Team Member Benefits 2024

Elara Caring

Table of Contents

Working together is what makes Elara Caring a success, and this teamwork extends to your benefits. We provide options to support your family's overall wellbeing. This guide offers details on your 2024 benefits. Contact Quantum Health with any questions.

See **page 37** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to BW NHHC Holdco, INC DBA Elara Caring. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Welcome

Elara Caring is committed to keeping your healthcare costs reasonable and adding benefits that make your life easier. You work hard. You deserve benefits that add convenience, promote wellness, and improve security – allowing you to better care for yourself and your loved ones.

Quantum Health: Your Personal Healthcare Guide

Navigating healthcare can be time consuming and complex, and no team member should have to do it alone! That's why we've partnered with Quantum Health, a service partner that makes healthcare smarter, simpler, and more cost-effective for our team members and their loved ones. Think of Quantum Health as your personal assistant, dedicated to ensuring you get the most from your benefits. Simply call Quantum if you need to:

- Understand your healthcare benefits
- Find an in-network provider and make an appointment
- Sort out a new diagnosis and what to do next
- Find an alternative to the emergency room (ER) for non-emergencies
- Find out how much a service or procedure will cost
- Help you save money by finding high value providers
- Understand a bill or explanation of benefits (EOB)

Quantum Health is your one resource to contact whenever you need help with your medical, dental, vision, pharmacy benefits, or any other benefits. Reach out to Quantum at 866-920-1963 or log on at www.MyElaraCaringBenefits.com.

Eligibility and Enrollment

Elara Caring's benefits are designed to support your unique needs.

Eligibility

If you are a full-time employee of Elara Caring who is regularly scheduled to work 36+ hours per week, you are benefits-eligible the first of the month following 30 days of employment. Part-time employees who move to full-time status become eligible on the first of the following month.

Part-time employees working either an average of 30 hours per week or 130 hours during a month, based on a 12-month look-back period, also are benefits-eligible. Anyone who fits this category will receive notification through Workday.

Dependents

Dependents eligible for coverage include:

- Your legal spouse (or domestic partner where recognized).
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom you or your spouse have legal guardianship).
- Dependent children 26 or older, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility is required. Acceptable proof may include the following: marriage license, birth certificate, or formal court designation.

Working Spousal/Domestic Partner Surcharge

If you elect medical coverage for your spouse/domestic partner and they are eligible for a medical plan through their employer, there will be a $150 surcharge per month added to your medical premium. You will be required to answer a spouse/domestic partner eligibility question during your enrollment in Workday.

Note: The company reserves the right to verify if your spouse is provided coverage elsewhere. This information must be consistent with the information you report. Misrepresenting whether your spouse has access to medical coverage may result in disciplinary action.

3 Enrollment Periods

You may be able to enroll or change benefits at three times during the year, based on your employment status, as follows:

New Employees – Make your benefit elections within 30 days of employment.

Current Employees – Enroll during the annual Open Enrollment period each year. Open Enrollment for the 2025 plan year will be in the Fall of 2024.

Midyear Benefit Changes – When a Qualifying Life Event (QLE) occurs during the benefits plan year, generally, you have 30 days to change any benefits consistent with the event. If the event is due to eligibility for or loss of Medicaid or Children's Health Insurance Program (CHIP) coverage, you have 60 days to make changes to your benefits coverage. Contact your Plan Administrator at 833-433-5272 to make appropriate changes and provide proof of the event and documentation for dependent verification, if applicable.

Wellness

It's never too late to better your wellness. Elara Caring is here to help with programs like tobacco cessation support, Wondr Health, Hinge Health and Virtual Primary Care. These programs are included for all medical-enrolled employees and are completely confidential.

Tobacco User Surcharge

Quitting is more than an ending — it's a fresh start! We want to support your quitting journey and save you money. Elara Caring has a tobacco user surcharge to help control employee medical premium costs. If you or your spouse/domestic partner have used tobacco products within the past 3 months, you'll pay a monthly surcharge of $100 per applicable person. Using tobacco includes, but isn't limited to, using pipes, cigarettes, e-cigarettes, vaping, cigars, chewing tobacco, snuff, and any other type of smoking or smokeless tobacco, regardless of frequency or method of use. You must verify tobacco status each year. You can find the surcharge rates in the Medical section of this guide.

Need help quitting? We've got you! Elara Caring provides tobacco cessation support through Blue Cross Blue Shield, including personal coaching, online tools, an audio health library, and discounts on wellness-related products and services. During open enrollment, if you have been tobacco free for 3 months the surcharge will no longer apply for the next plan year. The tobacco surcharge can only be changed at open enrollment.

If you currently don't meet the tobacco-free requirement but you're trying to quit, you may be eligible to avoid the surcharge. Contact Quantum Health to complete or enroll in a tobacco cessation program or to submit confirmation of being under a physician's care for tobacco or nicotine use.

Note

Quitting smoking improves your health and quality of life and can even add as much as 10 years to your life expectancy!
(Source: CDC)

Wondr Health

Wondr is a common-sense online program that focuses on when and how you eat instead of what you eat, allowing you to still eat the foods you love while losing weight and improving your health. There are no points to count or food groups to avoid. The program is conveniently delivered online, so there are no meetings to schedule – just log on when it's convenient for you and start losing weight.

Here's how Wondr works:

Instead of making you count points, track calories or change your diet to kale smoothies, we use a science-based approach based on the eating patterns that people who don't struggle with their weight use naturally. During the initial 12 weeks of the program, you'll log-in to your Wondr dashboard to learn tips like:

- Ways to enjoy your favorite foods without going overboard
- How to manage the differences between appetite and hunger
- How to keep thirst from hijacking your weight loss
- The reasons we eat, many of which have nothing to do with hunger
- How to stop eating around emotions like stress, anger and depression
- How to sleep better, become more physically active, reduce stress and more!

Who's eligible?

Employees, spouses and covered dependents age 18 and over enrolled in one of Elara Caring BCBS's medical plans are eligible to apply to the program.

Hinge Health

Hinge Health is a digital health program that can assist you with chronic pain and pre/post-surgical rehab from the comfort of your home.

Get all the tools you need to get moving again from the comfort of your home. Here are a few examples of the ways your treatment plan could be tailored to you:

- Get a personal care team, including a physical therapist and health coach
- Schedule personal physical therapy sessions as needed
- Receive wearable sensors that give live feedback on your form in the app

To learn more, visit www.hingehealth.com/ElaraCaringOE to sign up.

Best of all, Hinge Health's programs are provided at no cost to you and your eligible dependents. You must be enrolled in a BCBS medical plan to have access to the Hinge Health Program.

Teladoc Primary Care (Primary360)

The Teladoc Primary360 Program, for Blue Cross and Blue Shield of Texas members, inspires lasting relationships between you and your care providers – from anywhere, any time. Continuous support from your care team gives you a unified, whole-person experience that makes it possible to reach your health goals, even when you are on the go. Additional details are on page 17.

Medical Benefits

Medical benefits are provided through Blue Cross Blue Shield and American Worker. Consider the physician networks, premiums, and out-of-pocket costs for each plan when choosing for you and your family. Keep in mind your choice is effective for the entire 2024 plan year unless you have a Qualifying Life Event.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your monthly contributions.

