REDHORSE

Redhorse Corporation

2025 Employee Benefits Guide

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A Message from the CEO

We recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments, so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of all our employees and their dependents by providing a benefit package that is easy to understand, easy to access, and affordable. This brochure will help you choose the type of plan and level of coverage that is right for you.

Sincerely,

John Zangardi
Redhorse CEO

Eligibility

Eligible Employees:
Employees are eligible for Redhorse benefits if they are classified as regular, full-time/reduced working an average of 30+ hours per week.

Eligible Dependents:
In general, eligible dependents include your spouse/ registered domestic partner and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. “Children” may include natural, adopted, step, and children obtained through court- appointed legal guardianship, as well as children of same sex state-registered domestic partners.

When Coverage Begins:
The plan year for benefits is January 1st – December 31st. Current employees will have an opportunity to enroll in the various options during Open Enrollment with an effective date of January 1.

Newly hired employees and covered dependents will have 30 days from date of hire to complete the enrollment process with elections being effective the first of the month following date of hire (unless the start date is the 1st of the month, where benefits are effective that day).

Changes in Benefit Elections

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefits plan. All elections and changes take effect on the first day of the plan year (Redhorse's Plan Year: January 1st – December 31st).

During Open Enrollment, you can:

- Add, change, or delete coverage
- Add, or drop dependents from coverage
- Enroll, or re-enroll in dependent or health care flexible spending accounts (FSAs). **To continue your FSA benefits, you must re-enroll each plan year.**

Note: Some states (currently, California, Massachusetts, New Jersey, Rhode Island, Washington D.C., and Vermont) may impose a tax on residents who do not have health insurance coverage, subject to limited exceptions.

Redhorse holds open enrollment sessions, provides materials, and summary plan descriptions/summaries for all applicable benefit plans so employees can make the best choices for them and their families.

Benefit elections can only be changed during Open Enrollment, unless you experience a qualifying life event or family status change. Exceptions are retirement, HSA contributions, and commuter elections which can be updated at any time during the year.

Qualifying Life Event:

A qualifying life event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some qualifying life events:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. You can submit a qualifying life event in the Benefits Portal. Please contact HR if you have questions or issues with these changes.

Medical Options

We are proud to offer a choice of three medical plans provided through Cigna. Coverage under all plans includes comprehensive medical care and prescription drug coverage. The following chart provides a brief outline of the available plan options. Please refer to the Summary Plan Description for complete plan details.

	Cigna HSA High	Cigna HSA Low	Cigna PPO
Annual Deductible (Ind / Fam)	$3,300 / $6,400	$1,650 / $3,300	$250 / $500
Annual Out-of-Pocket Maximum (Ind / Fam)	$5,000 / $10,000	$4,000 / $8,000	$4,000 / $8,000
Plan Coinsurance	90%	90%	90%
Preventive Care	100%	100%	100%
Office Visit	90% after deductible	Deductible, then $30 copay	$15 copay
Specialist Visit	90% after deductible	Deductible, then $50 copay	$30 copay
Lab & X-ray	90% after deductible	90% after deductible	90%
Complex Radiology	90% after deductible	90% after deductible	90%
Inpatient Hospital	90% after deductible	90% after deductible	90% after deductible
Emergency Room	90% after deductible	Deductible, then $200 copay	$150 copay
Out-of-Network Benefits			
Annual Deductible (Ind / Fam)	$6,400 / $12,800	$3,000 / $6,000	$500 / $1,000
Annual Out-of-Pocket Maximum (Ind / Fam)	$10,000 / $20,000	$9,000 / $18,000	$5,000 / $10,000
Plan Coinsurance	70%	70%	70%
Prescription Drugs			
Prescription Deductible	Included with Medical	Included with Medical	$0
Retail Prescription Drugs			
Generic	Ded., then $10 copay	Ded., then $20 copay	$10 copay
Preferred Brand Name	Ded., then $30 copay	Ded., then $60 copay	$30 copay
Non-Preferred Brand Name	Ded., then $50 copay	Ded., then $100 copay	$50 copay
Mail Order Prescriptions			
Generic	Ded., then $25 copay	Ded., then $50 copay	$25 copay
Preferred Brand Name	Ded., then $75 copay	Ded., then $150 copay	$75 copay
Non-Preferred Brand Name	Ded., then $125 copay	Ded., then $250 copay	$125 copay

Health Savings Account (HSA)

What is a Health Savings Account?

A Health Savings Account or HSA is an account that you set aside, let grow through investments, and use to pay qualified medical expenses. This account helps offset your medical costs by giving you tax advantages, allowing your income to stretch farther by using the dollars that would have otherwise been paid in taxes. An HSA is a savings account that belongs to you even if you leave your job.

Qualified Expenses

In general, a qualifying expense is any medical, dental, or vision expense, for treating or alleviating a medical condition. Distributions can be made for any incurred expense since the HSA was opened. Examples include:

- Doctor's office visits.
- Eyeglasses and contacts.
- Chiropractic services
- Prescriptions
- Dental care and braces

Examples of non-qualified expenses:

- ✗ Cosmetic surgery
- ✗ Electrolysis or hair removal
- ✗ Teeth whitening

HSA Considerations

- ✓ Deposits are exempt from income tax.
- ✓ Savings grow income tax-free.
- ✓ Money spent on qualified medical expenses comes out of your HSA income tax-free.
- ✓ If you are covered on COBRA or collecting unemployment, your HSA can be used to reimburse premiums income tax-free.
- ✓ You can use your HSA dollars to pay for over-the-counter medication, even if you do not have a prescription.
- ✓ You must be enrolled in a qualifying high-deductible health plan (HDHP)

- ✖ You cannot be covered by any other health coverage.
- ✖ You cannot be enrolled in Medicare, TRICARE, or TRICARE for Life.
- ✖ You cannot be claimed as a dependent on someone else's tax return.

