option care health®

2025 Benefits Guide

This publication contains important information about your team member benefit program. **Please read thoroughly.**

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Welcome to Option Care Health

We are glad that you have joined the Option Care Health Team! We proudly offer a comprehensive benefits package and encourage you to read this booklet in its entirety to fully understand your options. Once you are ready to enroll, log into Workday and check your Inbox for the enrollment message. Be certain to complete the process within 31 days from your date of hire. Failure to do so means you will not have an opportunity to gain coverage until 2026, unless a qualifying life event occurs.

Enhancements in 2025

ChoiceCare Infusion Therapy Services with Option Care Health

Our culture of care extends beyond our daily work, and we are proud to provide Option Care Health team members access to cost effective infusion treatments when utilizing an OCH facility as the provider of their infusion needs. Team members that take advantage of Option Care Health infusion services will pay a low $5 copay with any PPO plan, or 5% coinsurance after deductible with any HDHP HSA plan.

Hinge Health for Joint & Muscle Care

Hinge Health provides in-home, personalized care for joint and muscle pain, fully covered for eligible BCBSIL enrollees, with access to tailored treatment plans and exercise plans.

Enhanced Dental

Our Delta 50 and Delta 100 plans now provide 60% orthodontia coverage with a maximum benefit of $5,000, extending coverage to adults and children.

Identity Theft Protection

Get peace of mind with AI powered identity and fraud protection from MetLife and Aura for families, covering up to 10 additional adults and unlimited children.

MetLife Legal Enhancement

You now have complimentary access to TurboTax services for preparing and filing one federal and state tax return per year.

Benefit Resources

Real-Time Benefits with iNGAGED

Download the iNGAGED app by Mercer to access personalized benefits information, health tips, and support right at your fingertips.

Access to a Personal Health Clinician (MHA)

Your BCBSIL plan now includes Personal Health Clinicians who will proactively assist with care coordination, healthcare navigation, and assist with post-surgery or hospital care in complex situations.

Decision Support Tool

Use this tool to calculate personalized medical costs in real-time by modeling different health care scenarios. https://www.MedPlanCompare.com/OptionCareHealth

Benefits Showcase

This year-round resource offers an interactive view of all Benefits and Total Rewards, including educational videos, SBCs, and other materials.

You must actively enroll for the Health and/or Dependent Care Flexible Spending Account (FSA), Health Savings Account (HSA), Parking, and Transit at every Annual Enrollment. These elections will not roll forward into 2025.

Benefits at a Glance

Medical Plans

- BCBSIL is our primary provider, and we offer 5 medical plans:
  - $750 Deductible Plan
  - $2,000 Deductible Plan
  - $3,000 Deductible Plan
  - $2,500 Deductible HSA Plan
  - $5,000 Deductible HSA Plan
- To find an in-network provider, visit the BCBS Website https://www.bcbsil.com and follow the below steps:
  1. Find a Doctor and login to search. If not a member yet, search as guest.
  2. Find an In-Network Provider; Search In-Network Providers
  3. How do you get Insurance (Through my employer or Spouse's employer)
  4. What state do you live in? (Select Home State)
  5. Select Network or Plan (Participating Provider Option – (PPO) or Blue High Performance Network (HPN)).
  6. Located Near (Enter zip code, city or an address)
  7. Click "Find a Doctor or Hospital" for results

Medical Plan - $5000 HSA Deductible Plan* (High Performance Network)

- You must use BlueHPN doctors and hospitals to receive benefits. There are no out-of-network benefits. Therefore, it's important to make sure your hospitals and doctors are part of the BlueHPN network.
- To find a Blue High Performance in-network provider, visit https://www.bcbsilcommunications.com/bluehpn/index.html

*This network is narrower in comparison to the PPO network that the other plans offer. Team members are responsible to verify the network status of their providers prior to electing this plan as mid-year changes are not allowed outside of qualifying life events.

California and Mid-Atlantic Team Members

- Kaiser HMO is available for team members located in California and the Mid-Atlantic, and we offer 3 medical plans:
  - $750 HMO Plan
  - $2,000 HMO Plan
  - $3,000 HMO Plan
- To find an in-network provider, visit the Kaiser website **https://healthy.kaiserpermanente.org/doctors-locations**

Hawaii Team Members

- HMSA HMO is available for all full-time team members and those part-time team members working 20 or more hours, who are located in Hawaii
- To find an in-network provider, visit the HMSA website https://www.hmsa.com/search/providers

ID Cards

- New ID cards will only be sent to team members who make plan changes

Tobacco Surcharge

- $1,200 per year for any team member and/or their spouse who use tobacco and are enrolled in the medical plan

Dental Plans

- Delta Dental offers two dental plans (Delta 50 and Delta 100)
- ID cards will only be issued to new enrollees

Vision Plan

- VSP offers two plan options (Base and Premier)
- VSP does not provide ID cards to participants. Simply tell your provider you have coverage with VSP

Benefits at a Glance

Life and Accidental Death and Dismemberment (AD&D) Plan

- Unum is our carrier
- Basic Life Insurance and AD&D coverage, equal to 1 times salary, will be offered at no cost to all team members working 30 or more hours per week.
- Team member voluntary life and AD&D is also available for purchase in increments of $10,000 up to $750,000 not to exceed 7x annual salary
- Spousal voluntary life and AD&D is available for purchase in increments of $10,000 up to $750,000
- Child voluntary and AD&D coverage is also available
- Team members who previously declined voluntary coverage will be required to complete the Evidence of Insurability form
  - Increases up to $20,000 are allowed for both the team member and/or spouse coverage but cannot exceed the guaranteed issue amount of $200,000 for team member coverage or $40,000 for spouse coverage

Headspace Care

- App-based mental and emotional support
- Available 24/7/365 using your smartphone
- Behavioral coaches create personalized care to fit your needs

Employee Assistance Program

- 100% employer-paid
- Dedicated toll-free crisis line: 800.854.1446
- **www.unum.com/lifebalance**
- Up to 3 visits at no charge to you or your family member for counseling services

Disability Insurance

- Unum is our carrier
- Short term disability benefits are paid depending on years of service and designated job classification
- Long term disability is offered on a voluntary basis (additional information on page 29)
- Evidence of Insurability is required if long term disability was previously waived

Health Savings Account

- HSA Bank is our carrier
- In order to contribute to an HSA Plan, you must be enrolled in a High Deductible plan.
- IRS maximum contribution of $4,300 for an individual or $8,550 for a household
- Option Care Health will sponsor a quarterly HSA match of up to $500 annually for individuals and $1,000 annually for non-single tiers

Flexible Spending Account

- NueSynergy is our carrier
- Healthcare FSA—IRS maximum of $3,300 (max at time of print)
- Dependent Care FSA—IRS maximum of $5,000 per household per year
- Transportation Benefits
  - Parking limit is $325/mo (max at time of print)
  - Transit limit is $325/mo (max at time of print)

401(k)

- Team members are eligible to make contributions upon hire
- Option Care Health offers a company match of 100% up to 4% of your contributions after one year of service and 1,000 hours worked
- Annual fee is $4.00 per participant per quarter

Voluntary Benefits

Voluntary coverages through Unum include accident, critical illness, and hospital indemnity

- Exclusive discounts available through PerkSpot
- Identity theft coverage offered through MetLife Aura
- Legal coverage offered through MetLife Legal
- Student loan refinancing offered through SoFi

Eligibility

Team Members

- Full-time team members must be regularly scheduled to work at least 30 hours per week to participate in the medical*, dental, vision, and life insurance plans
- Part-time team members working between 20–29 hours are eligible for Headspace Care, Option Care Health's limited–purpose flexible spending account, PerkSpot, SoFi student loan refinancing, and 401(k); part-time team members residing in Hawaii are eligible to enroll in the HMSA Medical Plan
- Per Diem team members working on an "as needed" basis (scheduled less than 19 hours per week) are ineligible for Option Care Health's benefit plans with the exception of the 401(k) plan, PerkSpot, and SoFi student loan refinancing

* Per state mandate, part-time team members working 20 or more hours are eligible for medical coverage in the State of Hawaii.

Dependents

- Your legal spouse
- Your dependent children up to age 26
- Your unmarried, disabled dependent children of any age (you may be required to provide proof of disability)
- Note: If you are adding new dependents, you will be required to include documentation to your benefits enrollment for dependent verification. Required documentation for your spouse is a legal marriage certificate. Required documentation for child(ren) is their birth certificate listing you or your spouse as the parent.
  IF YOU DO NOT PROVIDE THIS INFORMATION AT THE TIME OF ENROLLMENT, YOUR DEPENDENTS WILL NOT BE ADDED TO YOUR BENEFIT ELECTIONS.