	ELITE EPO PLAN	ENHANCED EPO PLAN	HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	MEC AND GROUP LIMITED INDEMNITY
MONTHLY CONTRIBUTIONS				
EMPLOYEE-ONLY	$350.47	$99.00	$200.62	$28.66
EMPLOYEE + SPOUSE/ DOMESTIC PARTNER	$819.79	$419.08	$596.37	$118.57
EMPLOYEE + CHILD(REN)	$799.30	$397.79	$560.95	$101.80
FAMILY	$1,166.85	$608.23	$876.35	$170.82

How to Find a Provider

Visit MyElaraCaringBenefits.com or call Customer Care at 866-920-1963 for a list of Blue Cross Blue Shield network providers.

Visit www.TheAmericanWorker.com or call 888-798-9480 for a list of American Worker network providers.

Note

Preventive care offered by an in-network physician, such as an annual physical, is often covered at 100%.

Medical Plan Summary

This chart summarizes the 2024 medical coverage provided by Blue Cross Blue Shield and American Worker. All covered services are subject to medical necessity as determined by the plan.

	ELITE EPO PLAN		ENHANCED EPO PLAN		HIGH DEDUCTIBLE HEALTH PLAN (HDHP)		MEC AND GROUP LIMITED INDEMNITY*
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK
CALENDAR YEAR DEDUCTIBLE							
INDIVIDUAL	$1,750	Not Covered	$4,500	Not Covered	$3,500	Not Covered	N/A
FAMILY	$3,500	Not Covered	$9,000	Not Covered	$7,000	Not Covered	
COINSURANCE (PLAN PAYS)	80% after Ded.	Not Covered	70%* after Ded.	Not Covered	80% after Ded.	Not Covered	
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)							
INDIVIDUAL	$4,500	Not Covered	$8,500	Not Covered	$6,500	Not Covered	N/A
FAMILY	$9,000	Not Covered	$17,000	Not Covered	$13,000	Not Covered	
COPAYS/COINSURANCE							
PREVENTIVE CARE	No Charge	Not Covered	No Charge	Not Covered	No Charge	Not Covered	No Charge Plan pays $75 per day (6 days/year)
PRIMARY CARE OFFICE VISITS	$30	Not Covered	$40	Not Covered	20% after Ded.	Not Covered	
SPECIALIST VISITS	$50	Not Covered	$60	Not Covered	20% after Ded.	Not Covered	
URGENT CARE	$50	Not Covered	$75	Not Covered	20% after Ded.	Not Covered	
OUTPATIENT SURGERY	20% after Ded.	Not Covered	30% after Ded.	Not Covered	20% after Ded.	Not Covered	$500 per day (1 day per year) and $100 for minor surgery (1 day per year)
INPATIENT HOSPITAL	20% after Ded.	Not Covered	30% after Ded.	Not Covered	20% after Ded.	Not Covered	Confinement: $300 per day, 100 days per year. Admission: $300 per day, 1 day per year Surgery: $1,000 per day, 1 day per year Anesthesia: 30% of surgical benefit
EMERGENCY ROOM (EMERGENT)	$300 Copay	$300 Copay	$400 Copay	$400 Copay	20% after Ded.	20% after Ded.	Plan pays $100 per day (2 days/year)**
EMERGENCY ROOM (NON-EMERGENT)	$300 Copay + 20%	$300 Copay + 20%	$400 Copay + 30%	$400 Copay + 30%	20% after Ded.	20% after Ded.	
LABS AND X-RAYS***	20% after Ded.	Not Covered	30% after Ded.	Not Covered	20% after Ded.	Not Covered	Lab: $50 per day, 3 days per year X-Ray: $50 per day, 3 days per year Major Diagnostic: $500 per day, 1 day per year

*MEC plan is underwritten by American Worker
**Benefit is for sickness only
***MEC plan only provides outpatient benefits

Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. Elara Caring offers affordable plan options from Blue Cross Blue Shield for routine care and beyond.

Stay In-Network

If your dentist doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Blue Cross Blue Shield at bcbstx.com.

Dental Premiums

Dental premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your monthly premium.

Dental Plan Summary

This chart summarizes the dental coverage provided by Blue Cross Blue Shield for 2024.

	LOW PLAN	MID PLAN	HIGH PLAN
MONTHLY CONTRIBUTIONS			
EMPLOYEE ONLY	$14.02	$35.56	$38.81
EMPLOYEE + SPOUSE/DOMESTIC PARTNER	$50.71	$80.78	$87.01
EMPLOYEE + CHILD(REN)	$51.50	$82.03	$88.36
FAMILY	$80.66	$128.49	$138.40
CALENDAR YEAR DEDUCTIBLE			
INDIVIDUAL	$50	$50	$50
FAMILY	$150	$150	$150
CALENDAR YEAR MAXIMUM			
PER PERSON	$1,000	$2,000	$2,000
COVERED SERVICES			
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers	100%	100%	100%
BASIC SERVICES Amalgam Restorations, Resin-Based Composite Restorations, Non-Surgical Extractions, Periodontics, Endodontics	80%	80%	80%
MAJOR SERVICES Crown, Labial Veneers, Dentures, Bridges, Implants	N/A	50%	50%
ORTHODONTIC LIFETIME MAXIMUM	N/A	N/A	$1,500

Note

Oral health is linked to your overall health — keeping your mouth healthy can protect you from cardiovascular disease, pregnancy complications, and pneumonia.

Vision Benefits

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through Superior Vision by MetLife.

Vision Premiums

Vision premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your monthly premium.

Vision Plan Summary

This chart summarizes the vision coverage provided by Superior Vision by MetLife for 2024.

	SUPERIOR VISION PLAN
MONTHLY CONTRIBUTIONS	
EMPLOYEE-ONLY	$6.10
EMPLOYEE + SPOUSE/DOMESTIC PARTNER	$12.20
EMPLOYEE + CHILD(REN)	$14.39
FAMILY	$22.04
EXAMS (ONCE EVERY 12 MONTHS)	
COPAY	$10
LENSES (ONCE EVERY 12 MONTHS)	
SINGLE VISION	$15
BIFOCAL	$15
TRIFOCAL	$15
LENTICULAR	$15
CONTACTS (IN LIEU OF LENSES AND FRAMES) (ONCE EVERY 12 MONTHS)	
FITTING AND EVALUATION*	$25
ELECTIVE	$175 allowance
MEDICALLY NECESSARY	Covered in Full
FRAMES (ONCE EVERY 24 MONTHS)	
COPAY	$15
ALLOWANCE	$175 allowance

*Fitting and Evaluation fee applied to contact lens allowance.

Note

Early detection of vision conditions like diabetic retinopathy leads to more effective treatment and cost savings.

Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through Express Scripts. You will have one ID card for medical and pharmacy. You may find information on our benefits coverage and search for network pharmacies by logging on to express-scripts.com or by calling the Customer Care number on your ID Card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Brand Formulary, Brand Non-Formulary, or Specialty.

