HODGE

EMPLOYEE BENEFITS GUIDE 2023 / 2024

WHATEVER IT TAKES

MEDICARE D COVERAGE DISCLOSURE IS LOCATED ON PAGE 22-28.

TABLE OF CONTENTS

HODGE

WELCOME TO YOUR EMPLOYEE BENEFITS!

At HODGE, we understand that your life extends beyond the workplace. That is why we offer a variety of benefit plans to help you and your family. We provide health and financial security options so you can focus on being the best at what you do and enjoy your life.

As an Employee of HODGE, you have the opportunity to enroll in valuable benefits to protect the health and financial security of you and your family. Within this guide you will find the highlights of each of the benefits including medical, dental and vision insurance, life insurance, disability insurance, and more! Some of these coverages are paid for entirely by HODGE and you will be automatically enrolled when eligible. Others are yours to choose and if elected will be paid for through convenient payroll deductions as long as you are a benefit-eligible employee of HODGE.

We encourage you to read through this guide, share it with your family members, and ask us any questions you have so you are educated and empowered to choose the benefits that are best for you. Make sure to complete your enrollment before the deadline to ensure you have coverage.

IMPORTANT MESSAGE TO EMPLOYEES:

Our goal is to provide the highest quality and most affordable coverage possible to our employees. Highlights for 2023 benefits include:

- **Medical** – Staying with Wellmark Blue Cross and Blue Shield. Wellmark Blue Cross and Blue Shield offers a broad national provider network.
- **Accident & Critical Illness Plans** – Protect your wallet from unexpected expenses related to injuries and illness through these affordable benefits.
- **Dental** – Coverage provided by MetLife. MetLife offers a national network of dentist which will help control dental costs. You can still go anywhere, however, if you are out of network, there is a slight chance for balance billing.
- **Vision** – Coverage provided by MetLife! MetLife is offering a stand-alone vision plan which offers enhanced benefits at very affordable rates.
- **Voluntary Life and AD&D** – New hires can enroll up to $150,000 without answering health questions! Accidental Death & Dismemberment will be 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.
- **Short & Long Term Disability** – We strive to provide you adequate coverage at the best possible rates. Long Term Disability is provided at no cost to you. You can purchase Short Term Disability to help protect your income.

IMPORTANT: All employees are required to log in to iSolved to elect, change or waive benefits for 2023. You can access iSolved through the Benefits Hub.

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

Scan the QR code with your mobile device. Simply open your camera app, hover over the square, and tap on the link.

BENEFIT CONTACT INFORMATION

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
Wellness Program	HealthCheck360	support@HealthCheck360.com myhealthcheck360.com 866-511-0360
Flexible Spending Accounts	iSolved	FSA@iSolvedhcm.com www.iSolvedbenefitservices.com (800) 300-3838
Accident Insurance	MetLife	www.metlife.com/mybenefits (888) 438-6388
Critical Illness Insurance		
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	Heartland Financial	retirement@heartlandrps.com 800-399-2083
HODGE Benefits Department Contact	Email/Phone	Company Address
HR@hodgecompany.com	(563) 587-6920	7465 Chavenelle Road Dubuque, IA 52002

The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

ENROLLMENT, ELIGIBILITY & CHANGES

Current Employees: Annual open enrollment happens each year in May. This is your opportunity to add or drop dependents and benefits. Once Open Enrollment ends, you will not have another opportunity to make changes until next year unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

New Employees: This is your chance to elect benefits and enroll yourself and your eligible dependents. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverages. If you take no action now, you will have no benefits and you will not have another chance to elect them until next year's open enrollment - unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

Employee Eligibility (Medical, Dental and Vision Benefits)

- Direct Hire Employees: Eligible for coverage on the first day of the month following 30 days of Employment.
- Agency 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 & Agency Employees: Eligible for coverage on the first day of the month following 30 days of Employment.

Employee Eligibility (Retirement Plan Benefits)

- Direct Hire & Agency Employees: Eligible for coverage on the first day of next Quarter following HODGE Hire Date. (January / April / July / October)

Your Eligible Dependents

- Your legally married spouse who is a resident of the same country in which the Employee resides. 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 up to age 26 including natural born, step-children, legally adopted, or children placed with you for adoption.
- Children up to age 26 whose primary residence is with the employee and who depend upon the employee for support and maintenance, for whom the employee or employee's spouse has been named legal guardian.
- Children of the employee who are required to be covered by reason of a Qualified Medical Child Support Order (QMCSO), as defined in ERISA §609(a).

Benefit election changes during the year may be made for the following reasons (qualifying events):

- Changes in the employee's legal marital status such as marriage, divorce, separation, or the death of a spouse.
- A change in the number of dependents such as birth, death, or adoption.
- Changes in employment status of the employee or of the employee's spouse or dependents. This includes at the beginning or ending of employment, new or different work hours, change from full-time to part-time status or vice versa.
- An employee's spouse's Open Enrollment
- A dependent becomes eligible or ceases to be eligible for coverage due to age.
- Employee, spouse or dependent becoming, or ceasing to be, eligible for Medicare or Medicaid.
- A judgment, decree, or order that results from a divorce or legal separation.
- **An election change must be made within 30 days of the qualifying event.**

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.

HOW MY MEDICAL PLAN WORKS

Participating Provider Option (PPO)

The HODGE Health Plan uses a PPO Network, which is all about choice. You get to choose which providers to visit each time you need care and you can help control your own medical costs by choosing providers from within the PPO. When you go out-of-network, you can visit any doctor or hospital you want, but you pay a greater portion of the cost. To search for a provider, please go to www.mywellmark.com, click on find a provider and continue your search.