Qualifying Life Events

Once Annual Enrollment closes, you will only be able to make changes to your coverage when a Qualifying Life Event occurs. Once you experience a Qualifying Life Event, you have 31 days from the date of the event to make changes to your benefit elections. If you do not make changes within the 31-day window, you will not be allowed to change your benefit plan elections and/or add covered dependents until the next Annual Enrollment period. Qualifying life events include:

Copy of marriage certificate

Marriage/divorce

Birth or adoption of child(ren)

Death of spouse/child(ren)

Change in employment status of self/spouse

How to Enroll

Enrollment Process is completed through the Workday portal via the web, Workday App, or on an iPad. Once logged in, click your inbox in the top right hand corner and select the message titled Benefits Enrollment. You will be taken to the screen where your elections can be entered.

NOTE: All benefits are displayed in "Tile" format. Each tile represents a separate benefit. We encourage you to click on all the benefit tiles to confirm your selections for 2025. Don't forget to select the "Submit" button and print a .pdf version of your elections for your records since this will be the only proof of your elections.

The selections you make will be in effect through December 31, 2025, unless you have a qualifying life event.

Tools to help you choose!

You now have access to a health plan cost estimator tool to help you and your family make an informed decision about your health plan options. This interactive tool helps you see annual cost estimates for each health plan option in a real-life scenario that matches your particular situation. Then, you can create your own personalized estimate using the interactive calculator.

How to access:

Visit https://www.MedPlanCompare.com/OptionCareHealth and answer the questions to see which plan may work best for you.

PROVIDER	PLAN	WEBSITE
BCBSIL	750 PPO High Deductible Plan 2000 PPO High Deductible Plan 3000 PPO High Deductible Plan 2500 High Deductible HSA Plan	**https://www.bcbsil.com/find-care/providers-in-your-network/find-a-doctor-or-hospital**
	5000 High performance Network	**https://www.bcbsilcommunications.com/bluehpn/index.html**
Kaiser	750 HMO Plan 2000 HMO Plan 3000 HMO Plan	**https://healthy.kaiserpermanente.org/doctors-locations**
HMSA	HMO	**https://www.hmsa.com/search/providers/**

Medical Plans

Medical Insurance Plan Comparison—Blue Cross Blue Shield of Illinois

NETWORK	$750 DEDUCTIBLE PLAN		$2,000 DEDUCTIBLE PLAN		$3,000 DEDUCTIBLE PLAN	
ANNUAL DEDUCTIBLE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Single	$750	$1,500	$2,000	$4,000	$3,000	$6,000
Family	$1,500	$3,000	$4,000	$8,000	$6,000	$12,000
Annual Maximums						
Single	$3,000	$6,000	$5,000	$10,000	$6,000	$12,000
Family	$6,000	$12,000	$10,000	$20,000	$12,000	$24,000
Coinsurance (you pay)						
	25%	50%	25%	50%	25%	50%
Office Visits						
PCP	$20	Ded./coins.	$25	Ded./coins.	$25	Ded./coins.
Specialist	$35	Ded./coins.	$50	Ded./coins.	$50	Ded./coins.
Preventive Care						
	100%	Ded./coins.	100%	Ded./coins.	100%	Ded./coins.
Emergency Room						
	Ded./coins.	Ded./coins.	Ded./coins.	Ded./coins.	Ded./coins.	Ded./coins.
Inpatient Services						
	Ded./coins.	Ded./coins.	Ded./coins.	Ded./coins.	Ded./coins.	Ded./coins.
Outpatient Services						
	Ded./coins.	Ded./coins.	Ded./coins.	Ded./coins.	Ded./coins.	Ded./coins.
Infusion Therapy Services	OCH Provider		In-Network		Out-of-Network	
PPO	$5 copay		Ded./coins.		Ded./coins.	
HDHP	5% coinsurance		Ded./coins.		Ded./coins.	
Prescription Drugs	In-Network		In-Network		In-Network	
Generic (Preferred or Non-Preferred)	$10		$10		$10	
Preferred-Brand	$50		$50		$50	
Non-Preferred Brand	$100		$100		$100	
Specialty (Preferred or Non-Preferred)	$150		$150		$150	

* 90-day Mail Order or Retail supply is available and is 2.5x the retail cost.

BLUE CROSS BLUE SHIELD OF ILLINOIS PREMIUMS

EMPLOYEE BI-WEEKLY CONTRIBUTIONS			
	$750 DEDUCTIBLE PLAN	$2,000 DEDUCTIBLE PLAN	$3,000 DEDUCTIBLE PLAN
Team Member	$209.39	$88.50	$59.29
Team Member + Spouse	$464.63	$309.75	$207.54
Team Member + Child(ren)	$363.16	$221.25	$148.24
Team Member + Family	$663.76	$442.50	$296.48

Medical Insurance Plan Comparison—Blue Cross Blue Shield of Illinois

NETWORK	$2,500 DEDUCTIBLE HSA PLAN		$5,000 DEDUCTIBLE HSA PLAN	
ANNUAL DEDUCTIBLE	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Single	$2,500	$5,000	$5,000	
Family	$5,000	$10,000	$10,000	
Annual Maximums				
Single	$5,000	$10,000	$8,000	$8,000
Family	$9,100	$20,000	$16,000	$16,000
Coinsurance (you pay)				
	25%	50%	35%	35%
Office Visits				
PCP	Ded./coins.	Ded./coins.	Ded./coins.	Not covered
Specialist	Ded./ coins.	Ded./coins.	Ded./coins.	Not covered
Preventive Care				
	100%	Ded./coins.	100%	Not covered
Emergency Room				
	Ded./coins.	Ded./coins.	Ded./coins.	Ded./coins.
Inpatient Services				
	Ded./coins.	Ded./coins.	Ded./coins.	Not covered
Outpatient Services				
	Ded./coins.	Ded./coins.	Ded./coins.	Not covered
Infusion Therapy Services	OCH Provider	In-Network	Out-of-Network	
PPO	$5 copay	Ded./coins.	Ded./coins.	
HDHP	5% coinsurance.	Ded./coins.	Ded./coins.	

Prescription Drugs	In-Network	In-Network
Generic (Preferred or Non-Preferred)	Ded./coins.	Ded./coins.
Preferred-Brand	Ded./coins.	Ded./coins.
Non-Preferred Brand	Ded./coins.	Ded./coins.
Specialty (Preferred or Non-Preferred)	Ded./coins.	Ded./coins.

* 90-day Mail Order or Retail supply is available and is 2.5 the retail cost.

BLUE CROSS BLUE SHIELD OF ILLINOIS PREMIUMS

	$2,500 DEDUCTIBLE HSA PLAN	$5,000 DEDUCTIBLE HSA PLAN
Team Member Bi-Weekly Contributions		
Team Member Only	$62.83	$26.55
Team Member + Spouse	$219.92	$92.93
Team Member + Child(ren)	$157.09	$66.37
Team Member + Family	$314.18	$132.75

* Tobacco Surcharge—$1,200 per year (equals $46.15 per paycheck) for a team member who uses tobacco PLUS $1,200 per year ($46.15 per paycheck) for a spouse who uses tobacco

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve expenses from everyone in the family reaches the annual limit. It can also be met when one individual's expenses reach or exceed the family limit.

Medical Insurance Plan Comparison—Kaiser California HMO

NETWORK	$750 DEDUCTIBLE PLAN	$2,000 DEDUCTIBLE PLAN	$3,000 DEDUCTIBLE PLAN
ANNUAL DEDUCTIBLE	IN-NETWORK	IN-NETWORK	IN-NETWORK
Single	$750	$2,000	$3,000
Family	$1,500	$4,000	$6,000
Annual Maximums			
Single	$3,000	$5,000	$6,000
Family	$6,000	$10,000	$12,000
Coinsurance (you pay)			
	25%	25%	25%
Office Visits			
PCP	$20	Ded./coins.	Ded./coins.
Specialist	$30	Ded./coins.	Ded./coins.
Preventive Care			
	100%	100%	100%
Emergency Room			
	$200	Ded./coins.	Ded./coins.
Inpatient Services			
	Ded./coins.	Ded./coins.	Ded./coins.
Outpatient Services			
	Ded./coins.	Ded./coins.	Ded./coins.
Prescription Drugs			
Generic	$10	$10	$10
Preferred Brand	$30	$50	$50
Non-Preferred	$30	$50	$50

Kaiser California HMO Premiums

	$750 DEDUCTIBLE PLAN	$2,000 DEDUCTIBLE PLAN	$3,000 DEDUCTIBLE PLAN
Team Member Bi-Weekly Contributions			
Team Member Only	$102.02	$29.17	$13.20
Team Member + Spouse	$326.46	$147.81	$111.72
Team Member + Child(ren)	$265.25	$107.53	$88.35
Team Member + Family	$469.29	$232.86	$196.61

* Tobacco Surcharge—$1,200 per year (equals $46.15 per paycheck) for a team member who uses tobacco PLUS $1,200 per year ($46.15 per paycheck) for a spouse who uses tobacco

Medical Insurance Plan Comparison—Kaiser Mid-Atlantic HMO

MARYLAND, VIRGINIA, AND WASHINGTON, D.C.