Other restrictions apply. Please consult a tax, benefits, or financial advisor.

Annual Contribution Maximums

New Hires: Remember to consider any HSA contributions made before joining Redhorse's plan.

	IRS Calendar Year Contribution Maximums 2025
Employee Only	$4,300
Employee + Dependent(s)	$8,550
55 and Older	$1,000 – additional contribution annually

Redhorse Annual HSA Contributions*		
	Cigna HSA Low	Cigna HSA High
Employee Only	$750	$1,000
Employee + Dependents	$1,200	$2,800

**Redhorse will contribute to an Employee's HSA account per pay period, to these annual maximums depending on the level of coverage; if newly hired mid-year, HSA contributions will be prorated accordingly.*

Triple Tax

Cigna Resources & Tools

Find a Provider

To find a provider in your network, visit www.cigna.com and follow the instructions below:

1. Click on "Find a Doctor" > "Employer or School."
2. Enter in your preferred location.
3. Select one of the three categories and begin your search!

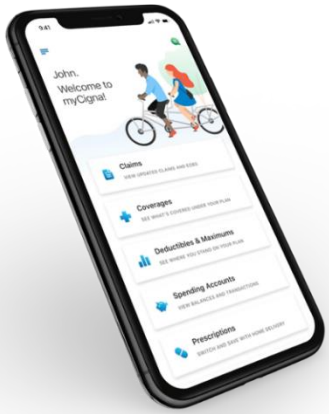
To confirm if your current provider(s) is in Cigna's OAP network, ask your provider directly.

myCigna App

With the myCigna App you are able to access your health plan anytime and anywhere! Life can be busy and complicated, and the myCigna App is there to make life a little easier and accessible to you. The myCigna App allows you to personalize, organize, and access important plan information on your phone or tablet.

Some of the things you can do with the myCigna App are:

- **Manage** and track claims.
- **View**, fax, or email ID card information
- **Find** in-network doctors and compare cost and quality information.
- **Review** your coverage
- **Track** your account balances and deductibles
- **Order** your Cigna Home Delivery Pharmacy℠ prescriptions online and view order history
- **View** medication costs based on your plan and look for lower-cost alternatives



Download the myCigna app on the Apple App Store, Google Play, and Kindle Fire for easy access!

Cigna Virtual Care

Get care whenever and wherever with virtual medical and behavioral care. With Cigna Virtual Care you can:

- Access care from anywhere via video or phone
- Get minor medical virtual care 24/7/365 – even on weekends and holidays.
- Schedule a behavioral/mental health virtual care appointment online in minutes.
- Connect with quality board-certified doctors and pediatricians as well as licensed counselors and psychiatrists.
- Have a prescription sent directly to your local pharmacy, if appropriate.

Convenient? Yes. Costly? No.

Medical virtual care for minor conditions costs less than ER or urgent care center visits, and maybe even less than an in-office primary care provider visit.

Below are some of the many conditions that be diagnosed and treated with virtual care:

Virtual medical care

Board-certified doctors and pediatricians can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and flu
- Constipation
- Diarrhea
- Earaches
- Fever
- Headaches
- Infections
- Insect bites
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections

Virtual behavioral care

Licensed counselors and psychiatrists can diagnose, treat and prescribe most medications for nonemergency behavioral health conditions, such as:

- Addictions
- Bipolar disorders
- Child/Adolescent issues
- Depression
- Eating disorders
- Grief/Loss
- Life changes
- Men's issues
- Panic disorders
- Parenting issues
- Postpartum depression
- Relationship and marriage issues
- Stress
- Trauma/PTSD
- Women's issues

To connect with an MDLIVE virtual provider, visit myCigna.com and click on the "Talk to a doctor" callout.

To locate an Evernorth Behavioral Health provider, visit myCigna.com, go to "Find Care & Costs" and enter "Virtual counselor" under "Doctor by Type," or call the number on the back of your Cigna ID card 24/7.

To get connected with virtual care:

- Contact your in-network provider or counselor.
- Talk to an MDLIVE medical provider on demand on myCigna.com.
- Schedule an appointment with an MDLIVE provider or licensed therapist on myCigna
- Call MDLIVE 24/7 at 888.726.3171

Cigna Health Coaching

My Health Assistant on myCigna includes a variety of online health management programs that can help you turn unhealthy behaviors into healthier achievements. Each program helps you establish personal goals and track your progress. Why so many programs? We want to make sure there is a program to meet your personal needs, as well as your personal health improvement style. There are programs for stress, weight loss, heart health, and so much more!

Cigna Health and Wellness Solutions

Ginger is an integrated mental healthcare system where coaches, therapists, and psychiatrists work as a team to coordinate the best, personalized care right from your smartphone, whenever you need it. It is like a virtual clinic without the waiting room.

Talkspace is a digital space for private and convenient mental health support. With Talkspace, you can choose your therapist from a list of recommended, licensed providers and receive support day and night from the convenience of your device (iOS, Android, and Web).

Happify is a free app with science-based games and activities that are designed to help you defeat negative thoughts, gain confidence, boost health and performance, and more!

iPrevail is a digital therapeutics platform, designed by experienced clinicians to help you take control of the stresses of everyday life and challenges associated with life's difficult transitions.

Dental Insurance

We are proud to offer a choice between two different dental plans offered through Cigna. The chart below provides a brief outline of each plan. Please refer to the summary plan description for complete plan details.