In-Network Benefits

- When you visit a provider that is within the PPO network, you will maximize the benefits of your medical plan. You do not have to select a Primary Care Physician, nor do you need a referral to see a specialist. Simply visit any doctor you choose within the PPO network for whatever care you need.
- Even within the PPO Network, you are responsible for the annual deductible before your plan begins paying coinsurance for most benefits. After your deductible is met, you are only responsible for your portion up to your annual out-of-pocket maximum.

Out-of-Network Benefits

- Your plan allows you to visit any provider you want, even if they are not within the PPO network. However, you will pay more for the services of any provider who is out-of-network and you will have to satisfy your out-of-network deductible before the plan's coinsurance kicks in.
- When you visit an out-of-network provider, the plan bases its payments on what it considers the usual, customary, and reasonable rate (UCR) for each service provided. If the charge incurred is more than the UCR limit set forth by the plan, you are responsible for paying the full difference between the charge and what the plan pays.
- When you receive out-of-network care, you are responsible for filing claim forms for reimbursement. As with in-network providers, you will still need to contact Wellmark Blue Cross and Blue Shield to pre-certify hospital stays and certain outpatient procedures.

Hospital Pre-Admission Certification:

- The Plan requires that all non-emergency inpatient hospitalizations be pre-certified prior to the hospitalization.
- If an individual fails to pre-certify a Hospital stay, eligible expenses related to the hospitalization will be payable at 50% to a maximum penalty of $500. (The penalty does not apply to the Annual Deductible or Out of Pocket Maximum.)

Outpatient Management Pre-Certification:

- The Plan requires that certain scheduled procedures/services be pre-certified prior to receiving treatment/service. Emergency outpatient services do not require pre-certification.
- If you are unsure if a procedure or service should be pre-certified, call Wellmark Blue Cross and Blue Shield and speak to someone about pre-certification by using the number on your medical ID card.

How to Pre-Certify:

- **Call Wellmark Blue Cross and Blue Shield at 800-552-3993**
- *Pre-certification is not a guarantee of benefits!*

MEDICAL PLAN SUMMARY

Wellmark Blue Cross and Blue Shield

HODGE offers you medical insurance administered by **Wellmark Blue Cross and Blue Shield**. This plan allows you to receive care both in and out of network; however, you will always get the most out of your benefits and pay less out of pocket by staying in-network. Please log into www.wellmark.com or call the number on the back of your ID card if you need assistance locating an in-network provider.

Medical Plan Details	In-Network	Out-of-Network
Calendar Year Deductible	Single: $2,500 / Family: $5,000	Single: $5,000 / Family: $10,000
Coinsurance *(% paid after reaching your deductible)*	Plan Pays: 80% Employee Pays: 20%	Plan Pays: 60% Employee Pays: 40%
Medical Out-of-Pocket Maximum	Single: $6,850 / Family: $13,700	Single: $10,000 / Family: $20,000
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 a new medication for the first time.

DENTAL PLAN SUMMARY

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.

It is important to note: the plan bases its payment off the "reasonable and customary" charges for each service. If you see a dentist who charges more than the plan considers reasonable, you may be left to pay the "balance bill" to the dentist yourself. **Avoid expensive surprises** by visiting an in-network provider with MetLife. You can look up providers at www.metlife.com using the "PDP+" Dental Network.

DENTAL COVERAGE HIGHLIGHTS	In-Network (PDP+ Network) [1]	Out-of-Network[1]
Reimbursement	% of Negotiated Fee Schedule[2]	% of R&C Fee[4]
Type A - Preventive Care	100%	100%
Type B - Basic Services	80%	80%
Type C - Major Services	50%	50%
Annual Deductible[3]	$25 / $75	$25 / $75
Annual Benefit Maximum	$2,000	$2,000

[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.

Examples of Type A, B & C Include but are not limited to:

- ***Type A:*** *Oral Exams, Routine Cleaning & Scaling, Fluoride (kids under 19), Space Maintainers (kids under 15), Sealants (kids under 15), Dental X-rays, Etc.*
- ***Type B:*** *Oral Surgery, Extractions, Fillings, Emergency Palliative Treatment, General Anesthesia, Prefabricated Crowns, Periodontal Maintenance, Etc.*
- ***Type C:*** *Bridges, Dentures, Crowns, Inlays, Onlays, Endodontics Root Canal, Periodontal Surgery, Periodontal Scaling and Root Planing, Etc.*



VOLUNTARY VISION PLAN SUMMARY

MetLife/VSP

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of 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.

Go to www.metlife.com and choose “Vision PPO” to look up in-network providers.

Vision Plan Details	In-Network	Out-of-Network
Copays	$10 Exam $25 Materials	None
Exam Once every 12 months	100% after Copay	Up to $45 reimbursement
Lenses Once every 12 months	***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 Once every 24 months	$150 allowance $85 allowance at Costco, Walmart and Sam’s Club	Up to $70 reimbursement
Contact Lenses Once every 12 months; in lieu of lenses/frames glasses	$150 retail allowance	Up to $105 reimbursement

***Limitations:** One set of frames and lenses OR one regimen of contacts (but not both) in a 24 month period. (Does not cover sunglasses.)*

FLEXIBLE SPENDING ACCOUNTS

Administered by iSolved

HODGE offers you two different Flexible Spending Account (FSA) options: a Medical Reimbursement Account and a Dependent Care Reimbursement Account. By using these accounts, you can save money and bring home more of your income by paying for medical care and dependent care expenses using PRE-TAX dollars from your payroll.

How Much Can I Save by Using an FSA?

