HODGE

2025 | All Employees

BENEFITS GUIDE

» WHATEVER IT TAKES

INSIDE

WELCOME

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

HOW TO ENROLL

- **Current Employees:** Open enrollment, which usually occurs in May, is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries.
- **New Hires:** Once eligible, you must complete your enrollment within 30 days. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverage.

Enroll online through iSolved!

Scan QR code or visit
https://www.hkp-usa.com/cloudservice/login

Need Help?

Please see HR if you have questions on how to enroll.
Email HR@hodgecompany.com or call (563) 587-6920.

HOW TO MAKE CHANGES

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Examples include:

- Marriage, divorce, legal separation, or death of a spouse
- Birth, adoption, or death of a child
- Change in child's dependent status
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

Medicare Part D Notice:

If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to page **32** for details.

BENEFIT HIGHLIGHTS

Benefit changes take effect on **06/01/2025**.

NEW in 2025

- **Medical:** – Employee + Spouse option!
- **Dental:** Now includes orthodontia coverage for dependent children up to age 19.
- **Hospital Indemnity:** Pays a cash benefit if you are hospitalized.
- **Parental Leave Policy:** See page 23 for details.

Protect Your **Health**

- **Medical:** Wellmark Blue Cross and Blue Shield offers a broad national provider network.
- **Regenexx:** Get back to life faster with no surgery! Explore the possibilities of using bone marrow to heal injuries. Included in medical plan with Wellmark.
- **Dental:** MetLife offers a national network of dentists which will help control dental costs. You can go anywhere, however, there is a slight chance for balance billing with out of network providers.
- **Vision:** MetLife offers a stand-alone vision plan with enhanced benefits at very affordable rates.

Protect Your **Family**

- **Company Paid Life/AD&D:** HODGE provides $15,000 of coverage at no cost to you!
- **Voluntary Life/AD&D:** New hires can elect up to $150,000 without answering health questions! Accidental Death & Dismemberment is included with your election. If you previously declined this coverage and want to enroll now, you will be subject to approval based on medical questions.

Protect Your **Income**

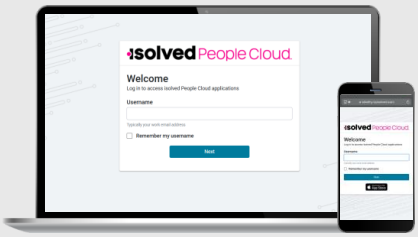
- **Voluntary Short-Term and Long-Term Disability:** You can elect to purchase Short Term Disability to protect your income during a Leave of Absence due to a medical illness, injury or disability. Long Term Disability is provided at no cost to you.

Protect Your **Wallet**

- **Accident:** This coverage pays you cash benefits for a variety of accidental injuries. You can purchase it for yourself or your whole family. A $50 wellness benefit is available.
- **Critical Illness:** This coverage pays a cash benefit to you and/or your dependents when diagnosed with a covered condition (including cancer). A $50 wellness benefit is available.
- **Hospital Indemnity:** This coverage pays you cash benefits for hospital stays, including routine pregnancy. You can purchase it for yourself or your whole family. A $100 wellness benefit is available.

IMPORTANT:

All employees are required to log in to iSolved to elect, change or waive benefits for 2025. You can access iSolved through the Benefits Hub.



Enroll online through iSolved!

Scan the QR code to get started. Simply open your camera app, hover over the square, and tap on the link.

You can also access the site on your desktop or laptop computer:

www.hkp-usa.com/cloudservice/login

Please see HR if you have questions on how to enroll.

HR@hodgecompany.com

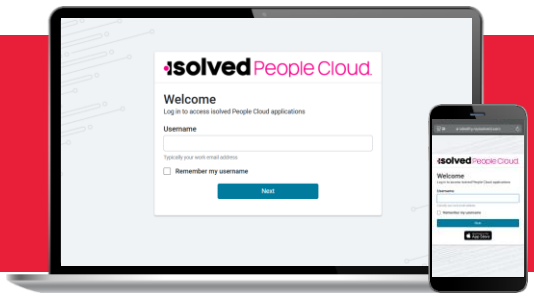
(563) 587-6920

BENEFIT CONTACTS

Coverage	Carrier	Contact
Medical Insurance	Wellmark Blue Cross and Blue Shield	www.mywellmark.com 800-524-9242
Pre-Certification	Wellmark Blue Cross and Blue Shield	800-552-3993
Prescription Drug Card	MedOne Rx	www.medonehs.com (888) 884-6331
NaviCareRx	MedOne Rx	(877)371-3351
Wellness Program	HealthCheck360	support@HealthCheck360.com myhealthcheck360.com 866-511-0360
Flexible Spending Accounts	iSolved	FSA@iSolvedhcm.com www.iSolvedbenefitservices.com (800) 300-3838
Orthopedic Surgery Alternative	Regenexx	Regenexxbenefits.com/hodgecompany (866) 725-3519
Accident Insurance	MetLife	www.metlife.com/mybenefits (888) 438-6388
Critical Illness Insurance		
Hospital Indemnity		
Dental Insurance		
Vision Insurance		
Life/AD&D Insurance	Mutual of Omaha	See Human Resources
Disability Insurances		
Employee Assistance Program		800-316-2796 www.mutualofomaha.com/eap
401(k) Retirement Plan	July Services	PSATeam@julyservices.com 888.333.6315
Additional Benefits	HODGE Benefits Team Email/Phone	Company Address
Paid Time off, Holidays, Leaves of Absence and more	HR@hodgecompany.com (563) 587-6920	400 Ice Harbor Drive Dubuque, IA 52002

Enroll online through iSolved!

Scan QR code or visit
www.hkp-usa.com/cloudservice/login



ELIGIBILITY

EMPLOYEE ELIGIBILITY

All full-time employees working 30 or more hours per week will be eligible for benefits. As a new employee, you have 30 days from your initial start date to enroll in benefits.

