STERLINGRISK

Corporate Headquarters

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Employee Benefits Guide

Effective January 1, 2025 - December 31, 2025

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Human Resources Department

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Our Commitment

The SterlingRisk Benefits Plan is designed to:

- provide competitive and comprehensive benefit options to supply your individual needs.
- provide long term financial security for you and your family should you become unable to work.
- encourage healthy behaviors and the use of preventative care.

This guide describes the benefit plans available to you as an employee of SterlingRisk.

This enrollment guide is not intended to be nor shall it be construed as, a contract of any type. It highlights features of the benefits offered and does not contain all of the details that are included in your Summary Plan Description (SPD) or Certificates of Coverage. All SPD's and applicable notices may be accessed on company intranet.

Every effort has been made to ensure the accuracy of the information presented. However, in the event of any discrepancies, your actual coverage will be determined by the legal plan documents that govern the respective coverage. SterlingRisk reserves the right to change or end any of the benefit plans, at any time and for any reason, to the extent allowed by the law.

Please direct all questions to the Human Resources Department.

Plan/Administrator	Group/Policy Number	Customer Service	Website
Medical **UMR**	76417445	(800) 826-9781	www.umr.com
Dental **UnitedHealthcare**	922512	(866) 414-1959	www.Myuhc.com
Vision **UnitedHealthcare**	922512	(866) 414-1959	www.Myuhcvision.com
Pharmacy **SmithRx**		(844) 454-5201	www.smithrx.com
Life Insurance and AD&D Long Term Disability (LTD) Short Term Disability (STD) **Mutual of Omaha**	G000402K	(800) 769-7159	www.mutualofomaha.com
401(k) Retirement Plan **Fidelity**	28021	(800) 835-5095.	www.fidelity.com
Employee Assistance Program **Mutual of Omaha**	G000402K	(800) 316-2796	www.mutualofomaha.com
Health Spending Account (HSA) **UMB Bank**	N/A	(866) 520-4472	www.hsa.umb.com
Flexible Spending Account (FSA) **P & A Group**	501	(800) 688-2611	www.padmin.com
Lifelock **Norton**	Norton Lifelock	(800) 607 -9174	www.NortonLifeLock.com

Eligibility

As a fulltime employee of SterlingRisk, you and your dependents are eligible for the following benefits effective the first of the month following 30 days of employment:

- Medical
- Dental
- Vision
- Term Life Insurance and Accidental Death & Dismemberment (AD&D)
- Voluntary Life Insurance
- Long Term Disability (LTD)
- Voluntary Short Term Disability (STD)
- Employee Assistance Plan (EAP)
- Flexible Spending Account
- 401K Retirement Plan
- Identify Theft Protection

Medical: Eligible dependents include your spouse and dependent children to age 26

Dental: Eligible dependents include your spouse and dependent children to age 26

Vision: Eligible dependents include your spouse and dependent children to age 26

***Please note that domestic partners are not covered**

Pre-Tax Contributions

The company maintains a Premium Conversion Plan (POP) that allows our employees to make plan contributions on a pre-tax basis.

All benefit elections will remain in effect for the entire plan year (January 1 - December 31) unless you experience a ***life change event.***

Examples of life changing events are marriage, divorce, legal separation, death of a spouse or child, birth or adoption of a child, termination or commencement of employment of a spouse; a change in you or your spouse's employment fulltime status or unpaid leave, or such other events as indicated in the Summary Plan Document (SPD).

If you need to make a change before the next open enrollment period due to a change in status, you must submit the required documentation to support the change to the Human Resources Department within ***30 days*** of the life change event.