FSAs provide you with an important tax advantage that can help you pay for health care expenses on a pre-tax basis. Due to the personal tax savings you incur, your spendable income will increase. The example that follows illustrates how an FSA can save money. *Bob and Jane's combined gross income is $30,000. They are married and file their income taxes jointly. Since Bob and Jane expect to spend $3,500 in medical expenses in the next plan year, they decide to direct a total of $3,050 (the maximum allowed amount per individual, for that taxable year) into their medical FSAs.*

	Without FSA	With FSA
Gross income	$30,000	$30,000
FSA contributions	$0	(-$3,050)
Gross income	$30,000	$26,950
Estimated taxes		
Federal	(-$2,550*)	(-$1,776*)
State	(-$900**)	(-$809**)
FICA	(-$2,295)	(-$2,084)
After-tax earnings	$24,255	$22,423
Eligible out-of-pocket medical expenses	(-$3,500)	(-$450)
Remaining spendable income	$20,755	$22,003
Spendable income increase	--	$1,248

**Assumes standard deductions and four exemptions. **Varies, assumes 3 percent. This example is for illustrative purposes only. Every situation varies and it is recommended you consult a tax advisor for all tax advice.*

FSA Frequently Asked Questions

- **Why Participate?** When you participate, you save on FICA and federal income tax. You are not taxed on the income you choose to divert to your FSA. Also, the money in your medical FSA is available for you to use immediately at the start of the plan-year even though your contributions come out evenly across your paychecks all year.
- **When Can I Make Elections?** You need to make your election during open enrollment or upon being hired. You may not make changes outside these times unless you experience a qualifying life event and alert HR/make your changes within 30 days of that event.
- **What If I Leave The Company?** You would be entitled to reimbursement for expenses which were incurred within the same plan year and before your termination date. Your plan allows you to submit claims up to 90 days after termination in the plan.
- **What If I Don't Spend All of My Money Within The Year?** Flexible Spending Accounts are "Use it, or Lose it". This means that whatever money is left in your account at the end of the plan year will be forfeited and will not rollover into the following year.
- **When Can I Incur and Submit Claims?** The plan year runs from 6/1/2023 - 5/31/2024. You may incur expenses during that time and you may submit claims for reimbursement through 90 days following the close of the plan year (8/29/2024).

FLEXIBLE SPENDING DEBIT CARD

Administered by iSolved

If you sign up for the Flexible Spending Account, you will receive a debit card to use when paying for eligible expenses. No more paying out-of-pocket and waiting for reimbursement! iSolved supplies up to two pre-paid debit cards per family at no cost. These cards are good for five years. If you need a replacement card, there is a $5 fee.

Using Your Flex Card:

How does the Flex Card work? Present the debit card as payment for eligible goods and services. Qualified purchases will be paid directly from your Flex Account. The Flex Card works like any other debit card, except with a few important differences:

- It is limited to specific merchants and eligible expenses. Review your Flexible Spending Enrollment Packet for more details and specific examples of eligible expenses.
- You can use the Scan Item option in the mobile app to determine if an item is an eligible expense
- Your debit card transactions can be done as debit with the PIN provided, or as credit with no PIN required.
- The debit card cannot be used at an ATM or for cash back when making a purchase.

Where can I use my Flex Card? You can use your debit card at qualified locations, including hospitals, physician and dental offices, pharmacies and merchants with IIAS certification.

What is IIAS? IIAS is an Inventory Information Approval System as specified by the IRS. This system allows retailers to automatically substantiate eligible purchases through their inventory control system. For example, if you purchase contact lens solution, which is an eligible expense, the UPC code will recognize that item as eligible and will allow the charge on your debit card. Shopping at a retailer with the IIAS system, only the eligible items will be process on your debit card. Any remaining items will need to be paid for with another form of payment.

What if there is not enough money in the account to cover the entire purchase? Your claims will be paid in full, up to the annual amount you have elected to have withheld for the plan year. Once you have reached your election limit, you will pay any remaining charges out of pocket with the method of your choice.

Dependent care reimbursement account claims will be processed and paid up to the balance in your account. If your claim exceeds that balance, iSolved will automatically reprocess your claims as your balance allows.

Please Note: Although you only have one debit card for all FSA activity, the medical reimbursement account is separate from the dependent care account. Balances cannot be transferred from one account to the other.

What if a doctor or merchant does not accept the debit card? You will need to use another form of payment, and submit a request for reimbursement. Review your Flexible Spending Enrollment Packet for details on how to submit a claim for reimbursement.

Flexible Spending Web Portal:

Enjoy secure access to accounts 24/7/365. ISolved's user friendly web portal and mobile app will be available if you select the FSA option during open enrollment. An additional web portal guide will be provided to you with further information.

VOLUNTARY TERM LIFE/AD&D PLAN SUMMARY

Mutual of Omaha

In addition to the basic life insurance benefit provided by HODGE, you have the opportunity to purchase Term Life and Accidental Death & Dismemberment (AD&D) coverage through **Mutual of Omaha**. AD&D coverage provides an additional benefit on top of the Life Insurance if death is caused by a covered accident or if you suffer a covered dismemberment even if it does not result in death. For a list of your employee premiums, see Human Resources.

Voluntary Life and Accidental Death & Dismemberment Plan Details	
Term Life and AD&D Coverage Amounts	**Employee Amount:** The lesser of 5x your annual earnings up to a maximum of $500,000. ($10,000 increment) **Spouse Amount:** Maximum of $100,000, not to exceed 50% of employee amount. ($5,000 increment) **Dependent Child(ren) Amount:** $10,000.
Guarantee Issue Amount*	**Employee Amount:** 5 times Annual Earning or $150,000, whichever is less. **Spouse Amount:** $30,000 (valid only with Employee coverage purchased) **Dependent Child(ren) Amount:** $10,000 (valid only with Employee coverage purchased).
Reduction Schedule	Life Benefit amount will reduce 35% at age 65, 50% at age 70.
Benefit Cost	100% Employee Paid. See HR for benefit levels and costs.

