2027

BENEFITS GUIDE

((CENTRIC))



This publication contains important information about your employee benefit program.

Please read thoroughly.

2027

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Your Centric Consulting Benefits

At Centric Consulting, we embrace all employees by providing a comprehensive benefits program with a variety of options to choose from. Our program combines innovative solutions with traditional benefits to provide you a safety net when and where it matters most. As you review this guide, consider how each of these benefits will support you and your loved ones. Then, create a custom benefits package by enrolling in the benefits that meet your needs.

For All Your Benefits Questions

We're here to help answer your benefits questions and support you throughout enrollment. For assistance, email **benefits@centricconsulting.com**.



Opportunities to Enroll

As a Centric employee, you have three opportunities to enroll in benefits or change your elections as well as the dependents you cover.

New Hire Enrollment

Your benefits coverage begins the first of the month following your date of hire. You must enroll within 30 days of your hire date. If you miss this deadline, you will not be able to enroll in benefits again until open enrollment or you experience a qualifying life event.

Open Enrollment Information Sessions

Attend one session to learn about 2027 benefits, ask questions, and include family members, if desired.

Session Dates

The schedule of dates/times are listed below:

- Tuesday, October 27th: 12:00p-1:00p EST
- Thursday, October 29th: 3:00p-4:00p EST
- Monday, November 2nd: 12:00p-1:00p EST
- Thursday, November 5th: 7:00p-8:00p EST
- Friday, November 6th: 9:00a-10:00a EST
- Monday, November 9th: 12:00p-1:00p EST

Changing Benefits During the Plan Year

You may change your benefits throughout the plan year if you experience a qualifying life event. You must notify the Benefits Team within 30 days of the event date. Examples of qualifying events include a change in:

- **Legal marital status** (e.g., marriage, divorce, death of spouse, legal separation)
- **Change in domestic partnership status** (e.g., partnership registration, termination of domestic partnership, death of domestic partner)
- **Number of dependents** (e.g., birth, adoption, death of dependent, ineligibility due to age)
- **A dependent's eligibility status** (e.g., a dependent child is no longer eligible)
- **Employment or job status**

Keep in mind, you will be required to provide documentation, such as a marriage or birth certificate or letter of prior coverage termination or new coverage election, for the change to be completed.



ACCESSING ADP SELF-SERVICE PORTAL

Log in to ADP using your Centric SSO by visiting **adp.centricconsulting.com**. In the ADP Self-Service Portal you can:

- 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@centricconsilting.com**.

Who Is Eligible for Benefits?

You and your loved ones are eligible to enroll in benefits if you meet the following requirements.

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 A SPOUSE OR DOMESTIC PARTNER

You can enroll your legal spouse or domestic partner (same-sex or opposite-sex). For domestic partners to have coverage under Centric benefits, a Domestic Partnership Affidavit must be completed and sent to **benefits@centricconsulting.com**.

Domestic Partnership Affidavit

COVERING CHILDREN

You can enroll children under 26 years old, including:

- Biological
- Adopted
- Stepchildren
- Children you are the full, legal guardian for

Please note: Children who became handicapped or fully disabled before 26 may be eligible for coverage after 26. Reach out to **benefits@centricconsulting.com** for more information on eligibility documentation.

DEPENDENT ELIGIBILITY DOCUMENTATION

Proof of eligibility is required when adding a dependent to benefits. Examples of accepted documentation include a marriage license, tax return, domestic partnership registration, birth certificate, or adoption orders. Records are to be submitted to Benefits at **benefits@centricconsulting.com**.

ALEX—Benefits Decision Support Tool

What Is ALEX?

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

Is ALEX Confidential?

Yes. ALEX is 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 and Pharmacy Benefits

When it comes to choosing the medical plan best for you and your family, you have the choice between three plans offered through Anthem.

Which Plan Is Right for You?

How the Plans Are Similar

All three medical plans support your health by:

- Using the same broad network of providers and facilities
- Covering in-network preventive care at 100%
- Covering in-network services at 80% or 90% after you meet the deductible
- Including prescription drug coverage

How the Plans Compare

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 copay.

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 80% or 90%; and you pay either 20% or 10% for in-network care depending on which HDHP you select.



Explore resources, including plan details and a provider search, by visiting **https://benefitsatcentric.com/**.

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

HDHP monthly costs are lower. Monthly costs for an 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 an 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.

