

((CENTRIC))

BENEFITS GUIDE

Your Roadmap for Making Informed Decisions Around Benefits



2026

Important Information regarding 2026 Benefits at Centric

For additional resources and information regarding our benefits, please visit,
<https://benefitsatcentric.com/>

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Eligibility and Enrollment

Centric Consulting cares about you and your family. We offer a comprehensive benefits program that allows you to choose the benefits that are best for you. This guide provides an overview. Please review your plan documents for more details.

Covering Yourself

You may enroll in benefits at Centric if you're a regular full-time, part-time or a W2 Temporary employee actively working at least 25 hours per week. New hires must enroll in benefits within 30 days of the date of hire. Your benefits coverage begins the first of the month following your date of hire. Annual enrollment is your opportunity to enroll in benefits for the next plan year. At this time, you will be able to add, change or decline coverage.

Covering Your Family Members

Eligible dependents include your legally married Spouse, Domestic Partner and children up to age 26. This includes natural and adopted children, step-children, and children for whom you are the court-appointed legal guardian.

Changing Benefits Mid-Year

Once you make your elections, you won't be able to change them until next year's annual enrollment, unless you experience a qualifying life event. You must make changes to your benefits within 30 days of your qualifying life event, due to IRS regulations. If you miss the deadline, you may have to wait until next year's annual enrollment.

To notify Benefits of a Life Event, please email:

benefits@centricconsulting.com.

Eligibility Documentation

For all new dependents, records such as birth certificates, marriage license or Domestic Partner Affidavit are required to be submitted to Benefits at benefits@centricconsulting.com.

Qualifying Life Event
Birth or Adoption
Marriage/Domestic Partnership or Divorce/Legal Separation
Death of a Spouse or Domestic Partner
Loss or gain of coverage
Child medical support order
Change in employment or Job Status

Access to the ADP Self-Service Portal

To log in to ADP please visit www.adp.centricconsulting.com and you will utilize SSO and your Microsoft Authenticator to log in to ADP. You will not utilize the log in you created above.

- Make changes to your tax information
- View your pay statements/request electronic statements
- Make changes to your personal information, dependents, and beneficiaries
- Make initial benefits elections and elections at open enrollment for the following year

NOTE: If you have a life event, you will not be able to make these adjustments in ADP yourself and MUST contact Benefits

Additional Eligibility:

Benefit	Full Time Regular	Part Time Regular	W2 Temporary
Vacation/Illness/Funeral	Paid Time Off Policy "PTO"	No Paid Leave	No Paid Leave
Holidays	Eight (8) Paid holidays	No Paid holidays	No Paid holidays
WFH Reimbursement (\$75 monthly / \$250 at time of hire)	Eligible	Eligible	Not Eligible
401(k) Match	Eligible	Eligible	Not Eligible
Court Leave	Paid Leave	Paid Leave	Not Eligible
Parental Leave	Paid Leave	Paid Leave	Not Eligible

ALEX – Benefits Decision Support Tool



alex®

What is ALEX?

A virtual interactive tool that offers a step-by-step walkthrough of enrollment options to help you make the best choices for your individual situation.

Is ALEX confidential?

Yes. ALEX is a completely confidential and HIPAA compliant. None of the information given to ALEX is available to anyone at Centric or ALEX. You are also able to make your own account to save the information you input into ALEX and the recommendations ALEX gives for your benefits.

Who can utilize ALEX?

Anyone who is eligible for benefits at Centric as well as any family members are able to utilize ALEX.

How does ALEX help me?

Alex utilizes the information that you put in the system about your individual situation to not only educate you on the benefit offerings at Centric but also share with you how the benefits work. ALEX will share with you a recommendation for the plans and benefits that will best benefit you and your individual situation.

To use ALEX yourself, please visit:

<https://start.myalex.com/centric-consulting>



Medical Coverage



Centric Consulting partners with Anthem to offer medical insurance. You have the option of choosing one of three plans — a PPO plan and two High-Deductible Health Plans. These plans offer coverage for most healthcare services. When you receive care in-network, you benefit from our negotiated discounts with Anthem. Anthem ID cards will be sent in the mail to your home address. We suggest downloading the Anthem Sydney mobile app so you can view your card electronically starting on 1.1.26!

	PPO Medical Plan (P1)		HSA Medical Plan (H1)		HSA Medical Plan (H2)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible						
Individual	\$1,000	\$2,000	\$3,400	\$6,300	\$4,500	\$4,500
Family	\$2,000	\$4,000	\$6,800	\$12,600	\$9,000	\$9,000
Coinsurance	80%	60%	90%	70%	80%	60%
Out-of-Pocket Maximum (includes deductible)						
Individual	\$3,000	\$6,000	\$5,000	\$7,500	\$6,000	\$9,000
Family	\$6,000	\$12,000	\$10,000	\$15,000	\$12,000	\$18,000
Physician Office Visits						
Preventive Care	100%	Ded+40%	100%	Ded+30%	100%	Ded+40%
Primary Care Visit (PCP)	\$25	Ded+40%	Ded+10%	Ded+30%	Ded+20%	Ded+40%
Specialist Office Visit	\$40	Ded+40%	Ded+10%	Ded+30%	Ded+20%	Ded+40%
LiveHealthOnline- PCP	\$0	Not Covered	Ded+10%	Not Covered	Ded+20%	Not Covered
Urgent Care	\$50	Ded+40%	Ded+10%	Ded+30%	Ded+20%	Ded+40%
Hospital Services						
Inpatient	Ded+20%	Ded+40%	Ded+10%	Ded+30%	Ded+20%	Ded+40%
Outpatient	Ded+20%	Ded+40%	Ded+10%	Ded+30%	Ded+20%	Ded+40%
Emergency Room	\$250/20%	\$250 copay/20%	Ded+10%	Ded + 10%	Ded+20%	Ded+20%
Biweekly Rates						
	Full-Time Employees	W2 Temporary	Full-Time Employees	W2 Temporary	Full-Time Employees	W2 Temporary
Employee Only	\$124.16	\$647.30	\$61.83	\$479.30	\$45.61	\$431.76
Employee + Spouse	\$421.13	\$1,339.47	\$190.04	\$1,004.11	\$149.50	\$910.23
Employee + Children	\$311.66	\$1,034.93	\$108.96	\$756.90	\$78.55	\$711.29
Employee + Family	\$672.99	\$1,879.18	\$292.41	\$1,373.93	\$234.13	\$1,298.95