	Cigna Dental	
	Low Plan	High Plan
Annual Deductible		
Individual	$50	$50
Family	$150	$150
Waived for Preventive Care?	Yes	Yes
Annual Maximum*		
Per Person / Family	$1,000	$2,000
Preventive	100%	100%
Basic	80%	90%
Major	50%	60%
Orthodontia		
Benefit Percentage	Not Covered	50%
Adults (and Covered Full-Time Students, if Eligible)	N/A	Yes
Dependent Child(ren)	N/A	Yes
Lifetime Maximum	N/A	$1,500

**Annual Maximums in dental coverage indicates the maximum amount Cigna will pay after the deductible is met. This is different from medical maximums.*

Vision Insurance

You can enroll in the Cigna Vision Plan at an affordable group rate. The table below provides a high-level overview of the vision plan.

	Cigna Healthcare All Employees Vision Plan
Copay	
Routine Exams (Annual)	$10
Vision Materials	
Materials Copay	$10
Lenses	100% every 12 months
Contacts (covered in lieu of frames) Medically necessary contacts may be covered at a higher benefit level	100% up to $180 Every 12 months
Frames	100% up to $180 Every 12 months

Flexible Spending Accounts (FSA)

You can set aside tax-free dollars each year to cover eligible out-of-pocket healthcare and child daycare expenses. The plan is comprised of a health care spending account and a dependent care account. Each account is separate; you cannot use health care funds to pay for dependent care expenses or vice versa. You can elect to participate in one or more accounts, or you can waive coverage.

How the Plans Work

- You elect a contribution amount to be deducted from your pay on a before-tax basis and put into the flexible spending account.
- You may not change your contribution amount during the plan year unless it is consistent with a change in family status.
- Expenses must be incurred within the plan year.
- You may submit claims for expenses incurred within the plan year.

FSA 2025 Plan Year is 1/1/2025 to 12/31/2025.
The 2025 IRS Contribution Maximums*

- $3,300 – Healthcare FSA
- $5,000 – Dependent Care FSA

**Please note that the IRS maximums are on a calendar year basis*

It is important to plan your contribution amounts carefully. **NEW** In a change from last year, the FSA plan will operate with a rollover from 2025 to 2026, instead of a grace period. This means that if you have any funds left in your account at the end of 2025, you will be able to rollover those funds into the 2026 plan year, up to the IRS maximum allowed of $660. This allows you extra flexibility in case you do not use as much of your funds throughout the year as you expected.

Healthcare FSA

Funds that you set aside in a Healthcare FSA can be used to reimburse yourself for eligible healthcare expenses not covered under the medical, prescription drug, dental, or vision plans. Reimbursements can be made for most expenses that would qualify for a healthcare deduction on your income tax return.

Eligible Healthcare Expenses

- Deductibles, copayments, coinsurance
- Prescription drugs and medicines
- Over-the-counter medications that are medically necessary (Dr. Rx required)
- Hearing aids, batteries, and exams
- Vision care
- Dental care (including orthodontia)

Ineligible Healthcare Expenses

- Over-the-counter medications not medically necessary
- Cosmetic expenses
- Massage therapy
- Health club dues
- Weight loss programs
- Insurance premiums

FSA Debit Card Process

If you enroll in the Healthcare FSA, WEX will automatically send you a debit card to your home. Many eligible transactions can be auto substantiated at the point of service. However, there are certain purchases that may be declined and require you to submit receipts to validate the expense. You will be reimbursed by WEX for items purchased once the expenses have been approved.

Healthcare Limited Purpose FSA

The Healthcare Limited Purpose Flexible Spending Account (LFSA) may be used with an HSA medical plan only for any eligible dental and vision expenses for participants enrolled in a High Deduction Health Plan (HDHP).

Dependent Care Spending Account

A Dependent Care Account can be used to pay for certain child/day care, or elder care expenses incurred during the plan year. Your dependent care expenses must be necessary for you (and your spouse) to work or actively look for work or attend school as a full-time student.

Eligible Dependent Care Expenses

- Childcare for a dependent age 13 or younger, provided at a day care center or through a private provider
- Childcare for a dependent over age 13 if he/she is physically or mentally incapable of caring for him or herself
- Nanny services in the home associated with the care of a dependent
- Day camps associated with the care of a dependent
- Pre-school tuition that is day care related (price of tuition alone is not eligible)
- After-hours care that results from working odd hours or overtime

Ineligible Dependent Care Expenses

- Tuition cost for pre-school that is not associated with day care services, or for first grade and above
- Housekeeper/nanny services in the home that is not associated with care of a dependent
- Education related fees for classes or camps not associated with care of a dependent
- Entertainment related expenses
- Materials fee (i.e., books, clothing, food, etc.)
- After-hours care not associated with work

Dependent Care claims will be reimbursed only up to your account's current balance. If a dependent care expense exceeds the dependent care balance, you'll be reimbursed the additional amount as contributions are made to your account through your payroll deductions.

Use-it or lose-it Rule: With the use-it or lose-it rule, any unused funds leftover in your account at the end of the plan year will be forfeited to the plan. This means it is important to take the necessary time to determine your contribution amount, so you don't lose any unused funds at the end of the year.

To learn more, visit: https://www.wexinc.com/products/employee-benefits/

Commuter Benefits

This allows participating employees to pay for qualified work-related commuting and parking expenses on a pre-tax basis. You will receive a WEX commuter debit card for your convenience, at no cost to you. You can also submit for reimbursement (for eligible expenses), view balances, view transitions, and more on their website.