Your Monthly Cost of Medical Coverage

	PPO Medical Plan (P1)		HSA Medical Plan (H1)		HSA Medical Plan (H2)	
	Full-Time Employees	W2 Temporary	Full-Time Employees	W2 Temporary	Full-Time Employees	W2 Temporary
Employee	$279.24	$1,455.82	$139.06	$1,077.99	$102.58	$971.07
Employee + Spouse	$947.15	$3,012.59	$427.41	$2,258.33	$336.23	$2,047.19
Employee + Children	$700.96	$2,327.64	$245.05	$1,702.33	$176.66	$1,599.75
Family	$1,513.61	$4,226.43	$657.65	$3,090.09	$526.58	$2,921.45

Medical and Pharmacy Benefits Summary

	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	$3,500	$6,300	$4,500	$4,500
Family	$2,000	$4,000	$7,000	$12,600	$9,000	$9,000
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
Coinsurance (after you reach the deductible)						
Plan Pays	80%	60%	90%	70%	80%	60%
Physician Office Visits						
Preventive Care	100%	Ded. + 40%	100%	Ded. + 30%	100%	Ded. + 40%
Virtual Visits	$0	Not covered	Ded. + 10%	Not covered	Ded. + 20%	Not covered
Primary Care Physician	$25	Ded. + 40%	Ded. + 10%	Ded. + 30%	Ded. + 20%	Ded. + 40%
Specialist	$40	Ded. + 40%	Ded. + 10%	Ded. + 30%	Ded. + 20%	Ded. + 40%
Hospital Services						
Urgent Care	$50	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%
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%
Prescription Drug						
Retail Prescription Copay (30-day supply)						
Generic	$10	Ded. + 50%	Ded. + 10%	Ded. + 30%	Ded. + 20%	Ded. + 40%
Formulary	$30	Ded. + 50%	Ded. + 10%	Ded. + 30%	Ded. + 20%	Ded. + 40%
Non-Formulary	$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 Prescription Copay (90-day supply)						
Generic	$30	Not covered	Ded. + 10%	Not covered	Ded. + 20%	Not covered
Formulary	$90	Not covered	Ded. + 10%	Not covered	Ded. + 20%	Not covered
Non-Formulary	$180	Not covered	Ded. + 10%	Not covered	Ded. + 20%	Not covered
Specialty	$270	Not covered	Ded. + 10%	Not covered	Ded. + 20%	Not covered

How Medical Plans Work

You have the choice between three medical plans offered through Anthem. As you consider which plan is best for you and your family, it's important to understand how the plans work.

PPO

The PPO Medical Plan is a Preferred Provider Organization (PPO) Plan. This plan has a lower deductible and higher monthly costs compared to the other medical plans. You will pay a set copay for many common services. Below is an overview of how PPO works.

AT FIRST

You pay copays for most medical services and prescriptions

MEET DEDUCTIBLE

You and the plan share costs, called coinsurance

REACH OUT-OF-POCKET MAXIMUM

Plan pays 100% for the rest of the plan year

HDHP

HSA Medical Plan H1 and H2 are High Deductible Health plans (HDHP) with an HSA, which puts you in control of your healthcare spending. These plans have a higher deductible and lower monthly costs compared to the other medical plans. Below is an overview of how these plans works.

AT FIRST

You pay 100% for medical services and prescriptions (*HSA can be used to help offset expenses*)

MEET DEDUCTIBLE

You and the plan share costs, called coinsurance (*HSA can be used to help offset expenses*)

REACH OUT-OF-POCKET MAXIMUM

Plan pays 100% for the rest of the plan year

KEEP IN MIND

In-network preventive care is covered 100% in all plans.

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

Centric will make contributions to your HSA account. The contributions is $50 monthly for individual coverage and $100 monthly for non-individual coverage.

Anthem Medical Plan Tools

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 **833.639.1634** to talk with a customer service representative today, download the Sydney Health app, or register for **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 Sydney℠ Health app or **anthem.com**.

You can also call 24/7 NurseLine anytime, day or night at **800.337.4770** at no additional cost for health questions and receive guidance on where to go for care, if needed.

Lookup tool: **Provider Find**

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

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.

Weight Loss-Noom

Noom'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, Noom 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

To enroll in this program, please use the Sydney app or go here: **NOOM**.

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 healthcare 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.

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 Temporary employees that receive a preventive exam and turn in an EOB (Estimate of Benefits) to **Benefits@centricconsulting.com** 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.