***Guarantee Issue Amount:** This is the amount of Life and AD&D Insurance you may purchase without answering medical questions AS LONG AS you elect it at your first opportunity (i.e. as a new hire). If you decline coverage then choose to elect it in the future, you will be subject to approval based on medical questions.*

***Delayed Effective Date Notice:** If you are not Actively Working on the day any new election or increase in insurance would otherwise take effect, the new election or increase will become effective on the day the Employee returns to Active Work. Dependents that are confined to a hospital as inpatient, any institution or facility other than a hospital or at home and under the care or supervision of a physician on the day insurance is to begin will not take effect until the day after the Dependent is no longer confined.*

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

ACCIDENT INSURANCE

MetLife

If you are accidentally injured, accident insurance can help you take care of out-of-pocket expenses and medical costs beyond what your existing health insurance plan covers.

Accidental Injury Benefits	Plan Benefits
Fracture Benefit*	$100- $6,000 depending on the fracture and type of repair
Dislocation Benefit*	$100- $8,000 depending on the dislocation and type of repair
Second or Third Degree Burn Benefit	$75- $10,000 depending on the degree of the burn and type of repair
Concussion Benefit	$250
Coma Benefit	$7,500
Laceration Benefit	$50-$400 depending on the length of the cut and type of repair
Broken Tooth Benefit Crown	**Crown:** $200 **Filling:** $25 **Extraction:** $100
Eye Injury Benefit	$300
Accident- Medical Services & Treatment Benefits	**Plan Benefits**
Ambulance Benefit Ground	**Ground:** $300 **Air:** $1,000
Emergency Care Benefit	$75- $150 depending on location of care
Non-Emergency Initial Care Benefit	$75
Physician Follow-Up Visit Benefit	$75
Therapy Services Benefit (including physical therapy)	$35
Medical Testing Benefit	$150
Medical Appliance Benefit	$75- $750 depending on the appliance
Transportation Benefit	$300
Pain Management Benefit (for epidural anesthesia)	$75
Prosthetic Device Benefit	**One device:** $750 **More than one device:** $1,500
Modification Benefit	$1,000
Blood/Plasma/Platelets Benefit	$200
Surgical Repair Benefit	$150-$1,500 depending on the type of surgery
Exploratory Surgery Benefit	$300
Other Outpatient Surgery Benefit	$300
Hospital Benefits*	**Plan Benefits**
Admission Benefit	$1,000 for the day of admission
ICU Supplemental Admission Benefit	$1,000 for the day of admission
Confinement Benefit (paid for up to 15 days per accident)	$200 per day
ICU Supplemental Confinement Benefit (paid for up to 15 days per accident)	$200 per day
Inpatient Rehabilitation Benefit (paid for up to 15 days per accident)	$150 per day
Accidental Death Benefit	**Plan Benefits**
Accidental Death Benefit	$50,000 (employee); $25,000 (spouse); $5,000 (children) Up to $150,000 for accidental death on common carrier
Accidental Dismemberment, Functional Loss & Paralysis Benefits	**Plan Benefits**
Dismemberment/Functional Loss **Paralysis**	$750- $20,000 depending on the injury $25,000- $50,000 depending on the number of limbs
Other Benefits	**Plan Benefits**
Lodging Benefit* - for a companion of a covered person who is hospitalized	$100 per day

*** Notes Regarding Certain Benefits**

- **Fracture and Dislocation benefits-** Chip fractures are paid at 25% of the applicable fracture benefit and partial dislocations are paid at 25% of the applicable dislocation benefit.
- **Hospital Benefits-** Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
- **Accidental Death Benefit-** The benefit amount will be reduced by the amount of any accidental dismemberment/functional loss/paralysis benefits and modification benefit paid for injuries sustained by the covered person in the same accident for which the accidental death benefit is being paid.
- **Common Carrier Benefit-** Common Carrier refers to airplanes, trains, buses, trolleys, subways and boats. Certain conditions apply. See your Disclosure Statement or Outline of Coverage/Disclosure Document for specific details. Be sure to review other information contained in this booklet for more details about plan benefits, monthly rates and other terms and conditions.
- **Lodging Benefit-** The lodging benefit is not available in all states. It provides a benefit for a companion accompanying a covered insured while hospitalized, provided that lodging is at least 50 miles from the insured's primary residence.

ACCIDENT INSURANCE

MetLife

Benefit Payment Example

Kathy's daughter, Molly, plays soccer on the varsity high school team. During a recent game, she collided with an opposing player, was knocked unconscious and taken to the local emergency room by ambulance for treatment. The ER doctor diagnosed a concussion and a broken tooth. He ordered a CT scan to check for facial fractures too, since Molly's face was very swollen. Molly was released to her primary care physician for follow-up treatment, and her dentist repaired her broken tooth with a crown. Depending on her health insurance, Kathy's out-of-pocket costs could run into hundreds of dollars to cover expenses like insurance co-payments and deductibles. MetLife Group Accident Insurance payments can be used to help cover these unexpected costs.

Covered Event	Benefit Amount
Ambulance (ground)	$300
Emergency Care	$150
Physician Follow-Up ($75 x2)	$150
Medical Testing	$150
Concussion	$250
Broken Tooth (repaired by crown)	$200
Benefits paid by MetLife Group Accident Insurance	$1,200

Insurance Rates

MetLife offers competitive group rates and convenient payroll deduction, so you don't have to worry about writing a check or missing a payment! See HR for your personalized rates.