NETWORK	$750 DEDUCTIBLE PLAN	$2,000 DEDUCTIBLE PLAN	$3,000 DEDUCTIBLE PLAN
ANNUAL DEDUCTIBLE	IN-NETWORK	IN-NETWORK	IN-NETWORK
Single	$750	$2,000	$3,000
Family	$1,500	$4,000	$6,000
Annual Maximums			
Single	$3,500	$5,000	$6,000
Family	$7,000	$10,000	$12,000
Coinsurance (you pay)			
	25%	25%	25%
Office Visits			
PCP	$20	Ded./coins.	Ded./coins.
Specialist	$30	Ded./coins.	Ded./coins.
Preventive Care			
	100%	100%	100%
Emergency Room			
	$200	Ded./coins.	Ded./coins.
Inpatient Services			
	Ded./coins.	Ded./coins.	Ded./coins.
Outpatient Services			
	Ded./coins.	Ded./coins.	Ded./coins.
Prescription Drugs			
Generic	$10	$10	$10
Preferred Brand	$30	$50	$50
Non-Preferred Brand	$60	$100	$100

Kaiser Mid-Atlantic HMO Premiums

NETWORK	$750 DEDUCTIBLE PLAN	$2,000 DEDUCTIBLE PLAN	$3,000 DEDUCTIBLE PLAN
Team Member Bi-Weekly Contributions			
Team Member Only	$63.66	$19.66	$12.08
Team Member + Spouse	$229.66	$41.28	$25.38
Team Member + Child(ren)	$178.63	$35.38	$21.75
Team Member + Family	$345.87	$102.80	$53.35

* Tobacco Surcharge—$1,200 per year (equals $46.15 per paycheck) for a team member who uses tobacco PLUS $1,200 per year ($46.15 per paycheck) for a spouse who uses tobacco

Medical Insurance Plan Comparison—HMSA HMO

NETWORK	HAWAII PLAN
ANNUAL DEDUCTIBLE	IN-NETWORK
Single	$0
Family	$0
Medical Annual Maximums	
Single	$2,500
Family	$7,500
Coinsurance	
	80%–90% (varies by procedure and setting)
Office Visits	
PCP	$20
Specialist	$20
Preventive Care	
	100%
Emergency Room	
	$100
Inpatient Services	
	Ded./coins.
Outpatient Services	
	Ded./coins.
Pharmacy Annual Maximums	
Single	$3,600
Family	$4,200
Prescription Drugs	
Generic	$7
Preferred Brand	$30
Non-Preferred Brand	$75
Preferred Formulary Specialty	$100
Non-Preferred Formulary Specialty	$200

HMSA HMO Premium

	HMO—(X-S)
TEAM MEMBER BI-WEEKLY CONTRIBUTIONS	
Team Member Only	$13.05
Team Member + Spouse	$228.36
Team Member + Child(ren)	$206.56
Team Member + Family	$425.37

* Tobacco Surcharge—$1,200 per year (equals $46.15 per paycheck) for a team member who uses tobacco PLUS $1,200 per year ($46.15 per paycheck) for a spouse who uses tobacco

Allsup—Medicare Advocacy

Available to team members and spouses age 65+ who are actively enrolled in an Option Care Health medical plan. Allsup is a service provided at no cost to you. Their trained specialists will personally consult with you about your medical needs and help you compare your existing Option Care Health coverage to Medicare coverage available to you. Their goal is to simplify the selection process so you can make a clear and confident choice about your healthcare coverage.

Headspace Care—Mental Healthcare Vendor

ABOUT HEADSPACE CARE

On-demand access to mental and emotional support anytime, anywhere. Easy access to care—no matter where you are, when you need it, or what you're going through. Headspace Care can help with anything you're struggling with—from stress and depression to issues with work and relationships. Need to chat on the weekend? Or at 3 AM on a holiday? Headspace Care is around 24/7/365. Headspace Care goes where your smartphone goes.

Headspace Care's behavioral coaches create personalized care plans to fit your needs. Coaches use a variety of techniques to understand your unique needs and work with you to create a plan. They help you identify small steps, keep you on track, and hold you accountable so you can reach your goals.

Immediate Access to Mental Healthcare That's Tailored to Your Needs

Through the Headspace Care app, you can access care in a way that works for you—through texts, private video sessions, and self-care activities—all from the privacy of your smartphone.

Access For Your Dependents

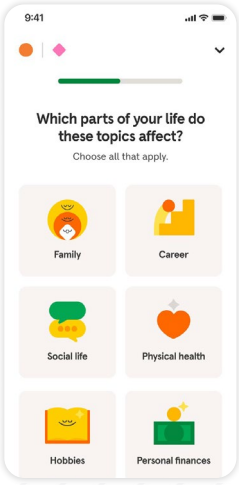
Mental healthcare is meant to be shared. Everyone can benefit from incredible mental healthcare —dependents included. You and your dependents age 13 and older also have access to mental health support through the Headspace Care app. When dependents sign up for Headspace Care, they create their own separate account. All information about their usage, conversations, and each person's data is kept confidential.

Get help with whatever's on your mind

Meet Headspace: your personal guide to caring for your mind. Learn to manage feelings of anxiety and depression, build healthy habits, and feel like your best self every day. Explore hundreds of guided exercises, and get one-on-one guidance from mental health coaches and clinicians.

Get started
work.headspace.com/optioncarehealth/member-enroll

Have a question? Visit help.headspace.com



Telemedicine

Telemedicine allows you to consult with a Board Certified Physician or Licensed Therapist 24 hours a day, 7 days a week. Consultations take place via telephone, secure video, or secure app, allowing you to discuss your symptoms and get the treatment you need—including prescription medications, all from the comfort of your home. Examples of commonly treated diagnoses include: sinus infection, ear infection, cough, fever, nausea/vomiting, pink eye, and urinary tract infections. There is no cost to you for this program, unless you are enrolled in the HSA Plan.

BCBSIL Members

- Website: **www.mdlive.com/bcbsil**
- Phone: 888.676.4204
- Cost: Cost $0
- Coinsurance/deductible apply to HSA Plans

Kaiser Members

- Website: **www.kp.org/mydoctor/videovisits**
- Phone: 800.777.7904
- Cost: $0

HMSA Members

- Website: **www.hmsa.com/onlinecare**
- Phone: 866.939.6013
- Cost: $0

Rx Savings Solutions

Available to BCBSIL members only, participants can choose to opt-in to the program and have their prescription purchases securely shared between Prime Therapeutics (BCBSIL) and Rx Savings Solutions (RxSS). Their comprehensive analytics can identify less expensive drug options when available, then deliver them to you via text message or email. Sometimes it's as simple as driving down the block to have your prescription filled. Other times it's asking your physician to switch your prescription or take other action. RxSS can work directly with your doctor as well.

REGISTER AND START SAVING IN THREE EASY STEPS!

1

Access Rx Savings Solutions Portal

Register for Rx Savings Solutions securely online at **auth.rxsavingssolutions.com/login**

2

Set up your Notifications

Adjust your preferences for text or email notifications by clicking "Profile" in the side navigation.

3

Search For Your Prescriptions

If savings are available, you'll receive instructions on how to review with your prescriber.

Additional BCBSIL Pharmacy Programs

- **90DayMyWay:** Receive a 90-day supply for only 2.5 the copay amount! This mandatory program allows you to conveniently receive a 90-day supply for select long-term medication through a retail pharmacy or mail-order.
- **Member Pay the Difference:** Generic drugs save you and the plan money; in order to promote generic utilization, you will be charged the difference in cost if you select a brand drug with a generic equivalent.
- **Flex Access Program:** BCBSIL will adjust your copay amounts to maximize the value of certain specialty drug manufacturer's coupons.