Centric Wellness Challenge—Fall 2026

Centric, it's time to **Make Movement Your Mission** this Fall! Centric Benefits is excited to bring you a company-wide Fall Wellness Challenge! This Wellness Challenge is available for all Regular Full-Time, Part-Time, and W2 Temporary Employees, as well as any spouses and dependents over the age of 13—you and your dependents do NOT need to be enrolled in the Anthem Plans to participate! Get your work buddies, spouses, and dependents together and form a network of support to encourage participation in daily challenges. Please direct any questions to **benefits@centricconsulting.com**. For more information, please visit the Employee Wellness Hub.

WHAT IS THE WELLNESS CHALLENGE?

This four-week individual challenge encourages employees to get active and stay active. Employees are encouraged to do 30 minutes of physical activity each day. To make it even simpler, it can be any physical activity that you want. This challenge is so easy that you have no reason not to participate!

HOW DO I REGISTER TO PARTICIPATE?

Go to the Employee Wellness Hub and sign up or use the QR Code to get to the hub. Registration is open September 29th. You must create a user account on the wellness portal from a computer or mobile browser before you can log into the Employee Wellness Hub app. You can join this challenge anytime during the challenge window.

WHEN DOES THE CHALLENGE BEGIN?

The challenge will begin on October 5th, 2026 and end on October 30th, 2026.

HOW DO I LOG MY ACTIVITY TIME?

Participants can track activities during the challenge in these ways:

- Use the Activities widget to enter the minutes you participate in your favorite fitness activities. There are hundreds of activities to choose from!
- Download the Employee Wellness Hub App (EWH) and enter data.
- Participants will earn 1 point for logging 30 minutes of any activity in one day. You may make multiple entries of activities per day. Your point will be earned once your time totals 30 minutes. You can earn up to 5 points per day.
- Link your Fitbit or other wearable device to the challenge. Please note: not all devices will send activities. If you link your device, please log in, check history under the Activity tracker to review. If you do not see your activity, please choose from our hundreds of options and manually add it.

PRIZES*

All winners will be drawn after the completion of the challenge:

One overall winner of those who have logged at least 30 minutes of activity every day of the challenge, will be chosen randomly for their choice of up to $2000: In-home gym equipment (i.e. Peleton, recumbent bike, weights, etc.) or an infrared sauna—for home use, and accessories (includes shipping and handling).

Two additional winners of those who have logged at least 30 minutes of activity every day of the challenge, will be chosen randomly for their choice.

- $500 Dicks Sporting Goods Gift Card (includes one gift card, $500 value)
- KitchenAid (up to $500 value, includes shipping and handling)

Each week 2 individuals who have logged at least 30 min of activity for that particular week will be entered into a raffle for their choice of one of 3 prizes up to $200 value:

- $200 gift card to Vuori Clothing
- 1 pair of On Cloud Sneakers (up to $200 value, includes shipping and handling)
- $200 gift card to Lululemon

* All prizes are subject to taxes paid by the employee winner. Taxes will be withdrawn from the winning employee's paycheck during the pay period when prize is sent. Prizes will be sent to winner in the month December 2026. If the employee winner is no longer employed at Centric in December 2026 when prize is to be sent, another winner will be drawn. Under ADA, Centric will offer an alternative prize that fits within ADA Wellness requirements of equal or lesser value if prize winner is physically unable to utilize the prize. Employee may choose to forgo prize and another employee winner will be drawn.

Dental Coverage

We partner with Delta Dental to offer you and your family members affordable dental insurance. Confirm your provider is in-network to make the most of your dental coverage and avoid balance billing. Visit **www.deltadentaloh.com** to find an in-network provider.

Reasonable and Customary (R&C) Fees/Negotiated Rates: Delta Dental determines payment for covered services using either the reasonable and customary fee or the negotiated rate. Reasonable and customary fees represent the typical charges for a dental service within a geographic area, while negotiated rates are discounted fees agreed upon between Delta Dental and participating providers. Benefits are based on these established amounts, and your actual out-of-pocket cost will depend on your plan's coverage level and whether you receive care from an in-network or out-of-network provider.

	In-Network	Out-of-Network*
Calendar Year Deductible		
Individual	$50	$50
Family	$150	$150
Non-Preferred Brand	$180	Not covered
Calendar Year Maximum Benefit		
Preventive, Basic, and Major Services	$1,750	
Coinsurance		
Preventive/Diagnostic		
Examples: Exams, Cleaning, Fluoride Treatment, X-rays, and Space Maintainers	100% no deductible	
Basic Services		
Examples: Fillings, Extractions, Periodontal Scaling and Root Planning, and Oral Surgery	80% after deductible	
Major Services		
Examples: Crown, Inlays, Fixed Bridgework, and Dentures	50% after deductible	
Orthodontia		
Coinsurance	50%	
Lifetime Maximum	$1,500	
Benefit Applies To	Up to age 26	

* If you choose to visit an out-of-network provider, you may be balance billed.