- Part-Time and Contingent Employees: Not eligible for Benefits.
- Employee Eligibility (Medical, Dental and Vision Benefits)
  - Direct Hire Full-time Employees: Eligible for coverage on the first day of the month following 30 days of Employment.
  - Agency Success Employees: Eligible for coverage on the first day of the month following HODGE Hire Date, provided they have met eligibility requirements.
- Employee Eligibility (Life Benefits, Accident and Critical Illness Benefits)
  - Direct Hire Full-time & Agency Success Employees: Eligible for coverage on the first day of the month following 30 days of Employment.
- Employee Eligibility (Retirement Plan Benefits)
  - Direct Hire Full-Time & Agency Success Employees: Eligible for coverage on the first day of next Quarter following HODGE Hire Date. (January / April / July / October)

* **IMPORTANT:** Benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

DEPENDENT ELIGIBILITY

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Definition of "Eligible Dependents"

Medical, Dental, and Vision Coverage dependents include:

- **Your legally married spouse.** Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, "spouse" shall not mean a common law spouse or domestic partner.
- **Your dependent children under age 26**. This includes natural, step, foster, adopted, or other children under your legal guardianship.
- Children of the employees are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined in ERISA §609(a).
- For additional eligibility details, please refer to the policy contract or summary plan documents.

Other Coverages: See page **16** for definitions of an "eligible dependent" under the Voluntary Life/AD&D Policy. Please note that benefit-eligible employees cannot be enrolled as a "spouse", and dependent children cannot be covered more than once. Please refer to the policy certificate or HR for more information.

PRETAX ELECTIONS:

Employee medical, dental and vision premiums will be deducted on a pre-tax basis through payroll deduction unless you choose to elect post tax election. Due to IRS rules regarding pre-tax elections, contributions cannot be revoked or changed during the plan year, unless you experience a qualifying "Status Change" as described herein.

HEALTHCARE TIPS

GET THE MOST OUT OF YOUR CARE

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-Network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-Network Provider**—A provider who is not contracted with your health insurance company.

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

BILLING & CLAIM DIFFERENCES

Because in-network and out-of-network providers are treated differently by your insurance company, you will be billed differently depending on the type of provider you use for your care.

Provider The patient receives treatment. The doctor then sends the bill to the insurance company.	>	**In-Network Discount** Appropriate discount for using an in-network provider is applied.	>	**Bill** The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.
				v
Patient Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.	<	**Insurance Company Payments, Explanation of Benefits (EOB)** Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.		

BE SURE TO USE PREVENTIVE CARE

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

KNOW WHERE TO GO

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs $1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

WHERE SHOULD I GO?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room ($$$$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Shortness of breath
- Uncontrollable bleeding
- Poisoning

Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Urgent Care ($$$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

Doctor's Office ($$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

MEDICAL

Wellmark Blue Cross and Blue Shield

Locate an in-network provider near you at www.mywellmark.com or call 800-524-9242.

This coverage allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Medical	In-Network	Out-of-Network
Annual Deductible		
Individual	$2,500	$5,000
Family	$5,000	$10,000
Coinsurance		
Plan Pays	80%	60%
You Pay	20%	40%
Annual Out-of-Pocket Maximum		
Individual	$6,850	$10,000
Family	$13,700	$20,000
Services	In-Network	Out-of-Network
Preventative Care	No Charge – **Deductible Waived**	You Pay 40% after Deductible
Primary Care Office Visit	$25 Copay Per Visit	You Pay 40% after Deductible
Specialist Office Visit	$50 Copay Per Visit	You Pay 40% after Deductible
Diagnostics (X-ray and lab at independent lab or outpatient hospital)	You Pay 20% – **Deductible Waived**	You Pay 40% after Deductible
MRI, PET/CT Scans, Nuclear Medicine (Pre-Certification Required)	You Pay 20% after Deductible	You Pay 40% after Deductible
Urgent Care	$75 Copay Per Visit	You Pay 40% after Deductible
Emergency Room Services	$150 Copay Per Visit	
Dr On Demand (Telemedicine)	$0 Copay	
Emergency Medical Transportation	You Pay 20% after Deductible	You Pay 40% after Deductible
Inpatient Hospitalization	You Pay 20% after Deductible	You Pay 40% after Deductible
Outpatient Surgery	You Pay 20% after Deductible	You Pay 40% after Deductible
Prenatal & Postnatal Care	You Pay 20% after Deductible	You Pay 40% after Deductible
Prescription Drugs (Retail 30 Day Supply)	Retail – 30 Day Supply	Mail Order – 90 Day Supply
Generic*	$15 Copay	$30 Copay
Formulary	25% Up To $60 Per Fill	25% Up To $180 Per Fill
Non-Formulary	25% Up To $100 Per Fill	25% Up To $300 Per Fill
Specialty	50% Copay with no Maximums	Not Covered

Prescription Drugs: **If a name brand drug is purchased when a generic is available, the participant will be responsible for the difference in cost in addition to the name brand Copay. Retail purchases limited to a 30-day supply for 1 Copay, 31–60-day supply may be purchased for 2 Copays and a 61–91-day supply may be purchased for 3 Copays. Mail order may be purchased for a 91 day supply. Specialty drugs will be subject to the manufacturers' Copay assistance program and only your true out of pocket cost will apply to your out-of-pocket maximum. These may only be purchased in a 30-day supply. MedOne performance formulary will be used for all medications and CanaRx will be a $0 brand name medication program available to employees. Contact MedOne at (888) 884-6331 for additional information.*

Step Therapy Drug Program: *Certain medications may require you to try a less-expensive version of the medication first. This provision will apply to all new employees and anyone taking new medication for the first time.*

Please review the full plan documents for details. *If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.*

SPECIALTY DRUG COVERAGE

MedOne | NaviCareRx | www.medone-rx.com | 866-335-9057

MedOne's cost savings program NaviCareRx will be utilized for all specialty medications.

SPECIALTY MEDICATIONS:

Specialty medications are managed through the **NaviCareRx** program. Members can reach their dedicated **Patient Care Coordinator at 877-371-3351** for assistance.

- Call a NaviCareRx Patient Care Coordinator (PCC) to provide information about your specialty drug needs
- A PCC provides you and your doctor with Patience Assistance Program paperwork for completion
- Application is submitted to the Patient Assistance Program
- A PCC provides you with the program contact information so status updates can be requested
- A PCC will stay in touch with you to determine assistance approval status and/or discuss other available options
- PCCs can provide further guidance as needed

MEMBER ASSISTANCE:

MedOne's Member Advocate team, all certified pharmacy technicians, is equipped to assist you with questions you may have.