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

UMR– UnitedHealthcare Medical Plans

		EPO Base Plan Choice	EPO Middle Plan Choice	POS Plan Choice Plus	
		In Network	*In Network*	*In Network*	*Out of Network**
Deductible	Individual	*Embedded* $4,000	*Embedded* $3,000	*Non-Embedded* $2,000	*Non-Embedded* $4,000
	Family	$8,000	$6,000*	$4,000	$8,000
Coinsurance		20%	10%	0%	30%
Out of Pocket Maximum *Includes Deductible*	Individual	$4,500	$4,000	$3,500	$7,000
	Family	$9,000	$8,000	$7,000	$14,000
Office Visit	**Preventative Care**	**Covered 100%, deductible waived**	**Covered 100%, deductible waived**	**Covered 100%, deductible waived**	**Covered 70%, after deductible met**
	Primary Care	Covered 80% after deductible met	Covered 90% after deductible met	Covered 100% after deductible met	Covered 70% after deductible met
	Specialist	Covered 80% after deductible met	Covered 90% after deductible met	Covered 100% after deductible met	Covered 70% after deductible met
Emergency Room		Covered 80% after deductible met	Covered 90% after deductible met	Covered 100% after deductible met	100% after deductible met
Hospital Services	Inpatient	Covered 80% after deductible met	Covered 90% after deductible met	Covered 100% after deductible met	Covered 70% after deductible met
	Outpatient	Covered 80% after deductible met	Covered 90% after deductible met	Covered 100% after deductible met	Covered 70% after deductible met
Mental Health Services	Inpatient	Covered 80% after deductible met	Covered 90% after deductible met	Covered 100% after deductible met	Covered 70% after deductible met
	Outpatient	Covered 80% after deductible met	Covered 90% after deductible met	Covered 100% after deductible met	Covered 70% after deductible met
Pharmacy Benefit		Deductible then,	Deductible then,	Deductible then,	Deductible then,
	Generic	$10 Copayment	$10 Copayment	$10 Copayment	$10 Copayment
	Brand-Name Formulary	$35 Copayment	$35 Copayment	$35 Copayment	$35 Copayment
	Non-Formulary	$60 Copayment	$60 Copayment	$60 Copayment	$60 Copayment

- Out of Network Reasonable and Customary Level is based on 300% of Medicare.

  This highlights features of the benefits offered and does not contain all the details, that are included in the summary plan description or certificates of coverage.
- Embedded Deductible—Each family member has an individual deductible in addition to the overall family deductible. Meaning if an individual in the family reaches his or her deductible before the family deductible is reached, his or her services will be paid by the insurance company.

  *The family individual embedded deductible on the Middle plan is $3,300, per IRS guidelines for 2025.
- Non-Embedded Deductible— There is no individual deductible. So the overall family deductible must be reached, either by an individual or by the family, in order for the insurance company to pay for services.

**See page 12 for employee contributions

Reminder: You will not be allowed to change these elections until the next Open Enrollment period, unless you have a life change event during the course of the year. Please notify the Human Resources Department within 30 days of the life event with documentation.

SmithRx Pharmacy Benefits

New for 2025! We are excited to announce that we have partnered with SmithRx to provide our employees with a comprehensive pharmacy benefits program.

SmithRx is a Pharmacy Benefits Manager (PBM) that coordinates the pharmacy benefits between physicians and pharmacies. They offer several programs and services designed to make prescription drugs more affordable and accessible for our employees.

SmithRx

- Has a nationwide pharmacy network of 65,000+ retail locations and growing.
- Also has a mail order network, including Amazon Pharmacy, Mark Cuban Cost Plus Drugs, and Walmart Pharmacy.
- Offers a specialty pharmacy network as well.
- Automatically covered when you enroll in your health plan.
- Manages clinical requirements for your prescriptions.

Member ID Card

Remember to present your new card at the pharmacy.

Medication Coverage

You can find your formulary and benefits resources in our Member Portal.

Member Support

Our dedicated Member Support team is available via 844.454.5201

6 am - 7 pm Mon-Fri

9 am - 2 pm Sat

Continue to Use Your Usual Pharmacy: Most members will see little to no change in their pharmacy experience. You can continue to fill your prescriptions at your preferred pharmacy.

- **Please note:** If you receive specialty medications and/or maintenance medications with 90-day supplies, you will need to obtain pre-authorization from the new carrier. This pre-authorization must be renewed each year.

