan**. However, these employees will only use or disclose such information as necessary to perform administration functions for the Plan or as otherwise required by HIPAA, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization.

Required By Law. The Plan may disclose your PHI when required to do so by federal, state or local law. For example, the Plan may disclose your PHI when required by public health disclosure laws.

Health or Safety. The Plan may disclose and/or use your PHI when necessary to prevent a serious threat to your health or safety or the health or safety of another individual or the public. Under these circumstances, any disclosure will be made only to the person or entity able to help prevent the threat.

Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your PHI without your consent, authorization or opportunity to agree or object. Note that not every permissible use or disclosure in a category is listed; however, all the ways in which the Plan is permitted to use or disclose PHI will fall within one of the categories.

Public Health Activities. The Plan may disclose your PHI when permitted for purposes of public health actions, including when necessary to report child abuse or neglect or domestic violence, to report reactions to drugs or problems with products or devices, and to notify individuals about a product recall. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

Health Oversight. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. Oversight activities can include civil, administrative or criminal actions, audits and inspections, licensure or disciplinary actions (for example, to investigate complaints against providers); other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud); compliance with civil rights laws and the health care system in general.

Lawsuits, Judicial and Administrative Proceedings. If you are involved in a lawsuit or similar proceeding, the Plan may disclose your PHI in response to a court or administrative order. The Plan may also disclose your PHI in response to a subpoena, discovery request or other lawful process by another individual involved in the dispute, provided certain conditions are met. One of these conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

Notice of Privacy Practices

Law Enforcement. The Plan may disclose your PHI when required for law enforcement purposes, including for the purposes of identifying or locating a suspect, fugitive, material witness or missing person.

Coroners, Medical Examiners and Funeral Directors. The Plan may disclose your PHI when required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

Workers' Compensation. The Plan may release your PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

National Security and Intelligence. The Plan may release PHI to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Military and Veterans. If you are a member of the armed forces, the Plan may disclose your PHI as required by military command authorities. The Plan may also release PHI about foreign military personnel to the appropriate foreign military authority.

Organ and Tissue Donations. If you are an organ donor, the Plan may disclose your PHI to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Research. The Plan may disclose your PHI for research when the individual identifiers have been removed or when the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosure to Secretary

The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with HIPAA.

Disclosures to Family Members and Personal Representatives

The Plan may disclose your PHI to family members, other relatives and your close personal friends but only to the extent that it is directly relevant to such individual's involvement with a coverage, eligibility or payment matter relating to your care, unless you have requested and the Plan has agreed not to disclose your PHI to such individual. The Plan will disclose your PHI to an individual authorized by you, or to an individual designated as your personal representative, provided the Plan has received the appropriate authorization and/or supporting documents. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

However, the Plan will not disclose information to an individual, including your personal representative, if it has a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse or neglect by such person or treating such person as your personal representative could endanger you; and
- In the exercise of professional judgment, it is not in your best interest to disclose the PHI.

This also applies to personal representatives of minors.

Authorization

Any uses or disclosures of your PHI not described above will be made only with your written authorization. Most disclosures involving psychotherapy notes will require your written authorization. In addition, the Plan generally cannot use your PHI for marketing purposes or engage in the sale of your PHI without your written authorization. You may revoke your written authorization at any time, so long as the revocation is in writing. Once the Plan receives your authorization, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2. RIGHTS OF INDIVIDUALS

You have the following rights with respect to your PHI:

Right to Request Restrictions on PHI Uses and Disclosures. You may request in writing that the Plan restrict or limit its uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to limit disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. For example, you could request that the Plan not use or disclose specific information about a specific medical procedure you had. However, the Plan is not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. The Plan will not ask you the reason for your request, which must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests to receive communications of PHI by alternative means if you clearly provide information that the disclosure of all or part of your PHI could endanger you.

Right to Inspect and Copy PHI. You have a right of access to inspect and obtain a copy of your PHI (including electronic PHI) contained in the Plan's "designated record set," for as long as the PHI is maintained by the Plan in a designated record set. If you request a copy of the information, the Plan may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

Important Notices

Notice of Privacy Practices

"Designated Record Set" includes the medical records and billing records about an individual maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about the individual. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

If your request is granted, the requested information will be provided to you within 30 days after the receipt of your request in the form and format requested, if it is readily producible in such form and format, or if not, in a readable hard copy form (or a readable electronic form and format in the case of PHI maintained in designated records sets electronically) or such other form and format as agreed upon by you and the Plan. If the Plan is unable to comply with request within the 30-day deadline, a one-time 30-day extension is permissible. In such case, you will receive notification of the need for an extension within the initial 30-day period.

Please note that your right does not apply to psychotherapy notes or information compiled in reasonable anticipation of a legal proceeding. The Plan may deny your request to inspect and copy your PHI in very limited circumstances. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI. If you believe that the PHI the Plan has about you is incorrect or incomplete, you have the right to request in writing that the Plan amend your PHI or a record contained in a designated record set for as long as the PHI is maintained by the Plan in the designated record set. The Plan has 60 days after the request is made to act on the request. However, a single 30-day extension is allowed if the Plan is unable to comply with the deadline.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask for the amendment of information that: (1) is not part of the medical information kept by or for the Plan; (2) was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment; (3) is not part of the information that you would be permitted to inspect or copy; or (4) is already accurate and complete. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You have the right to file a written statement of disagreement, and any future disclosures of the disputed information will include your statement.