- Phone: 866-335-9057
- Fax: 563-588-8725
- Prior authorization fax: 563-293-8156
- Live Chat: www.medone-rx.com
- Drug Lookup Tool: www.medone-rx.com/members/drug-lookup – Group ID is 0024
- Performance Formulary

MEMBER RESOURCES:

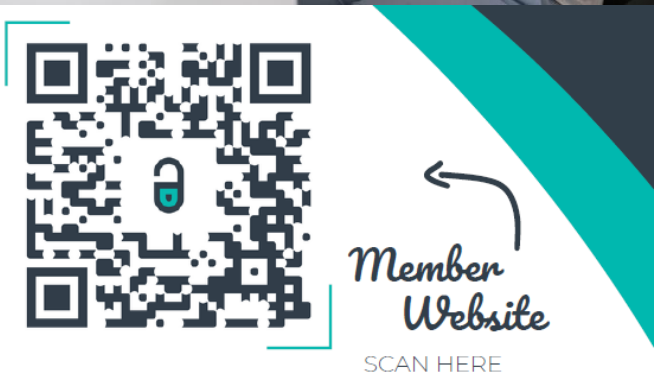
MedOne's website features a variety of resources for MedOne members:

- On the main website, tap or click the MEMBERS tile along the bottom of the home page, or select MEMBERS in the main menu
- Here, you can check the status of a prior authorization, schedule a consultation with a registered pharmacist, review FAQs, download documents and forms, and access the Member Portal

MEMBER PORTAL:

To access the member portal, go to www.medone-rx.com and click on MEMBER PORTAL:

- View claims details and Rx history
- Look up in-network pharmacies in your area
- Obtain pricing for your medications
- Review Out of Pocket Maximum
- Access the Drug Information Directory
- Gather ID card processing information
- Enroll in MedOne Mail Order



TELEMEDICINE

Dr. On Demand

Available to employees enrolled in the medical plan.

Telemedicine can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency medical conditions.

Using your computer, tablet, or smartphone device, you can conveniently access to U.S. board-certified doctors and licensed professionals from the comfort of your home or wherever you happen to be.

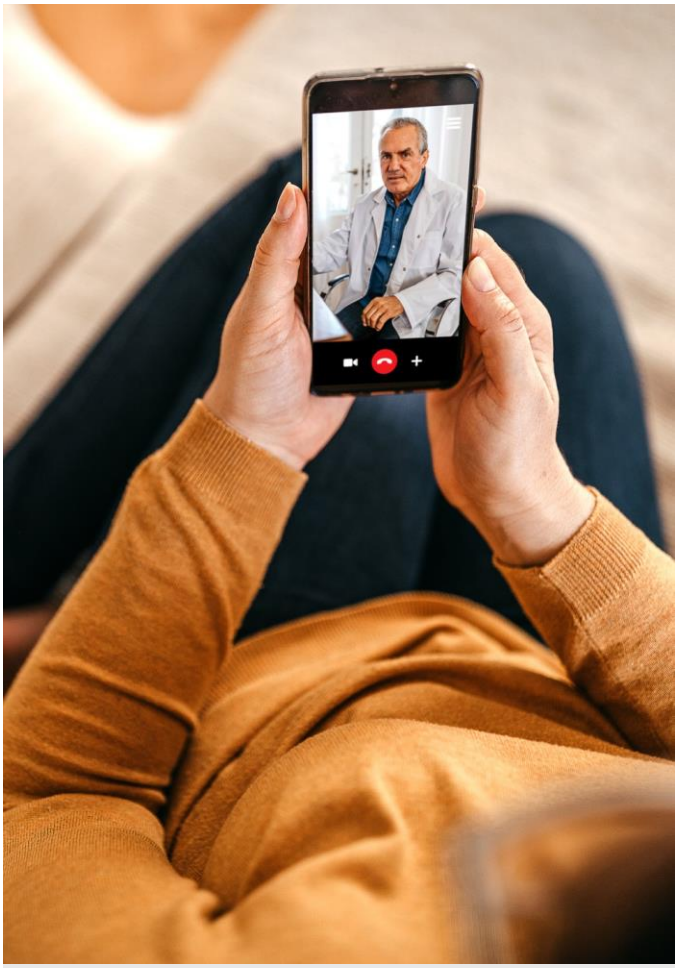
In some cases, doctors can write a prescription to a local pharmacy near you.[1]

Telemedicine	
Medical Visit	$0 if enrolled in the health plan $99 if not on the health plan
Commonly Treated Medical Conditions	Allergies Colds, respiratory problems, flu Ear infections Sore throat Pink eye Urinary tract infections
Benefit Cost	Included with Medical coverage

When can I use telemedicine?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

[1] Prescription services may not be available in all states.



SAVE TIME AND MONEY WITH TELEMEDICINE!

Telemedicine can provide significant savings over urgent care and emergency room visits. On top of that, you can connect with a doctor from the convenience of home or work, allowing you to avoid the hassle of traveling or sitting in a waiting room.

Doctor On Demand

- **Phone:** 1-800-997-6196
- **Online:** DoctorOnDemand.com

ORTHOPEDIC SURGERY ALTERNATIVE

Regenexx

*Available to employees enrolled in the **HODGE medical plan**.*

ENHANCE YOUR BODY'S NATURAL HEALING WITH REGENEXX!

Regenexx offers a lower-risk, lower-cost, minimally invasive option for many orthopedic surgeries, avoiding up to 70 percent of elective procedures. Using your blood platelets and bone marrow aspirate, Regenexx will process and inject them precisely at the injury site with image guidance. With Regenexx, you can get back to doing what you love without invasive surgery and lengthy recovery.

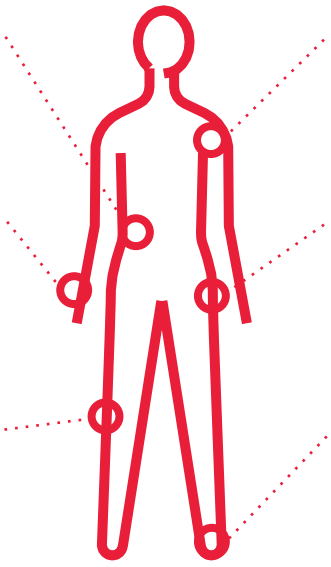
Regenexx offers a nonsurgical outpatient procedure, done in a day or three treatments over two weeks. Many patients, even those with health concerns like heart issues, can safely return to activity within a week, making it a preferable alternative to surgery.

Conditions Treated

Spine
back or neck nerve pain
bulging, collapsed, or herniated disc
ruptured or torn disc
degenerative disc disease
disc extrusion or protrusion

Hand/Wrist/Elbow
arthritis
carpal tunnel
CMC joint arthritis (thumb)
tennis elbow
trigger finger
ulnar nerve entrapment

Knee
arthritis
joint-replacement alternative
meniscus tear
sprain or tear of ACL/PCL or MCL/LCL
tendinopathy



Shoulder
arthritis
joint replacement alternative
labral tear
rotator cuff tears or tendinosis

Hip
arthritis
bursitis labral/labrum tear
joint-replacement alternative
osteonecrosis
tendinopathy

Ankle/Foot
achilles tendinopathy
arthritis
bunions
instability
ligament sprain or tear
plantar fasciitis

LEARN MORE

Consult with your health insurance to verify how Regenexx is covered.