Wellness

BCBSIL, Kaiser, and HMSA Offer a Wide Variety of Wellness Tools and Resources

BCBSIL

- **Well onTarget**— Wellness program is designed to give you support to make healthy choices through personalized tools and resources. You can earn "Blue Points" by doing things like completing a Health Risk Assessment and following a wellness plan. Blue Points will be redeemable for digital gift cards from a variety of merchants (over 100 merchants to choose from).
- **Fitness program**— Members have access to discounts, flexible membership opportunities, and a chance to obtain Blue Points for visits. Blue Points will be redeemable for digital gift cards from a variety of merchants (over 100 merchants to choose from). Enroll today online by logging into Blue Access for Members at bcbsil.com or call 888.762.2583.
- **Blue365**—With this program, you may save money on health and wellness products and services from top retailers that are not covered by insurance. There are no claims to file and no referrals or pre-authorizations. Once you sign up for Blue365 at blue365deals.com/BCBSIL, weekly "Featured Deals" will be emailed to you. These deals offer special savings for a short period of time.
- **Women's and Family Health Pregnancy and Parenting Support**—BCBSIL, in partnership with Ovia Health will support all your family planning needs from fertility support, week by week pregnancy support and through your child's fourth birthday! Download any of the Ovia Health mobile apps today to get started!
- **24/7 Nurseline**—Nurses can answer your health questions and try to help you decide whether you should go to the emergency room or urgent care center or make an appointment with your doctor. You can also call the 24/7 Nurseline whenever you or your covered family members need answers to health questions at 800.299.0274.
- **Teladoc Health for Improved Diabetes and High Blood Pressure Management**—Teladoc Health is modern diabetes and high blood pressure management at no cost to you. With Teladoc Health, you get a high blood pressure monitor or an advanced glucose meter, unlimited strips, tips with every check, and personalized coaching. Enrolled members of the BCBSIL medical plans are eligible for the program but must meet certain criteria. If eligible, please sign up by responding to the mailer sent out by BCBSIL.
- **Hinge Health** If you suffer from neck, shoulder, back, hip or knee pain—whether chronic or acute— or are participating in pre- or post-surgery rehab, Hinge Health may be able to help you discover healthy ways to manage or eliminate your pain. Hinge Health provides tools you need to get moving again from the comfort of your home. Your treatment plan will be tailored to you and includes your own Care Team. The app provides easy access to exercises, video tutorials, and tracking tools. This benefit is 100% covered by Option Care Heath to eligible team members and dependents 18+ enrolled in a BCBSIL medical plan.
- **Clinically** proven to reduce pain, avoid opioid. Hinge Health's clinical care and advanced technology to go beyond traditional physical therapy.

Kaiser

- **Online wellness tools**—Visit **https://healthy.kaiserpermanente.org/health-wellness?kp_shortcut_referrer=kp.org/healthyliving** for helpful articles, wellness information, health calculators, fitness videos, music channels, podcasts, and recipes from world-class chefs.
- **Healthy lifestyle programs**—Connect to better health. The online programs can help you lose weight, quit smoking, reduce stress, sleep better, and more—all at no cost. Learn more at **kp.org/healthyliving**.
- **Health classes**—Choose from classes held at our facilities, online classes, and community support groups for help improving your health. Most do not require a fee. Find classes near you at **kp.org/classes**.
- **Personal wellness coaching**—Work one on-one by phone with a personal wellness coach—at no extra cost. You can get help and inspiration for reaching a variety of health goals. Find out more at kp.org/wellnesscoach.
- **Special rates for members**—Our members get reduced rates on a variety of products and services—like gym memberships, massage therapy, and more. See your options at **www.kp.org/choosehealthy**.

HMSA

HMSA members should access **www.hmsa.com/wbc**, click **"Member Login,"** then click **"Create an Account"** to explore the wellness programs available under that plan. Once in the site, take the Well-Being 5 survey, track your fitness progress, look up healthy recipes, and access a host of wellness related articles and videos. For questions or assistance with the wellness program, contact the dedicated wellness team at 855.329.5461.

GET STARTED TODAY! REGISTER ONLINE FOR WELL ONTARGET®

You can use the following information to create your personal Well onTarget account:

1. Log on to **www.wellontarget.com**
2 Select Register Now
3. Fill in the requested information:
   - Your Name; Date of Birth;
   - Your Subscriber/Member ID Number
4. Create an username and password
5. Confirm Registration
6. Login to **www.wellontarget.com**

QUESTIONS?

If you have any questions about Well onTarget, call Customer Service at 877-806-9380.

Experience a New Kind of Wellness — Log In to the Well onTarget Portal

Well onTarget is designed to give you the support you need to make healthy lifestyle choices — and reward you for your hard work.

MEMBER WELLNESS PORTAL

The Well onTarget Wellness Portal uses the latest technology to give you the tools you need for better health. Your wellness journey begins with a suggested list of physical and mental wellbeing activities based on the information you provided in the Health Assessment.* Now you have a step-by-step plan to guide you on the way to living your best life. The suite of programs and tools include:

- **Digital Self-Management Programs:** Learn about managing stress, improving sleep, maintaining a healthy weight, enhancing physical activity, planning for financial fitness and more.
- **Health and Wellness Library**: The health library has useful articles, podcasts and videos on health topics that are important to you.
- **Blue PointsSM Program:**** Earn points for wellness activities. Redeem your points for a wide variety of merchandise in the online shopping mall.
- **Tools and Trackers:** These interactive resources help keep you on track while making wellness fun.
- Health Assessment: Answer some questions to learn more about your health and receive a personal wellness report.
- **Fitness Tracking:** Get Blue Points for tracking activity with popular fitness devices and mobile apps.
- Nutrition Help: Members can choose a nutrition app to connect and monitor their food intake via the **"View Nutrition"** page. Enter calorie targets, carbs, fats, protein and more. Apps include Fitbit, MyFitnessPal and others.
- **Personal Challenges:** Join a personal challenge to help you reach your goals. There are over 30 challenges, so you can choose the best one to fit your wellness journey. Topics include stress, sleep, physical activity and more!

* Well onTarget is a voluntary wellness program. Completion of the Health Assessment is not required for participation in the program.

** Blue Points Program Rules are subject to change without prior notice. See the Program Rules on the Well on Target Member Wellness Portal for further information.

Dental Plan

Delta Dental

Delta Dental of Illinois will serve as our only dental provider in 2025, servicing team members in all states. Delta Dental is the largest dental benefits carrier in the country, providing benefits to nearly one-third of all dental plan participants in America.

Delta Dental offers two plans. The Delta 50 costs a bit more, but combines a $50 deductible with orthodontic coverage for adults and children. The Delta 100 plan offers lower premiums, but has a $100 deductible and only covers orthodontic coverage for children under 26.

Within each of those plans, you have network options. While you do not need to visit an in-network provider to obtain services, doing so means you will not be billed for amounts charged in excess of the negotiated allowances.

1. Delta Dental's PPO Network offers participants the deepest discounts. You are not responsible for those discounted amounts and only pay for deductible, coinsurance, and non-covered charges.
2. Delta Dental's Premier Network provides substantial discounts to participants. You are not responsible for discounted amounts, but are responsible for deductible, coinsurance, and non-covered charges.
3. Non PPO Providers offer no discounts. Participants are responsible for any amounts not covered by insurance.

Delta Dental Plan Highlights

TYPE OF COVERAGE	DELTA 50	DELTA 100
Deductible	$50	$100
Calendar Year Maximum	$2,000	$1,500
Preventative Services	100%	100%
Basic Services	80%	80%
Major Services	80%	60%
Orthodontics	60%	60%
Orthodontia Maximum	$5000	$5000
Orthodontic Restrictions	Adults and children	Children < 26 only

To locate a dentist near you, log in to **www.deltadentalil.com** and click on "Find a Provider," then "Dental." While you're there, set up your online access. Doing so will allow you to review your claims, check on benefits paid to date, and explore your benefits.

DENTAL PREMIUMS FOR THE 2025 PLAN YEAR

	DELTA 50	DELTA 100
BI-WEEKLY CONTRIBUTIONS		
Team Member Only	$16.53	$12.61
Team Member + Spouse	$34.97	$26.66
Team Member + Child(ren)	$41.38	$31.55
Team Member + Family	$59.52	$45.39

Vision Plan

Option Care Health partners with Vision Service Plan (VSP) to provide comprehensive vision coverage to all participating team members in 2025. With more than 28,000 physicians working in 20,000 offices, participants receive the most competitive discounts when utilizing a VSP provider. If you visit a non-VSP provider, you will pay substantially more out-of-pocket.

VSP offers additional benefits and discounts for hearing aids. Find out more by visiting **www.vsp.com** or by calling 800.877.7195.

Create an account on **www.vsp.com** to view your in-network coverage and find the VSP network doctor who's right for you, as well as discover savings with exclusive member extras. At your appointment, tell them your provider is VSP.

- Exam copay = $10
- Lens copay = $10
- Frame or contact lens allowance = $200* ($220 for VSP "featured frames")
- Log in to www.vsp.com to locate a participating provider, check claim status, or verify your benefits.

* $275 allowance for Premier Plan

WITH A VSP PROVIDER		
	BASE PLAN	PREMIER PLAN
Well Vision Exam Focuses On Your Eye Health And Overall Wellness	$10 copay; every calendar year	$10 copay; every calendar year
Prescription Glasses		
Lenses	$10 copay; every calendar year	$10 copay; every calendar year
Frames	$200 allowance for a wide selection of frames; every other calendar year $250 allowance for featured frame brands 20% savings on the amount over your allowance $110 Costco®/Walmart®/Sam's Club® frame allowance $200/$250 allowance for LightCare	$200 allowance for a wide selection of frames; every calendar year $220 allowance for featured frame brands 20% savings on the amount over your allowance $110 Costco*/Walmart*/Sam's Club* frame allowance
Contact Lenses	$200 allowance for contacts; copay does not apply; every calendar year Contact lens exam (fitting and evaluation); up to $10 copay	$200 allowance for contacts; copay does not apply; every calendar year Contact lens exam (fitting and evaluation); up to $10 copay
EasyOptions	N/A	Members can choose one of the following options to be covered in full: +$75 retail frame allowance +$75 elective contact allowance Antireflective Coating, Progressive Lenses, or Photochromic Lenses covered in full
With Other Provider		
Exam	$10 copay; up to $45	$10 copay; up to $45
Frame	$10 copay; up to $70	$10 copay; up to $70
Contacts	$10 copay; up to $105	$10 copay; up to $105

VSP		
	BASE PLAN	PREMIER PLAN
Bi-Weekly Contributions		
Team Member Only	$4.15	$6.53
Team Member + Spouse	$8.29	$13.05
Team Member + Child(ren)	$8.88	$13.96
Team Member + Family	$14.18	$22.31

The VSP plan is the best choice if you wear glasses or contacts. If you are not a lens wearer, yet recognize the importance of an annual eye exam, take advantage of the coverage provided under the BCBSIL plan. Eye exams are covered at 75%, subject to the usual and customary allowance.