	ELITE EPO PLAN		ENHANCED EPO PLAN		HIGH DEDUCTIBLE HEALTH PLAN (HDHP)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY)						
GENERIC	$15	Not Covered	$15	Not Covered	$15 after Ded.	Not Covered
BRAND FORMULARY	$45	Not Covered	25% ($24 min/ $67 max)	Not Covered	25% after Ded. ($24 min/ $67 max)	Not Covered
BRAND NON-FORMULARY	$75	Not Covered	33% ($53 min/ $137 max)	Not Covered	33% after Ded. ($53 min/ $137 max)	Not Covered
SPECIALTY	$350	Not Covered	$350	Not Covered	$350 after Ded.	Not Covered
MAIL ORDER RX (90-DAY SUPPLY)						
GENERIC	$30	Not Covered	$30	Not Covered	$30 after Ded.	Not Covered
BRAND FORMULARY	$90	Not Covered	25% ($48 min/ $134 max)	Not Covered	25% after Ded. ($48 min/ $134 max)	Not Covered
BRAND NON-FORMULARY	$150	Not Covered	33% ($106 min/ $274 max)	Not Covered	33% after Ded. ($106 min/ $274 max)	Not Covered

	MEC AND GROUP LIMITED INDEMNITY*
	IN-NETWORK
RETAIL RX (30-DAY SUPPLY)	
TIER 1	$10 or less
TIER 2	$25 or less
TIER 3	$50 or less
NON-FORMULARY	Discounts averaging $78 per prescription or 67% or U&C
SPECIALTY	N/A
MAIL ORDER RX (90-DAY SUPPLY)	
	Discount Only

*MEC plan is underwritten by American Worker

Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they undergo the same rigid FDA standards. **But generic versions cost 80% to 85% less on average than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

NOTE: Apps and prescription discount programs such as GoodRx, Amazon Prime RX Savings, and Optum Perks let you compare prices of prescription drugs and find possible discounts.

How do they work? These discounts can't be combined with your benefit plan's coverage, so make sure to check the price against the cost of using your insurance's prescription drug benefit. Something else to consider: If you choose to use a discount card and are therefore not tapping into your insurance's prescription drug benefit, the cash amount you pay for the prescription will not count toward your deductible or out-of-pocket maximum under the benefit plan.

GoodRX is a web- and app-based platform that allows you to search for prescription drug coupons and compare pharmacy prices. The company claims a savings of up to 80%. **Optum Perks** also provides coupons for medications and a searchable database for drug cost comparison at participating pharmacies near you. The Optum Perks member card, which can be used at more than 64,000 pharmacies, is free to use and requires no personal data. Another discount option is the **Amazon Prime RX Savings** discount card, which is included with an Amazon Prime membership and is administered by InsideRX. It provides discounts of up to 80% for generics and up to 40% for brand-name medication at participating pharmacies.

SaveOn and Smart90 - Express Scripts

We understand that saving money is important and so are your medications. Elara Caring has partnered with Express Scripts to bring two new programs to help you save money and time filling medications.

SaveOn - if you have a specialty drug prescriptions, the SaveOn program can help to reduce or eliminate your cost for applicable drugs.

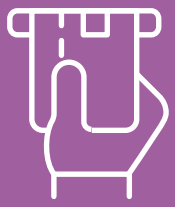
Smart90 - maintenance medications (drugs that you fill every 30 days) are now required to be filled in 90-day quantities at CVS, Walgreens, or via mail order through Express Scripts. This program can reduce your cost for maintenance medications and also reduce the frequency in which you have to go to the pharmacy to fill them.

Out-of-Pocket Costs

These are the types of payments you're responsible for:

Copay

The fixed amount you pay for healthcare services at the time you receive them.



Deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

Deductible

The individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a “per individual” deductible amount will also be applied toward the “per family” deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the “per family” deductible amount. The same typically applies for the out-of-pocket maximum.

Each covered individual is not required to meet the individual deductible. The HDHP has an aggregate deductible, meaning the family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan. The same typically applies for the out-of-pocket maximum.

Our Plans are Self-Funded

Our medical and pharmacy plans are self-funded. What does that mean? Rather than paying premiums to an insurance carrier as with fully insured plans, the Company pays fixed costs to use the carrier’s network and variable costs for members’ claims. Self-insured plans allow for more freedom in plan design. Together, the Company and employees share the cost of healthcare.

Healthcare Cost Transparency

There are so many different providers and varying costs for healthcare services — how do you choose? Online services called healthcare cost transparency tools can help. These tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit www.TheAmericanWorker.com to learn more.

Note

The cost of an MRI can vary between $500 and $4,000 — even within your area.

How to Pick a Plan

What plan is right for you? Consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

How does a PPO (Preferred Provider Organization) work?

- You'll pay more in premiums, but perhaps less at the time of service.
- You can choose from a network of providers who offer a fixed copay for services.
- If you expect to need more medical care this year or you have a chronic illness, the PPO may be the right choice for you to ensure your healthcare needs are covered.

How does a HDHP (High Deductible Health Plan) work?

- You'll pay for the full cost of non-preventive medical services until you reach your deductible.
- You can also use a Health Savings Account in conjunction, which provides a safety net for unexpected medical costs and tax advantages.
- If you expect to mostly use preventive care (which is covered), this plan could be for you.

How does a MEC (Minimum Essential Coverage) work?

Covers 100% of the cost of certain preventive services, when delivered by a network provider. Helps cover the costs of certain medical expenses incurred due to an accident or sickness at a specified benefit amount for a limited number of days per year.

The MEC Plus Standard Plan may not meet the minimum essential coverage requirements in certain states.

Nationwide: Residents of KS, NH, NM, MN, WA, and VT are not eligible for any of the benefit programs offered by The American Worker.

Preventive Care

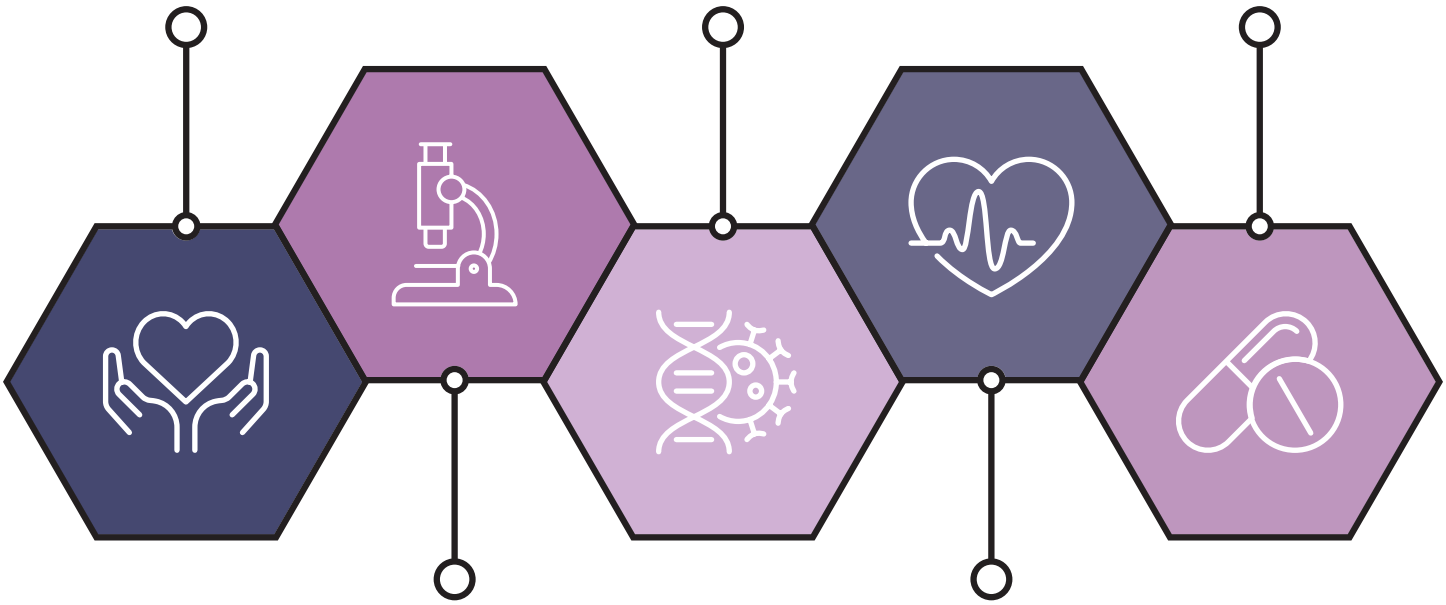
Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance.