The Right to Receive an Accounting of PHI Disclosures. You have the right to receive a list of disclosures of your PHI that have been made by the Plan on or after April 14, 2003 (or January 1, 2011 in the case of disclosures of your PHI from electronic health records maintained by the Plan, if any) over a period of up to six years (three years in the case of disclosures from an electronic health record) prior to the date of your request. Certain disclosures are not required to be included in such accounting of disclosures, including but not limited to disclosures made by the Plan (1) for treatment, payment or health care operations (unless the disclosure is made from an electronic health record), or (2) in accordance with your authorization. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request. You have the right to receive a paper copy of this Notice even if you have agreed to receive this Notice electronically.

To exercise any of your HIPAA rights described above, you or your personal representative must contact the HIPAA Privacy Officer in writing at jjones@wellhaven.com or by calling 952-463-5392. You or your personal representative may be required to complete a form required by the Plan in connection with your specific request.

Section 3. THE PLAN'S DUTIES

Notice of Privacy Practices. The Plan is required by law to provide individuals covered under the Plan with notice of its legal duties and privacy practices. The Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. In the event of any material change to this Notice, a revised version of this Notice will be distributed to all individuals covered under the Plan within 60 days of the effective date of such change by first-class U.S. mail or with other Plan communications.

Breach Notification. The Plan has a legal duty to notify you following the discovery of a breach involving your unsecured PHI

Minimum Necessary Standard. When using or disclosing PHI, the Plan will use and/or disclose only the minimum amount of PHI necessary to accomplish the intended purposes of the use or disclosure. However, the minimum necessary standard will not apply in the following situations:

- Disclosure to or requests by a health care provider for treatment;
- Uses or disclosures made to you; and
- Uses or disclosures that are required by law.

Section 4. COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human

Services. To file a complaint with the Plan, contact the HIPAA Privacy Officer in writing at jjones@wellhaven.com or by calling (952)463-5392.

You will not be penalized or in any other way retaliated against for filing a complaint with the Office for Civil Rights or with the Plan.

Section 5. ADDITIONAL INFORMATION

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the HIPAA Privacy Officer in writing at jjones@wellhaven.com or by calling (952)463-5392.

Important Notices

General Notice Of COBRA Continuation Coverage Rights

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

- Your spouse dies.

Important Notices

General Notice Of COBRA Continuation Coverage Rights

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 after the qualifying event occurs. You must provide this notice to: Human Resources Department

How is COBRA continuation coverage provided?

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

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

Important Notices

General Notice Of COBRA Continuation Coverage Rights

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

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If you have questions

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

Keep your Plan informed of address changes

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

Important Notices

Medicare Part D Creditable Disclosure Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with WellHaven Pet Health, LLC (WellHaven) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. WellHaven has determined that the prescription drug coverage offered by the BRMS Medical Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

CMS Form 10182-CC

Updated April 1, 2011

Important Notices

Medicare Part D Creditable Disclosure Notice

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

If you decide to join a Medicare drug plan, your current Medical Plan coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drug. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. [See page 7-9 of the CMS Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

If you do decide to join a Medicare drug plan and drop your current Regence Medical Plan coverage, be aware that you and your dependents may not be able to get this coverage back. Only through a qualified life event or open enrollment would coverage be available again.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Regence and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact WellHaven's Human Resources Department at (360) 368-1348 or email HR@wellhaven.com for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice at any time.

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Important Notices

Medicare Part D Creditable Disclosure Notice

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 2024
Name of Entity/Sender:	WellHaven Human Resources
Contact--Position/Office:	Kathy Klein, Benefits & HR Specialist
Address:	700 Washington St. Suite 401 Vancouver WA 98660
Phone Number:	(360) 386-1348

CMS Form 10182-CC

Updated April 1, 2011

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number.

The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Important Notices

Notice of Exchange

Form Approved OMB
No. 1210-0149
(expires 9-30-2023)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

---

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets 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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

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

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources

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.

[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Important Notices

Notice of Exchange

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 WellHaven Pet Health, LLC		4. Employer Identification Number (EIN) 82-2088644
5. Employer Address 700 Washington St. STE 401		6. Employer Phone Number 360-768-1706
7. City Vancouver	8. State WA	9. ZIP Code 98660
10. Who can we contact about employee health coverage at this job? Kathy Klein		
11. Phone Number (if different from above) 360-386-1348		12. Email Address HR@wellhaven.com

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

☐ All employees. Eligible employees are:

☑ All Full-Time Employees working 30 hours or more per week

☑ *With respect to dependents
We do offer coverage. Eligible dependents are:

Legally married spouse & Qualified domestic partner

Dependents to age 26

☐ We do not offer coverage.

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

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

If you decide to shop for coverage in the Marketplace, www.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.

Important Notices

Notice of Exchange

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

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

☐ Yes (Continue) 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)

☐ No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☑ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

A. How much would the employee have to pay in premiums for this plan? $84.81

B. How Often? ☐ Weekly ☐ Every 2 weeks ☑ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

Important Notices

FMLA General Notice

EMPLOYEE RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION

Leave Entitlements

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness. An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule. Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions. An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite. *Special "hours of service" requirements apply to airline flight crew employees.

Important Notices

FMLA General Notice

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures. Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified. Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility. Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor Wage and Hour Division

This Benefit Guide provides a brief description of plan benefits. For more information on plan benefits, exclusions, and limitations, please refer to the Plan documents or contact the carrier/administrator directly. If any conflict arises between this Guide and any plan provisions, the terms of the actual plan document or other applicable documents will govern in all cases. Benefits are subject to modification at any time.