Your Monthly Cost of Dental Coverage

	Full/Part-Time	W2 Temporary
Employee	$17.59	$37.73
Employee + Spouse	$35.55	$76.26
Employee + Children	$43.08	$92.43
Family	$65.67	$140.89



WHAT IS BALANCE BILLING?

In-network providers are contracted with the plans at negotiated rates. If you see an out-of-network provider, you may be balance billed by that provider. This means you would be responsible for paying the bill.

Vision Coverage

We partner with EyeMed to offer you and your family members affordable vision care, including generous allowances for glasses and contact lens. 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 (once per calendar year)	$0 (plus providers)/$10 copay	Up to $40
Prescription Glasses Lenses (once per calendar year)		
Single Vision	$10	Up to $30
Lined Bifocal	$10	Up to $50
Lined Trifocal	$10	Up to $70
Frames (once per calendar year)		
Frames Allowance	$180 allowance (Plus Providers)/ $130 allowance + 20% off balance	Up to $65
Contacts (once per calendar year, in lieu of glasses)		
Contacts	$180 allowance (Plus Providers)/ $130 allowance + 15% off balance	Up to $65
Contact Lens Exam	Up to $40	Not covered

Your Monthly Cost of Vision Coverage

	Full/Part-Time	W2 Temporary
Employee	$1.00	$7.13
Employee + Spouse	$4.00	$12.48
Employee + Children	$5.00	$13.56
Family	$12.00	$20.69



Health Savings Account (HSA)

A Health Savings Account (HSA) is a tax-favored personal savings account that works with your High Deductible Health Plan (HDHP). You can use it to pay qualified medical expenses such as deductibles, copays, dental, and vision care. For a complete list of qualified expenses, see **IRS Publication 502**.

HSA Major Benefits

- Your account always belongs to you; you can take it with you when you leave or retire
- Your balance rolls over from year to year
- Contributing lowers your taxable income
- The account helps you build a healthcare nest egg for emergencies or retirement

Triple Tax Savings

- Tax deduction when you contribute to your account
- Tax-free earnings through investment
- Tax-free withdrawal for qualified expenses

Opening an HSA

If you enroll in the High Deductible Health Plan (HDHP) and are eligible for an HSA, an HSA account will be set up for you through Fidelity. Fidelity will send an email with information on how to complete the opening of your HSA account. You will also receive, in the mail, your HSA debit card and instructions to access your account.

HSA Eligibility

You may open and contribute to an HSA if you're enrolled in the High Deductible Health Plan and you:

- Are not enrolled in a traditional PPO plan through your spouse or other employer-sponsored plan
- Are not enrolled in a Medicare plan
- Are not claimed as a dependent on someone else's tax return
- Do not have a Healthcare FSA or HRA

HSA Funding Limits

Coverage Level	2027 IRS Limits	Yearly Contribution	Your Total Possible Contribution
Individual Coverage	$4,500	$600	$3,900
Family Coverage	$9,000	$1,200	$7,800
Age 55+ Catch-Up Contribution	$1,000	$0	$1,000

Flexible Spending Accounts (FSAs)

Flexible Spending Accounts (FSAs) allow you to set aside pre-tax dollars from your paycheck to cover qualified expenses. We offer four types of FSAs through Surency.

Healthcare FSA

The Healthcare FSA helps you pay IRS-approved medical expenses. Funds you contribute to the Healthcare FSA are available in full on the first day of the plan year.

Limited Purpose FSA

The Limited Purpose FSA is similar to the Healthcare FSA, but it only covers dental and vision expenses. You can choose this FSA if you are enrolled in an HDHP and open an HSA. Healthcare FSA can be elected with PPO.

Dependent Care FSA

The Dependent Care FSA helps you pay for dependent care. This account works like a debit card; you need to accumulate the funds before you can use them.

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.

Use It or Lose It

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!

FSA Funding Limits

FSA Type	2027 IRS Limits
Healthcare FSA	$3,500
Limited Purpose FSA	$3,500
Dependent Care FSA	$7,500*

* Combined household limit. If married, filing separately, the IRS limit is $3,750.

ELIGIBLE EXPENSES

The funds in each FSA must be used for qualified expenses such as the examples listed below. For a more comprehensive list of eligible expenses, see **IRS Publication 502**.