Medical Plan Definitions

- **Annual Deductible:** For non-preventive care there is an annual deductible that must be met. If you cover Dependents (other family members) under this Plan, the “Family” amounts apply. Family deductible amounts can be satisfied by any combination of family members, but one family member would never need to satisfy more than the single deductible amount. Once the single deductible amount is met that individual will pay coinsurance until they reach the Out-of-Pocket Maximum.
- **Coinsurance:** Your share (percentage) of the costs of a healthcare service, for example 20%. You start paying coinsurance after you’ve paid your plan’s deductible.
- **Copay:** a fixed amount for certain services you pay in some of our plans.
- **Out-of-Pocket Maximum:** This is the most that you will have to pay for covered services in a plan year. Once you reach this limit, the plan covers all eligible expenses for the remainder of the plan year.
- **In-Network vs. Out-of-Network:** Your plan contracts with a group of providers for discounted rates. You will almost always pay less when you receive care from these in-network providers. If you choose to see an out-of-network provider, you may be balance billed, which means you will be responsible for charges above Anthem’s reimbursement amount.



Prescription Drug Coverage



	PPO Medical Plan (P1)		HSA Medical Plan (H1)		HSA Medical Plan (H2)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network

Retail Pharmacy

Please note: for the HSA-qualified plans, all prescription drug expenses are subject to the medical deductible. Once you have met your deductible, coinsurance will apply.

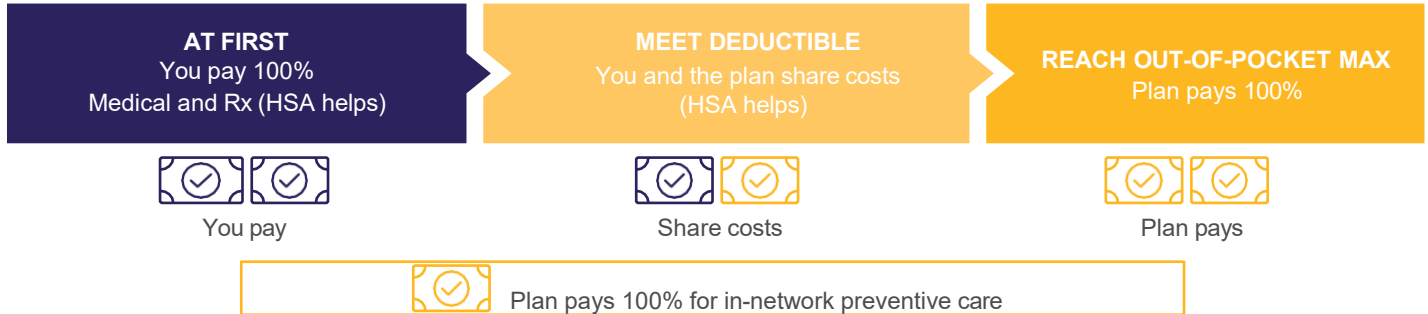
Generic	\$10	Ded+50%	Ded+10%	Ded+30%	Ded+20%	Ded+40%
Preferred Brand	\$30	Ded+50%	Ded+10%	Ded+30%	Ded+20%	Ded+40%
Non-Preferred Brand	\$60	Ded+50%	Ded+10%	Ded+30%	Ded+20%	Ded+40%
Specialty	\$90	Ded+50%	Ded+10%	Ded_30%	Ded+20%	Ded+40%

Mail Order

Generic	\$30	Not covered	Ded+10%	Not covered	Ded+20%	Not covered
Preferred Brand	\$90	Not covered	Ded+10%	Not covered	Ded+20%	Not covered
Non-Preferred Brand	\$180	Not covered	Ded+10%	Not covered	Ded+20%	Not covered
Specialty	\$270	Not covered	Ded+10%	Not covered	Ded+20%	Not covered

High-Deductible Health Plan

Whether you're new to the concept of High-Deductible Health Plans or have utilized one before, you might benefit from an overview of how they work—and how they're different from a more-traditional Preferred Provider Organization or PPO plan.



High Deductible Health Plan vs. PPO

How They Are Alike

You choose providers from a network. Like PPOs, HDHPs have a network of providers. You can choose any provider you like, but you'll almost always pay less when you use providers and facilities that are in-network.

You pay nothing for preventive care. Both HDHPs and PPOs cover in-network preventive care at 100%; you don't have to pay a co-pay.

TO HELP YOU SAVE, CENTRIC WILL CONTRIBUTE TO YOUR HSA!

Centric will make bi-weekly contributions twice monthly, to your HSA account. The contribution is \$23.08 per pay for individual coverage and \$46.15 per pay for non-individual coverage.

How They're Different

You pay the full cost for other services until you reach the deductible. With an HDHP, you pay the full cost when you visit the doctor, get a test, or pick up a prescription. When your out-of-pocket costs meet the deductible, the plan starts paying either 90% or 100%, and you pay either 10% or 0% for in-network care depending on which HDHP you select. If you reach the out-of-pocket maximum—and most people never do—the plan pays 100% of the cost for in-network care.