Eligible expenses include:

- Public Transportation (bus, train, ferry, subway/metro, UberPool, Lyft-Line)
- Commuter Highway Vehicles (vanpools)
- Parking (ramp/garage, park-n-ride)

Program Requirements

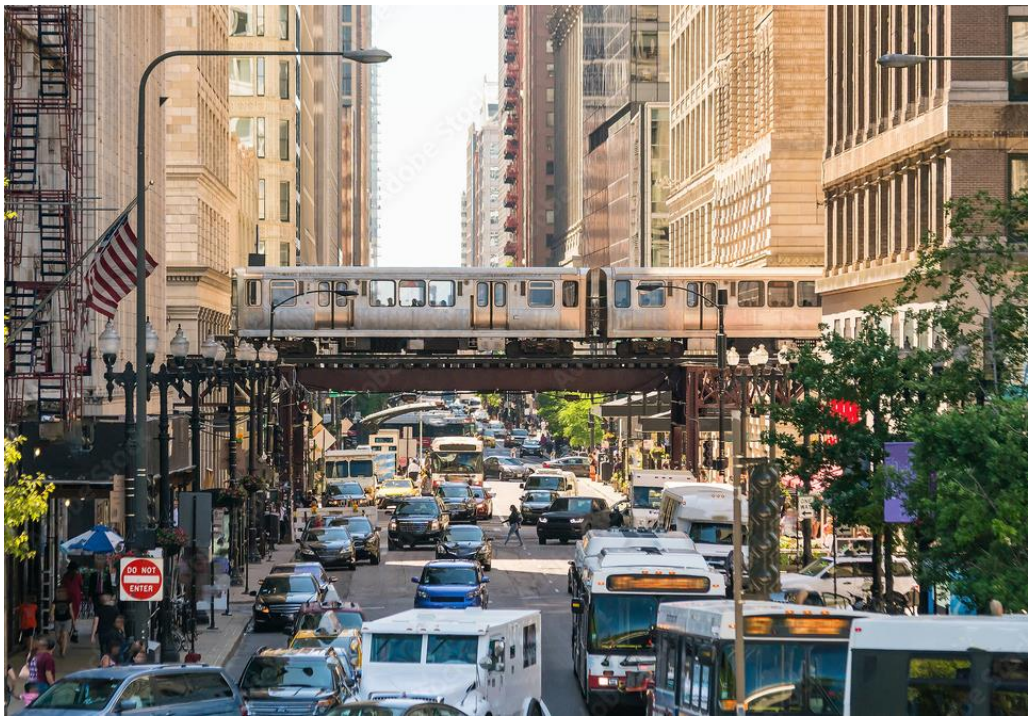
- Eligible commuter expenses must be work-related
- Eligible parking expenses must include parking at or near your place of employment, or at a location from which you commute to work

How much can you contribute monthly?

- Parking limit: $325 per month
- Commuter/Transit limit: $325 per month

Additional Details

- If you are currently enrolled and you elect commuter benefits in the next plan year, your current balance of funds will rollover
- You cannot use commuter benefits for fast tolls
- If you separate from Redhorse, your WEX card will be deactivated; any expenses incurred prior to separation can be submitted for reimbursement. However, the card or funds will not be available for expenses incurred post separation



Basic Life and Accidental Death & Dismemberment

The company provides Basic Life and AD&D benefits to eligible employees. The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident

Important Reminder! Be sure to assign a beneficiary or living trust to ensure your assets are distributed according to your wishes.

Lincoln Financial All Employees	
Benefit Maximum	2x Annual salary up to $500,000
*Guaranteed Issue	$500,000

Note: The above benefits will begin to decrease at age 70.

*Guaranteed Issue is only guaranteed as a new enrollee.

Voluntary Life and AD&D

In addition to the employer paid Basic Life and AD&D coverage, you have the option to purchase additional voluntary life insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc. Your election, however, could be subject to medical questions and an evidence of insurability (EOI) questionnaire.

Your contributions will depend on your age and the amount of coverage you elect. You must elect for yourself to be able to elect for others. Note that that your spouse life coverage cannot exceed your self-elected coverage. Additionally, the maximum coverage you can elect is $500,000 for yourself, $100,000 for your spouse and $10,000 for your child(ren).

Lincoln Financial Voluntary Life and AD&D	
You	
Benefit Maximum	5x annual salary up to $500,000 in increments of $10,000
*Guaranteed Issue	$150,000
Your Spouse	
Benefit Maximum	100% of employee amount in increments of $5,000
*Guaranteed Issue	$50,000
Your Child	
Benefit Maximum	100% of employee amount in increments of $2,000
*Guaranteed Issue	$10,000

**Guaranteed Issue* is only guaranteed as a new enrollee. At open enrollment, you can increase by two increment levels ($10,000 increments for Employee and $5,000 for Spouse) without needing an EOI (as long as you have not been previously denied).

Disability Insurance

Redhorse Corporation offers short-term disability and long-term disability through Lincoln Financial at no additional cost to you. Disability insurance provides financial benefits that replace part of your lost income when you become unable to work due to a covered injury or illness.

Short-Term Disability (STD) Insurance

This benefit covers 60% of your weekly base salary up to $2,500/week. The benefit begins after a 7-calendar day waiting period for an illness and immediately for an accident and can last up to 26 weeks pending approval. Please see the Summary Plan Description for complete plan details.

Lincoln Financial Short-Term Disability (STD)	
Elimination Period / Waiting Period • **Due to an accident** • **Due to an illness/medical event**	 0 days 7 days
Benefit Percentage	60% of weekly base pay
Weekly Benefit Maximum	$2,500
Maximum Benefit Period	26 weeks
Pre-Existing Condition Limitations	Any condition occurring 3 months prior to effective date / Any disability resulting from a pre-existing condition in the 12 months following effective date.

Long-Term Disability (LTD) Insurance

This benefit covers 60% of your monthly base salary up to $10,000 per month. Benefit payments begin after 180 days of disability. See your Certificate of Coverage for benefit duration. Please see the Summary Plan Description for complete plan details.