Kaiser California covers a routine eye exam with a Plan Optometrist at no charge. Kaiser Mid-Atlantic covers a routine eye exam at the primary care copay level.

HMSA covers one eye exam per calendar year, subject to a $20 copay.

Health Savings Account (HSA)

What is a Health Savings Account or HSA?

Enrolling in a qualified HSA Medical Plan makes you eligible to participate in a health savings account (HSA).

An HSA is a personal healthcare account to which you can contribute dollars on a pre-tax basis (up to an annual maximum). Those funds can be used to cover your out-of-pocket health expenses, such as deductibles and coinsurance. Unlike an FSA which also allows pre-tax contributions, an HSA has additional perks.

1. You own the account forever.
2. There are no use-it-or-lose-it annual restrictions. Your unused balance rolls over indefinitely into each new plan year.
3. If you terminate employment or enrollment in the plan, you do not lose your balance. It is yours to keep and take with you.
4. You can begin contributing or change your contributions at any time throughout the year, but are responsible for making sure you don't exceed the annual contribution limit.
5. Long term investments are available once your account balance exceeds $1,000.

There Are Also Triple Tax Savings

1. Funds put into your HSA (up to the IRS maximum) are tax-deductible.
2. Withdrawals from the account for eligible health expenses (medical, dental, and vision) are tax-free.
3. Any earnings you receive are also tax-free.

HSA CONTRIBUTION LIMITS 2025	
Self Only	$4,300
Family	$8,550

For more information, please reach out to our new HSA vendor, HSA Bank, at 800.357.6246 or **www.hsabank.com**.

Option Care Health Sponsored Match

Option Care Health provides an HSA Quarterly Employer Sponsored Match up to $500 annually for individuals and $1000 annually for non-single tier coverage.

Team members must be active at the time the Quarterly Employer Sponsored match is awarded. Team member must have contributed to the HSA plan during the corresponding quarter.

The Employer Sponsored Match will not exceed the lesser of your total quarterly contributions or $125 for single coverage and $250 for non-single coverage. The match will count towards the team member's contribution limits.

Healthcare Flexible Spending Account (FSA)

A Healthcare FSA enables you to set aside pre-tax funds from each paycheck to reimburse yourself for eligible out-of-pocket healthcare expenses including copays, deductibles, coinsurance, expenses above the plan's maximum payment amounts, and certain over-the-counter items that are purchased with a Doctors written prescription. For a complete list of eligible expenses, visit **www.irs.gov**.

Limited Purpose Flexible Spending Account

(PART-TIME TEAM MEMBERS ONLY)

A Limited–Purpose FSA is similar to a Healthcare FSA, however eligible expenses are limited to qualifying dental and vision expenses only for you and your qualified dependents.

How an FSA Works

You decide the amount you want to contribute based on your expected healthcare and/or dependent childcare/eldercare expenses.

FSA CONTRIBUTIONS	
Minimum for Either Account	$100
Healthcare Maximum	$3,300 (max at time of print)
Dependent Care Maximum	$5,000

You may incur eligible Healthcare and Dependent Care FSA expenses from January 1, 2025, to December 31, 2025. You must submit all 2025 FSA claims for reimbursement by March 31, 2026. While $640 in unused FSA funds may be rolled from one year to the next, any contributions in excess of $640 that remain in your account from the prior year, will be forfeited. Be certain to carefully calculate your projected expenses and elect an FSA contribution that you will fully utilize over the coming year.

FSA Card

The Healthcare and Limited-Purpose FSAs include a card that:

- Allows you to pay for purchases and services directly from your Healthcare FSA at the time of service
- Works like a debit card, with the funds deducted directly out of your FSA account
- Decreases the number of claims that have to be filed manually

You can swipe your card at qualified merchants, including your doctor's office, dentist's office, or pharmacy. There is usually no need to complete a claim form or wait for reimbursement when you use the debit card. However, receipts should be saved and submitted to NueSynergy when requested.

If you do not use the debit card at the time of service, upload a copy of your bill and receipt for speedy reimbursements. Reimbursements are made via ACH. When you register with NueSynergy, you will have the opportunity to provide your banking information.

How Much Can You Save?

The example below illustrates how you can save by participating in an FSA.

WITHOUT FSA		WITH FSA	
Your Gross Annual Pay	$45,000	**Your Gross Annual Pay**	$45,000
Estimated Tax Rate (30%)	$13,500	**Your Annual Healthcare Expenses**	$2,000
Your Net Annual Pay	$31,500	**Your Adjusted Gross Pay**	$43,000
Your Annual Healthcare Expenses	$2,000	**Estimated Tax Rate (30%)**	$12,900
Your Final Take-Home Pay	$29,500	**Your Final Take-Home Pay**	$30,100

In this example, you'd save $600 with an FSA!

The account cannot be used to reimburse you for some expenses, including:

- Non-medically supervised programs to help you lose weight
- Non-medically necessary cosmetic surgery
- Non-prescription sunglasses
- Teeth bleaching
- Funeral expenses
- Any expense not considered "medically necessary" by the IRS

Refer to **www.nuesynergy.com** for more information or call 855.890.7239.

Dependent Care FSA

The Dependent Care FSA allows you to pay for eligible childcare and eldercare expenses with pre-tax funds. You can be reimbursed for dependent daycare expenses for your children under age 13, and for physically or mentally incapable dependents of any age that live with you and rely on you for at least 50% of their support. If you are married, you are eligible for the Dependent Care FSA only if your spouse works, goes to school at least five months each year, or is disabled.

If you and your spouse file separate income tax returns, the maximum annual contribution to one FSA is $2,500 per person or $5,000 per household.

Eligible expenses include costs for:

- Babysitters (other than your own dependents)
- Daycare
- Day camps
- Nursery school
- Outside dependent or childcare services
- Eldercare

For a complete list of eligible expenses, visit **www.irs.gov**.

Commuter Transit Account

The Commuter Transit Account allows you to set aside pre-tax dollars to reimburse yourself for approved mass transit expenses including train, subway, light-rail, ferry, and bus fares. The Commuter Parking Account allows you to set aside pre-tax dollars to reimburse yourself for parking expenses incurred as part of your daily commute to work.

The IRS maximum (at time of print) is $325 for both transit and parking per month.

Like our other spending accounts, Commuter Transit Accounts are administered by NueSynergy. Once enrolled, you are allowed to make changes to your Commuter elections at any time in Workday.

Please note a Commuter FSA does not reimburse tolls, nor is it intended for infrequent commuters or those who pay to park while visiting clients or prospects. If you are interested in this program, please make your elections during your enrollment period.

NOTE

When considering funding a Dependent Care Spending Account, you need to weigh the potential savings from the spending account versus savings through the dependent care tax credit. The money reimbursed through a Dependent Care Spending Account will reduce the amount of eligible expenses you can use for the tax credit on a dollar-for-dollar basis. Tax savings with a Dependent Care Spending Account become more valuable as your income increases. Generally, if your family's adjusted gross income is less than $39,000 a year, it is best for you to take the tax credit rather than participating in the Dependent Care Spending Account. However, you should consult your tax advisor to see if these accounts make sense for your situation.

Life and Accidental Death and Disability (AD&D)

Group Life and AD&D Insurance

Basic Life Insurance and AD&D coverage, equal to 1 times salary, will be offered at no cost to all team members working 30 or more hours per week.

Team Member Voluntary Life and AD&D

You may purchase additional term life insurance for yourself, in increments of $10,000 up to $750,000.* Rates are based upon your age and increase as you grow older.

Additional AD&D insurance is also available in increments of $10,000 up to $750,000 and is not subject to Evidence of Insurability (EOI).

You are required to complete the Evidence of Insurability (EOI) form if:

- You previously waived voluntary life coverage on yourself or your spouse
- You would like to increase your coverage by more than $20,000, OR
- Your election will exceed the guaranteed issue coverage amount ($200,000 for yourself and $40,000 for your spouse)

VOLUNTARY AD&D—100% TEAM MEMBER PAID PER $1,000	
Team Member	$0.018
Spouse	$0.030
Child	$0.020

*Evidence of Insurability may be required.