With a PPO, you pay less upfront, because you only pay a copayment when you go to the doctor or get a prescription.

HDHP premiums are lower. Premiums for a HDHP plan are typically lower than those for a PPO. That's the tradeoff for having to pay most costs upfront.

A Health Savings Account can help you save money. A Health Savings Account (HSA) is an interest-bearing checking account that you can fund with pre-tax contributions. You can use the money in your HSA to pay for your Qualified Medical Expenses including your prescriptions, medical, dental, and vision expenses. With a HDHP, you can enroll in a Health Savings Account or HSA. It is like a bank account where you set aside money to help pay those upfront costs. PPOs don't include an HSA.

Anthem's Customer Service Team can assist you in understanding your coverage, verify covered providers and help with any changes or disruption that may occur to your medical care coverage or pharmacy needs. Call 833-952-2042 to talk with a customer service representative today, download the Sydney Health app or register for [anthem.com](https://www.anthem.com). The following programs are also available:

Sydney Health App

With Sydney Health, you can find everything you need to know about your medical and pharmacy benefits all in one place. Download the Sydney Health app today!

Key features include:

- Find care and check costs
- See all benefits
- View claims
- View and use digital ID cards
- Use the interactive chat feature to get answers quickly
- Sync your favorite fitness tracker

Virtual Care

All your virtual care will be provided through our Sydney Health app.

You can seek virtual care for:

- Urgent care: cough, cold, rash, sprains, pink eye, etc.
- Primary Care: annual preventive care visit
- Mental Health: anxiety, depression
- Dermatology
- Symptom Checker
- Prescriptions: new and refills

When it's time for your virtual appointment, use your smartphone, tablet, or computer with a camera to meet securely through our SydneySM Health app or [anthem.com](https://www.anthem.com).

You can also call 24/7 NurseLine anytime, day or night at 800-337-4770 at no additional cost for health questions & received guidance on where to go for care, if needed.

Healthy Families

Whether trying to conceive, expecting a child, or in the thick of raising young children, Building Healthy Families offers personalized, digital support to help each family navigate their unique journey. You can find Building Healthy Families in your plan's mobile health app to do things like:

- Track baby's feedings, diaper changes, and developmental milestones.
- Monitor prenatal health risks and receive updates on your pregnancy progress.
- Explore a library with thousands of educational articles and videos.
- Connect with one-on-one pregnancy support

Weight Loss- Lark

Lark's Weight Management Program is designed to help you lose weight and keep it off at no extra cost to you. No matter where you are in your weight loss journey, Lark has a program for you with:

- 24/7 personalized digital coaching from your smartphone or tablet
 - Weight loss medications
- Personalized plans with a wellness coach

See if you qualify for the Lark program today, visit [Lark.com/AnthemWMP](https://www.Lark.com/AnthemWMP)

ConditionCare

Managing chronic conditions, such as asthma, diabetes, chronic obstructive pulmonary disease (COPD), or heart disease requires extra care and attention. To help you be at your best, the ConditionCare program offers free resources, including:

- 24/7 phone access to nurses who can address your health concerns
- Support from healthcare professionals to help you reach your health goals.
- Educational guides and useful tools to help you learn more about a certain conditions

Connect with the support you need:

ConditionCare: 866-962-1071

Cost Comparison

Anthem's Cost Comparison tool is an internet-based self-service tool that contains personalized out-of-pocket cost information for many covered health care items and services. This tool enables members to compare the amount of cost they would be responsible for with respect to a specific item or service. You can access the Cost Comparison Tool via the Sydney Health mobile app.

Find Care

Having access to the right doctor can have a positive impact on your health and well-being. Choosing one in your plan's network also saves you money.

Our online Find Care resource includes a search function to locate medical doctors, hospitals, labs, and other healthcare professionals in your plan's network.

If you use a healthcare professional or facility outside your plan's network, your part of the cost will be higher and your care may not be covered.

Health Savings Account (HSA)

An HSA works with your high deductible health plan and is funded with pre-tax payroll contributions. You can use it to pay qualified medical expenses such as deductibles, copays, dental, and vision care. For a complete list of qualified medical expenses, see [IRS Publication 502](#). Centric utilizes Fidelity as our HSA Provider.

HSA Major Benefits

- Your account always belongs to you; you can take it with you if you leave Centric or retire.
- Your balance rolls over from year to year.
- Contributing lowers your taxable income, because it is funded with pre-tax contributions.
- The account helps you build a healthcare nest egg for emergencies or retirement. You can adjust your contributions to the HSA at any time by contacting benefits@centricconsulting.com
- Centric will make monthly contributions to your account. The contribution is \$50 per month for individual coverage and \$100 per month for EE/ SP, EE/CH, and family. These contributions count towards the IRS limit.

Coverage Level	IRS Yearly Maximum Contribution
Individual Coverage	\$4,400
Family Coverage	\$8,750
Age 55 or Older	Contribute an additional \$1,000 in addition to these amounts

HSA Eligibility

When you elect a High Deductible Health Plan through Anthem, you are eligible to open a HSA bank account with Fidelity. Your elected employee pre-tax payroll contributions and the Centric contributions based on medical plan tier will begin after the account is opened. After the completion of your Annual Enrollment election in an eligible plan, you will be able to log on to NetBenefits to open your HSA using the same credentials as you use for your other Fidelity accounts.

You are eligible if:

- You are not enrolled in a traditional PPO plan through your spouse or other employer-sponsored plan options.
- You are not enrolled in a government-sponsored program (Medicare, Medicaid, Tricare, etc.).
- You have not received VA benefits within the last three months (unless for a service-related disability).
- You are not claimed as a dependent on someone else's tax return.
- You do not have a healthcare FSA; your spouse also cannot have a healthcare FSA through their own employer. If you had an FSA at a prior employer or in a prior year, you must have a \$0 balance in your FSA before your HSA can be opened.