HEALTHCARE FSA

- Doctor's visits
- Prescription drugs
- Medical and dental deductibles
- Over-the-counter items
- Hearing aids
- Eyeglasses

LIMITED PURPOSE FSA

- Braces
- Dental services
- Eyeglasses
- Eye exams

DEPENDENT CARE FSA

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

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

Life and AD&D Coverage

Protect yourself and your loved ones when the unexpected occurs. Life and accidental death and dismemberment (AD&D) insurance is provided in partnership with Prudential.

Don't forget! It's important to designate a beneficiary or ensure your current beneficiary information is up to date by logging in to ADP.

Centric Provided Basic Life and AD&D

Centric provides company paid Basic Term Life insurance and Accidental Death and 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. It is important to verify your beneficiaries' names and SSNs are up to date in ADP.

Employee Optional Life and AD&D

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.

WHAT IS EOI?

Evidence of Insurability (EOI), sometimes known as proof of good health, is health information the insurance company requires to approve you for coverage. You may be required to submit EOI if you elect coverage outside new hire enrollment or if you elect above the guaranteed issue amount.

WHAT IS GUARANTEED ISSUE?

This is the amount of coverage available without having to provide information about your health.

Disability Coverage

Disability insurance protects your income by financially supporting you and your family when you are unable to work. We partner with Prudential to provide this coverage.

If you participate in a voluntary disability plan, monthly costs are taken as a post-tax deduction, so any benefits you receive can be paid to you tax-free.

Voluntary Short Term Disability

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

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.



Voluntary Benefits

When life throws you a curveball, our voluntary benefits administered by Prudential create an added layer of financial protection for you and your family. These plans make cash payments directly to you, and you can use the benefit however you wish.

Accident Insurance

Accidents can happen when you least expect them. This plan is designed to pay a tax-free cash benefit directly to you when an injury occurs off the job.

Examples of Covered Accidents and Payments

Hospital Admission Benefit (once per year)
Daily Hospital Confinement (up to 30 days per confinement)
Daily ICU Confinement (up to 15 days per confinement)
Burns
Ambulance (ground/air)
Torn Knee Cartilage

Monthly Cost of Coverage

Employee	$9.26
Employee + Spouse	$18.54
Employee + Children	$22.00
Family	$26.60

HEALTH SCREENING BENEFIT

Each person covered under the plan is eligible to receive a $50 benefit per calendar year for taking an eligible health screening.

FILING A CLAIM

To file a claim under one of the voluntary benefits plans:

- Call **800.524.0542**
- Visit **mybenefits.prudential.com**

Critical Illness Insurance

There can be a lot of expenses associated with a critical illness, and a major medical plan may not cover them all. Critical Illness insurance provides you a lump-sum payment so you can focus on what matters most—getting better. You can purchase coverage of $10,000-$30,000. Spouse coverage is available at 50% of your elected amount and children are automatically included at 50% for no additional cost.

Covered critical illnesses include:

- Cancer
- Heart attack
- Stroke
- Alzheimer's disease
- Major organ transplant

How the Plan Works

A Centric employee's life is turned upside down after suffering a heart attack followed by a stroke a week later. This employee and their spouse missed work to help in recovery. Not only was their income affected, but medical bills started piling up while the need for childcare increased.

Amount Paid to Employee	
Heart Attack	$15,000
Stroke	$15,000
Total Direct Benefit Payment	$30,000

Hospital Indemnity Insurance

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

Monthly Cost of Coverage

	Low Plan Monthly Costs	High Plan Monthly Costs
Employee	$7.43	$15.72
Employee + Spouse	$19.40	$31.98
Employee + Children	$15.14	$26.50
Family	$23.99	$44.40

IMPORTANT: This is a fixed indemnity policy, NOT health insurance. This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

LOOKING FOR COMPREHENSIVE HEALTH INSURANCE?

- Visit **HealthCare.gov** or call **800.318.2596** (TTY: **855.889.4325**) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

QUESTIONS ABOUT THIS POLICY?

- For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.



401(k) Plan

Centric wants you to feel secure and prepared for life after your career. In partnership with Fidelity, our 401(k) savings plan is designed to help you plan ahead and feel prepared for retirement.

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 to your 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.

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** 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).

Centric Company Match

Full-time and part-time regular employees are eligible for the company match. W2 Temporary employees do not receive the company match.

Example of annual match:

- Base salary = $100,000
- 6% of $100,000 = $6,000
- 25% of $6,000 = $1,500 match

Account Ownership

In a retirement plan, the term "vesting" refers to who owns the funds. You are always vested in your own 401(k) contributions, which means you always own the funds you contribute. You are 100% vested in company contributions after 3 years of service.