Questions & Answers

Who is eligible to enroll for this accident coverage?

You are eligible to enroll yourself and your eligible family members. You need to enroll during your Enrollment Period and be actively at work for your coverage to be effective.

How do I pay for my accident coverage?

Premiums will be conveniently paid through payroll deduction, so you don't have to worry about writing a check or missing a payment.

What happens if my employment status changes? Can I take my coverage with me?

Yes, you can take your coverage with you. You will need to continue to pay your premiums to keep your coverage in force. Your coverage will only end if you stop paying your premium or if your employer offers you similar coverage with a different insurance carrier.

Who do I call for assistance?

Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.

1. Covered services/treatments must be the result of a covered accident as defined in the group policy/certificate. See your Disclosure Statement or Outline of Coverage/Disclosure Document for full details.
2. Availability of benefits varies by state. See your Disclosure Statement or Outline of Coverage/Disclosure Document for state variations.
3. Benefits and amounts are based on sample MetLife plan design. Plan design and plan benefits may vary.
4. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents to be covered are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage.
5. Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE'S ACCIDENT INSURANCE IS A LIMITED BENEFIT GROUP INSURANCE POLICY. The policy is not intended to be a substitute for medical coverage and certain states may require the insured to have medical coverage to enroll for the coverage. The policy or its provisions may vary or be unavailable in some states. There are benefit reductions that begin at age 65, if applicable. Like most group accident and health insurance policies, policies offered by MetLife may include waiting periods and contain certain exclusions, limitations and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP12-AX or contact MetLife.

Benefits are underwritten by Metropolitan Life Insurance Company, New York, NY. Hospital does not include certain facilities such as nursing homes, convalescent care or extended care facilities. See MetLife's Disclosure Statement or Outline of Coverage/Disclosure Document for full details.

CRITICAL ILLNESS INSURANCE

MetLife

Critical Illness Insurance can help you pay for expenses that aren't covered by your existing health insurance plan. Critical illness coverage pays you a lump-sum cash benefit to help pay for treatment or bills, and you can add a wellness benefit option to help cover the cost of health screening tests.

Coverage Options

Critical Illness Insurance		
Eligible Individual	**Initial Benefit**	**Requirements**
Employee	$15,000 or $30,000	Coverage is guaranteed provided you are actively at work.
Spouse/Domestic Partner	50% of the employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the spouse/domestic partner is not subject to a medical restriction as set forth in the Certificate.
Dependent Child(ren)	50% of the employee's Initial Benefit	Coverage is guaranteed provided the employee is actively at work and the dependent is not subject to a medical restriction as set forth in the Certificate.

Benefit Payment

Your initial benefit provides a lump-sum payment upon the first diagnosis of a Covered Condition. Your plan pays a recurrence benefit for the following covered conditions: heart attack, stroke, coronary artery bypass graft, full benefit cancer and partial benefit cancer. A recurrence benefit is only available if an Initial Benefit has been paid for the covered condition. There is a benefit suspension period between recurrences.

The maximum amount that you can receive through your Critical Illness Insurance plan is called the total benefit and is 3 times the amount of your initial benefit. This means that you can receive multiple Initial benefit and recurrence benefit payments until you reach the maximum of 300% or $45,000 or $90,000.

Please refer to the table below for the percentage benefit amount for each Covered Condition.

Covered Conditions	Initial Benefit	Recurrence Benefit
Full Benefit Cancer	100% of Initial Benefit	50% of Initial Benefit
Partial Benefit Cancer	25% of Initial Benefit	12.5% of Initial Benefit
Heart Attack	100% of Initial Benefit	50% of Initial Benefit
Stroke	100% of Initial Benefit	50% of Initial Benefit
Coronary Artery Bypass Graft	100% of Initial Benefit	50% of Initial Benefit
Kidney Failure	100% of Initial Benefit	Not applicable
Alzheimer's Disease	100% of Initial Benefit	Not applicable
Major Organ Transplant Benefit	100% of Initial Benefit	Not applicable
Occupational HIV	100% of Initial Benefit	Not applicable
22 Listed Conditions	25% of Initial Benefit	Not applicable

22 Listed Conditions

MetLife Critical Illness Insurance will pay 25% of the Initial Benefit Amount when a covered person is diagnosed with one of the 22 Listed Conditions. A Covered Person may only receive one benefit payment for one Listed Condition in his/her lifetime. The Listed Conditions are Addison's disease (adrenal hypofunction); amyotrophic lateral sclerosis (Lou Gehrig's disease); cerebrospinal meningitis (bacterial); cerebral palsy; cystic fibrosis; diphtheria; encephalitis; Huntington's disease (Huntington's chorea); Legionnaire's disease; malaria; multiple sclerosis (definitive diagnosis); muscular dystrophy; myasthenia gravis; necrotizing fasciitis; osteomyelitis; poliomyelitis; rabies; sickle cell anemia (excluding sickle cell trait); systemic lupus erythematosus (SLE); systemic sclerosis (scleroderma); tetanus; and tuberculosis.

CRITICAL ILLNESS INSURANCE

MetLife

Example of Initial & Recurrence Benefit Payments

The example below illustrates an employee who elected an Initial Benefit of $15,000 and has a Total Benefit of 3 times the Initial Benefit Amount or $45,000.

Illness- Covered Condition	Payment	Total Benefit Remaining
Heart Attack- First diagnosis	Initial Benefit payment of $15,000 or 100%	$30,000
Heart Attack- Second diagnosis, two years later	Recurrence Benefit payment of $7,500 or 50%	$22,500
Kidney Failure- First diagnosis, three years later	Initial Benefit payment of $15,000 or 100%	$7,500

Supplemental Benefits

MetLife provides coverage for the Supplemental Benefits listed below. This coverage would be in addition to the Total Benefit Amount payable for the previously mentioned Covered Conditions.