Dependent Voluntary Life and AD&D

Voluntary life and AD&D insurance is available for your spouse and dependent children. Spousal voluntary life insurance may be purchased in $10,000 increments up to 100% of your combined basic life and team member voluntary life coverage. Voluntary dependent child life insurance is available in the amount of $25,000 and is not subject to EOI. Dependent AD&D coverage is available up to a maximum of $112,500 and is not subject to EOI.

Rates will automatically populate for all coverages in Workday, and will be specific for your age and the amount of coverage requested (or your spouse's age for spousal coverage).

* Evidence of Insurability may be required.

VOLUNTARY LIFE—100% TEAM MEMBER PAID PER $1,000		
AGE BAND	TEAM MEMBER	SPOUSE
<25	$0.05	$0.05
25-29	$0.06	$0.06
30-34	$0.08	$0.08
35-39	$0.09	$0.09
40-44	$0.13	$0.13
45-49	$0.20	$0.20
50-54	$0.30	$0.30
55-59	$0.43	$0.43
60-64	$0.66	$0.66
65-69	$1.27	$1.27
70-74	$2.06	$2.06
75+	$2.06	$2.06
Child		
	$0.08	

Disability Insurance

Option Care Health provides full-time team members regularly scheduled to work 30 or more hours per week with short term disability coverage, and offers long term disability for eligible team members on a voluntary basis.

- Short term disability benefits pay depends on your years of service and job classification, and is 100% employer-paid.
- The voluntary long term benefit pays 60% of your basic monthly earnings up to $15,000, and is 100% team member-paid.
- Evidence of insurability will be required if you are not currently enrolled for the long term disability plan.

Both plans have required waiting periods before benefits are payable.

VOLUNTARY LONG TERM DISABILITY— 100% TEAM MEMBER PAID PER $100			
AGE BAND	RATE	AGE BAND	RATE
<25	$0.06	**50-54**	$0.96
25-29	$0.11	**55-59**	$1.11
30-34	$0.21	**60-64**	$1.00
35-39	$0.40	**65-69**	$0.67
40-44	$0.57	**70-74**	$0.43
45-49	$0.812	**75+**	$0.425

Cost is personalized based on salary. Log in to the Workday portal to access personal rate information.

Voluntary Products

24-Hour Accident Insurance

Unum Accident Insurance is designed to cover unexpected expenses that result from all kinds of accidents, even sports-related and household accidents. It provides cash benefits to cover things your health insurance doesn't, such as:

- Deductibles
- Copayments
- Transportation and lodging costs

Your benefits come directly to you without any restrictions on how you can use them. You can't predict when unexpected accidents will happen, but you can help protect your family from the expenses accidents bring them.

COVERAGE	
AGE BAND	RATE
Dislocations	Varies (Max: $6,000)
Fractures	Varies (Max: $8,000)
Doctors Office	$150
Emergency Room Treatment	$150
Hospital Admission	$1,000
Hospital Confinement	$300 per day; up to 365 days
Ambulance Ground/Air	$500/$1,500
Accidental Death	$50,000
Accidental Dismemberment	Varies

VOLUNTARY ACCIDENT— 100% PER TEAM MEMBER PAID PER $1,000	
Team Member	$5.08
Team Member + Spouse	$8.32
Team Member + Child(ren)	$9.87
Team Member + Family	$13.11

Critical Illness

Unum Critical Illness insurance can provide immediate financial relief from the overwhelming expenses of a serious illness, such as heart attack or stroke. It pays a lump-sum cash benefit when you are diagnosed with a covered illness easing your financial worries. In short, Unum Critical Illness insurance can provide a financial cushion to help you manage your illness, your way. Spouse premiums are based upon the Team Member's age and tobacco usage.

BENEFIT AMOUNTS AVAILABLE	$10,000/$15,000/$30,000
Coverage	
Invasive Cancer	100%
Non-Invasive Cancer (carcinoma in situ)	25%
Heart Attack	100%
Stroke	100%
Major Organ Transplant	100%
Wellness/Health Screening Benefit	50%

CRITICAL ILLNESS—100% TEAM MEMBER PAID		
TEAM MEMBER BI-WEEKLY RATES PER $1000		
AGE BAND	NON-TOBACCO	TOBACCO
<25	$0.16	$0.16
25-29	$0.23	$0.30
30-34	$0.33	$0.42
35-39	$0.49	$0.68
40-44	$0.68	$0.97
45-49	$0.94	$1.44
50-54	$1.23	$1.94
55-59	$1.71	$2.76
60-64	$2.44	$3.92
65-69	$3.65	$5.19
70-74	$5.80	$7.68
75-79	$8.63	$10.67
80-84	$12.60	$15.29
85+	$20.39	$24.09
Be Well Rider	EE:	$1.69

Hospital Indemnity

Unum's Hospital Indemnity insurance provides benefit payments made directly to the covered person to be used as the individual sees fit. Benefits are a result of certain hospital-related events, which can include hospital admissions, hospital observation stays, inpatient/outpatient, and emergency services.

Hospital		
Hospital Admission	Payable for a maximum of 1 day per year	$1,000
Hospital admission due to childbirth	Paid in addition to the Hospital Admission	$100
ICU Admission	Payable for a maximum of 1 day per year	$500
Hospital Daily Stay	Payable per day up to 90 days	$100
Hospital Daily Stay due to childbirth	Paid in addition to the Hospital Daily Stay	$50
ICU Daily Stay	Payable per day up to 60 days	$200

HOSPITAL INDEMNITY—100% TEAM MEMBER PAID	
Bi-Weekly Rates	
Team Member	$8.14
Team Member + Spouse	$17.76
Team Member + Child(ren)	$11.76
Team Member + Family	$21.38

Identity Theft

MetLife and Aura Identity & Fraud Protection is an award-winning, AI-powered solution that helps keep team members and their loved ones safe from threats and scams – all in one, easy-to-use app.

Family Safety – Our inclusive family plans cover up to 10 additional adults and unlimited children. They include family safety tools to help parents and caregivers protect their loved ones online.

Service and Support – Each adult gets access to 24/7 US-based customer support, white glove fraud resolution service, and a $5M ID theft insurance policy.

Questions?

Visit **www.metlife.com/identity-and-fraud-protection** or call 844-931-2872.

BENEFITS INCLUDED IN BOTH PLAN OPTIONS		
MONITOR AND DETECT	PRIVACY & DEVICE PROTECTION	FAMILY SAFETY (included with family plan only)
– Privacy Assistant – Dark Web Monitoring – SSN & Identity Authentication Alerts – Criminal, Court & Public Records Monitoring – USPS Address Monitoring – Digital Vault – Social Media Monitoring & Takeover Alerts – Social Media Privacy Checkup – Gamertag Monitoring	– Password Manager – Automated Password Change – Email Alias – Safe Web Browsing – IP Address Monitoring – Wi-Fi Security/VPN – Antivirus – AI-Powered Call & Text Screening – Mobile Phone Takeover Protection2	– Parental Controls – Child Cyberbullying Protection – 3-Bureau Child Credit Freeze Wizard – Child SSN Monitoring & Alerts – Sex Offender Geo Alerts – Family Sharing – docs, passwords, alerts, etc. – Safe Gaming2

* Helps better protect children

	BI-WEEKLY RATES	
	Protection	Protection Plus
Team Member Only	$2.75	$3.67
Team Member + Family	$4.82	$6.21

Legal Plan

The group legal plan is offered through MetLife and gives you access to a network of more than 12,000 highly qualified plan attorneys, as well as free phone advice and office consultations for any number of personal legal matters. Your information is kept strictly confidential. Covered services include:

- Dealing with credit card debt
- Buying a first home
- Refinancing a home
- Adopting a child
- Preparing a will
- Preparing for a tax audit
- Arranging care for an elderly parent

MetLife Legal Plan partners with TurboTax to help you strengthen financial wellness with tax services at no cost to you.

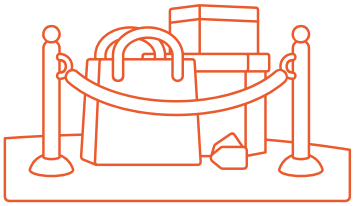
Plan members receive a discount up to $188 when filing your taxes through Turbo Tax.

Note: To learn more, visit **www.info.legalplans.com** and enter access code GetLaw or call 800.821.6400 Monday–Friday 8:00AM–8:00PM (ET).

	BI-WEEKLY CONTRIBUTIONS
Per Participant + Dependents	$7.62

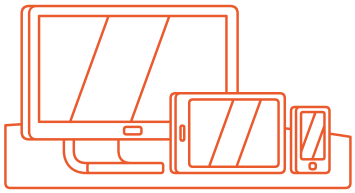
PerkSpot Discount Program

Team members now have access to hundreds of exclusive discounts at some of your favorite national and local merchants. You can use PerkSpot to find hundreds of deals on everything from household essentials to once-in-a-lifetime vacations. PerkSpot is mobile optimized, so you can access it at home, from work, or on the go! The best part is that it's no cost to you!