For information on the Regenexx benefit and eligibility, contact the education center.

- Register for weekly webinars at www.regenexxbenefits.com/webinar?mailer.
- Contact us at 866-725-3519 or visit regenexxbenefits.com/hodgecompany

HEALTH & WELLNESS PROGRAM

Locate an in-network provider near you at www.mywellmark.com or call 800-524-9242.

HealthCheck360

The mission of the HODGE wellness program is *to create a corporate culture that places the health status and safety of employees amongst the highest priorities.* HealthCheck360 provides our biggest wellness benefit, including a biometric screening, Health Risk Assessment survey, and health coaching, available to all full-time employees and their spouses on the health plan at no cost. Through the HealthCheck360 screening process, you will be given the tools necessary to identify and improve your health and well-being. This benefit is offered in the Spring of each year. Employees hired after the screening period is completed will be eligible the following year.

HEALTH RISK ASSESSMENT – WHY PARTICIPATE?

- Know Your Numbers: Completing your biometric screening each year helps you identify your personal health risks and allows you to control your well-being.
- Save Money: HODGE feels strongly about supporting your health improvement and is offering reduced health plan premiums for participating and improving your health over time.
- Gain Awareness: Participants receive a personalized health report with information on "do-able" actions to improve current and future quality of life.
- Improve Your Health: Along with the biometric screening, you have access to educational newsletters and webinars, online and mobile tracking, and online wellness challenges through HealthCheck360.

Incentive Levels: Employees and spouses enrolled in the health plan can each receive the below reward based on their results leading to a maximum health insurance premium savings of $100/month.

- Gold Level: Score 85-100 or a 10-point improvement from the previous year's score for a $50 monthly discount.
- Silver Level: Score 75-84 or 5+ point improvement from the prior year for a $25 monthly discount.
- Participation Level: Employees that participate in the screening will receive 8 hours of PTO, if they complete the online survey and coaching call (if required) in the timeframe set by HODGE.

If you are unable to meet a health outcome for an incentive under the HealthCheck360 Program, you can work with HealthCheck360 for an opportunity to earn the same incentive through a reasonable alternative process. To speak with a representative about what options are available to you, contact HealthCheck360 at 1-866-511-0360

CONDITION MANAGEMENT

HealthCheck360's condition management program aids team members in managing their health, controlling medical expenses, and understanding the effects of recommended care guidelines on their well-being. The program also helps in having informed conversations with primary care physicians.

Covered conditions include:

- Diabetes
- High blood pressure
- High cholesterol.

If enrolled in the program, a dedicated nurse from HealthCheck360 will be reaching out to you directly to ensure all information is received by the end of the year deadline. All your information will remain secure and confidential.

HODGE Standard Insurance Rates: Participants who are up to date with the recommended cares will be considered compliant. Based on your compliance with office visits, labs, and medication as prescribed, you may qualify to keep the standard health insurance rates the following year. If a participant is not compliant during the first year, they will pay an additional $25/ pay period toward insurance premiums in the following year, starting January 1. If a participant is not compliant for two or more years after being considered for a deadline, they will pay $50/pay period toward insurance premiums in the following year, starting January 1.

HODGE is not involved in the management of your care, nor does HODGE have access to any of your care records. Our partners at HealthCheck360 only inform the company of who is enrolled in the program and who has completed recommended cares by the end of the year. This information is provided to HealthCheck360 by our insurance partners at Blue Cross Blue Shield and MedOne.

FLEXIBLE SPENDING ACCOUNT

Administered by iSolved

FSAs can save you money on eligible expenses because you don't have to pay taxes on the amount contributed to the account. However, using an FSA does require careful planning to reap the financial benefits.

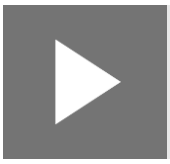
Health FSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Copays
- Coinsurance
- Other health-related expenses

2025 annual contribution limit	$3,300

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.



Is a Health FSA Right for You?
www.cbmicrosite.com/video/healthfsa

Dependent Care FSA

Set aside tax-free money to care for children under age 13 or an elderly, dependent parent who is unable to care for themselves. Cover care expenses while you work, such as:

- Preschool
- Summer day camp
- Before and after school programs
- Elder care

2025 annual contribution limit	Married (Filing separately)	$2,500
	Single/Married (Filing jointly)	$5,000

Visit www.irs.gov and search for IRS Publications 502 (Medical and Dental) and 503 (Dependent Care) to learn more about eligible expenses.

FLEXIBLE SPENDING DEBIT CARD

Card Basics:

- Two free cards per family (valid for 5 years)
- $5 fee for replacement cards
- Can be used as debit (with PIN) or credit (no PIN)
- Not usable at ATMs or for cash back

Where to Use:

- Hospitals and medical offices
- Dental offices
- Pharmacies
- IIAS-certified merchants

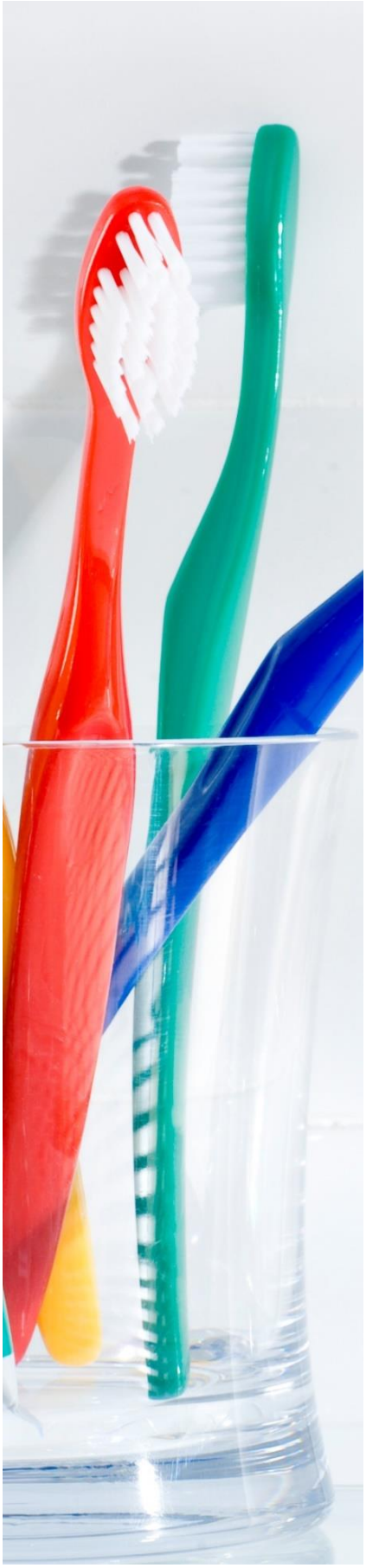
When Card Doesn't Work:

- Pay with another method
- Submit reimbursement claim
- Check eligibility using mobile app's "Scan Item" feature

Account Management:

- Access 24/7 through iSolved web portal and mobile app
- Medical and dependent care accounts remain separate
- Monitor balances and submit claims online

Frequently Asked Question	Answer
Why should I participate in an FSA?	You save on FICA and federal income taxes. Full medical FSA funds are available immediately, while contributions spread across paychecks.
When can I make FSA elections?	During open enrollment, upon being hired, or within 30 days of qualifying life events.
What happens if I leave the company?	You can be reimbursed only for expenses incurred before termination. Submit claims up to 90 days after termination.
What if I don't use all my FSA funds?	Unused funds are forfeited at year-end with no rollovers.
When can I incur and submit claims?	The plan year runs 6/1/2025-5/31/2026. Submit claims up to 90 days after the plan year ends (8/29/2025).



DENTAL

MetLife

In addition to protecting your smile, dental insurance helps pay for dental care. 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.

Dental	MetLife Plan	
	In-Network (PDP+ Network)[1]	Out-of-Network[1]
Annual Deductible	$25 per individual $75 per family	$25 per individual $75 per family
Annual Benefit Maximum	$2,000	$2,000
Lifetime Orthodontia Maximum	$1,500	$1,500
Plan Pays		
Preventive Care (Deductible waived)	100% Covered	100% Covered
Basic	80%	80%
Major	50%	50%
Orthodontia (up to age 19)	50%	50%

Locate an in-network provider near you to avoid expensive surprises at www.metlife.com or call (888) 438-6388.

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

[1] "In-Network Benefits" refers to benefits provided under this plan for covered dental services that are provided by a participating dentist. "Out-of-Network Benefits" refers to benefits provided under this plan for covered dental services that are not provided by a participating dentist.

[2] Negotiated fees refer to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

[3] Applies to Type B and C services only.

[4] Out-of-network benefits are payable for services rendered by a dentist who is not a participating provider. The Reasonable and Customary Charge is based on the lesser of:

- the dentist's actual charge (the 'Actual Charge') or
- the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife (the 'Customary Charge'). For your plan, the Customary Charge is based on the 99th percentile.

VISION

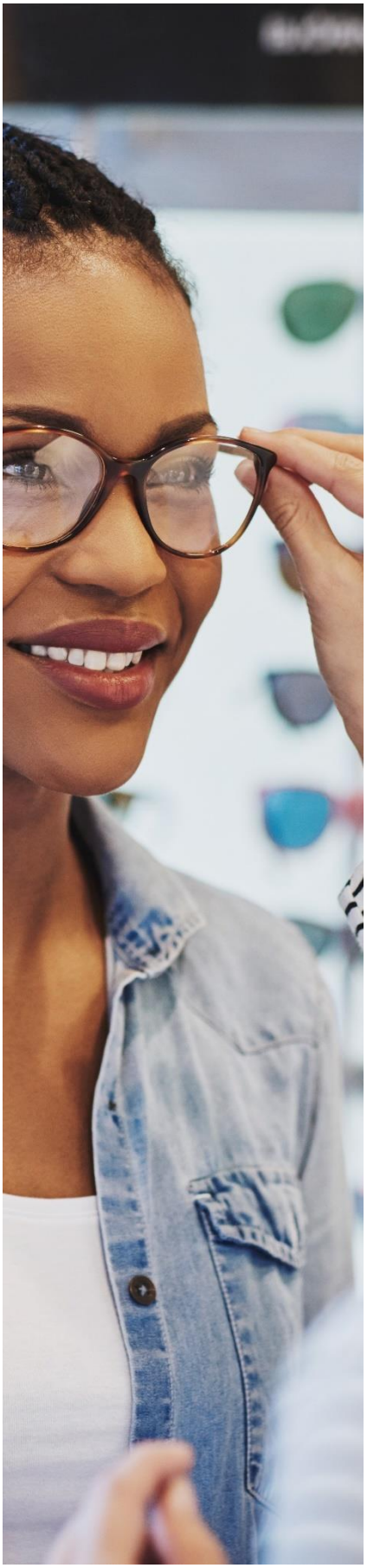
MetLife | VSP

Driving to work, reading news articles and watching TV are all activities you likely do every day. Your ability to do all 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. HODGE offers you this new option to enroll in voluntary Vision Insurance through MetLife/VSP.

Vision	MetLife/VSP Plan	
	In-Network	Out-of-Network
Copays	$10 Exam $25 Materials	None
Exam	100% after Copay	Up to $45 reimbursement
Lenses	*Single Vision:* 100% after Materials Copay *Lined Bifocal:* 100% after Materials Copay *Lined Trifocal:* 100% after Materials Copay *Lenticular:* 100% after Materials Copay	*Single Vision:* Up to $30 reimbursement *Lined Bifocal:* Up to $50 reimbursement *Lined Trifocal:* Up to $65 reimbursement *Lenticular:* Up to $100 reimbursement
Frames	$150 allowance $85 allowance at Costco, Walmart and Sam's Club	Up to $70 reimbursement
Contact Lenses	$150 retail allowance	Up to $105 reimbursement
Frequencies		
Exams	1 per 12 months	
Lenses	1 per 12 months	
Frames	1 per 24 months	
Contact Lenses	1 per 12 months; in lieu of lenses/frames glasses	

Locate an in-network choose "Vision PPO" provider near you at www.metlife.com or call (888) 438-6388.

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.



LIFE/AD&D

Mutual of Omaha

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

Basic Life/AD&D	
Benefit Amount	**Employee:** $15,000*
Benefit Cost	Employer-provided

Voluntary Term Life/AD&D	
Benefit Amount	**Employee:** The lesser of 5x your annual earnings up to a maximum of $500,000. ($10,000 increment) **Spouse:** Maximum of $100,000 ($5,000 increment)^ **Child(ren):** $10,000^
Guaranteed Issue Amount[A]	**Employee:** 5x Annual Earning or $150,000, whichever is less. **Spouse:** $30,000^ **Child(ren):** $10,000^
Benefit Cost	To view your personalized rates, contact HR or refer to your benefit highlight sheet for details.