Lincoln Financial Long-Term Disability (LTD)	
Elimination Period / Waiting Period	180 days
Benefit Percentage	60%
Monthly Benefit Maximum	$10,000
Maximum Disability Period	Social Security Normal Retirement Age (SSNRA)
Pre-Existing Condition Exclusions	Any condition occurring 3 months prior to effective date / Any disability resulting from a pre-existing condition in the 12 months following effective date.

Voluntary Supplemental Insurance

You can further protect the health of yourself and your dependents by participating in one or all of the supplemental worksite benefits provided through Cigna. These plans are designed to replace some of the wages lost due to accidents, hospital stays, or critical illnesses by paying cash directly to you - not the doctors and hospitals - regardless of other insurance. The supplemental policies provided include Accident, Critical Illness, and Hospital Indemnity. Please note, the premiums for these plans are on a post-tax basis.

Accident Insurance

We do not expect accidents, and most of us do not plan or budget for them. But when they happen, the costs can be overwhelming, even with medical coverage. That is where Accident Insurance can help. These special plans pay out a cash benefit in one lump sum if you, or a covered family member, is injured because of an accident. You decide how to use the benefits to best support your recovery. We offer two options for Accident coverage. See below for a glance at some of the benefits the Accident plan covers. Please see your Plan Summary for more details.

Benefit Type	Benefit Amounts	
	Low Plan	High Plan
Emergency Care Treatment Limited to 1 per accident.	$100	$200
Physician Office Visit – *Includes urgent care, Virtual Care accepted* Limited to 1 per accident.	$50	$100
Diagnostic Exam (x-ray or lab) Limited 1 per accident.	$50	$75
Ground / Water Ambulance (to nearest hospital)	$300	$400
Air Ambulance Limited 1 per accident.	$1,200	$1,600
Hospital Admission Limited to 1 per accident.	$500	$1,000
Hospital Stay Limited to 365 days, 1 stay per accident.	$100 per day	$200 per day

Hospital Indemnity Insurance

Hospital stays are never the same. Yet whether they are planned or unexpected, long or short - the costs can quickly add up. Some of the costs may be covered by your medical plan, but you can expect to pay some of the costs out of pocket. Protect yourself from these unexpected expenses with Hospital Indemnity Insurance.

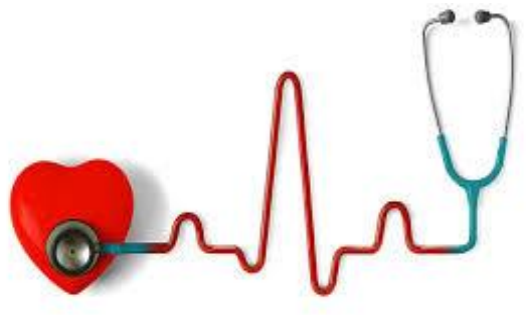
Hospital Indemnity provides a lump-sum, tax-free cash benefit to help pay for costs that can come with a hospital stay that your health plan does not cover. Think of it as a bit of financial assistance when you need it most.

You can use the lump-sum payment however you want. You might use it to help pay for out-of-pocket medical costs related to a hospital stay such as hospital bills, medical tests, or rehab due to accident or illness. Or you might choose to use it for daily expenses like rent, food, transportation, childcare, or help around the house.

Hospitalization Benefits	Benefit Amounts
Hospital Admission (Non-ICU and ICU) No elimination period, limited to 1 day, 1 benefit(s) every 365 days	$1000
Hospital Chronic Condition Admission No elimination period, limited to 1 day, 1 benefit(s) every 90 days	$50
Hospital Stay No elimination period, limited to 30 days, 1 benefit(s) every 90 days	$100
Hospital Intensive Care Unit (ICU) Stay No elimination period, limited to 30 days, 1 benefit(s) every 90 days	$200
Hospital Observation Stay 24-hour elimination period, limited to 72 hrs	$100 per 24-hour period
Newborn Nursery Care Stay Limited to 30 days, 1 benefit per newborn	$200

Additional Benefits	Benefit Amounts
Wellness Treatment, Health Screening Test, and Preventative Care Incentive Benefit	$50, limited to 1 per year

Critical Illness Insurance



If you ever have a critical illness, such as a heart attack or cancer, you want the best care. At times like these, you should not have to worry about how you are going to pay for it. Critical illness coverage provides the added layer of security you want and need – a lump-sum cash benefit to help pay for unexpected costs. You decide how to use the benefits to best support recovery for yourself or a family member.

The Critical Illness coverage provides benefits for heart attack, stroke, invasive cancer, major organ transplant, and neurological conditions such as advanced Alzheimer's and advanced Parkinson's. Coverage pays for the first diagnosis of certain illnesses after your coverage becomes effective. It may also cover a new cancer diagnosis even with a previous cancer diagnosis (or reoccurrences).

You might use it for:

- **Out of pocket medical costs,** such as ambulance fees, physical therapy, X-rays, or crutches.
- **Daily expenses** like rent, food, transportation or help around the house.

Note: You must elect for yourself to be able to elect for others

Benefit level	Benefit Amounts
Employee	$10,000 or $20,000
Spouse	50% of issued employee amount
Child(ren)	25% of issued employee amount

TRICARE Supplemental Insurance Plan

You have the option to elect a TRICARE supplemental insurance through SelmanCo, to help with out-of-pocket healthcare and pharmacy expenses if you meet the following eligibility requirements. Note: this is a post-tax, voluntary benefit.

Who is Eligible?

Military personnel who have TRICARE that are not active duty, not eligible for Medicare, and under the age of 65. This could include the following individuals:

- Military Retirees
- Spouses and Surviving Spouses
- Retired Reservists and National Guardsman
- Eligible Dependent Children

What it Covers:

- Cost shares, co-pays, and excess charges
- Reimburses for all or most of your TRICARE deductible
- Reimburses for prescription co-pays up to 100%
- Provides coverage for pre-existing conditions

Members can check eligibility by contacting the Defense Enrollment Eligibility Reporting System (DEERS) at:

800-538-9552

Lincoln Financial Group Resources

LifeKeys

No matter how well you plan, unexpected challenges will arise. When they do, help and support are nearby — thanks to *LifeKeys* services from Lincoln Financial Group.