Consolidating HSA Accounts

If you have an existing HSA account, you are able to consolidate the accounts by transferring the funds to Fidelity. In order to do so, please visit the [transfer of funds](#) page on the Fidelity website.



Flexible Spending Accounts (FSAs)



Flexible spending accounts (FSAs) allow you to set aside pre-tax dollars from your paycheck to cover qualified expenses you would normally pay out of your pocket. We offer four types of FSAs. FSAs are a use it or lose it fund. Any funds remaining in the account at the end of the Plan year are forfeit, so plan carefully!

Healthcare FSA*

The Healthcare FSA helps you pay IRS-approved medical expenses. Funds you elect to contribute to the healthcare FSA are available in full on the first day of the plan year. For example, if you elect to contribute \$1,000, the full election is available on day one. You can only open an FSA if you aren't enrolled in an HDHP. **The 2026 IRS Annual Contribution Maximum is \$3,400.**



- Doctor's visit copays
- Prescription drug copays
- Medical and dental deductibles
- Over-the-counter medications/supplies. Please refer to [IRS Publication 502](#)
- Hearing aids
- Eyeglasses

Limited Purpose FSA

The Limited Purpose Healthcare FSA is similar to the Healthcare FSA, but it only covers dental and vision services. You can choose this option if you are in a HDHP and open an HSA.



- Hearing aids
- Eyeglasses
- Dental cleanings
- Eye exams

Dependent Care FSA

The Dependent Care FSA helps you pay for dependent care. You can contribute up to \$7,500 (or \$3,750 if married and filing separately) per plan year. Your account works like a debit card; you need to accumulate the funds before you can use them.



- Child or adult daycare*
- Nursery school
- Preschool (excluding kindergarten)

Qualified Transit Expense (QTE)

The Qualified Transit Expense account is a different type of FSA that allows you to pay for eligible transportation and parking expenses.



- Public transit to and from work
- Parking expenses

*An eligible dependent is a tax dependent child under age 13 or a tax dependent spouse, parent, or child unable to care for themselves.

Dental



We partner with Delta Dental to offer you and your family members dental insurance. Visit [Delta Dental Dentist Login](#) | [Dentist Network Information](#) to find in-network providers and access a variety of online tools and programs.

	In-Network	Out-of-Network
Deductible		
Individual	\$50	\$50
Family	\$150	\$150
Non-Preferred Brand	\$180	Not covered
Preventative		
Preventative	100%	100%
Basic	80%	80%
Major	50%	50%
Orthodontia	50%	50%
Annual Maximum	\$1,750	\$1,750
Ortho Maximum	\$1,500	\$1,500
	Full/Part-Time	W2T
Biweekly Rates		
Employee	\$8.12	\$17.41
Employee + Spouse	\$16.41	\$35.20
Employee + Children	\$19.88	\$42.66
Employee + Family	\$30.31	\$65.03



Vision



We partner with EyeMed to offer you and your family members vision insurance. Visit <https://eyemanage.eyemedvisioncare.com> And search the "Insight" network to find in-network providers and access a variety of online tools and perks.

	In-Network	Out-of-Network
Copays		
Exam	\$0 (Plus Providers)/\$10 copay	Up to \$40
Frequency	Every 12 Months	
Frames		
Frames Allowance	\$180 allowance (Plus Providers)/\$130 allowance + 20% off Balance	Up to \$65
Basic	Every 12 Months	
Lenses		
Single Vision	\$10	Up to \$30
Bifocal	\$10	Up to \$50
Trifocal	\$10	Up to \$70
Frequency	Every 12 Months	
Contacts		
Elective Disposable Contacts	\$180 allowance (Plus Provider) / \$130 + 15% off Balance	Up to \$65
Contact Lens Exam (Fit+Eval)	Up to \$40	Not covered
Frequency	Every 12 Months	
	Full/Part-Time	W2T
Biweekly Rates		
Employee	\$.46	\$3.29
Employee + Spouse	\$1.85	\$5.76
Employee + Children	\$2.31	\$6.26
Employee + Family	\$5.54	\$9.55

Please note: Delta Dental does not mail out physical cards to new participants. When visiting your dentist, please advise them of your Delta Dental insurance and they can verify coverage with your Social Security number.

Centric Sponsored Benefits

Basic Life and AD&D



Centric provides company paid Basic Term Life insurance and Accidental Death & Dismemberment (AD&D) coverage to all eligible employees in the amount of \$75,000. In addition, all eligible dependents including spouses/domestic partners and children, receive \$5,000 term life coverage, each, at no cost to you. Please remember to designate a beneficiary in ADP for your employee life insurance.

Employee Assistance Program



We partner with Carelon Behavioral Health to provide an employee assistance program (EAP) to help you and your family members find solutions and resources to tackle life's challenges. From simple topics such as quick ways to de-stress or how to find more time in your schedule, to more difficult issues such as finding support after the loss of a loved one, our program is there to work with you and offer suggestions, options, and information.

EAP specialists will confidentially discuss challenges you may be facing and provide consultation, information, action plans and resources. Carelon Behavioral Health offers unlimited access to master's level consultants by telephone, resources and tools online, and up to 8 no-cost sessions. for help with a short-term problem.

Accessing the EAP

- Phone consultations: **800.435.1986**; unlimited calls, 24/7
- Online tools & resources: [Carelon Behavioral Health Website](#) or call **800.435.1986** or download the **Carelon BH Mobile App**
- Services include:
 - 8 no-cost counseling sessions per event
 - Financial Support including a free 60-minute financial consultation with a financial expert
 - Legal support that allows you to receive a telephonic legal consult up to 60 minutes
 - Work/Life Services including childcare resources, education services and more!