Health Screening Benefit

MetLife will provide an annual benefit* of $50 per calendar year for taking one of the eligible screening/prevention measures. MetLife will pay only one health screening benefit per covered person per calendar year.

Eligible screening/prevention measures may include, but not limited to annual physical exam, blood test to determine total cholesterol, blood test to determine triglycerides, lipid panel, and mammogram. See Policy for complete list of eligible screenings and preventative measures.

Insurance Rates

MetLife offers competitive group rates and convenient payroll deduction so you don't have to worry about writing a check or missing a payment!

Questions & Answers

- **Who is eligible to enroll?** [3]
  Regular active full-time employees who are actively at work along with their spouse/domestic partner and dependent children can enroll for MetLife Critical Illness Insurance coverage.
- **How do I pay for coverage?**
  Coverage is paid through convenient payroll deduction.
- **What is the coverage effective date?**
  The coverage effective date is 06/01/2023.
- **If I Leave the Company, Can I Keep My Coverage?** [11]
  Under certain circumstances, you can take your coverage with you if you leave. You must make a request in writing within a specified period after you leave your employer. You must also continue to pay premiums to keep the coverage in force.
- **Who do I call for assistance?**
  Contact a MetLife Customer Service Representative at 1 800- GET-MET8 (1-800-438-6388), Monday through Friday from 8:00 a.m. to 8:00 p.m., EST.

1. Coverage for Domestic Partners, civil union partners and reciprocal beneficiaries varies by state. Please contact MetLife for more information.
2. Dependent Child coverage varies by state. Please contact MetLife for more information.
3. Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas. Coverage is guaranteed provided (1) the employee is performing all of the usual and customary duties of your job at the employer's place of business or at an alternate place approved by your employer (2) dependents are not subject to medical restrictions as set forth on the enrollment form and in the Certificate. Some states require the insured to have medical coverage. Additional restrictions apply to dependents serving in the armed forces or living overseas.
4. We will not pay a Recurrence Benefit for a Covered Condition that Recurs during a Benefit Suspension Period. We will not pay a Recurrence Benefit for either a Full Benefit Cancer or a Partial Benefit Cancer unless the Covered Person has not had symptoms of or been treated for the Full Benefit Cancer or Partial Benefit Cancer for which we paid an Initial Benefit during the Benefit Suspension Period.
5.Please review the Disclosure Statement or Outline of Coverage/Disclosure Document for specific information about cancer benefits. Not all types of cancer are covered. Some cancers are covered at less than the Initial Benefit Amount. For NHsitused cases and NH residents, there is an initial benefit of $100 for All Other Cancers.
6. In certain states, the covered condition is Severe Stroke.
7. In NJ sitused cases, the Covered Condition is Coronary Artery Disease.
8. Please review the Outline of Coverage for specific information about Alzheimer's disease.
10. The Health Screening Benefit is not available in all states. See your certificate for any applicable waiting periods. There is a separate mammogram benefit for MT residents and for cases sitused in CA and MT.
Metropolitan Life Insurance Company | 200 Park Avenue | New York, NY 10166
L0519514696[exp0720][All States] © 2019 MetLife Services and Solutions, LLC
NW 3.5 AA OHIV
11. Eligibility for portability through the Continuation of Insurance with Premium Payment provision may be subject to certain eligibility requirements and limitations. For more information, contact your MetLife representative.

METLIFE'S CRITICAL ILLNESS INSURANCE (CII) IS A LIMITED BENEFIT GROUP INSURANCE POLICY. Like most group accident and health insurance policies, MetLife's CII policies contain certain exclusions, limitations and terms for keeping them in force. Product features and availability vary by state. In most plans, there is a preexisting condition exclusion. After a covered condition occurs, there is a benefit suspension period during which benefits will not be paid for a recurrence, except in the case of individuals covered under a New York certificate. Attained Age rates are based on 5-year age bands and will increase when a Covered Person reaches a new age band. A more detailed description of the benefits, limitations, and exclusions applicable can be found in the applicable Disclosure Statement or Outline of
Coverage/Disclosure Document available at time of enrollment. For complete details of coverage and availability, please refer to the group policy form GPNP07-CI, GPNP09-CI or contact MetLife for more information. Benefits are underwritten by Metropolitan Life Insurance Company, New York, New York. MetLife's Critical Illness Insurance is not intended to be a substitute for Medical Coverage providing benefits for medical treatment, including hospital, surgical and medical expenses.

MetLife's Critical Illness Insurance does not provide reimbursement for such expenses.

DISABILITY PLAN SUMMARIES

Mutual of Omaha

HODGE believes in the importance of protecting your income and is happy to partner with **Mutual of Omaha** to offer Short-Term & Long-Term Disability Coverage at competitive group rate pricing. Both Short-Term Disability and Long-Term Disability insurance are intended to replace a portion of your income when you are deemed disabled and unable to work due to a non-work-related injury or illness.

Voluntary Short-Term Disability Plan Details (*This benefit is available at open enrollment without medical questions. NOTE: You will be subject to the pre-existing condition limitations during the first 6 months of coverage.* *Adding the benefit mid-year will require evidence of insurability.)*	
Weekly Benefit Amount	60% of pre-disability earnings to a maximum benefit of $1,000 per week
Elimination Period	**Injury:** 7 days **Sickness:** 7 days
Benefit Duration	Up to 26 weeks
Pre-Existing Condition Limitation	A *Pre-existing Condition* means any Injury or Sickness for which you received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day you become insured under the Policy. We will not provide benefits for any Disability caused by, attributable to, or resulting from a Pre-existing Condition which begins in the first 6 months after you are continuously insured under the Policy.
Employee Cost	100% Employee Paid. See HR for benefit levels and costs.