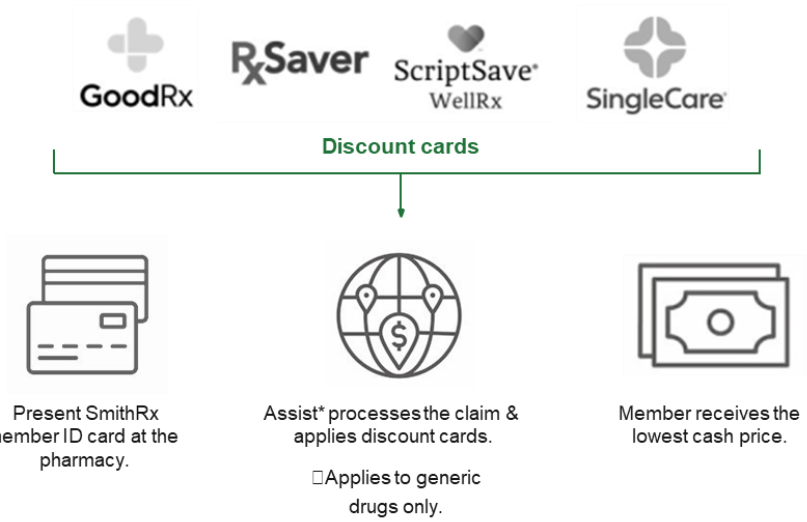
Member Portal

- Access your Member ID Card and forms.
- View prescription claims.
- Get Prior Authorization Status Notifications.
- Track total spends against your plan deductible and out-of-pocket limits.
- Find the lowest-cost pharmacy near you with the Find My Meds tool.

Connect 360

SmithRx offers additional cost savings programs for qualifying drugs.

- Use manufacturer coupon savings for low or $0 copay.
- Access Plus: Utilize advocacy foundations and grant programs for high-cost medications not covered.
- Assist: Automatically apply discount cards at the point of sale.
- Autoimmune, Low-Cost Insulin, and Diabetes Non-Insulin programs offer affordable options for specific conditions.



Dental Benefits

UnitedHealthcare Dental provides SterlingRisk employee's with 2 PPO dental plans that cover the main types of expenses. To find a participating provider in the PPO plans, choose the **National Options PPO 30 network.**

		PPO Base Dental	PPO High Dental
In-Network Deductible	Individual	$100	$50
	Family	$300	$100
Out-of-Network Deductible	Individual	$150	$100
	Family	$450	$300
Annual Maximum *(combined In & Out-of-Network)*	*In-Network*	$1,500	$1,500
	Out-of-Network	$1,500	$1,250
Preventative Services (deductible waived)	*In-Network*	100% Covered	100% Covered
	Out-of-Network	70% Covered	
Basic Services	*In-Network*	80% Covered	80% Covered
	Out-of-Network	60% Covered	
Major Services	*In-Network*	50% Covered	50% Covered
	Out-of-Network		
Dental Implants	*In-Network*	50% Covered	50% Covered
	Out-of-Network		
Orthodontia		Adult and Child	Not Covered
Orthodontia Max		$1,000 Lifetime per person	Not Covered
Reasonable and Customary Rates for Out of Network Expenses		Out of network reimbursement rates are based on what an in network provider would have charged.	Out of network reimbursement is based on what 9 out of 10 other out of network dentists charge.

Vision Benefits

Vision benefits are offered to all eligible employee and is administered by UnitedHealthcare with the Spectrum Network. Services may be rendered in both In– and Out-of-Network. **Dependent children are covered on the vision plan until age 26.** This highlights features of the benefits offered and does not contain all the details, that are included in the summary plan description or certificates of coverage.

		In-Network	Out-of-Network Reimbursement
Eye Examination: *Every 12 months*		$10 Copayment	Up to $40
Lenses *Every 12 month*	Single Vision	$25 Copayment	Up to $40
	Bifocal	$25 Copayment	Up to $60
	Trifocal	$25 Copayment	Up to $80
	Lenticular	$25 Copayment	Up to $80
Frames: *Every 24 months*		$120 Allowance 30% off retail price over $120	Up to $45
Medical Contact Lenses *Every 12 months*		$0 Copayment; Paid in Full	Up to $210
Contact Lenses *Every 12 months*	Non-Formulary	$130 Allowance	Up to $130
	Formulary	Up to 4 boxes	Up to $130

Dental:
Go to myuhc.com.

1. Select "Find a dentist."
2. Choose "Employer and individual plan."
3. Enter your zip code.
4. Select "National Options PPO 30."
5. Search by name, address, or category.

Vision:
Go to myuhcvision.com.

1. Select "Provider Quick Search."
2. Choose "UnitedHealthcare Vision" and "plans under network".
3. Enter your zip code.
4. Select your plan from the list.

Reminder: You will not be allowed to change these elections until the next Open Enrollment period, unless you have a life change event during the course of the year. Please notify the Human Resources Department within 30 days of the life event with documentation.