Strict standards of confidentiality are in place to protect your privacy. Treatment information is not shared with anyone without your written permission.

Counseling and Work Life Services

- Stress management
- Work and home relationships
- Depression and grief
- Alcohol and substance abuse
- Child, adult and elder care
- Legal and financial consultations
- Identity theft

Wellness Program

Please join us in the Working Towards Wellness Channel in the "ALL Centric Team" in Teams for ongoing updates!

Preventive Visit Incentive

- All full-time, part-time and W2 employees that receive a preventive exam and turn in an EOB (Estimate of Benefits) to Benefits@centricconsulting.com anytime between 11.1.2025 – 10.31.2026 will be entered into a prize drawing later this year! You do NOT need to be enrolled on the Anthem Medical plan to participate.

Wellness Challenges

- Centric will be hosting 2 wellness challenges during the year.

All benefits eligible employees are able to enroll in Voluntary Life & AD&D, Voluntary Short-Term and Voluntary Long-Term Disability through Prudential.

Voluntary Life and AD&D Insurance

You're eligible to purchase additional life insurance in increments of up to 5 times your annual salary up to a maximum benefit of \$500,000. You have the same coverage options for voluntary AD&D insurance. Amounts exceeding the lesser of two times your annual salary or \$300,000 will require evidence of insurability. Employees that have waived coverage previously, will be require to complete Evidence of Insurability for any amount requested. Please remember to designate a beneficiary in ADP for your employee life insurance.

Voluntary Spouse and Dependent Life and AD&D Insurance

If you elect voluntary life coverage for yourself, you can also elect voluntary life coverage for your spouse/domestic partner in increments of \$10,000 up to a maximum of \$250,000 or 50% of the employee approved amount. Spousal life exceeding \$30,000 will require evidence of insurability. Employees that have waived coverage for their spouse previously will need to complete Evidence of Insurability for any amount requested.

Dependent child life coverage is offered at \$10,000 and is automatically guaranteed.

Voluntary Short-Term Disability (STD)

Employees can purchase voluntary short-term disability (STD) insurance to help replace a portion of your income if you are unable to work due to illness or accident. The plan covers 60% of your pre-disability earnings, up to a weekly maximum of \$1,500. The benefit duration is 12 weeks. There is a 7 day waiting period for illnesses and pregnancy, but coverage for an accident will begin immediately. Employees that have waived STD previously will need to complete Evidence of Insurability and be approved by Prudential before they are covered under this benefit. Pre-existing conditions apply.

Voluntary Long-Term Disability (LTD)

Employees can purchase voluntary long-term disability (LTD) insurance to replace a portion of your income in the event you're unable to work for an extended period. The plan covers 60% of your monthly pre-disability earnings up to a maximum of \$8,000, less deductible sources of income. Employees that have waived LTD previously will need to complete Evidence of Insurability and be approved by Prudential before they are covered under this benefit. Pre-existing conditions apply.



What is Evidence of Insurability (EOI)?

EOI or Statement of Health, is information about your health, which the insurance company may require to approve you for coverage.

If you're newly eligible, you can elect up to the guaranteed issue amount without submitting EOI for Vol Life AD&D, STD or LTD. If you have waived coverage in the past, you will be required to submit EOI for Vol Life AD&D, STD and LTD.

Accident insurance through Prudential provides direct payments to you in the case of an off-the-job accident that results in:

- Emergency care and/ or follow-up care
- Hospital admission
- Hospital confinement
- Accidental death

Accident insurance is a post-tax payroll deducted benefit elected during your enrollment period.

	Biweekly Rates
Employee Only	\$4.27
Employee + Spouse	\$8.56
Employee + Children	\$10.15
Employee + Family	\$12.28

Critical Illness

Critical illness insurance through Prudential provides direct payments to you if you are diagnosed with a covered critical illness such as:

- Cancer
- Heart attack
- Stroke
- Major organ transplant
- End stage renal failure

Critical Illness is a post-tax payroll deducted benefit elected during annual enrollment. Please visit www.benefitsatcentric.com to review the rates.

Hospital Indemnity

Hospital indemnity insurance through Prudential provides direct payments if you are hospitalized. It includes separate amounts for events such as:

- Hospital admission
- Hospital confinement
- Hospital intensive care

	Low Plan Biweekly Rates	High Plan Biweekly Rates
Employee Only	\$3.43	\$7.26
Employee + Spouse	\$8.95	\$14.76
Employee + Children	\$6.99	\$12.23
Employee + Family	\$11.07	\$20.49

Legal insurance through MetLife offers easy access to the legal help you need for the common legal issues many people face such as:

- Unlimited use of network attorneys
- Estate planning
- Civil lawsuits
- Elder-care issues

Legal insurance is a post-tax payroll deducted benefit elected during your enrollment period. **Cost is a \$9.12 biweekly rate.**

Auto & Home Insurance

This offering through Farmers GroupSelect by MetLife provides you with savings on a full suite of products. In addition to auto and homeowners insurance, they also offer policies and endorsements including:

- Condo insurance
- Renter insurance
- Personal excess liability
- Boat insurance

Auto & Home insurance is a benefit elected directly with Farmers GroupSelect and is billed to you directly from the carrier.

Pet Insurance

Pet insurance through MetLife offers affordable, extensive coverage so that your pets can get the care they need to help them live long and healthy lives. You will receive:

- Flexible product offerings with straightforward pricing and options
- Group discounts
- Customizable limits and deductible savings!