Keep up to date with your primary care physician to stay on top of your overall health. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

Wellness visits, physicals, and standard immunizations

Pediatric screenings for hearing, vision, obesity, and developmental disorders

Iron supplements (for children ages 6 to 12 months at risk for anemia)



Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes

Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women

Don't miss out on these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

What about the COVID-19 vaccine? The COVID-19 vaccine itself is considered preventive. For the vast majority of individuals who have insurance through an employer, the vaccine will be at no cost.

Where to Go for Care

When you're under the weather, there's no place like home. If you're feeling sick or you have a question about the side effects of a new prescription, but your provider is not available, or the pharmacy is closed, consider all your site-of-care options.

Teladoc

When to Use

You need care for routine treatments or minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Types of Care*

- The Teladoc Primary360 Program lets you coordinate all of your routine, primary care on-the-go without actually stepping foot inside a doctor's office. Visit www.teladochealth.com for more information about the Primary360 Program. You can also call 800-TELADOC.
  - Full spectrum of care needs – From wellness and prevention to chronic condition management, mental health support and more.
  - Dedicated care team – Includes a primary care provider, nurse, and medical associate. Your team supplies ongoing guidance and support to ensure you reach your health goals.
  - Personalized care plan – Receive a personalized, longitudinal care plan that's flexible to change as your needs change and engages you in a lasting relationship with your care team.
  - 24/7 access – Teladoc Primary360 is there when you need it, whenever and wherever. Take advantage of unlimited messaging, reminders and health nudges to keep you connected.
  - Specialty care, too – You also can navigate to in-network, high-quality specialty providers and facilities, as needed.
  - Teladoc doctors can share information with your primary care physician with your consent. Please note that some states do not allow physicians to prescribe medications via telemedicine.
- Minor Urgent Care through Teladoc provides you with quick care for minor illnesses without leaving your home.
  - Cold & flu symptoms
  - Allergies
  - Bronchitis
  - Urinary tract infection
  - Sinus problems
- Dermatology through Teladoc allows you to upload photos through the secure portal and get custom treatment plans for skin issues such as:
  - Eczema
  - Psoriasis
  - Acne
  - Rosacea
  - Skin infections
- Behavioral Health Care through Teladoc gives access to mental healthcare like therapy and medicines from the comfort of your home. You and your covered family members can get support for issues such as:
  - Depression
  - Anxiety and panic attacks
  - Substance use
  - Attention deficit (ADHD/ADD)
  - Autism
  - Bipolar
  - Eating disorders

Costs and Time Considerations**

Teladoc is available for BCBS of Texas members for a copay of $0 copay for the HDHP, Elite and Enhanced plans per consultation.

Primary Care Center

When to Use

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*

- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

Costs and Time Considerations**

- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Urgent Care Center

When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

Costs and Time Considerations**

- Often requires a copay and/or coinsurance usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer (urgency decides order)

Emergency Room

When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*

- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

Costs and Time Considerations**

- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

DO YOUR HOMEWORK

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

*This is a sample list of services and may not be all inclusive.
**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Health Savings Account

Want funds handy to help cover out-of-pocket healthcare expenses? A Health Savings Account (HSA) is a personal healthcare bank account used to pay for qualified medical expenses. HSA contributions and withdrawals for qualified healthcare expenses are tax-free. You must be enrolled in a HDHP to participate.

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in a HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

HSA Bank will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse's non-HDHP.
- Your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

You Own Your HSA

Your HSA is a personal bank account that you own and administer. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements or forfeiture provisions.

How to Enroll

To enroll in Elara Caring's HSA, you must elect the HDHP with Elara Caring. Submit all HSA enrollment materials and choose the amount to contribute on a pre-tax basis. Elara Caring will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with HSA Bank. The money in your HSA (including interest and investment earnings) grows tax-free. When the funds are used for qualified medical expenses, they are spent tax-free.

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax.

Note

Not sure how much to contribute? Think about how much you may need in order to cover any anticipated or emergency medical services this year. Consider contributing the amount of your plan's in-network deductible so you know you're covered.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2024, contributions (which include any employer contribution) are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$4,150
FAMILY	$8,300
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

Elara Caring provides an annual HSA employer contribution that will be deposited on a per-pay-period basis.

EMPLOYER HSA CONTRIBUTION	
EMPLOYEE	$500
FAMILY	$1,000

HSA contributions over the IRS annual contribution limits ($4,150 for individual coverage and $8,300 for family coverage for 2024) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The Elara Caring HSA is established with HSA Bank. You may be able to roll over funds from another HSA. For more enrollment information, contact People Services Center or visit hsabank.com.

Flexible Spending Accounts

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses. The FSA plan is available through HSA Bank.

Healthcare Flexible Spending Account

You can contribute up to $3,200 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Flexible Spending Commuter Benefits

The Commuter Benefit Account lets you set aside pretax dollars to pay for expenses related to your commute to and from work. This includes:

- Mass transit
- Vanpooling
- Paid parking

You may contribute up to $315 per month for both transportation and parking. Funds are added to a debit card for use as you make contributions each month.

Note: This benefit is only available to residents who live in New York and New Jersey.

Note

You can use your FSA funds to pay for deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, and more.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $5,000 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- Expenses are reimbursable if the provider is not your dependent.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent day care expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or day care provider
- Before- and after-school care
- Day camp
- In-house dependent day care

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

To request for reimbursement, please submit a claim form along with the required documentation to HSA Bank. If any additional information such as a receipt is needed, HSA Bank will notify you. If you have any questions regarding reimbursement, you can contact HSA Bank.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2024 plan year.
- Funds cannot be transferred between FSAs.
- You cannot participate in a Dependent Care FSA and claim a dependent care tax deduction at the same time.
- You must “use it or lose it” — any unused funds will be forfeited.
- You cannot change your FSA election in the middle of the plan year without a qualifying life event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $150,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

FSA vs HSA

Flexible Spending Accounts (FSAs) and Health Savings Accounts (HSAs) are both ways to save pre-tax money to pay for eligible healthcare costs. Which one is best for you?