Health Saving Account (HSA)

SterlingRisk offers a Health Savings Account (HSA) which is a personal health care bank account that you can use to pay out-of-pocket medical expenses with pre-tax dollars when you are enrolled in a High Deductible Health Plan (HDHP). You can use HSA money to pay for eligible medical, dental and vision expenses now or in the future. Your HSA account can be used for your expenses and those of your spouse and dependents.

Eligible medical expenses are defined by the IRS and include such things as deductibles, coinsurance, prescription drugs and lab tests. The complete list can be found at www.IRS.gov.

In order to be eligible and qualify, the following requirements must be met:

- Must be covered under a High Deductible Health Plan (HDHP)
- Cannot be covered by your spouse's health plan that is not an HDHP, Flexible Spending Account (FSA) or Health Reimbursement Account (HRA)
- Cannot be claimed as a dependent on someone else's tax return
- Cannot be enrolled in Medicare
- Cannot be enrolled in the Transparent Healthcare plan offered by SterlingRisk

If you or your spouse is enrolled in any HSA, you can only enroll in the limited Flexible Spending Account.

Contributions:

- You own, administer and determine how much money you will contribute to the account. HSA's also allow you to save and roll-over money if you do not spend it within the calendar year.
- As an eligible employee, for the **2025 plan year**, SterlingRisk, contributes the following to the HSA.
- Middle and High Plan **$850** (single coverage) or **$1,700** (family coverage).
- Base Plan - **$1,350** (single coverage) or **$2,700** (family coverage).
- Any eligible individual can contribute to their HSA in addition to the employer's contribution

****Effective January 1, 2025**** the maximum annual contribution is $4,300 ($150 increase from 2025) for single coverage; $8,550 ($250 increase from 2025) for family coverage (this includes the employer's contribution). If you are over age 55, you can contribute an additional $1,000 in "catch up" contributions.

Flexible Spending Account (FSA)

Flexible Spending or Reimbursement Accounts are a great way to save money on services you know you will be rendering. Employees can maximize their benefits and minimize their overall cost. The FSA accounts work like savings accounts, it allows employees to use their pre-taxed dollars to pay for health care and dependent care expenses. This plan deducts dollars you decided on from your paycheck and places the money into a tax deferred account for your Health Care and/or Dependent Care Reimbursement Account.

Limited Health Care FSA—If you or your spouse is covered by a High Deductible Health Plan (HDHP) and contributes to the HSA, you may continue to participate in an FSA on a limited basis.

- Healthcare FSA and Limited FSA are "use it or lose it". If there are any funds remaining after 12/31/25, you have an additional 2.5 months grace period to incur claims to use up your balance. After that time any balance is forfeited.
- If you are currently enrolled in the FSA, you **must** enroll each plan year.

Parking & Commuter Benefits (NYC office employees only)

This plan allows you to use tax free dollars to pay for the cost of commuter fare and parking costs that you incur when you go to work. Whether you take the bus or ride the train to work, you can use tax free dollars to pay for those expenses.

Account	Purpose	Maximum Allowable Contribution
Health Care	Most medical, dental and vision care expenses (copayments, deductibles, eyeglasses and certain over-the-counter medications.)	For plan year 2025: **$3,300**
Limited Health Care	A limited purpose health flexible spending account may reimburse for dental and vision expenses, however medical expenses are excluded.	
Dependent Care	Dependent care expenses (daycare, after-school programs or elder care programs) for qualified dependents: • taxpayer's dependent who is under the age of 13; or • taxpayer's dependent or spouse who is physically/mentally incapable of self-care and has same principal residence as taxpayer for more than 1/2 of the taxable year.	Head of Household or married filing a joint tax return may contribute: **$5,000** Married filing separate tax return may contribute: **$2,500**
Parking & Commuter Benefits	Parking and commuter benefits are available to help employees save money on their commuting costs (Pre-tax parking, Public transportation passes, Bicycle commuting allowances.)	Maximum monthly contribution for 2025: **$325**

Life & Disability Insurance Benefits

SterlingRisk provides the following benefits to all eligible employees.

Administered by Mutual of Omaha

Basic Life Insurance and Accidental Death & Dismemberment

Upon meeting eligibility requirements, you are automatically enrolled in the benefits at **no cost to you**.
The benefit is 100% employer paid.