Pet insurance is a benefit elected directly with MetLife and is billed to you directly from the carrier.

Retirement Savings Plan



Your financial security is important to you, your family, and to us as your employer. We want you to feel secure and prepared for life after your career. In partnership with Fidelity, our 401(k) plan is designed to help you plan ahead and feel prepared.

How the Plan Works

- All employees (age 21 and over) are eligible to immediately begin participating in the 401(k) plan.
- You can contribute before-tax dollars account through payroll deductions (up to the annual IRS limits).
- You can contribute after-tax dollars to your Roth 401(k) account through payroll deductions (up to the annual IRS limits). Your savings are not taxed when you withdraw them at retirement.
- You choose how to invest your money in a variety of investment options.
- You're always 100% vested in your own contributions.
- Your company contributions are subject to a vesting schedule.

Centric Company Match

- In 2026: Matches **25% of every dollar** up to a **6% employee deferral per pay**
- Vesting Schedule:

Years of Service	Employer Contribution Vesting Percentage
Less than 1 year of service	0%
1 year	0%
2 years	0%
3 years	100%

- **Full-time** and **part-time** regular employees are **eligible**
- Match is determined on a per-pay basis

IRS 401(k) Maximums

For 2026, you can tentatively contribute up to \$24,500 into your 401(k) account. If you're age 50 by December 31, you may contribute an additional "catch-up" contribution of \$8,000

Fidelity Tools

Fidelity offers helpful tools including:

- **Investment Tools**- Fidelity offers investment advice; a curated investment lineup with the Fidelity HSA Funds to Consider, tools to help auto-invest, broad brokerage platform
- **Goal Booster**- a goal-based savings and investing experience designed to help savers with their emergency savings and other saving goals.
- **Medicare Services**- providing complimentary guidance, enrollment assistance and year-over-year support, so you can make Medicare decisions with confidence, visit [medicare.fidelity.com](https://www.fidelity.com/medicare) or call 833-886-0033

Remember to add a beneficiary for your 401(k) on the Fidelity website through their convenient online beneficiary tool. Please note, you will need to elect beneficiaries separately for life insurance and your 401(k).



Employee Discount Programs

Consumer Discount Program



Centric provides a Consumer Discount Program through BenefitHub. BenefitHub offers discounts, rewards and perks on thousands of the brands you love and utilize on a daily basis. The following are some of the categories with offered discounts:

- Travel
- Auto
- Electronics
- Apparel
- Local Deals
- Education
- Entertainment
- Restaurants
- Health and Wellness
- Beauty and Spa
- Tickets
- Sports and Outdoors

To Start Saving:

1. Go to: <https://centric.benefithub.com/>
2. Enter Referral Code: P7T5JM
3. Save your Password and start saving!

Gym Membership Discount Program



Active & Fit Direct is a Self-Pay Fitness Program that gives members access to 16,800+ gyms nationwide and 8,100 online workout videos.

Digital Fitness Choices

- 200 Workout Videos Available to all Eligible Members
- Curated Member Experience
- 8,100 Workout Videos Available to all Enrolled Members

Well-Being Choices

- Live Lifestyle Coaching; Exercise, Nutrition, and more
- Digital Resources, Education & Classes
- Connect with 250+ Trackers & Apps

Fitness Memberships

- **Standard Fitness Network Choices (13,000+):** Includes Fitness Centers, YMCAs, Gender-Specific, Instructor-Based, Senior Centers, and sessions at Fitness Studios, Yoga, Pilates, and more. **Member price: \$28/mo.**
- **Premium Fitness Network Choices:** Includes higher priced Fitness Centers, unique experiences like Rock Climbing Gyms, Rowing Centers, and sessions at Fitness Studios, Yoga, Pilates, and more. **Member Price: \$30-\$200/mo (Substantial discounts on most memberships)**

Discounts and Special Program:

To start saving, visit the link above to the Centric benefit website and sign up for the Active & Fit program

Additional Benefits:

- Spouse Benefits
- Workout Videos
- Lifestyle Coaching
- Connect your favorite mobile apps and fitness trackers

Vitamix Discount Program

Centric has partnered with Vitamix to offer discounts on Vitamix products. Visit www.vitamix.com/shop to view all available products. Enter the discount code at checkout. Call 866.278.5772 or email corpwellness@vitamix.com with any questions.

To Start Saving:

Visit the [Centric Website](#) for the most recent discount code.

Important Policies

To view the entire policy of any of the policies outlined below, please visit www.benefitsatcentric.com or the [Lounge](#).

Paid Time Off (PTO)

For PTO, employees should plan their time accordingly to include the following:

- Vacation
- Casual Illness—(defined as no more than 5 consecutive days)
- Funeral Leave
- Health Care Exams
- Other Personal Time

Employees should schedule their PTO as far in advance as possible with their client/manager. This allows balancing the personal needs of each employee with the workflow demands of the client/office. Centric trusts all employees to manage their own work life balance when determining the amount of vacation, sick days, and any other time off needed. Each employee will be able to take the time off needed to care for yourself, your family and the things you are passionate about, balance time off to ensure client and internal Centric commitments will still be met. Client and OG approval must be obtained before taking more than five (5) consecutive days of PTO. As there is no accrued PTO, employees will not be paid for any PTO upon termination whether the employee's departure is voluntary or involuntary.

Holidays

All full-time regular employees are eligible for eight (8) paid holidays per year as follows:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Eve
- Christmas Day

Where a holiday falls on a weekend, it will be observed on either the preceding Friday or following Monday. If Centric's holiday schedule is not in line with the employee's client holiday schedule, the employee may choose to follow the client holiday schedule instead of Centric's as long as the total number of holidays taken for the calendar year is eight (8). If an employee chooses to follow the client holiday schedule, time worked for these holidays should be entered into Centric's time reporting application as the employee worked them. For example, if an employee works December 22 (Centric scheduled holiday) and takes December 26 (client scheduled holiday) off, the employee should charge hours on December 22 to the client when entering time for the month. If a client observes a holiday that we do not as a Company, the employee may charge that time to unstaffed or administrative time.