Exclusive Discounts from Your Favorite Brands

30,000 National and Local Offers



Designed for Your Device of Choice

Start by signing up or logging in at **pslogin.perkspot.com/login?communityId=948** Access at home, work, or on the go and browse thousands of discounts! Keep an eye out for new featured discounts in your weekly email.

TRAVEL

GYMS

CELL PHONES

RESTAURANTS

AUTO

APPAREL

ELECTRONICS

Get started today! **https://pslogin.perkspot.com/login?communityId=948**

SoFi Student Loan Refinancing

Option Care Health and SoFi have teamed up to help you take down student debt—with student loan benefits, exclusively for Option Care Health team members, family, and friends.

SoFi Student Loan Refinancing

SoFi's refinancing can help those with student debt save money on total interest, make lower monthly payments, or shorten the duration of their loans. SoFi can refinance both Federal and/or private student loans into a single loan with one monthly payment as well as offer low fixed or variable rates with flexible loan term options (5-20 years).

SoFi Parent PLUS Loan Refinancing

Like those who have existing student loans, SoFi can help save money and simplify payments for those who have an existing Federal Parent PLUS loan by consolidating and refinancing these existing loans.

SoFi's rate discount is available to all Option Care Health team members, family, and friends as long as the application is initiated through SoFi.com/OptionCare.

ADDITIONAL BENEFITS INCLUDE:

- **Savings:** Members save thousands by refinancing
- **Membership perks:** Access to free financial planning, career counseling, exclusive member events, educational workshops, and more
- **Rates:** Low variable and fixed rates with options for short and long term repayment periods
- **No extra fees:** No application/origination fees or prepayment penalties
- **Easy experience:** Apply in minutes online to refinance your loans or borrow for any kind of personal use
- **Support when needed:** Access to live customer support 7 days a week

Employee Assistance/ Work-Life Program

The Employee Assistance Program is a confidential, voluntary service that provides professional counseling and referral services designed to help you and your family members with personal, job or family related problems.

Some common concerns the EAP can help with:

- Stress, anxiety, depression
- Life transitions
- Grief and loss
- Divorce/separation
- Conflict resolution
- Substance abuse
- Work-life counseling

Dedicated Toll Free Crisis Line
800.854.1446

- 24 hours a day
- Seven days a week
- 365 days a year

Short Term Issues

Team members and family members have up to three in-person sessions with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

ONLINE WORK LIFE
EAP RESOURCES

www.unum.com/lifebalance

401(k)

In addition to your physical health, Option Care Health cares about your financial well-being and proudly offers a 401(k) plan to help you meet your retirement goals. The IRS maximum amount you may contribute to the 401(k) plan is $23,500 for the 2025 plan year. Team Members who are 50 years or older any time during the plan year may contribute up to an additional $7,500 by making a separate election in your Empower account.

401(k) Max Contribution	$23,500* at the time of printing
50+	Additional $7,500

Team members who are between the ages of 60 to 63 can contribute the greater of $10,000 or 150% of the regular catch-up contribution limit.

After one year of service, and 1,000 hours worked, Option Care Health offers a generous dollar-for-dollar match up to the first 4% you contribute. While you may enroll or make contribution changes at any time, Annual Enrollment provides a great opportunity for you to set aside time to review your financial goals and objectives and to take action to alter your strategy if needed.

Your 401(k) match will be deposited into your account on a per-pay-period basis. No waiting until the end of the year to receive Option Care Health's matching funds!

Log in to **www.empowermyretirement.com** to view your account balance, make contribution changes, transition into different funds, or tap into the wide variety of available planning tools—and don't forget to download their mobile app!

Retirement will be here before you know it. It's not too late to begin saving. Take advantage of Option Care Health's generous match, and enroll or increase your contribution today!

This guidebook and all attachments provide a summary of Option Care Health's health and welfare plans and are intended solely for informational purposes. All benefits are determined and administered in accordance with the legal plan documents. If any information provided herein conflicts with the legal plan documents, the legal plan documents will govern. Option Care Health retains the right to amend or terminate these plans without prior notice.

A Special Program for Option Care Health Team Members

Good news! As an Option Care Health Team Member, you have special access to enroll in the Bank of America Preferred Rewards program and receive Gold tier benefits. All you need to do is set up your Option Care Health payroll direct deposit into your personal eligible Bank of America® checking or savings account then enroll in Preferred Rewards to start receiving your Gold tier benefits.

This special program for team members offers:

- Preferred Rewards Gold tier. After you enroll, you'll enjoy a wide range of benefits and rewards based on the ways you save, spend and borrow with Bank of America.
- Financial education. Bank of America offers a wide range of resources that can help you learn about finances and make it easier to pursue your financial goals.
- Digital tools. Bank of America's mobile and digital banking can help you bank securely from almost anywhere, plus get easy access to personalized help.

Scan here to learn more

Or visit **https://go.bofa.com/optioncarehealth**

Glossary of Terms

Coinsurance

Coinsurance is usually listed as a percentage, and it refers to the amount that you must pay for a covered service. It does not apply until after you meet your deductible.

Copayment (Copay)

A flat per service charge that you are responsible to pay for services such as doctor visits or prescription drugs.

Deductible

The dollar amount you must pay before the plan begins to pay for covered services. The deductible is satisfied when each family member has paid their individual deductible or when the total family deductible amount has been reached by any combination of family members.

Health Maintenance Organization (HMO) Plan

A plan where coverage is provided to participants that use providers exclusively contracted in the HMO network. Enrollees must establish a primary care physician and referrals are required for specialists. There is no coverage for out-of-network providers.

Voluntary Benefits

Offered by Option Care Health on a group basis, 100% paid by you.

Out-of-Pocket Costs

The amount you pay for copays, deductibles, coinsurance, or fees for health services or prescription drugs.

Out-of-Pocket Maximum

This is the maximum amount of covered expenses you (the team member) will pay in a plan year (depending on the medical plan you choose). After you have paid the annual out-of-pocket maximum, the plan usually pays the full cost of covered expenses—up to the usual, customary, and reasonable rates—for the remainder of the plan year.

Primary Care Physician (PCP)

A doctor trained to give basic care, like a family doctor or pediatrician, who participates in the insurance company's network.

Preferred Provider Organization (PPO) Plan

A plan where coverage is provided to participants through a network of selected healthcare providers (such as hospitals and physicians). Enrollees may go outside the network but would incur increased costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.

Content Carrier List

BENEFIT	PROVIDER	PHONE NUMBER	WEBSITE
Option Care Health Benefits Support Team		312.940.2562	**www.myworkday.com/optioncare/wdhelp/helpcenter**
Medical Plan—All states except Hawaii	Blue Cross Blue Shield of Illinois	800.327.8497	**www.bcbsil.com**
Medical Plan—Hawaii	HMSA	808.948.6372	**www.hmsa.com**
Medical Plan—California	Kaiser Permanente	800. 464.4000	**www.kp.org**
Medical Plan—Maryland, Virginia, and Washington D.C.	Kaiser Permanente	800.777.7902	**www.kp.org**
Dental Plan	Delta Dental of Illinois	800.323.1743	**www.deltadentalil.com**
Hinge Health	Blue Cross Blue Shield of Illinois	855-902-2777	**hinge.health/optioncarehealth**
Vision Plan	VSP	800.877.7195	**www.vsp.com**
HSA	HSA Bank	800.357.6246	**www.hsabank.com**
Flexible Spending and Commuter Reimbursement Accounts	NueSynergy	855.890.7239	**www.NueSynergy.com**
Life and Disability Insurance	Unum	866.779.1054	**www.unum.com**
Life and Disability Portability and Conversion	Unum	866.220.8460	**www.unum.com**
Employee Assistance Program	Unum	800.421.0344	**www.unum.com/lifebalance**
401(k) Plan	Empower Retirement	888.411.4015	**www.empowermyretirement.com**
Voluntary Benefits	Unum	800.635.5597	**www.unum.com**
Mental Health	Headspace Care		**help.headspace.com/hc/en-us**
Medicare Consultant	Allsup	888.271.1173	**www.Allsup.com**
Prescription Savings Program	Rx Saving Solutions (RxSS)	800.268.4476	**auth.rxsavingssolutions.com/login**
Student Loan Refinancing	SoFi	855.456.7634	**SoFi.com**
Identity Theft	MetLife Aura	844.931.2872	**my.aura.com/start**
Legal Coverage	MetLife Legal	800.821.6400	**info.legalplans.com**
COBRA Support	NueSynergy	855.890.7239	**COBRA@nuesynergy.com**

Required Notices

Option Care Health, Inc.

HEALTH PLAN NOTICES TABLE OF CONTENTS

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Option Care Health, Inc. About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM OPTION CARE HEALTH, INC. 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 Option Care Health, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Option Care Health, Inc. has determined that the prescription drug coverage offered by the Option Care Health, Inc. Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

ENROLLING IN MEDICARE—GENERAL RULES

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

LATE ENROLLMENT AND THE LATE ENROLLMENT PENALTY

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. However, there are some important exceptions to the late enrollment penalty.