- Principal Sum Life Insurance: $50,000
- Age Reductions: 50% at age 70
- Waiver of Premium Benefits: You may be able to continue life insurance until age 65, without payment of premium, if you become Totally Disabled while insured under the Policy prior to age 60.

Long Term Disability Insurance (LTD)

As an eligible employee, SterlingRisk will allow the employee to choose to either pay the premium or have the employer pay the premium (tax choice).

Tax Choice: Employees have two options when electing to pay for Long Term Disability Insurance (LTD)

- An employer can pay for the employees coverage, at the time of the claim, the benefit is subject to income tax.
- Second option, is for the employee to pay premium, which leads to a tax-free benefit at claim time

	All Employees
Monthly Benefit	60% of prior year W2 earnings not to exceed the plan's maximum monthly benefit
Maximum Monthly Benefit	$10,000
Benefits Begin (Elimination Period)	90 Days
Own Occupation	To age 65
Pre-existing Condition Exclusion	No benefits will be provided for any Disability caused by, contributed to by, or resulting from a Pre-existing condition until the day after a 12-month period, from the effective date of your coverage under the policy, has passed during which you were continuously insured, if any required Elimination Period has been satisfied.
Mental Disorders	24 month per lifetime
Alcohol & Drug Abuse	24 month per lifetime

Voluntary Short Term Disability Insurance (STD)

SterlingRisk offers a voluntary Short Term Disability (STD) plan to all eligible employees upon eligibility who are unable to work because of a disability due to an injury or illness that is not job-related.

- Benefits begin after 7 days of disability
- 60% of weekly earnings up to $2,000 per week
- Benefits are provided for up to twelve (12) weeks
- Disabilities or illnesses caused by pregnancy are treated the same as any other medical condition or illness
- Preexisting condition exclusion–Any disability that occurs within 6 months of your first date of coverage date will not be covered

This highlights features of the benefits offered and does not contain all the details, that are included in the summary plan description or certificates of coverage.

Employees outside of New York State should check their state disability benefits before enrolling in this voluntary supplemental benefit.

**** Basic, Voluntary life and AD&D are not part of Open Enrollment elections. These elections are permitted after the new hire waiting period.***

Additional Benefits

Voluntary Term Life

As an eligible employee you have the opportunity to purchase additional life insurance policies for yourself, spouse and dependent children. Evidence of Insurability is required when requested amount exceeds Guaranteed Issue limits. Guaranteed Issue is only applicable upon initial offering, otherwise all requested amounts are subject to evidence of insurability.

- Principal Sum Term Life Insurance: $10,000, Guaranteed Issue: 5x annual salary up to $150,000
- Maximum benefit is 5x annual salary up to $500,000
- The voluntary Life coverage may change at age milestones, with a reduction in volume and changes to spousal coverage upon age milestone.

401(k) Retirement Plan

A 401(k) retirement plan, held with Fidelity, is designed to help build income for the future through tax-advantaged savings. With Fidelity, the money you contribute is on a pre-taxed basis, which reduces your current income tax bill. You postpone tax on all the money in your 401(k) account while it remains in the plan. Upon receiving a withdrawal or distribution of your plan money, you will then pay income tax on any money that has not yet been taxed.

Company Contribution

As an employee of SterlingRisk:

SterlingRisk will match up to 3.5% of the employee's salary if the chosen contribution rate remains at 6%.

For every dollar you contribute to your 401(k), we will also make a contribution to your account up the plan's maximum amount. Sterling will match 100% of the first 1% of your compensation and then 50% of the next 5%.

For example:
An employee earning $75,000 annually and contributing 6% to the 401(k) plan ($4,500) will receive a matching contribution of $2,625.

You may withdraw money from the plan for the following reasons:

- You leave your current employer
- You become disabled
- You attain the normal retirement age
- Your death

Employee Assistance Program (EAP)

SterlingRisk provides ALL employees access to an Employee Assistance Program (EAP) as part of it's Life Insurance plan. Many employees often struggle to manage personal and work responsibilities on their own. In response to this problem, SterlingRisk offers a comprehensive and integrated benefit solution for work and life management issues. Assistance for a variety of personal and professional matters, including, stress, parenting, grief, resiliency, financial issues, drug & alcohol abuse, depression, life changes, mental health, gambling and addictive behavior, relationships, balancing work and home.