Paid Parental Leave

Centric Consulting will provide up to four weeks of paid parental leave to employees following the birth of an employee's child or the placement of a child with an employee in connection with adoption or foster care. The purpose of paid parental leave is to enable the employee to care for and bond with a newborn or a newly adopted or newly placed child. This policy will run concurrently with Family and Medical Leave Act (FMLA) leave, as applicable. This policy will be in effect for births, adoptions or placements of foster children occurring on or after January 1, 2018.

FMLA

In the event of any conflict between this policy and the applicable law, employees will be afforded all rights required by law. Under this policy, the Company will grant up to 12 weeks (or up to 26 weeks of military caregiver leave to care for a covered service member with a serious injury or illness) during a 12-month period to eligible employees. The leave may be paid, unpaid or a combination of paid and unpaid leave, depending on the circumstances of the leave and as specified in this policy. If you have any questions, concerns, or disputes with this policy, you must contact the Human Resources Manager. For those employees who do not meet the requirements of this policy, other types of leave may be available under other policies in this handbook.

Centric Benefits Contacts

Benefit	Whom To Call	Plan Number	Phone Number	Website
Medical Plan	Anthem	L14593	1-833-639-1634	https://www.anthem.com/oh/contact-us
Dental Plan	Delta Dental	11443	1-800-524-0149	https://www.deltadental.com/us/en/about-us/contact-us
Vision Plan	EyeMed	1061403	1-866-939-3633	https://www.eyemed.com/en-us/contactus
Basic Life	Prudential	72667	Life Claims: 800-524-0542	mybenefits.prudential.com
Employee Voluntary Life	Prudential	72667	Life Claims: 800-524-0542	mybenefits.prudential.com
Spouse & Child Voluntary Life	Prudential	72667	Life Claims: 800-524-0542	mybenefits.prudential.com
Short- Term and Long-Term Disability	Prudential	72667	DI with ABS Phone: 877-367-7781 Fax: 877-889-4885	mybenefits.prudential.com
Absence/Leave Management	Prudential	72667	DI with ABS Phone: 877-367-7781 Fax: 877-889-4885	mybenefits.prudential.com
Health Savings Account	Fidelity	N/A	1-800-544-3716	www.NetBenefits.com
Flexible Spending Account	Surency	N/A	1-866-818-8805	www.surency.com
Dependent Care	Surency	N/A	1-866-818-8805	www.surency.com
Qualified Transit Account	Surency	N/A	1-866-818-8805	www.surency.com
Employee Assistance Program	Carelon	N/A	1-800-435-1986	EAP Carelon
Accident Insurance	Prudential	72667	General Services: 844-455-1002	mybenefits.prudential.com
Critical Illness	Prudential	72667	General Services: 844-455-1002	mybenefits.prudential.com
Hospital Indemnity	Prudential	72667	General Services: 844-455-1002	mybenefits.prudential.com
Legal Insurance	MetLife	259139	1-800-438-6388	Legal Insurance MetLife
Pet Insurance	MetLife	259139	To Enroll: 855-412-2562	To Enroll: Pet Insurance MetLife
Auto & Home Insurance	Farmers Insurance / MetLife	259139	1-800-438-6381	To Enroll: Auto & Home Met Life
Retirement – 401(K)	Fidelity Investments	24875	1-866-811-6041	Fidelity.com

Centric Benefits Team

Email: benefits@centricconsulting.com



(((CENTRIC)))

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. Please visit <https://benefitsatcentric.com/> for all up to date information and additional resources.

**IMPORTANT NOTICE FROM CENTRIC CONSULTING, LLC 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 Centric Consulting, LLC 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.

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.

Centric Consulting, LLC has determined that the prescription drug coverage offered by the Centric Consulting, LLC 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 Centric Consulting, LLC 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 Centric Consulting, LLC Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Centric Consulting, LLC 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 Centric Consulting, LLC 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 330-304-5003. **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 Centric Consulting, LLC 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, 2026
Name of Entity/Sender: Sarah Adams
Contact—Position/Office: Senior Benefit Specialist
Address: 10564 Success Lane, Suite D
Dayton, Ohio 45458
Phone Number: 330-304-5003

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.

NOTICE OF SPECIAL ENROLLMENT RIGHTS
CENTRIC CONSULTING, LLC 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 *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or 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 *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Sarah Adams
Senior Benefits Specialist
330-304-5003

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

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

The date that is one year following the date the medically necessary leave of absence began; or
The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Sarah Adams, Senior Benefits Specialist, 330-304-5003.

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 to sign up for Medicare Part A or B, beginning on the earlier of

The month after your employment ends; or

The month after group health plan coverage based on current employment ends.

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

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

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

If you have questions

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

Sarah Adams
Senior Benefits Specialist
10564 Success Lane, Suite D
Dayton, OH 45458
330-304-5003

<https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>

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

WOMEN’S HEALTH AND CANCER RIGHTS NOTICE

Centric Consulting, LLC Employee Health Care Plan is required by law to provide you with the following notice:

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 Centric Consulting, LLC 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:

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

Sarah Adams
Senior Benefit Specialist
330-304-5003

HSA Medial Plan (H2)	In-Network	Out-of-Network
Individual Deductible	\$4,500	\$4,500
Family Deductible	\$9,000	\$9,000
Coinsurance	20%	40%
HSA Medial Plan (H1)	In-Network	Out-of-Network
Individual Deductible	\$3,400	\$6,300
Family Deductible	\$6,800	\$12,600
Coinsurance	10%	30%
PPO Medial Plan (P1)	In-Network	Out-of-Network
Individual Deductible	\$1,000	\$2,000
Family Deductible	\$2,000	\$4,000
Coinsurance	20%	40%

CENTRIC CONSULTING, LLC
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:

Centric Consulting, LLC Wrap Benefit Plan*

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

For the remainder of this notice, Centric Consulting, LLC is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan. Examples of "payment" activities include billing, claims management, and medical necessity reviews. Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

5. Disclosure for Underwriting Purposes: A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities;
- When required for judicial or administrative proceedings;
- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other than the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 23).

21. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

22. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

23. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official

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

Sarah Adams
Senior Benefits Specialist
330-304-5003

Effective Date

The effective date of this notice is: January 1, 2026.

**NOTICE OF SPECIAL ENROLLMENT RIGHTS
CENTRIC CONSULTING, LLC 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 **30 days** after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or 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 **30 days** after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Sarah Adams
Senior Benefits Specialist
330-304-5003

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

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

Centric Consulting, LLC Wellness Program is a voluntary wellness program available to All employees regardless of enrollment. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

You are not required to complete the HRA or to participate in the blood test or other medical examinations.

Employees who choose to participate in the wellness program may receive an incentive in the form of a prize for participating, completing or winning a challenge or wellness program.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Sarah Adams, Senior Benefit Specialist, 330-304-5003.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Centric Consulting, LLC may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive.

Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) A doctor in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Sarah Adams, Senior Benefit Specialist, 330-304-5003.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

<p>ALABAMA – Medicaid</p> <p>Website: http://myalhipp.com/ Phone: 1-855-692-5447</p>	<p>ALASKA – Medicaid</p> <p>The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx</p>
<p>ARKANSAS – Medicaid</p> <p>Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)</p>	<p>CALIFORNIA – Medicaid</p> <p>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</p>
<p>COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)</p> <p>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: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442</p>	<p>FLORIDA – Medicaid</p> <p>Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268</p>
<p>GEORGIA – Medicaid</p> <p>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</p>	<p>INDIANA – Medicaid</p> <p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/df/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:

Iowa Medicaid | Health & Human Services

Medicaid Phone: 1-800-338-8366

Hawki Website:

[Hawki - Healthy and Well Kids in Iowa | Health & Human Services](#)

Hawki Phone: 1-800-257-8563

HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](#)

HIPP Phone: 1-888-346-9562

KANSAS – MedicaidWebsite: <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.govKCHIP Website: <https://kynect.ky.gov>

Phone: 1-877-524-4718

Kentucky Medicaid Website:

<https://chfs.ky.gov/agencies/dms>**LOUISIANA – Medicaid**Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or

1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:

https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:

<https://www.maine.gov/dbhs/ofi/applications-forms>

Phone: 1-800-977-6740

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIPWebsite: <https://www.mass.gov/masshealth/pa>

Phone: 1-800-862-4840

TTY: 711

Email: masspremassistance@accenture.com**MINNESOTA – Medicaid**

Website:

<https://mn.gov/dhs/health-care-coverage/>

Phone: 1-800-657-3672

MISSOURI – Medicaid

Website:

<http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

Phone: 573-751-2005

MONTANA – Medicaid

Website:

<http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

Phone: 1-800-694-3084

Email: HSHIPPprogram@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**NEW HAMPSHIRE – Medicaid**

Medicaid Website: <http://dhcfnv.gov>
 Medicaid Phone: 1-800-992-0900

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

NEW JERSEY – Medicaid and CHIP**NEW YORK – Medicaid**

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

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

NORTH CAROLINA – Medicaid**NORTH DAKOTA – Medicaid**

Website: <https://medicaid.ncdhhs.gov/>
 Phone: 919-855-4100

Website: <https://www.hhs.nd.gov/healthcare>
 Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP**OREGON – Medicaid and CHIP**

Website: <http://www.insureoklahoma.org>
 Phone: 1-888-365-3742

Website: <http://healthcare.oregon.gov/Pages/index.aspx>
 Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP**RHODE ISLAND – Medicaid and CHIP**

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicoid-health-insurance-premium-payment-program-hipp.html>
 Phone: 1-800-692-7462
 CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](http://www.pa.gov)
 CHIP Phone: 1-800-986-KIDS (5437)

Website: <http://www.eohhs.ri.gov/>
 Phone: 1-855-697-4347, or
 401-462-0311 (Direct RItE Share Line)

SOUTH CAROLINA – Medicaid**SOUTH DAKOTA - Medicaid**

Website: <https://www.scdhhs.gov>
 Phone: 1-888-549-0820

Website: <http://dss.sd.gov>
 Phone: 1-888-828-0059

VERMONT – Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	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	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2024, 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.

Illinois DOL Employer Essential Health Benefits Notice - Only pertains to those living in Illinois

Employer Name:	Centric Consulting, LLC
Employer State of Situs:	Ohio
Name of Issuer:	Anthem
Plan Marketing Name:	Medical pLans H1, H2, P1
Plan Year:	2026

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

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

2020-2025 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

Item	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit?
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Yes
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Yes
4	Durable Medical Equipment	Ambulatory	Pg. 13	Yes
5	Hospice	Ambulatory	Pg. 28	Yes
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Yes
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Yes
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	No
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Yes
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Yes
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Yes
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Yes
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Yes
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Yes
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Yes
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	No
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	No
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Yes
26	Tele-Psychiatry	MH/SUD	Pg. 11	Yes
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Yes

29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Yes
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Yes
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Yes
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Yes
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Yes
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Yes
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Yes
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Yes

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