	FLEXIBLE SPENDING ACCOUNTS	HEALTH SAVINGS ACCOUNTS
OWNERSHIP	Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	You own your HSA. It is a savings account in your name and you always have access to the funds, even if you change jobs.
ELIGIBILITY & ENROLLMENT	You're eligible for an FSA if it's offered by your employer. You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	1. You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. 2. You can change your contribution at any time during the Plan Year.
TAXATION	Contributions are tax-free via payroll deduction. Funds are spent tax-free when used for qualified expenses.	For Federal tax purposes, the money in the account is "triple tax-free," meaning: 1. Contributions are tax-free. 2. The account grows tax-free. 3. Funds are spent tax-free when used for qualified expenses.
CONTRIBUTIONS	Both you and your employer can contribute according to IRS limits. The contribution limit for the Healthcare FSA for 2024 is $3,200.	Both you and your employer can contribute according to IRS limits. The contribution limit for 2024 is $4,150 for individuals and $8,300 for families. This includes the employer contribution. If you are 55 or older, you may make an annual "catch-up" contribution of $1,000.
PAYMENT	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	Many HSAs include a debit card, ATM withdrawal, or checkbook to pay for qualified expenses directly. You can also use online bill payment services from the HSA financial bank. You decide when to use the money in your HSA to pay for qualified expenses, or you may use another account to pay for services and save the money in your HSA for future expenses or retirement.
RUNOUT PERIOD	You must use the money in the account by end of Plan Year. The Healthcare FSA and Dependent Care FSA include a 3-month runout period after the end of the Plan Year for expenses to be reimbursed. Any unclaimed funds at the end of the run out are lost and returned to your employer.	HSA funds roll over from year to year. Money is always yours and may be used for future qualified expenses — even in retirement years.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
OTHER TYPES	• Dependent Care FSA - Allows you to set aside pre-tax dollars for elder or child dependent care and covers expenses such as day care and before- and after-school care. • Commuter Benefit Account - Allows you to set aside pretax dollars to pay for expenses related to your commute to and from work. You may contribute up to $315 per month for both transportation and parking. This benefit is only available to residents who live in New York and New Jersey.	There is only one type of HSA.

Please refer to your summary plan description or plan certificate for your plan's specific FSA or HSA benefits.

Supplemental Health Benefits

Elara Caring offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and offered at discounted group rates.

Accident Coverage

Accidents happen. You can't always prevent them, but you can take steps to reduce the financial impact. Accident coverage, available through Aflac, provides benefits for you and your covered family members if you have expenses related to an accident that occurs on or off the job. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help you pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits under this plan are payable to you, to use as you wish.

WELLNESS BENEFIT: (once per calendar year) A $50 benefit for wellness tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

SUMMARY OF BENEFITS*	HIGH PLAN	LOW PLAN
HOSPITAL ADMISSION	$2,000 per confinement	$1,000 per confinement
HOSPITAL CONFINEMENT	$200 per day	$100 per day
DISLOCATIONS	Up to $6,000 based on a schedule	Up to $4,000 based on a schedule
FRACTURES	Up to $10,000 based on a schedule	Up to $6,000 based on a schedule
AMBULANCE	$450: Ground / Air: $1,000	$200: Ground / Air: $600
ER/URGENT CARE/ DOCTOR'S OFFICE - WITHOUT X-RAY	$250 / $250 / $150	$150 / $150 / $75
ER/URGENT CARE/ DOCTOR'S OFFICE - WITH X-RAY	$325 / $325 / $225	$200 / $200 / $125
ACCIDENT FOLLOW-UP TREATMENT	$100	$50
BURNS	Up to $15,000	Up to $7,000
MAJOR DIAGNOSTIC TESTING	$225	$125
REHABILITATION UNIT	$50 per day	$35 per day
INPATIENT SURGERY AND ANESTHESIA	$800	$400
CONCUSSION	$350	$200
LACERATIONS	Up to $500	Up to $200
BLOOD/PLASMA/ PLATELETS	$200	$100
THERAPY	$60	$30
APPLIANCES	Up to $300	Up to $150

*This list is a summary. Refer to plan documents for a comprehensive list of covered benefits.

MONTHLY CONTRIBUTIONS	HIGH PLAN	LOW PLAN
EMPLOYEE ONLY	$7.53	$5.18
EMPLOYEE + SPOUSAL/ DOMESTIC PARTNER	$11.81	$8.15
EMPLOYEE + CHILD(REN)	$14.25	$10.09
EMPLOYEE + FAMILY	$18.53	$13.06

Critical Illness Coverage

Critical Illness coverage through Aflac pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like; for example: to help pay for expenses not covered by your medical plan, lost wages, child care, travel, home healthcare costs or any of your regular household expenses.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
- Children are covered at NO COST when you elect employee coverage.
- Benefits are payable based on the date of the covered event occurring or the date of diagnosis.; Illnesses or occurrences prior to the effective date of coverage will not be payable events.
- WELLNESS BENEFIT: (once per calendar year) A $50 benefit for wellness tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations.

Coverage Amounts:

- Employee: $15,000 or $30,000
- Spouse: 50% of employee benefit
- Child(ren): 50% of employee benefit at no additional cost

MONTHLY CONTRIBUTIONS

NON-TOBACCO

AGE	$15,000 EMPLOYEE	$7,500 SPOUSE	$30,000 EMPLOYEE	$15,000 SPOUSE
Age <25	$4.09	$2.23	$7.24	$3.52
25–29	$5.24	$2.81	$9.55	$4.68
30–34	$5.85	$3.11	$10.77	$5.29
35–39	$7.36	$3.87	$13.78	$6.79
40–44	$9.10	$4.74	$17.25	$8.53
45–49	$9.63	$5.00	$18.32	$9.06
50–54	$16.74	$8.56	$32.53	$16.17
55–59	$15.45	$7.91	$29.95	$14.88
60–64	$26.41	$13.40	$51.89	$25.85
65–69	$57.15	$28.76	$113.35	$56.58
70+	$57.15	$28.76	$113.35	$56.58

TOBACCO

AGE	$15,000 EMPLOYEE	$7,500 SPOUSE	$30,000 EMPLOYEE	$15,000 SPOUSE
Age <25	$5.24	$2.81	$9.54	$4.68
25–29	$6.59	$3.48	$12.24	$6.03
30–34	$8.05	$4.21	$15.16	$7.48
35–39	$10.76	$5.57	$20.58	$10.19
40–44	$13.38	$6.88	$25.81	$12.81
45–49	$14.15	$7.26	$27.36	$13.58
50–54	$25.19	$12.78	$49.43	$24.62
55–59	$24.29	$12.33	$47.64	$23.73
60–64	$41.05	$20.71	$81.16	$40.49
65–69	$86.05	$43.21	$171.16	$85.48
70+	$86.05	$43.21	$171.16	$85.48

COVERED CONDITIONS AND BENEFIT AMOUNTS*

A covered employee has the full benefit amount illustrated below. Any covered dependent is covered at 50% of the benefit amount illustrated below.