Administered by Mutual of Omaha, highly trained professionals who will asses your needs (or your immediate dependent family members) and provide support and if required, the ability to refer you to other helpful resources.

This program is voluntary and confidential; only your EAP professional will know you have called.

Norton Lifelock

Norton offers advanced security to help against existing and emerging threats in various ways. Protecting your home , family and online privacy. Norton Life lock Monitors for fraudulent use of personal information and sends alerts when a potential threat is detected. Opt-in to Cyber Safety with Norton Life Lock who helps protect you and your families identity and devices .

Additional Benefits Continued

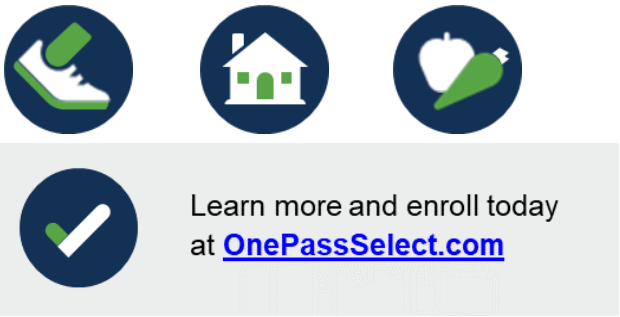
One Pass select– **New for 2025**

One Pass Select is a voluntary program featuring a subscription-based nationwide gym network, digital fitness, and grocery delivery service. The program has different membership tiers to fit your lifestyle and provides everything you need for whole-body health in one easy, affordable plan. You and your eligible family members or friends can get started with One Pass Select today!

Find your fit with One Pass Select:

- **At the gym:** Choose from a large nationwide network of gym brands and local fitness studios. Use any gym in the network and create a routine just for you.
- **At home:** Work out at home with live or on-demand online fitness classes. Try the workout builder to get routines created just for you, no matter what your fitness level and interests are.
- **In the kitchen:** Get groceries and household essentials delivered to your home. One Pass Select makes it easy to plan for everything you need to enjoy delicious, nutritious meals.

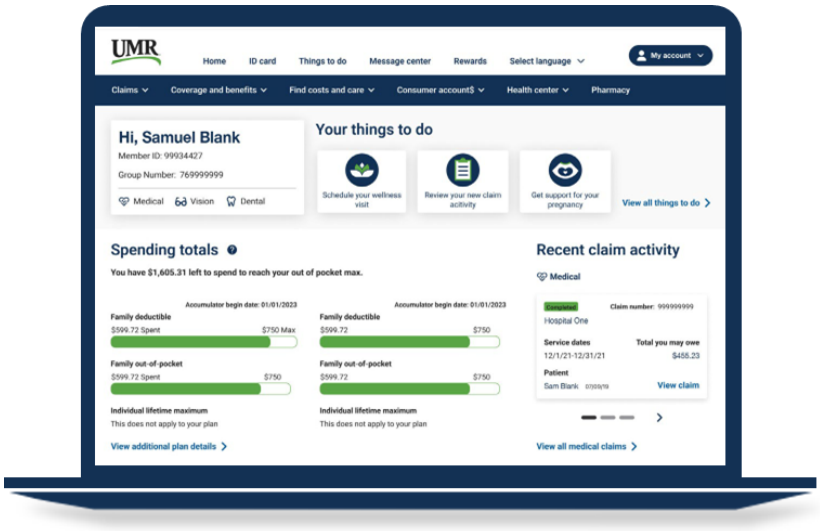
Category	Monthly Fee	Gym Network Size
Digital	$10	N/A (online fitness classes)
Classic	$29	11,000+ gym locations
Standard	$64	12,000+ gym and premium locations
Premium	$99	14,000+ gym and premium locations
Elite	$144	16,000+ gym and premium locations



UMR: Your Go-To for Health Care Management

Manage your health care easily and efficiently with UMR, a UnitedHealthcare Company. Here's how UMR can help you:

- **Quick Access:** Sign in to umr.com to find answers anytime, day or night.
- **UMR App**: Download the UMR app for a smarter, simpler, and faster way to manage your health care benefits from your mobile device.
- **Digital ID Card**: Access your ID card digitally, eliminating the need to carry a physical card.
- **Claims Management:** Easily track and manage your claims, view your spending totals, and see what you might owe.
- **Coverage and Benefits:** Check what health care services are covered, find out your deductible status, and learn about copayments.
- **Cost Estimator:** Use the Health Cost Estimator tool to find in-network providers and estimate your health care costs.
- **Personalized To-Do List:** View and manage your personalized benefits to-do list for tasks such as scheduling wellness visits and reviewing claim activity.