Employee Contributions

All full-time regular, part-time, and W2 temporary employees participate through convenient payroll deductions, you may contribute traditional pre-tax, Roth after-tax, or a combination of these. The projected 2027 401(k) employee deferral limit is $25,500, with a $8,500 catch-up limit for those 50+ and a $11,750 super catch-up for ages 60-63.

Vesting Schedule

Years of Service	Vesting Percent
Less Than 1 Year of Service	0%
1 Year	0%
2 Years	0%
3 Years	100%

Employee Assistance Program (EAP)

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 and 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

HOW TO GET STARTED



Learn More About the Resources Available 24/7

- Visit **https://www.carelonwellbeing.com/centric**



Get Connected with the Right Resource or Professional

- Call **800.435.1986**

Employee Discount Programs

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/month.

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/month (substantial discounts on most memberships).

To Start Saving

- Go to: **https://centric.benefithub.com/**
- Enter Referral Code: P7T5JM
- 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, and classes
- Connect with 250+ trackers and apps

Discounts and Special Program

To start saving, visit the link on the left to access 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.

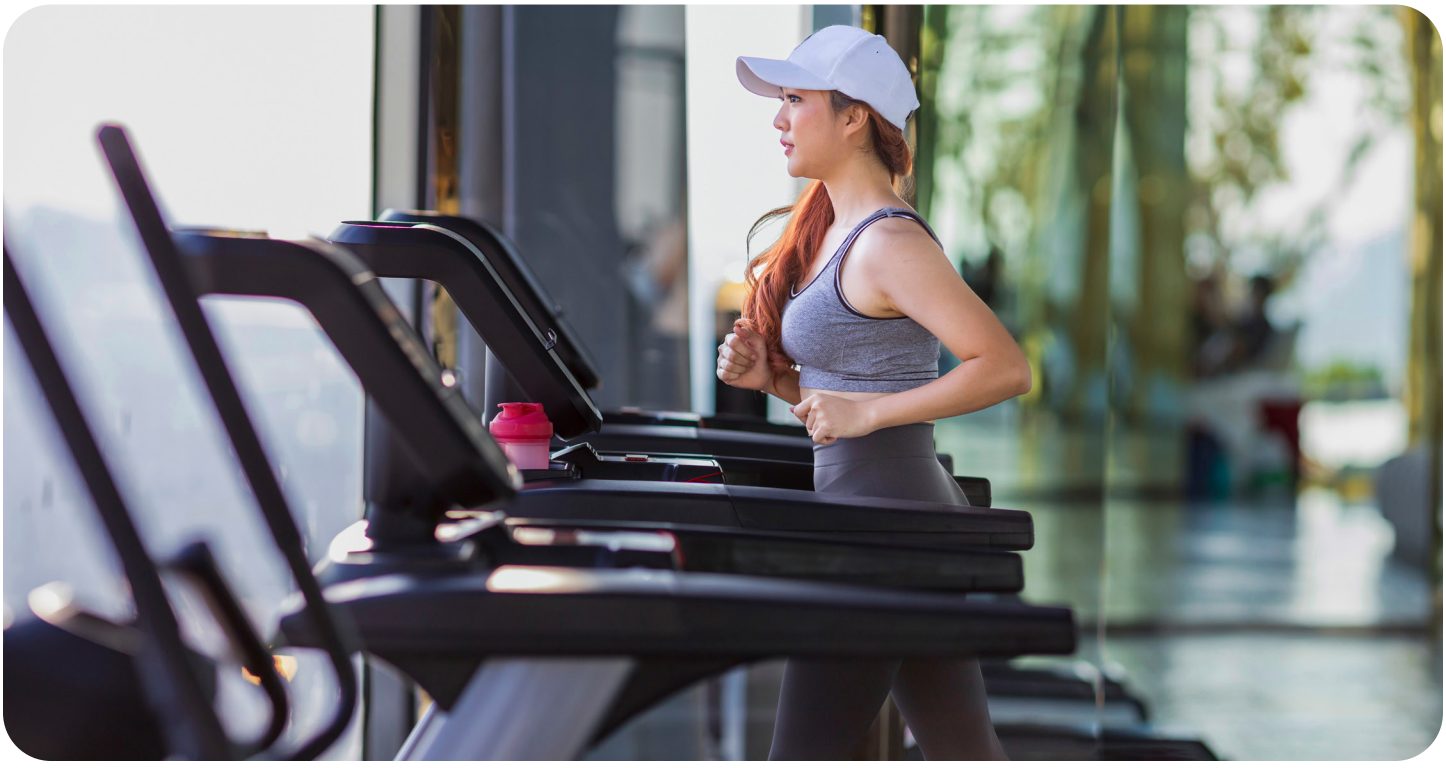
Consumer Discount Program

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

Visit the Centric website for the most recent discount code.