BASE BENEFITS	
CANCER (INTERNAL OR INVASIVE)	100%
HEART ATTACK (MYOCARDIAL INFRACTION)	100%
STROKE (ISCHEMIC OR HEMORRHAGIC)	100%
MAJOR ORGAN TRANSPLANT	100%
KIDNEY FAILURE (END-STAGE RENAL FAILURE)	100%
BONE MARROW TRANSPLANT	100%
SUDDEN CARDIAC ARREST	100%
SEVERE BURN	100%
PARALYSIS	100%
COMA	100%
LOSS OF SPEECH/SIGHT/HEARING	100%
NON-INVASIVE CANCER	25%
CORONARY ARTERY BYPASS SURGERY	25%
PROGRESSIVE DISEASE RIDER	
AMYOTRAPHIC LATERAL SCLEROSIS (ALS)	100%
SUSTAINED MULTIPLE SCLEROSIS	100%
OPTIONAL BENEFITS RIDER	
BENIGN BRIAN TUMOR	100%
ADVANCED ALZHEIMER'S DISEASE	100%
ADVANCED PARKINSON'S DISEASE	25%
Specified Diseases Rider: Benefits are payable if an insured is diagnosed with one of the diseases listed below. These benefits will be paid based on face amount. ADDISON'S DISEASE, CEREBROSPINAL MENINGITIS, DIPHTHERIA, HUNTINGTON'S CHOREA, LEGIONNAIRE'S DISEASE, MALARIA, MUSCULAR DYSTROPHY, MYASTHENIA GRAVIS, NECROTIZING FASCIITIS, OSTEOMYELITIS, POLIOMYELITIS (POLIO), RABIES, SICKLE CELL ANEMIA, SYSTEMIC LUPUS, SYSTEMIC SCLEROSIS (SCLERODERMA), TENANUS, TUBERCULOSIS	25%
CHILDHOOD CONDITIONS	
CYSTIC FIBROSIS	50%
CEREBRAL PALSY	50%
CLEFT LIP OR CLEFT PALATE	50%
DOWN SYNDROME	50%
PHENYLALANINE HYDROXYLASE DEFICIENCY DISEASE (PKU)	50%
SPINA BIFIDA	50%
TYPE 1 DIABETES	50%
AUTISM SPECTRUM DISORDER (ASD)	$3,000

*This is a summary. Refer to plan document for details including definitions, plan exclusions and limitations.

Hospital Indemnity Coverage

Hospital Indemnity Coverage through Aflac pays cash benefits directly to you if you have a covered stay in a hospital or critical care unit (ICU). You can use the benefits from this policy to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging, or everyday expenses such as groceries and utilities.

- **Benefits are payable for pregnancy on the first day of coverage**
- **Coverage is guaranteed issue; no medical questions**

SUMMARY OF BENEFITS*	HIGH PLAN	LOW PLAN
HOSPITAL ADMISSION (ONCE PER COVERED SICKNESS OR ACCIDENT PER CALENDAR YEAR)	$2,000 per confinement	$1,000 per confinement
HOSPITAL CONFINEMENT (MAXIMUM CONFINEMENT PERIOD: 31 DAYS PER COVERED SICKNESS OR COVERED ACCIDENT)	$200 per day	$100 per day
HOSPITAL INTENSIVE CARE (MAXIMUM CONFINEMENT PERIOD: 15 DAYS PER COVERED SICKNESS OR COVERED ACCIDENT)	$200 per day	$100 per day
INTERMEDIATE INTENSIVE CARE STEP-DOWN (MAXIMUM CONFINEMENT PERIOD: 10 DAYS PER COVERED SICKNESS OR ACCIDENT FOR EACH INSURED)	$100	$50

*This list is a summary. Refer to plan documents for a comprehensive list of covered benefits

MONTHLY CONTRIBUTIONS	HIGH PLAN	LOW PLAN
EMPLOYEE ONLY	$20.44	$10.22
EMPLOYEE + SPOUSAL/ DOMESTIC PARTNER	$41.38	$20.68
EMPLOYEE + CHILD(REN)	$32.16	$16.06
EMPLOYEE + FAMILY	$53.10	$26.52

Mental Health

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. But your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help? Whether you need assistance with work-life balance or anxiety, there are resources available to help you out.

Mental Health and Your Medical Plan

The medical plan through Blue Cross Blue Shield also covers behavioral and mental health services at $0 copay per visit under the Elite and Enhanced plans and 0% coinsurance after the deductible under the High Deductible Plan (HDHP). See plan documents for specifics on coverage for inpatient and outpatient services.

An important aspect of your overall wellbeing is emotional wellness — the ability to successfully adapt to changes and challenges as they arrive and handle life's stresses. These five actions have been shown to improve emotional wellness.

Employee Assistance Program

We're here for you when you need help. Our Employee Assistance Program (EAP) helps manage your and your family's total health, including mental, emotional, and physical. And there's no cost to you and your dependents when you enroll in Basic Life.

Through the EAP, you have access to mental health assistance and legal and financial help from professionals. You also have 24-hour access to helpful resources by phone, and the EAP benefit includes 5 face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with Elara Caring. You may access information, benefits, educational materials, and more by phone at 888-628-4824 or online at www.guidanceresources.com.
Username: LFGSupport
Password: LFGSupport1

The Program provides referrals to help with:

- Emotional health and wellbeing
- Alcohol or drug dependency
- Marriage or family problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

The Big Five of Emotional Wellness

Practice mindfulness.
Practice deep breathing, enjoy a stroll, and stay present in each moment.

Strengthen social connections.
Reach out to a friend or family member daily — even if it's just a video call or text.

Improve your outlook.
Treat people with kindness, including yourself.

Get quality sleep.
Keep a consistent sleep schedule and limit electronic use before bed.

Deal with your stress.
Think positively, exercise regularly, and set priorities.

Survivor Benefits

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection in the event of an unexpected event.

Basic Life and Accidental Death & Dismemberment Insurance

Elara Caring provides employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through Lincoln Financial Group, which guarantees that your spouse or other designated survivor(s) continue to receive benefits after death.

Your Basic Life and AD&D insurance benefit is 1x annual salary, up to $50,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you waive other coverage.

Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death under the Lincoln Financial Group insurance.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact People Services Center or your own legal counsel with any questions.

Voluntary Life and AD&D Insurance

You may wish for extra coverage for more peace of mind. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

BASIC EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	1x annual salary
WHO PAYS	Elara Caring
MAXIMUM BENEFIT	$50,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	Increments of $10,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	If you do not enroll within 30 days of employment, increase your coverage by more than $10,000, or you go over the Guaranteed Issue amount of $200,000, EOI is required
VOLUNTARY SPOUSE LIFE/AD&D	
COVERAGE AMOUNT	Increments of $5,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$250,000 or 100% of employee supplemental election amount
EVIDENCE OF INSURABILITY (EOI) REQUIRED	If you do not enroll within 30 days of employment, increase your coverage by more than $5,000, or go over the Guaranteed Issue amount of $30,000, EOI is required
VOLUNTARY CHILD LIFE/AD&D	
COVERAGE AMOUNT	Live birth to 6 months: $500 6 months to 26 years: $10,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$10,000

Evidence of Insurability (EOI)

- Any amount over the guaranteed issue will require EOI.
- If you do not elect employee life insurance as a new hire, but choose to enroll later during open enrollment, you will be considered a late entrant. As a late entrant, EOI will apply to any amount elected. Guaranteed issue will no longer apply.
- Employees who enroll in Supplemental Life (as a new hire or during annual enrollment) may increase election by one level each annual enrollment without EOI.
- If EOI is required, Lincoln will mail this to your home for completion. No amount subject to EOI will be approved until received and confirmed by Lincoln.