With *LifeKeys*, you can access resources for:

- EstateGuidance® will preparation
- GuidanceResources® online
- Identity Theft Resources
- Beneficiary Services for up to one year following the death of a covered individual (up to six (6) face-to-face sessions and unlimited counseling
- Online Will preparation
- And much more!

Access *LifeKeys* services at 866-335-4850.

WellnessPATH

Wellness isn't just about physical health; emotional and financial components also play a role. Whether you want to save more or need to pay off debt, getting your finances in order can have an impact on your overall well-being. That's where Lincoln can help.

Lincoln *WellnessPATH* provides tools and personalized steps to manage your financial life. From creating a budget to building an emergency fund to paying down debt, our easy-to-use online tool helps you turn information into action so you can focus on both short- and long-term goals, such as providing protection for your loved ones.

After a short quiz, your *WellnessPATH* tool will give you a wellness score and actionable steps to achieve financial wellness! With *WellnessPATH*, you can:

- Aggregate financial accounts
- Estimate retirement savings
- Create their to-dos
- Manage their budget
- Monitor cash flows
- Leverage resources and educational tools fully customized for their own financial situation.

Lincoln Financial Group®

TravelConnect®
GLOBAL ASSISTANCE PROGRAM

TravelConnect is a comprehensive program that can bring help, comfort, and reassurance if you face a medical emergency while traveling 100 or more miles from home. Whether traveling for business or leisure, you and your loved ones can count on TravelConnect for responsive and caring support — 24 hours a day, 7 days a week.

With TravelConnect you can acces help with:

- Coordinating transportation and travel services
- Select Medical Services
- Emergency ID recovery and stolen/lost travel documents
- And more!

For a complete list of *TravelConnect* services, go to mysearchlightportal.com and enter your group ID: LFGTravel123.

Employee Assistance Program (EAP)

Lincoln Financial Group®

ComPsych® GuidanceResources®

Included in the no-cost Basic Life and AD&D insurance through Lincoln Financial Group, all benefit eligible employees have access to EmployeeConnect. EmployeeConnect is an Employee Assistance Program (EAP) administered through Guidance Resources that offers professional, confidential services to help you and your dependents handle whatever life throws at you.

When you call the toll-free line, you'll talk to an experienced professional who will provide counseling, work-life advice, and referrals. All counselors hold master's degrees, with broad-based clinical skills and at least three years of experience in counseling on a variety of issues. For face-to-face sessions, you'll meet with a credentialed, state-licensed counselor.

In-person guidance

Some matters are best resolved by meeting with a professional in person. With *EmployeeConnect*SM, you and your family get:

- In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year)
- In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and **25% off** subsequent meetings

Unlimited 24/7 assistance

You and your family can access the following services anytime — online, on the mobile app or with a toll-free call:

- Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more
- Legal information and referrals for family law, estate planning, consumer and civil law
- Financial guidance on household budgeting and short- and long-term planning

Online resources

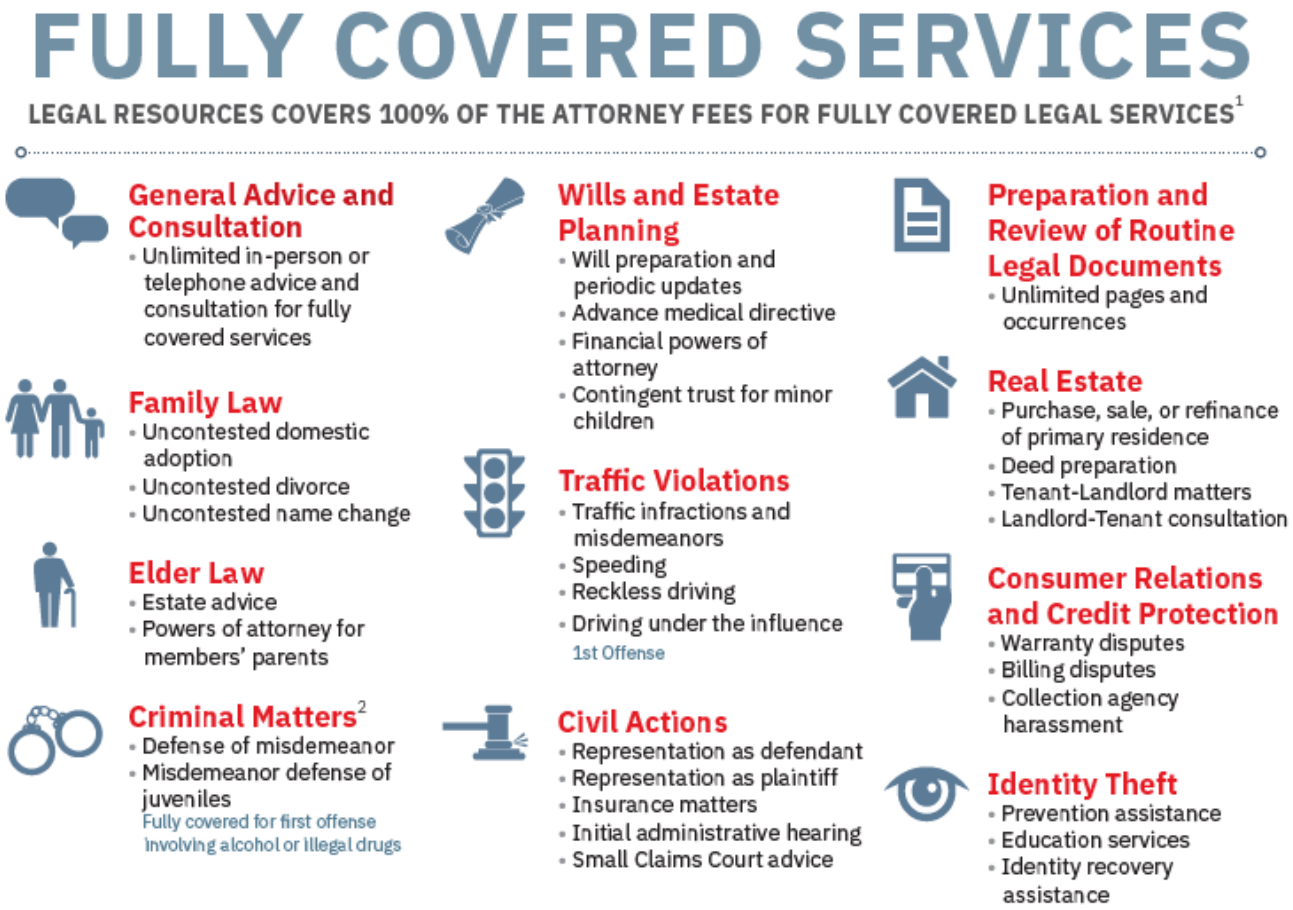
*EmployeeConnect*SM offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the GuidanceNowSM mobile app. You'll find:

- Articles and tutorials
- Videos
- Interactive tools, including financial calculators, budgeting worksheets and more

To take advantage of the *EmployeeConnect*SM program or for more information: Visit GuidanceResources.com (username: LFGSupport, password: LFGSupport1), download the GuidanceNowSM mobile app or call 888-628-4824.

Legal Resources

Few employee benefits offer so much for so little. As a Legal Resources member, you'll have immediate and ongoing access to **comprehensive legal coverage, services, and expertise** that will easily save you money – and could save you a whole lot more.



For more information, visit LegalResources.com or call Member Services at 800-728-5768.

Identity Theft Protection

Legal Resources' Identity Theft Protection Plans provide you and your family with peace of mind, so you can focus on what matters most. Redhorse, in partnership with Legal Resources, provides three levels of protection and options for identity theft protection services.

PLAN OPTIONS	BASIC ESSENTIAL PROTECTION	GOLD TRUSTED VALUE	PLATINUM COMPREHENSIVE COVERAGE
	STANDARD MONITORING WITH COMPLETE RECOVERY SERVICES	ADVANCED COVERAGE AT A COMPETITIVE PRICE	MAXIMUM PROTECTION FOR UNRIVALED CONFIDENCE
MANAGE AND PROTECT			
Personal Data-Monitoring Dashboard	🔒	🔒	🔒
Online Data Protection Software	🔒	🔒	🔒
Comprehensive Identity Monitoring	🔒	🔒	🔒
Unlimited # of Data Point and Account Monitoring	🔒	🔒	🔒
Dark Web and Suspicious Activity Monitoring	🔒	🔒	🔒
Personal ID Monitoring *ie SS#, Driver's License, Passport, etc*	🔒	🔒	🔒
Bank, Credit, and Investment Account Monitoring	🔒	🔒	🔒
Medical and Social Media Account Monitoring	🔒	🔒	🔒
Credit Freeze and Fraud Alert Services	🔒	🔒	🔒
Public Record Monitoring		🔒	🔒
ScamAssist®			🔒
Custom Alert Method	Email or Text	Email or Text	Email or Text
CREDIT REPORTS AND MONITORING			
Monthly Credit Reports and Scores		1 Bureau	3 Bureaus
Advanced Credit Monitoring		1 Bureau	3 Bureaus
Credit Change Monitoring		1 Bureau	3 Bureaus
VPN Monitoring			🔒
RESOLVE AND RESTORE			
Certified ID Theft Resolution Experts 24/7/365	🔒	🔒	🔒
Full-Service, Resolution, and Restoration Services	🔒	🔒	🔒
Identity Theft Affidavit Assistance and Submission	🔒	🔒	🔒
Multi-Lingual Support and Translation Services	🔒	🔒	🔒
Lost Wallet Assistance with Emergency Cash Advance	🔒	🔒	🔒
Cyber Restoration			🔒
Emergency Travel Arrangements	🔒	🔒	🔒
Identity Theft Insurance	$1 Million	$2 Million	$2 Million

For more information, visit LegalResources.com or call Member Services at 800-728-5768.

Additional Benefits & Perks

Pet Insurance by Pets Best

Pet Insurance offers affordable plans for dogs and cats. Policies cover and reimburse a wide range of care from minor ailments to serious conditions such as cancer and heart disease. Pet owners are free to visit any veterinarian.

Visit www.petsbest.com/RCPETS or call 877-738-7237 and reference RC PETS for more information, quotes, and to enroll in coverage!

Perks at Work

Perks at Work offers:

- **Discounts**: access to 30k employee discounts in over 20 categories (with e-commerce technology that provides price comparison)
- **Free Online Wellbeing Classes**: Community Online Academy is a FREE resource of live and on-demand classes for adults and children, from wellness to personal development

How to Register:

1. Go to: www.perksatwork.com and click "Sign Up for Free"
2. Enter your work email address, and type your company name ("Redhorse Corporation") in the Company box; Select "Create My Account" and start saving!

Wellable – Wellness Platform

With Wellable, you will have the opportunity to compete in different challenges AND qualify for exciting prizes, explore new ways to create and maintain an active and health lifestyle through on-demand fitness classes, guided meditation, health tips, and more! You can even connect to your fitness app to track progress!

Visit: https://app.wellable.co/Redhorse
Complete the form and you are in!