Important Policies

Paid Time Off for Full-Time Regular Employees

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
- Healthcare 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.

Part-time regular and W2 temporary employees may be eligible for state paid leave depending on your state of residence. If eligible, this information will be provided during company onboarding.

Observed Holidays

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

- New Year's Day
- Memorial Day
- Fourth of July
- Labor Day
- Thanksgiving
- 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.

Time off must be requested in advance and is subject to manager approval and scheduling needs.

Paid Parental Leave

Centric Consulting will provide up to 4 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 Business Partner (HRBP). 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.



Benefits Extras

The Centric benefits program provides you with a variety of additional services to support you no matter what age or stage you find yourself in.

Legal Insurance

Legal expenses can add up quickly. With legal insurance through MetLife, you can talk to an attorney without worrying about the high hourly cost. This plan offers access to a network of attorneys for support on services including, but not limited to, minor traffic tickets, divorces, adoption, trusts, tax services, and real estate. Visit **https://www.metlife.com/insurance/legal-plans/** or call **800.438.6388** to enroll and get started.

Auto and Home

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

Phone number: **800.438.6381**

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.

Website: **www.metlife.com/getpetquote** or call **800.GET.MET8**.



Insurance Terms You Should Know

Insurance can be confusing. Understanding these common insurance terms will help you make the most of your benefits.



BALANCE BILLING

This is a bill out-of-network providers can send you for a portion of the bill insurance does not cover.



COINSURANCE

This is a percentage of what you will pay for covered services after you reach any applicable deductible or copays. Typically, your percentage is lower than the plan's.



COPAY

This is a set fee you pay for certain services and expenses, such as doctor visits and prescriptions.



DEDUCTIBLE

This is the amount you pay out of your pocket before the plan begins to help pay for covered expenses.



EXPLANATION OF BENEFITS (EOB)

This is not a bill; it is a document sent by the insurance company to list the services you receive and what the insurance plan will cover.



FORMULARY

This is the list of medications covered under your health plan; they typically have different tiers, such as generic and brand name.



NETWORK

A group of doctors and facilities contracted with the plan at negotiated rates.



OUT-OF-POCKET MAXIMUM

This is the most you'll pay for eligible healthcare services during the plan year.



PREAUTHORIZATION

This is a process giving the insurance company a chance to review needed services and/or medication and determine if they will be covered.



PREMIUM

This is the cost you must pay to be covered by the plan.

Important Contacts

HEALTH

Medical	Anthem Group #L14593 **833.639.1634** **https://www.anthem.com/oh/contact-us**
Prescription	Anthem **833.639.1634** Group #L14593 **https://www.anthem.com/oh/contact-us**
Dental	Delta Dental **800.524.0149** Group #11443 **www.deltadentaloh.com**
Vision	EyeMed **866.939.3633** Group #1061403 **https://www.eyemed.com/en-us/contactus**
Life and AD&D Coverage	Prudential **800.524.0542** Group #72667 **mybenefits.prudential.com**
Disability Coverage	Prudential **800.524.0542** **mybenefits.prudential.com**
Voluntary Benefits	Prudential **800.524.0542** **mybenefits.prudential.com**

MONEY

Health Savings Account (HSA)	Fidelity **800.544.3716** **www.NetBenefits.com**
Flexible Spending Accounts (FSAs)	Surency **866.818.8805** **www.surency.com**
401(k) Plan	Fidelity Investments **866.811.6041** **Fidelity.com**

SUPPORT

Employee Assistance Program (EAP)	Carelon **800.435.1986** **https://www.carelonwellbeing.com/centric**
Auto and Home	Farmers Insurance/MetLife **800.438.6381** **https://www.metlife.com/farmers-redirect/?url=https%3A%2F%2Fwww.farmers.com%2Finsurance%2F**
Pet Insurance	MetLife To Enroll: **855.412.2562** **https://www.metlifepetinsurance.com/unpredictable/**
Legal Insurance	MetLife **800.438.6388** **https://www.metlife.com/insurance/legal-plans/**

FOR ALL YOUR BENEFITS QUESTIONS

We're here to help answer your benefits questions and support you throughout enrollment. For assistance, email **benefits@centricconsulting.com**.