Download the UMR app today!

Scan the QR code to the left or visit your app store to get started.

Bi-weekly Employee Contributions

Medical

HSA EPO Base Choice Plan	
Employee only	$49.43
Family	$192.77
HSA EPO Middle Choice Plan	
Employee only	$78.89
Family	$273.48
HSA POS High Choice Plan	
Employee only	$223.84
Family	$775.98

Dental

PPO Base DENTAL	
Employee:	$17.46
Employee+ Spouse:	$32.24
Employee + Child(ren):	$39.72
Family :	$58.35
PPO High DENTAL	
Employee:	$25.34
Employee+ Spouse:	$48.46
Employee + Child(ren):	$53.85
Family:	$77.36

Vision

All ELIGIBLE EMPLOYEES	
Employee:	$2.40
Employee+ 1:	$4.37
Family:	$7.57

Norton Lifelock

Benefit Essential		**Benefit Premier**	
Employee	$4.15	Employee	$6.92
Employee + Family	$8.30	Employee + Family	$13.84

Mutual of Omaha

Basic Life Insurance	**Company Paid**
Voluntary Life/AD&D	Employee Paid **premiums are calculated according to your age and the amount of coverage you prefer*
Voluntary Long Term Disability	Tax Choice **premium varies based on amount of earnings*
Voluntary Short Term Disability	Employee Paid **premium varies based on amount of earnings*

Notice of Obligations

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

Alabama – Medicaid	**Alaska – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
Arkansas – Medicaid	**California – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 946-440-5676 Email: hipp@dhcs.ca.gov
Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	

Florida – Medicaid	Georgia – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	GA HIPP Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra Phone: 678-564-1162, Press 2
Indiana – Medicaid	**Iowa – Medicaid & CHIP (Hawki)**
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	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	**Kentucky – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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	**Maine – 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)	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms 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	**Minnesota – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	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	**Montana – Medicaid**

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
Nebraska – Medicaid	**Nevada – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
New Hampshire – Medicaid	**New Jersey – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	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	**North Carolina – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
North Dakota – Medicaid	**Oklahoma – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
Oregon – Medicaid	**Pennsylvania – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.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	**South Carolina - Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347 Or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
South Dakota - Medicaid	**Texas – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://gethipptexas.com Phone: 1-800-440-0493
Utah – Medicaid and CHIP	**Vermont – Medicaid**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website http://greenmoutaincare.org/ Phone: 1-800-250-8427
Virginia – Medicaid and CHIP	**Washington – Medicaid**
Website: https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924	Website: https://hca.wa.gov Phone: 1-800-562-3022
West Virginia – Medicaid	**Wisconsin – Medicaid**

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)	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 July 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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20240 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

General Notice of COBRA Rights

Continuation Coverage Rights Under COBRA

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

- The parent-employee dies.

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment.

Death of the employee;

- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

Donna Raab

135 Crossways Park Drive
Woodbury, New York 11797

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child.

This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer), and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes.

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

Plan contact information

Donna Raab - 135 Crossways Park Drive, Woodbury, New York 11797

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

General FMLA Notice

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

The United States Department of Labor Wage and Hour Division

Leave Entitlements

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

- The birth of a child or placement of a child for adoption or foster care.
- To bond with a child (leave must be taken within 1 year of the child's birth or placement).
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition.
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job.
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitute accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits & Protections

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements

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

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

*Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities

Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

For additional information or to file a complaint:

1-866-4-USWAGE

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

www.dol.gov/whd

Genetic Information Nondiscrimination Act (GINA) Disclosures

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Health Insurance Exchange Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than

9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[2]

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

How Can I Get More Information?