Delayed Effective Date Notice: *If you are not Actively Working on the day any new election or increase in insurance would otherwise take effect, the new election or increase will become effective on the day the Employee returns to Active Work.*

Company-Paid Long-Term Disability Plan Details	
Monthly Benefit Amount	60% of pre-disability earnings to a maximum benefit of $6,000 per month
Elimination Period	**Injury:** 180 days / **Sickness:** 180 days
Benefit Duration	See HR for details.
Pre-Existing Condition Limitation	A *Pre-existing Condition* means any Injury or Sickness for which you received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day you become insured under the Policy. We will not provide benefits for any Disability caused by, attributable to, or resulting from Pre-existing Condition which begins in the first 6 months after you are continuously insured under the Policy.
Benefit Cost	This benefit is paid for by the company.

The full summary plan documents are available at your request for a list of your exclusions and limitations. *This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to the certificate booklet upon your request for the complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.*

COMPANY PAID BASIC LIFE/AD&D

Mutual of Omaha

All full time, regular, actively at work employees working over 30 hours or more per week will be enrolled in the HODGE Company-Paid Life plan through **Mutual of Omaha**. This coverage is provided by HODGE at no cost to you! Your basic Life benefit amount (covered by HODGE) is **$15,000**. This plan also includes an Accidental Death & Dismemberment feature which pays an additional benefit, when applicable. Benefit amounts reduce by 35% at 65, and 50% at age 70.

HOW MUCH LIFE INSURANCE COVERAGE DO YOU NEED?

If you so choose, you may purchase additional coverage at low-cost, HODGE group rates through **Mutual of Omaha**.

Use this worksheet to estimate how much additional life insurance you need and see the details of the voluntary life on the following page.

When considering how much life insurance you need, it's important to think about your outstanding debt, ongoing expenses and the future plans of your family. Fill in the blanks to figure out how much life insurance you may wish to purchase.

Outstanding Debt – How much will be left for your family to pay?	
Mortgage balance	$ _____
Other debt (credit cards, loans, car payment)	$ _____
TOTAL (A)	$ _____ (A)
Ongoing Expenses – How much do your dependents need each year?	
Utilities (electric, phone, cable, internet)	$ _____
Medical costs, insurance	$ _____
Food, clothing, gasoline	$ _____
Saving contributions	$ _____
TOTAL (B)	$ _____ (B)
Future Plans – How much will loved ones need for the future?	
College	$ _____
Other (retirement, long term care)	$ _____
TOTAL (C)	$ _____ (C)
Grand Total (A+B+C)	$ _____
Subtract existing coverage	$ _____
Subtract company-paid life	$ _____
Consider this amount of life insurance	$ _____

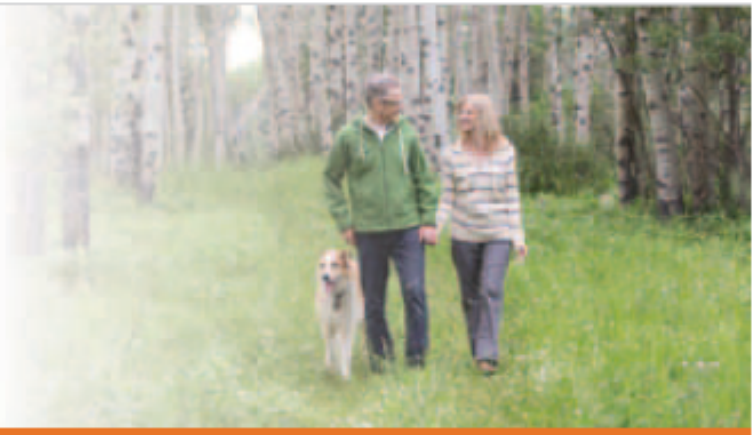
The full summary plan documents are available at your request for a list of your exclusions and limitations. *This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to the certificate booklet upon your request for the complete plan description. 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

All eligible employees may take advantage of this great service provided to you at no cost, by HODGE! The EAP is administered through **Mutual of Omaha** and includes features such as 24/7 confidential counseling services by phone, three face-to-face sessions with a local counselor, and web-based resources on a variety of topics. Call (800) 316-2796 or visit www.mutualofomaha.com/eap to access the service.

Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life.



Your Employee Assistance Program (EAP) can be the answer for you and your family.

Mutual of Omaha's EAP assists employees and their eligible dependents with personal or job-related concerns, including:

- Emotional well-being
- Family and relationships
- Legal and financial matters
- Healthy lifestyles
- Work and life transitions

EAP BENEFITS

- Unlimited telephone access to EAP professionals 24 hours a day, seven days a week
- Telephone assistance and referral
- Service for employees and eligible dependents
- Robust network of licensed mental health professionals
- Three face-to-face sessions* with a counselor (per household per calendar year)

  *Face-to-face visits can also be used toward legal consultations

  *California Residents: Knox-Keene Statute limits no more than three face-to-face sessions per six-month period per person.

- Legal assistance and financial services
  - *Online will preparation*
  - *Legal library & online forms*
  - *Telephonic financial consultation*
- Resources for:
  - *Financial tools & resources*
  - *Substance abuse and other addictions*
  - *Dependent and elder care assistance & referral services*
- Access to a library of educational articles, handouts and resources via *mutualofomaha.com/eap*

WHAT TO EXPECT

You can trust your EAP professional to assess your needs and handle your concerns in a confidential, respectful manner. Our goal is to collaborate with you and find solutions that are responsive to your needs.