Income Protection

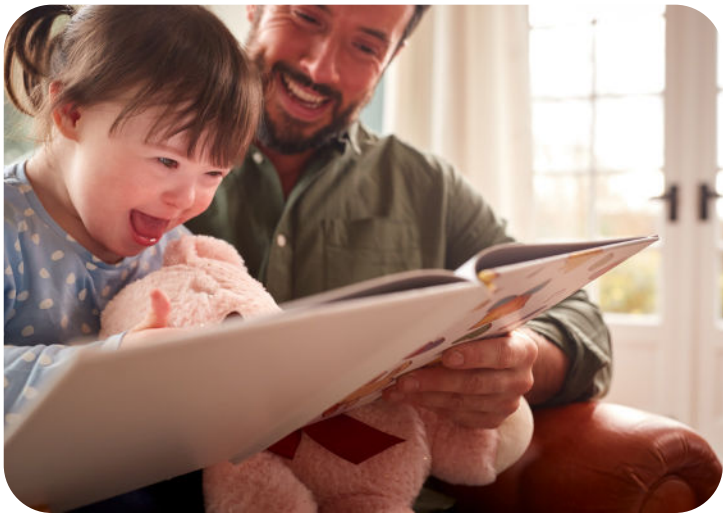
You and your loved ones depend on your regular income. That's why Elara Caring offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury or illness. A portion of your income is protected until you can return to work or you reach retirement age.

Voluntary Short Term Disability (STD) Insurance

Short Term Disability (STD) benefits are available for purchase on a voluntary basis. This insurance replaces 60% of your weekly income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or People Services Center for details. See Workday for specific rates for this plan.

WEEKLY MAXIMUM BENEFIT	$2,500
ELIMINATION PERIOD	7 days
MAXIMUM BENEFIT PERIOD	13 weeks

NOTE: As a new hire, you may enroll in short-term disability without Evidence of Insurability (EOI). If you do not elect short-term disability as a new hire, but choose to enroll later during open enrollment, you will be considered a late entrant. As a late entrant, EOI will apply. If EOI is required, Lincoln will mail this to your home for completion. No amount subject to EOI will be approved until received and confirmed by Lincoln.



Basic Long Term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are available at no cost. This insurance replaces 40% of your monthly income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or People Services Center for details.

MONTHLY MAXIMUM BENEFIT	$10,000
ELIMINATION PERIOD	90 consecutive days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

Voluntary Long Term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are available for purchase on a voluntary basis. This insurance replaces an additional 20% of your monthly earnings, for a total of 60%. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or People Services Center for details. See Workday for specific rates for this plan.

MONTHLY MAXIMUM BENEFIT	$10,000
ELIMINATION PERIOD	90 consecutive days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

Retirement Planning

No matter what point of your career you're in, it's never a bad time to think about your future and save for retirement.

Contributing to a 401(k) account now can help keep you financially secure later in life. The Elara Caring 401(k) plan provides you with the tools you need to prepare.

PLAN AT A GLANCE	
PLAN NAME	Elara Caring 401(k) Plan
RECORDKEEPER	Fidelity
WEBSITE	401k.com
ELIGIBILITY	Must be at least 21 years of age and have completed at least six months of service at Elara Caring
COMPANY MATCH	Elara Caring supports your savings efforts by offering you a company matching contribution to help you save even more.

All About 401(k)

Elara Caring supports your savings efforts by offering you a Company Match: 100% of first 3% and 50% on the next 2% (total of a 4% match on a 5% contribution).

Eligible employees can invest for retirement while receiving tax advantages. Elara Caring supports your savings efforts by offering you a company matching contribution to help you save even more. Administrative services are provided by Fidelity. You may start making pre-tax contributions into the plan after completing at least six months of service at the company. You must be at least 21 years of age to be eligible.

Pre-tax vs. Roth 401(k): What's the difference? If you contribute to your 401(k) pre-tax, your contributions are taken out before taxes each pay period, which will lower your annual taxable income. Pre-tax contributions grow on a tax-deferred basis and you won't pay taxes on these dollars until a distribution is taken at retirement. If you choose the available Roth 401(k), contributions are deducted from your paycheck after taxes — so although you are paying taxes on those dollars now, you won't pay taxes when you withdraw during retirement.

Contributing to the Plan

The deferred contribution limit set annually by the IRS is $23,000 for 2024.

If you are age 50 or older this year and you already contribute the maximum allowed to your 401(k) account, you may also make a "catch-up contribution." This additional deposit accelerates your progress toward your retirement goals. The maximum catch-up contribution is $7,500 for 2024 — for a combined total contribution allowance of $30,500.

Not sure if you're getting close to the annual contribution limit? Our payroll system tracks how much you've contributed. If you started at the company mid-year, let the Payroll Department know how much you contributed at your previous employer so that can be factored in.

Note

The average American starts saving for retirement at age 27. But it's never too late! (Source: Annuity.org)

How Much Should I Save?

Industry standards suggest saving at least 12% to 15% of your income, including Elara Caring's generous matching contribution. If you can't afford to save that much, make sure to save up to the matching amount so you don't leave free money behind.

Changing or Stopping Your Contributions

You may change the amount of your contributions any time. Changes are effective as soon as administratively feasible and remain in effect until you modify them. You may also discontinue your contributions and start them again at any time.

Consolidating Your Retirement Savings

If you have an existing qualified retirement plan (pre-tax) with a previous employer, you may transfer that account into the plan any time. Contact Fidelity at 800-835-5097 for details.

Regardless of which retirement account you choose or how much you contribute, remember to think of it as a long-term strategy. Dipping into the account early will jeopardize the quality of your retirement and you may be subject to early withdrawal penalties from the IRS.

Investing in the Plan

It's up to you how to invest the assets. The Elara Caring 401(k) plan offers a selection of investment options for you to choose from. You may change your investment choices any time. For more details, visit 401k.com.

Vesting

Vesting refers to how much of your 401(k) funds you can take with you if or when you leave Elara Caring. With the new safe harbor plan you are immediately vested in the company match, so you'll own 100% of the contributions. You always own and are fully vested in your own personal 401(k) contributions.

Reminder: You cannot enroll or make changes to your 401(k) through Workday. Team members must visit the Fidelity website or call Fidelity for assistance.

Additional Benefits

Elara Caring wants you to succeed in all aspects of life, so we offer a variety of additional benefits to make your day-to-day easier.

Pet Insurance

We know your pets are part of the family, and just like any other family member, our furry friends are bound to have some medical expenses from time to time. For the most part, these expenses come from standard checkups and immunizations, but the occasional unexpected illness or injury can rack up some significant bills when you least expect it. Pet insurance through Nationwide provides coverage for veterinary expenses related to accidents and illnesses. Policies are available for dogs, cats, birds, and exotic pets. To enroll or for additional information, please visit https://benefits.petinsurance.com/elara or Nationwide at 877-738-7874.

Coverage includes:

- Accidents
- Illnesses
- Hereditary and congenital conditions
- Cancer
- Behavioral treatments
- Rx therapeutic diets and supplements
- Multiple pet discounts
- And more

How to use your pet insurance plan

1. Visit any vet, anywhere
2. Submit claim
3. Get reimbursed for eligible expenses

Prepaid Legal Coverage

LegalEASE offers a legal insurance plan that provides support and protection for unexpected personal legal issues for you and your family. As a member, you have access to a national network of over 20,300 attorneys who are matched to your specific legal needs. Being a LegalEASE insurance member also saves you time and costly legal fees.

LegalEASE Features:

- Home and consumer (Buying, selling, foreclosure and tenant disputes)
- Financial (Debt collection, collections, contracts)
- Auto and traffic (Traffic matters and license suspensions)
- Family (Adoption, name change)
- Estate planning and wills (Will, living will, health care power of attorney)

The LegalEASE Plan is **$18.50 monthly,** via payroll deduction.

To learn more about your legal insurance plan, visit www.legaleaseplan.com/elara or call 855-230-9380.