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

Donna Raab
135 Crossways Park Drive
Woodbury, New York 11797

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Sterling & Sterling LLC, DBA, SterlingRisk	4. Employer Identification Number (EIN) 11-1957801	
5. Employer address 135 Crossways Park Drive	6. Employer phone number 516-487-0300	
7. City Woodbury	8. State New York	9. ZIP code 11797
10. Who can we contact about employee health coverage at this job? Donna Raab		
11. Phone number 516-773-8645	12. Email address DRaab@sterlingrisk.com	

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

- As your employer, we offer a health plan to:
  - ☑ All Full Time Employees Scheduled to Work 30 or More Hours Per Week
- With respect to dependents:
  - ☑ Spouse and Children

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

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

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

Medicare Part D Creditable Coverage Notice

Important Notice from Sterling & Sterling LLC, DBA, SterlingRisk. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Sterling & Sterling LLC, DBA, SterlingRisk. 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. Sterling & Sterling LLC, DBA, SterlingRisk. has determined that the prescription drug coverage offered by the 2025 Plan Year 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 Sterling & Sterling LLC, DBA, SterlingRisk. coverage will not will not be affected.

If you do decide to join a Medicare drug plan and drop your current Sterling & Sterling LLC, DBA, SterlingRisk. 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 Sterling & Sterling LLC, DBA, SterlingRisk. 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 Sterling & Sterling LLC, DBA, SterlingRisk, 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:	1/1/2025
Name of Entity/Sender:	Sterling & Sterling LLC, DBA, SterlingRisk
Contact--Position/Office:	Donna Raab
Address:	135 Crossways Park Drive, Woodbury, New York 11797
Phone Number:	516-487-0300

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the 2025 Plan Year with respect to mental health or substance use disorder benefits, please contact your plan administrator

Michelle's Law Notice

Note: Pursuant to Michelle's Law, you are being provided with the following notice because the group health plan provides dependent coverage beyond age 26 and bases eligibility for such dependent coverage on student status. Please review the following information with respect to your dependent child's rights under the plan in the event student status is lost.

When a dependent child loses student status for purposes of Sterling & Sterling LLC, DBA, SterlingRisk group health plan coverage as a result of a medically necessary leave of absence from a post-secondary educational institution, the group health plan will continue to provide coverage during the leave of absence for up to one year, or until coverage would otherwise terminate under the group health plan, whichever is earlier.

In order to be eligible to continue coverage as a dependent during such leave of absence:

- Sterling & Sterling LLC, DBA, SterlingRisk group health plan must receive written certification by a treating physician of the dependent child which states that the child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary

To obtain additional information, please contact:

Donna Raab
135 Crossways Park Drive
Woodbury, New York11797

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Patient Protections

2025 Plan Year generally 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Donna Raab at 135 Crossways Park Drive, Woodbury, New York 11797 516-773-8645.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Sterling & Sterling LLC, DBA, SterlingRisk. or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Donna Raab at 135 Crossways Park Drive, Woodbury, New York 11797 Phone: 516-773-8645

Notice of Privacy Practices

Sterling & Sterling LLC, DBA, SterlingRisk.
135 Crossways Park Drive
Woodbury, New York11797

Privacy Official:
Donna Raab
Sterling & Sterling LLC, DBA, SterlingRisk.
135 Crossways Park Drive
Woodbury, New York 11797

Effective Date 1/1/2025

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records.
- Correct your health and claims records.
- Request confidential communication.
- Ask us to limit the information we share.
- Get a list of those with whom we've shared your information.
- Get a copy of this privacy notice.
- Choose someone to act for you.
- File a complaint if you believe your privacy rights have been violated.

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief.
- Market our services and sell your information.

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive.

- Run our organization.
- Pay for your health services.
- Administer your health plan.
- Help with public health and safety issues.
- Do research.
- Comply with the law.
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director.
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records.

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records.

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information.

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice.

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by contacting us at:

  Donna Raab
  Sterling & Sterling LLC, DBA, SterlingRisk.
  135 Crossways Park Drive
  Woodbury, New York11797

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20241, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and share your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Donna Raab at 135 Crossways Park Drive, Woodbury, New York 11797 516-773-8645.

USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or

- Are obligated to serve in the uniformed service; then an employer may not deny you
    - Initial employment;
    - Reemployment;
    - Retention in employment;
    - Promotion; or
    - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at *http://www.dol.gov/vets.* An interactive online USERRA Advisor can be viewed at *http://www.dol.gov/elaws/userra.htm.*

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address: *http://www.dol.gov/vets/programs/userra/poster.htm.* Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 1-866-487-2365.

Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice

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

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

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

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at Donna Raab at 135 Crossways Park Drive, Woodbury, New York 11797 516-773-8645

Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

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

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

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

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

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact your plan administrator.