Your EAP benefits are provided through your employer. There is ***no cost*** to you for utilizing EAP services. If additional services are needed, your EAP will help locate appropriate resources in your area.

Don't delay if you need help. Visit *mutualofomaha.com/eap* or call 800-316-2796 for confidential consultation and resource services.

Benefits that work

401(K) RETIREMENT PLAN

Heartland Retirement Plan Services

Eligibility Requirements:

Deferrals

- All employees must be at least 18 years of age to participate in the 401(k) plan.
- Those eligible are able to participate in the plan on the first day of each plan year 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.
- One year of service with at least 1000 hours worked during that timeframe.
- Match starts one year from the date of the employee's first date of eligibility.

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 Heartland 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 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.

Log into your Heartland account today for more information, review your selections, and manage your contribution rates

- https://retirementaccountlogin.com/heartland/
- On your first login, you will need to enter company code **hod70006**

Vesting Schedule for Employer Contributions:

In order 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 Heartland 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

For More Information Contact – Heartland Retirement Plan Services

- **Email:** retirement@heartlandrps.com
- **Phone:** 800-399-2083

STATE & FEDERAL BENEFITS ADVOCATE

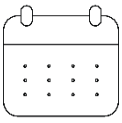
FEDlogic – Your Very Own Personal Navigator

Hodge has partnered with FEDlogic to provide state and federal benefits information and advocacy to you and your household members. The service is **confidential**, **unlimited** and **free** to you as an employee.

Reasons to Call FEDlogic

- You've reached or are approaching Medicare age and need to learn more
- You're approaching retirement age and want to learn more about your Social Security Benefits
- You or a household family member have been diagnosed with a major illness
- You have a child with a disability or born prematurely
- You have lost a spouse
- You need assistance navigating Medicaid, Marketplace, or COBRA
- You need help exploring alternative healthcare avenues based on your income
- You are currently on dialysis (ESRD)

How It Works



Make a phone consultation appointment

Call FEDlogic at 877-837-4196 to schedule a phone consultation appointment with one of their federal and state benefits experts. Be sure to make the appointment at a time when family members are available to listen and ask questions as well. Calls typically last an hour.

Tell FEDlogic your story, ask questions and learn

You don't have to wade through tons of complex and confusing information to try to figure out what applies to you. FEDlogic takes the time to listen to your story and understand your needs, concerns and goals. Then they empower you with the unbiased information you need so you can maximize your benefits and make the best decision for your situation.

Enroll for benefits

Once you feel confident you have the information you need to make the best decision for you and your family, FEDlogic will walk you through the application and approval process.

Relax and celebrate

Without education and advocacy, many people don't tap into all the Social Security and Medicare benefits they've paid into during a lifetime of employment. You'll have the peace of mind knowing that you're getting all the benefits you deserve. So, sit back, relax and celebrate!

Contact FEDlogic

FEDlogic is passionate about providing highly personalized, easy and practical phone consultation guidance to individuals and families. FEDlogic will never promote, endorse or sell any type of product or insurance.

- Phone: 877-837-4196
- Website: https://fedlogicgroup.com/
- Email: services@fedlogicgroup.com

HEALTH & WELLNESS PROGRAM

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 an extra $65/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.

VIRTUAL DOCTOR VISITS WITH DR ON DEMAND

Available to employees enrolled in the medical plan.

Doctor On Demand 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. With 24/7/365 access to U.S. board-certified doctors, you can access medical care with ***$0 copay amount***, from home or on the road—and in some cases, doctors can write a prescription to a local pharmacy near you.*



How Does It Work?

Log in to your account or register if you don't have one set-up. Then, contact Doctor On Demand from anywhere—and let the doctor come to you!

Doctor On Demand
Phone: 1-800-997-6196
Online: DoctorOnDemand.com

Doctor On Demand doctors can then diagnose non-emergency medical problems, recommend treatment, and can even call in a prescription to your pharmacy of choice, when necessary.*

**Prescription services may not be available in all states.*

When Can I Use It?

- 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.

Common Conditions We Treat

- Allergies
- Colds, respiratory problems, flu
- Ear infections
- Sore Throat
- Pink eye
- Urinary tract infections
- And more!

Save Money and Time!

With $0 consult cost, Doctor On Demand provides significant savings over urgent care and emergency room visits. Plus, you can use it from the convenience of home or work, allowing you to avoid the hassle of sitting in a waiting room.

Meet Our Doctors!

- U.S. board-certified with an average of 15 years of practice experience
- U.S. residents and licensed in your state

Required Annual Notices

Hodge Company Health 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 January 31, 2023. V 0.1.0. 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
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-766-9012

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://kidshealth.ky.gov/Pages/index.aspx

Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

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: (617) 886-8102

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

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. 5218

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

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: http://www.nd.gov/dhs/services/medicalserv/medicaid/
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 http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

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

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

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

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

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

VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp
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 January 31, 2023, 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 Company Health 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 9.12% 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 Group Medical Plan (the "Plan"), which includes medical, dental and flexible spending account coverages offered under the HODGE 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 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 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, 7465 Chavenelle Rd, 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, 7465 Chavenelle Rd, 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, 7465 Chavenelle Rd, 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, 7465 Chavenelle Rd, 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, 7465 Chavenelle Rd, 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, 7465 Chavenelle Rd, 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, 7465 Chavenelle Rd, 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 Company Health 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 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 has determined that the prescription drug coverage offered by the HODGE 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 coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current HODGE 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 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 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: 04/03/2023
Name of Entity/Sender: HODGE
Contact--Position/Office: Human Resources
Address: 7465 Chavenelle Rd, Dubuque IA 52002
Phone Number: 563-583-9781 ❖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