SPECIAL ENROLLMENT PERIOD EXCEPTIONS TO THE LATE ENROLLMENT PENALTY

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

COMPARE COVERAGE

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. See the Option Care Health, Inc. Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

COORDINATING OTHER COVERAGE WITH MEDICARE PART D

Generally speaking, if you decide to join a Medicare drug plan while covered under the Option Care Health, Inc. Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Option Care Health, Inc. Plan will 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 below.

If you do decide to join a Medicare drug plan and drop your Option Care Health, Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE…

Contact the person listed below for further information, or call 866-827-8203. 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 Option Care Health, Inc. changes. You also may request a copy.

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 whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2025

Contact—Position/Office: Option Care Human Resources Department

Address: 3000 Lakeside Drive, Bannockburn, IL 60015

Phone Number: 866-827-8203

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

OPTION CARE HEALTH, INC.
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

OPTION CARE HEALTH, INC. HEALTH AND WELFARE BENEFIT PLAN*

* This notice pertains only to healthcare coverage provided under the plan.

THE PLAN'S DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Option Care Health, Inc. that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

HOW THE PLAN MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Option Care Health, Inc.) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage;

information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.

- **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
- **Required by Law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record

be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

HOW TO COMPLAIN ABOUT THE PLAN'S PRIVACY PRACTICES

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

NOTIFICATION OF A PRIVACY BREACH

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

CONTACT PERSON FOR INFORMATION, OR TO SUBMIT A COMPLAINT

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Chief Compliance Officer
312-940-2526

Effective Date

The effective date of this notice is: January 1, 2024.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

OPTION CARE HEALTH, INC. EMPLOYEE HEALTH CARE PLAN

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 toward 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 (e.g., 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 eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within 60 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 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 toward 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 60 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Option Care Human Resources Department
866-827-8203

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

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 in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

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. If you believe you are eligible for this extension, contact the Plan Administrator.

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, Medicare, 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

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 in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

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- 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 phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

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

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Option Care Human Resources Department
3000 Lakeside Drive, Bannockburn, IL 60015
866-827-8203

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Option Care Health, Inc. Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

$750 DEDUCTIBLE PLAN	IN-NETWORK	OUT-OF-NETWORK
Individual Deductible	$750	$1,500
Family Deductible	$1,500	$3,000
Coinsurance	25%	50%

$2000 DEDUCTIBLE PLAN	IN-NETWORK	OUT-OF-NETWORK
Individual Deductible	$2,000	$4,000
Family Deductible	$4,000	$8,000
Coinsurance	25%	50%

$3000 DEDUCTIBLE PLAN	IN-NETWORK	OUT-OF-NETWORK
Individual Deductible	$3,000	$6,000
Family Deductible	$6,000	$12,000
Coinsurance	25%	50%

HSA PLAN	IN-NETWORK	OUT-OF-NETWORK
Individual Deductible	$2,500	$5,000
Family Deductible	$5,000	$10,000
Coinsurance	25%	50%

$5000 DEDUCTIBLE PLAN	IN-NETWORK	OUT-OF-NETWORK
Individual Deductible	$5,500	$10,000
Family Deductible	$10,000	$20,000
Coinsurance	35%	70%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Option Care Human Resources Department
866-827-8203

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866-827-8203

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).

ALABAMA – MEDICAID

Website: **http://myalhipp.com**

Phone: 855-692-5447

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program
Website: **http://myakhipp.com/**

Phone: 866-251-4861

Email: **CustomerService@MyAKHIPP.com**

Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**

ARKANSAS – MEDICAID

Website: **http://myarhipp.com/**

Phone: 855-MyARHIPP (855-692-7447)

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program

Website: **http://dhcs.ca.gov/hipp**

Phone: 916-445-8322

Fax: 916-440-5676

Email: **hipp@dhcs.ca.gov**

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM) & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website: **https://www.healthfirstcolorado.com/**

Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711

CHP+: **https://hcpf.colorado.gov/child-health-plan-plus**

CHP+ Customer Service: 800-359-1991/ State Relay 711

Health Insurance Buy-In Program (HIBI): **https://www.mycohibi.com/**

HIBI Customer Service: 855-692-6442

FLORIDA – MEDICAID

Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html**

Phone: 1-877-357-3268

GEORGIA – MEDICAID

GA HIPP Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**

Phone: 678-564-1162, Press 1

GA CHIPRA Website: **https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra**

Phone: 678-564-1162, Press 2

INDIANA – MEDICAID

Healthy Indiana Plan for low-income adults 19-64

Website: **http://www.in.gov/fssa/hip/**

Phone: 1-877-438-4479

All other Medicaid

Website: **https://www.in.gov/medicaid/**

Phone 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website: **https://dhs.iowa.gov/ime/members**

Medicaid Phone: 1-800-338-8366

Hawki Website: **http://dhs.iowa.gov/Hawki**

Hawki Phone: 1-800-257-8563

HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**

HIPP Phone: 1-888-346-9562

KANSAS – MEDICAID

Website: **https://www.kancare.ks.gov/**

Phone: 1-800-792.4884

HIPP Phone: 1-800-967-4660

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)

Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**

Phone: 1-855-459-6328

Email: **KIHIPP.PROGRAM@ky.gov**

KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx**

Phone: 1-877-524-4718

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

LOUISIANA – MEDICAID

Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp**

Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – MEDICAID

Enrollment Website: **https://www.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

Website: **https://www.mass.gov/masshealth/pa**

Phone: 1-800-862-4840

TTY: 711

Email: **masspremassistance@accenture.com**

MINNESOTA – MEDICAID

Website: **https://mn.gov/dhs/people-we-serv/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**

Phone: 1-800-657-3739

MISSOURI – MEDICAID

Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm**

Phone: 573-751-2005

MONTANA – MEDICAID

Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/**

HIPP Phone: 1-800-694-3084

Email: **HHSHIPPProgram@mt.gov**

NEBRASKA – MEDICAID

Website: **http://www.ACCESSNebraska.ne.gov**

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – MEDICAID

Medicaid Website: **http://dhcfp.nv.gov**

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – MEDICAID

Website: **https://www.dhhs.nh.gov/programs- services/medicaid/health-insurance-premium-program**

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/**

Medicaid Phone: 609-631-2392

CHIP Website: **http://www.njfamilycare.org/index.html**

CHIP Phone: 1-800-701-0710

NEW YORK – MEDICAID

Website: **https://www.health.ny.gov/health_care/medicaid/**

Phone: 1-800-541-2831

NORTH CAROLINA – MEDICAID

Website: **https://medicaid.ncdhhs.gov/**

Phone: 919-855-4100

NORTH DAKOTA – MEDICAID

Website: **https://www.hhs.nd.gov/healthcare**

Phone: 1-844-854-4825

OKLAHOMA – MEDICAID AND CHIP

Website: **http://www.insureoklahoma.org**

Phone: 1-888-365-3742

OREGON – MEDICAID

Website: **http://healthcare.oregon.gov/Pages/index.aspx**

Phone: 1-800-699-9075

PENNSYLVANIA – MEDICAID AND CHIP

Website: **https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx**

Phone: 1-800-692-7462

CHIP Website:

Children's Health Insurance Program (CHIP) (pa.gov)

CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – MEDICAID AND CHIP

Website: **http://www.eohhs.ri.gov/**

Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID

Website: **https://www.scdhhs.gov**

Phone: 888.549.0820

SOUTH DAKOTA – MEDICAID

Website: **http://dss.sd.gov**

Phone: 1-888-828-0059

TEXAS – MEDICAID

Website: **Health Insurance Premium Payment (HIPP)** Program | Texas Health and Human Services

Phone: 1-800-440-0493

UTAH – MEDICAID AND CHIP

Medicaid Website: **https://medicaid.utah.gov/**

CHIP Website: **https://chip.utah.gov/**

Phone: 1-877-543-7669

VERMONT – MEDICAID

Website:

Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427

VIRGINIA – MEDICAID AND CHIP

Website: **https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select**

https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs

Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – MEDICAID

Website: **https://www.hca.wa.gov/**

Phone: 1-800-562-3022

WEST VIRGINIA – MEDICAID

Website: **https://dhhr.wv.gov/bms/**

http://mywvhipp.com/

Medicaid Phone: 304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (855-699-8447)

WISCONSIN – MEDICAID AND CHIP
Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm** Phone: 800.362.3002
WYOMING – MEDICAID
Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/** Phone: 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 20210 or email **ebsa.opr@dol.gov** and reference the OMB Control Number 1210-0137.

option care health®

This benefit guide is only intended to highlight some of the major benefit provisions of the company plan and should not be relied upon as a complete detailed representation of the plan. Please refer to the plan's summary plan descriptions for further detail. Should this guide differ from the summary plan descriptions, the summary plan descriptions prevail.