Identity Theft

Access to identity theft protection is available on a voluntary basis through Allstate ID. In an always on, ever connected world, the risk of identity theft is real. There is a new identity fraud victim every two seconds. You can help protect yourself with Allstate ID monitors millions of transactions every second, alerting you to suspicious activity by text, phone or email. This protection is different than free credit monitoring and offers a full set of features to help proactively protect you and your covered family members against identity theft.

Allstate Membership Features:

- Comprehensive Identity Monitoring and Alerts
- Lost Wallet Protection
- Dark Web Monitoring
- Account Activity Alerts
- Data Breach Notifications
- Credit Monitoring
- Social Media Monitoring
- Credit Assistance
- Mobile App
- 24/7 Customer Care Center

This plan is available via payroll deduction and is yours to keep if you retire or Elara Caring.

ALLSTATE IDENTITY PROTECTION PRO	MONTHLY PREMIUM PLUS PLAN
EMPLOYEE ONLY	$9.95
EMPLOYEE + FAMILY	$17.95

KinderCare

Elara Caring is partnering with KinderCare to offer an affordable child care solution. If you enroll your child(ren) in a KinderCare center or Champions program, you now have access to a tuition subsidy. For more information, visit www.kindercare.com/elaracaring.

Glossary

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside.
FSAs are "use it or lose it," so funds not used by the end of the plan year will be
lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in a HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy –** The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Qualifying Life Events – You can update your benefits when you start a new job or during Open Enrollment. But changes in your life called Qualifying Life Events (QLEs) determined by the IRS can allow you to enroll in health insurance or make changes outside of these times. When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. If the event is due to a loss in Medicaid or Children's Health Insurance Program (CHIP) coverage, you have 60 days to request changes to your coverage. Your change in coverage must be consistent with your change in status.

Common QLEs include a change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent); a change in a spouse's employment status (resulting in a loss or gain of coverage); a change in your legal marital status (marriage, divorce, or legal separation); eligibility for coverage through the Marketplace; a change in employment status from full time to part-time, or part-time to full time, resulting in a gain or loss of eligibility; and Entitlement to Medicare or Medicaid.

Some Lesser-known QLEs include turning 26 and losing coverage through a parent's plan; death in the family (leading to change in dependents or loss of coverage); and changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP).

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice from BW NHHC Holdco, INC DBA Elara Caring About Your Prescription Drug Coverage and Medicare under the Blue Cross Blue Shield / American Worker (MEC) Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with BW NHHC Holdco, INC DBA Elara Caring 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. BW NHHC Holdco, INC DBA Elara Caring has determined that the prescription drug coverage offered by the Blue Cross Blue Shield / American Worker (MEC Plan) plan(s) 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 BW NHHC Holdco, INC DBA Elara Caring coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not 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 BW NHHC Holdco, INC DBA Elara Caring 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 at the end of these notices 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 BW NHHC Holdco, INC DBA Elara Caring 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 Medicare Part D 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:	January 1, 2024
Name of Entity/Sender:	BW NHHC Holdco, INC DBA Elara Caring
Contact—Position/Office:	People Services Center
Address:	3010 LBJ Freeway Suite 1100 Dallas, TX 75234
Phone Number:	833-433-5272

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact People Services Center at 833-433-5272.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for health care benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact People Services Center at 833-433-5272.

HIPAA Special Enrollment Rights

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

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact People Services Center at 833-433-5272.

Illinois Essential Health Benefit (EHB) Listing

Employer Name:	BW NHHC Holdco, INC DBA Elara Caring
Employer State of Situs:	Texas
Name of Issuer:	Blue Cross Blue Shield
Plan Marketing Name:	Elite PPO Plan, High Deductible Health Plan (HDHP), Enhanced PPO Plan, MEC Plan
Plan Year:	2024

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2022 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing		Pg. 11	Yes
3	Bone anchored hearing aids		Pgs. 17 & 35	Yes
4	Durable Medical Equipment		Pg. 13	Yes
5	Hospice		Pg. 28	Yes
6	Infertility (Fertility) Treatment		Pgs. 23 - 24	No
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)		Pgs. 15 - 16	Yes
9	Private-Duty Nursing		Pgs. 17 & 34	No
10	Prosthetics/Orthotics		Pg. 13	Yes
11	Sterilization (vasectomy men)		Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)		Pgs. 13 & 24	Yes
13	Emergency Room Services(Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/Ambulance		Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	No
16	Breast Reconstruction After Mastectomy		Pgs. 24 - 25	Yes
17	Reconstructive Surgery		Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)		Pg. 15	Yes
19	Skilled Nursing Facility		Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)		Pgs. 18 & 31	Yes

2020-2022 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)		Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)		Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)		Pgs. 9 & 21	Yes
26	Tele-Psychiatry		Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication		Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Yes
29	Pediatric Vision Coverage		Pgs. 26 - 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services		Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education		Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes		Pgs. 31 - 32	Yes
36	Mammography - Screening		Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement		Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test		Pg. 16	Yes
39	Preventive Care Services		Pg. 18	Yes
40	Sterilization (women)		Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services		Pgs. 8, 9, 11, 12, 22, & 35	Yes

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

Important Contacts

QUANTUM HEALTH
MyElaraCaringBenefits.com
866-920-1963

MEDICAL
Blue Cross Blue Shield
866-920-1963
MyElaraCaringBenefits.com
Policy #: 789908

American Worker
theamericanworker.com
888-798-9480

PHARMACY
Express Scripts
866-544-3787
express-scripts.com

NBFSA
877-539-3940
coterie.mypharmacyplan.com

SUPPLEMENTAL HEALTH (Accident, Critical Illness, Hospital Indemnity)
Aflac
800-433-3036
aflacgroupinsurance.com

TELEMEDICINE
Teladoc
800-TELADOC
teladochealth.com

BACK & JOINT CARE
Hinge Health
855-902-2777
hingehealth.com/elaracaringoe

DENTAL
Blue Cross Blue Shield
833-393-5433
metlife.com/mybenefits
Policy #: 252348

VISION
Superior Vision by MetLife
800-507-3800
superiorvision.com
Policy #: 243259

HEALTH SAVINGS ACCOUNT
HSA Bank
855-731-5220
hsabank.com

FLEXIBLE SPENDING ACCOUNTS
HSA Bank
855-731-5220
hsabank.com

LIFE AND AD&D
Lincoln Financial Group
800-320-7585
mylincolnportal.com
Company Code: Elara
Policy #: SA3-890-LF0067-01

DISABILITY
Lincoln Financial Group
800-320-7585
mylincolnportal.com
Company Code: Elara
Policy #: GD/GF3-890-LF0067-01

RETIREMENT
Fidelity
800-835-5097
401k.com

PET INSURANCE
Nationwide
877-738-7874
benefits.petinsurance.com/elara

PREPAID LEGAL
LegalEASE
www.legaleaseplan.com/elara
855-230-9380

IDENTITY THEFT
Allstate Identity Protection
myaip.com
800-789-2720

EMPLOYEE ASSISTANCE PROGRAM
888-628-4824
www.guidanceresources.com
Username: LFGSupport
Password: LFGSupport1

KINDERCARE
www.kindercare.com/elaracaring

WONDR
wondrhealth.com/elara

ELARA CARING PEOPLE SERVICES CENTER
3010 LBJ Freeway, Suite 1100
Dallas, TX 75234
833-433-5272

Notes

Elara Caring