Benefits may be reduced for employees over age 65 per ADEA.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at time of the effective date. Please refer to the policy certificate or HR for more details.

Definition of "Eligible Dependents"
It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies.

- **Spouse:** Eligibility may terminate at Spouse age 70.
- **Child:** Eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs. Benefits may be limited for children under age 6 months.

Please refer to the policy certificate or HR for more information.

REMEMBER TO UPDATE YOUR BENEFICIARIES.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

^ Dependent elections require employee enrollment and may be limited by employee volume.

A If you enroll when first eligible, you may receive up to the listed amount without having to answer medical questions.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

DISABILITY

Mutual of Omaha

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

Short-Term Disability	
Benefit Amount	Replaces 60% of earnings, up to a $1,000 benefit per week
Benefit Begins	Injury: after 7 days Illness: after 7 days
Benefit Duration	Up to 26 weeks
Pre-Existing Condition Limitations	3-month look back period 6-month exclusion period
Benefit Cost	To view your personalized rates, contact HR or refer to your benefit highlight sheet for details.

Short-term disability excludes work-related injury or illness.

Long-Term Disability	
Benefit Amount	Replaces 60% of earnings, up to a $6,000 benefit per month
Benefit Begins	After a period of 180 days
Benefit Duration	See HR for details
Pre-Existing Condition Limitations	3-month look back period 6-month exclusion period
Benefit Cost	Employer-provided

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Pre-Existing Condition Limitations:
If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Statutory Benefits Offset:
Your short-term disability benefit will be reduced by benefits from State Disability/Paid Family & Medical Leave for which you may be eligible.

SUPPLEMENTAL HEALTH

MetLife

The following benefits may protect your financial security in the event of an unexpected medical expense.

Accident

Helps cover the cost of expenses if you are injured in a non-work-related, covered accident.

Benefit Amount	Benefit amounts vary by severity. See schedule of benefits for details.	
Wellness Benefit	$50	
Common Covered Injuries	Dislocations Fractures	Concussions Lacerations
Common Medical Services	Ambulance Emergency room visits Hospital admission	Surgical benefits Follow-up treatments
Other Benefits	Travel Lodging Child organized sports-rider	Accidental death and dismemberment

Critical Illness

Helps cover the cost of expenses if you are diagnosed with a covered condition.

Benefit Amount	**Employee:** $15,000 or $30,000 **Spouse:** 50% of the employee's Initial Benefit **Child:** 50% of the employee's Initial Benefit	
Wellness Benefit	$50	
Common Covered Conditions	Cancer Heart attack Stroke	Major organ failure Degenerative neurological disorders

GET PAID FOR TAKING CARE OF YOUR HEALTH!

If you are enrolled in coverage, you can receive a wellness benefit payment each year when you have a qualifying screening or test.

Hospital Indemnity

Helps cover the cost of hospital stays—including pregnancy and childbirth.

Benefit Amount	$1,500 hospital admission benefit $100 daily confinement
Wellness Benefit	$100
Pre-Existing Condition Limitations	None

NEW in 2025

Supplemental Health Cost	To view your personalized rates, contact HR or refer to your benefit highlight sheet for details.

Actively-at-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-at-Work/eligible status.

Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at the time of the effective date. Please refer to the policy certificate or HR for more details.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

EMPLOYEE ASSISTANCE PROGRAM

Mutual of Omaha

Available to all eligible employees.

Life. Just when you think you've got it figured out, along comes a challenge. This safe and confidential program is here for you and can help you and your family find solutions and peace of mind.

CONFIDENTIAL SUPPORT

- Alcohol or substance abuse
- Childcare
- Eldercare
- Financial problems
- Gambling addiction
- Grief and loss
- Job pressures
- Mental health
- Legal concerns
- Relationships

CONNECT WITH A COUNSELOR.

800-316-2796

mutualofomaha.com/eap

UP TO 3 FREE COUNSELING SESSIONS EACH YEAR!

If you need additional support, the EAP team will try to refer you to resources that are affordable or covered by your medical insurance.

401(K) RETIREMENT PLAN

July Services

ELIGIBILITY REQUIREMENTS:

Deferrals

- All employees must be at least 18 years of age to participate in the 401(k) plan.
- Those eligible can participate in the plan on the first day of each quarter immediately following hire.
- Plan quarters begin January 1, April 1, July 1 and October 1.

Employer Contribution (Match and Non-elective)

- All employees must be at least 18 years of age to participate in the 401(k) plan.
- Minimum one year of service.
- At least 1000 hours worked in a rolling 12-month period.

CONTRIBUTIONS:

- Elective Deferrals:
  - May contribute up to 75% of eligible compensation or up to the IRS deferral limit for a given year whichever is lower.
  - Catch-up contributions permitted.
- Rollover into the Plan: Employees may roll qualified retirement accounts into the plan from outside providers. Contact July Services for further instruction
- Matching Contributions: Match formula is 50% up to 6% (3% maximum match). Match is at the discretion of the employer and is subject to change without notice. Match, when funded, is contributed per pay period.
- Non-elective Contribution:
  - Discretionary with employer.
  - If elected by the employer, an employee must be employed on the last day of Plan Year and have completed at least 1,000 hours of service during the plan year. These conditions are waived if employee terminates due to death, disability or has reached normal retirement age as defined by the plan document.

VESTING SCHEDULE FOR EMPLOYER CONTRIBUTIONS:

For an employee to become fully vested in employer contributions made on their behalf an employee must complete the following vesting schedule:

- 1 year of service: 0%
- 2 years of service: 25%
- 3 years of service: 50%
- 4 years of service: 75%
- 5 years of service: 100%

**A year of service is defined as working anniversary date to anniversary date without regard for how many hours worked during a given anniversary year.

MISCELLANEOUS:

Distributions

- Distributions are allowed to be taken at separation of employment or attainment of age 59.5.
- Distributions may be distributed as a lump-sum, partial withdrawal, or installment payments.

Loans

- Only one (1) outstanding loan permitted at a time per participant.
- Minimum loan amount is $1,000.
- Call July Services for additional information on availability.