Centric Consulting, LLC

HEALTH PLAN NOTICES

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2. HIPAA Comprehensive Notice of Privacy Policy and Procedures
3. Notice of Special Enrollment Rights
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6. Michelle's Law Notice
    - This notice is still required when a health plan permits dependent eligibility beyond age 26, but conditions such eligibility on student status. Further, the notice is still necessary if the plan permits coverage for non-child dependents (e.g., grandchildren) that is contingent on student status. The notice must go out whenever certification of student status is requested.
7. ADA Wellness Program Notice
8. Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

IMPORTANT NOTICE

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

MEDICARE PART D CREDITABLE COVERAGE NOTICE

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.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. 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 (740) 602-3300. **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, 2027
Name of Entity/Sender:	Centric Benefits Team
Contact—Position/Office:	Human Resources
Address:	10564 Success Lane Dayton, Ohio 45458
Email Address:	benefits@centricconsulting.com

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

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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 choose to 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 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 plan to make decisions about individuals.

The requested information will be provided within 30 days. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline, provided that you are given a written statement of the reasons for the delay and the date by which the group health plan will complete its action on the request. 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 23). 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.

24. **Substance Use Disorder Treatment:** The group health plan may receive certain substance use disorder (SUD) treatment records that are protected by Federal law under 42 C.F.R. Part 2 ("Part 2"). These records are subject to privacy protections that are more stringent than the HIPAA privacy rules. The group health plan will follow all applicable Part 2 requirements for safeguarding, maintaining, using, and disclosing any SUD treatment information it receives.

If the group health plan receives or maintains SUD information protected by Part 2, the group health plan may not use or disclose Part 2 records unless: (i) the plan has your written consent that meets the requirements of Part 2; (ii) the disclosure is expressly permitted by Part 2 regulations; or (iii) a court issues an order that complies with Part 2. Examples of permitted disclosures include medical emergencies, certain audit or evaluation activities by authorized agencies, or other limited circumstances allowed under Part 2.

Part 2 records generally may not be used or disclosed in any civil, criminal, administrative, or legislative proceeding to which you are a party unless you provide written consent in accordance with requirements of Part 2; or a court orders the disclosure after following the procedures required under Part 2.

The group health plan will not disclose any Part 2 records for fundraising purposes unless you are first provided with a clear and conspicuous opportunity to opt out of receiving fundraising communications. If Part 2 records are disclosed to another party, federal law may prohibit the recipient from redisclosing that information unless further disclosure is expressly permitted by Part 2.

As applicable, you have the right to: (i) request access to your Part 2 records maintained by the plan; (ii) request restrictions on disclosures, including those permitted under Part 2; and (iii) revoke your consent to disclosures permitted under Part 2, except to the extent we have already relied on it.

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

Human Resources
Centric Benefits Team
benefits@centricconsulting.com

Effective Date
The effective date of this notice is: January 1, 2027.

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:

Human Resources
Centric Benefits Team
benefits@centricconsulting.com

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

GENERAL COBRA NOTICE

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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

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

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

- 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:

Human Resources
Centric Benefits Team
benefits@centricconsulting.com

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

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:

PPO Medical Plan (P1)	In-Network	Out-of-Network
Individual Deductible	$1,000	$2,000
Family Deductible	$2,000	$4,000
Coinsurance	20%	40%
HSA Medical Plan (H1)	In-Network	Out-of-Network
Individual Deductible	$3,500	$6,300
Family Deductible	$7,000	$12,600
Coinsurance	10%	30%

HSA Medical Plan (H2)	In-Network	Out-of-Network
Individual Deductible	$4,500	$4,500
Family Deductible	$9,000	$9,000
Coinsurance	20%	40%

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

Human Resources
Centric Benefits Team
benefits@centricconsulting.com

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 Human Resources- Centric Benefits Team at benefits@centricconsulting.com.

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

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

Details about the wellness program, including criteria and incentives, can be found in the .

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 Human Resources- Centric Benefits Team at benefits@centricconsulting.com.

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 Human Resources- Centric Benefits Team at benefits@centricconsulting.com.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: hfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584	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 – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid	MAINE – Medicaid
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/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	Medicaid Website: https://www.nj.gov/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)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2026, 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.

OMB Control Number 1210-0137 (expires 5/31/2029)

Employer Name:	Centric Consulting, LLC
Employer State of Situs:	Ohio
Name of Issuer:	Anthem
Plan Marketing Name:	Medical pLans H1, H2, P1
Plan Year:	2027

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)

2020-2026 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.

Notes

Notes

((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.

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