Hardship Distributions

Permitted for the following reasons with supporting documentation:

- Medical expenses
- To prevent eviction or foreclosure
- Purchase of a primary residence
- Funeral expenses
- Secondary education tuition
- Natural Disaster assistance

Log into your July Services account today to review your selections and manage your contribution rates!
https://www.julyservices.com/for-employees/start-here/
Company Code (if needed): 70006

Questions? Contact July Services at PSATeam@julyservices.com or call 888.333.6315

STATE & FEDERAL BENEFITS

FEDlogic

We have partnered with FEDlogic to provide state and federal benefits information and advocacy to you and your household members.

THE SERVICE IS FREE, UNLIMITED, AND CONFIDENTIAL!

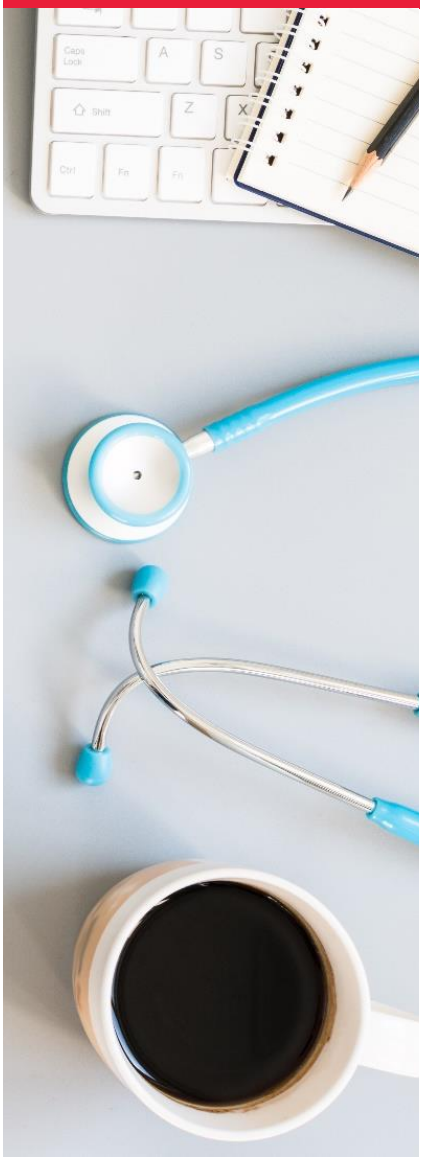
Get help navigating resources that you may be eligible for, such as:

- Medicare
- Medicaid
- Disability
- Social Security Retirement
- Child Benefits
- Widow Benefits
- Veterans Benefits
- Supplemental Security Income (SSI)
- Healthcare.gov (COBRA alternatives)
- End Stage Renal Disease
- ALS (Lou Gehrig's Disease)
- Cancer or Terminal Illness

Schedule a consultation today!

(877) 837-4196

www.fedlogicgroup.com
services@fedlogicgroup.com



HERE'S HOW IT WORKS:

1. **Make a phone consultation appointment.**

   Call to schedule time with a federal and state benefits expert. Invite your family to join. Calls typically last an hour.

2. **Tell us your story, ask questions, and learn.**

   Experts will listen to your story and understand your needs, then empower you with unbiased information so you can make the best decisions for your situation.

3. **If qualified, get enrolled.**

   Once you feel confident with the information, experts will walk you through the application and approval process.

4. **Enjoy peace of mind.**

   Now you know you have access to assistance programs created for situations like this.

HODGE LEAVES OF ABSENCE POLICIES

The following benefits are subject to change at any time without notice. For specific details, see Human Resources.

FAMILY AND MEDICAL LEAVE (FMLA)

Eligible Employees receive up to 12 weeks, unpaid, job-protected leave for:

- Care for newborn/adopted child
- Employee's serious health condition
- Care for family members with serious health condition
- Family leaves due to active duty
- Caregivers leave for injured service members (up to 26 weeks)

Eligibility requires:

- 50+ Employees within 75-mile radius
- 12+ months employment
- 1,250+ hours worked in the preceding 12 months
- 30 days' notice (when possible)
- Not a "Key Employee" per FMLA

12-month period calculated as rolling backward from leave date. Medical certification may be required. Contact HR for state-specific requirements.

PERSONAL LEAVE

Up to 30 calendar days for serious circumstances when not covered by other leaves. Must use available PTO. Requires approval from Supervisor, Operations Manager, and HR Manager. Reinstatement when possible. Benefit continuation requires arrangement with HR.

MILITARY LEAVE

Complies with USERRA and state laws. Documentation required. Reinstatement according to law. Contact HR for details

PARENTAL AND MATERNITY LEAVE

The following benefits are subject to change at any time without notice. For specific details, see Human Resources.

PAID MATERNITY LEAVE:

HODGE provides up to six weeks (240 hours) of paid maternity leave to benefit-eligible employees following the birth of a child or the placement of a child in connection with adoption or foster care. This leave will be paid at 40% of an employee's salary or hourly rate of pay.

The purpose of paid maternity leave is to enable the employee to recover from childbirth, and care for a newborn, newly adopted, or newly placed foster child.

This leave will run concurrently with the Family and Medical Leave Act (FMLA), if applicable.

PAID PATERNITY LEAVE:

HODGE provides up to two weeks (80 hours) of paid paternity leave to benefit eligible employees. This leave will be paid at 40% of an employee's salary or hourly rate of pay.

This leave will run concurrently with the Family and Medical Leave Act (FMLA), if applicable.

Employees must take paid paternity leave in one continuous period and must use the entirety of the leave within 30 days of the birth or placement of the child(ren).
Any unused leave will be forfeited at the end of the 30-day period.

ELIGIBILITY

To be eligible for paternal and maternity leave, an employee:

- Must be employed by HODGE for six months or more prior to taking the leave.
- Must be a full-time regular employee.
    - Temporary employees, part-time employees, and interns are not eligible.

In addition, an employee must meet at least one of the following criteria:

- Has given birth to a child within the past 30 days.
- Is a spouse of a person who has given birth to a child within the past 30 days.
- Has adopted a child or been placed with a foster child that is 17 years of age or younger within the past 30 days).
    - *The adoption of a new spouse's child is excluded from this policy.*

SHORT-TERM DISABILITY

Employees who have given birth and have elected to participate in the voluntary short-term disability benefit may file a claim to receive payments during their leave.

If approved, short-term disability will pay 60% of the employees' total income per week, up to a maximum of $1,000 per week. A one-week elimination period will apply.

Some exclusions to short-term disability may apply based on the pre-existing condition limitation detailed on page 20 of HODGE's Benefits Guide.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Employees may also be eligible for leave under the provisions of the Family and Medical Leave Act.

FMLA provides eligible employees leave for several reasons, including:

- To care for the employee's newborn child, or placement of a child for adoption/foster care.
- For a serious health condition that makes the employee unable to perform his/her job.

Please contact our Benefits Administrator with any questions.

HODGE POLICIES

The following benefits are subject to change at any time without notice. For specific details, see Human Resources.

PAID TIME OFF (PTO)

Full-time Employees receive PTO based on length of service:

- First year: 64 hours
- After one year: 104 hours
- After two years: 144 hours
- After ten years: 184 hours
- After fifteen years*: 224 hours

*For Employees hired before December 1, 2010

**Part time employees are eligible for 40 hours of Paid Leave to be used on regularly scheduled working days. Paid Leave is awarded annually with no carryover.

PTO must be pre-approved by your Supervisor.

PTO pay is eight hours at the current rate per full day. May be taken in one-hour increments.

Employees may not "borrow" PTO from next year's allotment.

No unpaid time off granted if PTO is available, unless approved.

Up to 40 hours may carry over annually.

HODGE shall not pay out, reimburse, or provide any other financial benefit for unused Paid Leave upon an employee's termination, resignation, retirement, or other separation from employment.

For Illinois Employee's Explanation of Benefits

The Illinois Paid Leave for All Workers Act provides paid leave ("PLAW Leave") for Illinois workers to maintain their health and well-being, care for their families, or use for any other reason of their choosing. PLAW Leave earned and granted under this policy is not personal, sick, or vacation leave, but rather is considered paid leave under the Illinois PLAW Act. Unused PLAW Leave is not subject to payout at the end of employment.

HOLIDAYS

Hodge observes the following holidays:

- New Year's Day
- Memorial Day
- Independence Day (July 4th)
- Labor Day
- Thanksgiving Day
- Friday after Thanksgiving
- Christmas Day

Full-time Employees receive 8 hours holiday pay; part-time receive 4 hours. Must work scheduled days before/after holiday to qualify. Company may designate alternative days or issue pay for weekend holidays. Holiday pay not applicable on last day of employment.

LEAVES OF ABSENCE

Submit requests promptly to supervisor for consideration.

HODGE POLICIES CONTINUED

The following benefits are subject to change at any time without notice. For specific details, see Human Resources.

BEREAVEMENT

Full-time: 8 hours pay per day; Part-time: 4 hours. Should be use by funeral date unless approved for delayed services or celebration of life.

Spouse, Child (Step)	**5 days**
Parent (Step), Spouse Parent (Step), Grandparent, Spouse Grandparent, Grandchild, Sibling, Brother/Sister in-law, Son/Daughter in-law, Others in household.	**3 days**
Aunt/Uncle, Niece/Nephew	**1 day**

BONE MARROW AND ORGAN DONATION LEAVE

Up to six weeks unpaid leave for eligible Employees (employee who has worked for the employer for 52 consecutive weeks and has worked at least 1000 hours during those weeks). Requires:

- Advance notice
- Reasonable scheduling
- Medical certification Health insurance maintained; position protected upon return.

JURY/WITNESS DUTY

- Jury service: Paid difference between regular earnings and jury fees for up to 10 days (full-time).
- Witness duty: Unpaid time off allowed.

VOTING

Time off granted when necessary. Should be taken at beginning/end of shift. Notify supervisor two days prior when possible.

BENEFITS CONTINUATION (COBRA)

Allows continued health coverage when qualifying events cause loss of eligibility. Employee/dependent pays full cost, plus admin fee. Written notice provided when eligible.

BENEFIT TERMS

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

DEFINITIONS

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

ACRONYMS

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

HODGE GROUP HEALTH AND WELFARE PLAN: IMPORTANT DISCLOSURES & NOTICES

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of March 17, 2025. V 0.5.0. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://dhss.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program
Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+ Website: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

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

GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

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

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

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

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

Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

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

MAINE – Medicaid
Enrollment Website:
https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine Relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

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

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

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

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

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

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

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

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

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

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

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

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

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

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

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

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

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

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

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

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

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone:
1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

Notice Regarding Wellness Program

HealthCheck360 is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions. You will also be asked to complete a biometric screening, which will include a blood test for diabetes and cholesterol. You are not required to complete the HRA or to participate in the blood test or other medical examinations. Employees who choose to participate in the wellness program will receive an incentive of reduced monthly medical premiums for participation in the Health Risk Assessment program. The amount of the reduction is based on

the results of the annual HRA and biometric screening. Although employees are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You are also encouraged to share your results or concerns with your own doctor.

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and HODGE may use aggregate information it collects to design a program based on identified health risks in the workplace, HealthCheck360 will never disclose any of your personal information except as necessary to respond to a request form you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a registered nurse or health coach in order to provide you with services under the wellness program. In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. ❖

Patient Protection Notice

If the HODGE Group Health and Welfare Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

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.
- Treatment of physical complications of the mastectomy, including lymphedema.

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

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?

Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

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

Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.02% of household income for the year, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

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

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including 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 the area.

* 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% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)
If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices
The HODGE Company Group Medical Plan (the "Plan"), which includes medical, dental and flexible spending account coverages offered under the HODGE Company Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures HODGE Company has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:
As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:
When required to do so by any federal, state or local law.

4. Health Oversight Activities:
To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:
As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written

notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:
To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:
If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:
For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation:
As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach
HODGE Company is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at HODGE Company, 400 Ice Harbor Dr, Dubuque IA 52002, 563-583-9781.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at HODGE Company, 400 Ice Harbor Dr, Dubuque IA 52002, 563-583-9781. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at HODGE Company, 400 Ice Harbor Dr, Dubuque IA 52002, 563-583-9781. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures:
An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at HODGE Company, 400 Ice Harbor Dr, Dubuque IA 52002, 563-583-9781. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at HODGE Company, 400 Ice Harbor Dr, Dubuque IA 52002, 563-583-9781. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice:
Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at HODGE Company, 400 Ice Harbor Dr, Dubuque IA 52002, 563-583-9781 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person:
If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at HODGE Company, 400 Ice Harbor Dr, Dubuque IA 52002, 563-583-9781. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from HODGE Group Health and Welfare Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with HODGE Company 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. HODGE Company has determined that the prescription drug coverage offered by the HODGE Company Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current HODGE Company coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current HODGE Company coverage, be aware that you and your dependents will be able to get this coverage back.

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

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

For More Information about this Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage

through HODGE Company changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 04/21/2025
Name of Entity/Sender: HODGE Company
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