Medicare Information & Assistance

Using the link below, you will find multiple presentations walking you through the different aspects of Medicare, as well as what is covered by Medicare Parts A, B, C, and D. You will also find a cost comparison workbook that will help in considering enrolling in Medicare or remaining on your group plan.

You can also connect with USI's Account Executive for Medicare:

Karen Coia
Direct: (856) 334-4356
Karen.Coia@mybenefitadvisor.com | www.mybenefitadvisor.com

Employee Premiums – Semi-Monthly (per Pay Period)

Medical Rates	Cigna HSA High	Cigna HSA Low	Cigna PPO
Employee	$0.00	$48.96	$94.68
Employee + Spouse/DP*	$120.89	$158.01	$208.32
Employee + Child(ren)	$98.92	$129.28	$170.43
Employee + Family	$164.86	$215.48	$319.59

**DP (domestic partner) rates are post-tax*

Dental Rates	Cigna Dental Low Plan	Cigna Dental High Plan
Employee	$0.00	$4.53
Employee + Spouse/DP*	$3.50	$9.17
Employee + Child(ren)	$4.77	$10.42
Employee + Family	$7.09	$16.15

**DP (domestic partner) rates are post-tax*

Vision Rates	Cigna Vision Plan
Employee	$0.00
Employee + Spouse/DP*	$2.56
Employee + Child(ren)	$2.61
Employee + Family	$4.21

**DP (domestic partner) rates are post-tax*

TRICARE Supplemental Rates	
Employee	$33.75
Employee + Spouse	$66.25
Employee + Child(ren)	$66.25
Employee + Family	$89.25

Voluntary Benefits – Accident, Critical Illness, Hospital

- Deductions taken from your paycheck after taxes; applicable rate charts are located within the Open Enrollment Portal in UKG.

Supplemental Life and AD&D

- Deductions taken from your paycheck after taxes; applicable rate charts are located within the Open Enrollment Portal in UKG.

Accident Insurance Rates	Low Plan	High Plan
Employee	$3.08	$5.32
Employee + Spouse	$5.59	$9.78
Employee + Child(ren)	$7.30	$12.96
Employee + Family	$9.81	$17.42

Hospital Indemnity Insurance	Rates
Employee	$7.84
Employee + Spouse	$19.02
Employee + Child(ren)	$12.94
Employee + Family	$24.13

Identity Theft Protection	Individual	Family
Basic	$3.25	$6.50
Gold	$4.50	$9.00
Platinum	$7.50	$15.00

Legal Resources	
One Level	$9.50

Contact Information and Group Numbers

Additional information regarding benefit plans can be found on the Intranet. Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

Redhorse HR Information:

- Human Resources: humanresources@redhorsecorp.com | (619) 241-4609

Benefit Resource Center (BRC) Information:

- Email: BRCEast@usi.com
- Phone: (855) 874-6699
  Reach out with any benefit/claim related questions or issues, and our broker USI can help!

Carrier Information

Benefit	Carrier	Group Number	Phone Number	Resource
Medical	Cigna Healthcare	00637470	(800) 244-6224	www.mycigna.com
Medical (TRICARE)	Selman and Co.	LB00003811	(800) 638-2610	memberservices@selmanco.com
Dental	Cigna Healthcare	00637470	(800) 244-6224	www.mycigna.com
Vision	Cigna Healthcare	00637470	(877) 478-7557	www.mycigna.com
Health Savings Account	HSA Bank - Cigna Healthcare	00637470	(800) 357-6246	www.hsabank.com
Flexible Spending Account (FSA)	Wex Inc.	36093	N/A	employerservices@wexhealthinc.com
Voluntary Critical Illness	Cigna Healthcare	CI112037	(800) 754-3207	http://www.supphealthclaims.com
Hospitalization Only	Cigna Healthcare	HC111669	(800) 754-3207	http://www.supphealthclaims.com
Accident	Cigna Healthcare	AI112106	(800) 754-3207	http://www.supphealthclaims.com
Life and AD&D	Lincoln Financial	SA3-890-LF1436-01	(800) 423-2765	clientservices@lfg.com
Voluntary Life and AD&D	Lincoln Financial	SA3-890-LF1436-01	(800) 423-2765	clientservices@lfg.com
Short Term Disability (STD)	Lincoln Financial	GD3-890-LF1436-01	(800) 423-2765	clientservices@lfg.com
Long Term Disability (LTD)	Lincoln Financial	GF3-890-LF1436-01	(800) 423-2765	clientservices@lfg.com
Employee Assistance Program (EAP)	Guidance Resources - Lincoln Financial	09-LF1436	(855) 891-3684	www.guidanceresources.com Web ID: LifeKeys
Travel Assistance	Lincoln Financial (EAP)	09LF1436	N/A	www.mysearchlightportal.com
Pet Insurance	Pets Best	6922864	(877) 738-7237	www.petsbest.com/RCPETS Discount Code: RCPETS
Identity Protection	LifeLock	E0006200	(800) 607-9174	www.LifeLock.com

This brochure summarizes the benefit plans that are available to Redhorse Corporation eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

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

	Cigna HSA High	Cigna HSA Low	Cigna OAP
Annual Deductible (Ind / Fam)	$3,300 / $6,400	$1,650 / $3,300	$250 / $500
Annual Out-of-Pocket Maximum (Ind / Fam)	$5,000 / $10,000	$4,000 / $8,000	$4,000 / $8,000
Plan Coinsurance	90%	90%	90%

NEWBORNS ACT DISCLOSURE − FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:
Human Resources
1777 N Kent Street, 12th Floor
Arlington, Virginia United States 22209
619-241-4609
humanresources@redhorsecorp.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html**.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

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

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

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

- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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

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

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Important Notice from Redhorse Corporation 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 Redhorse Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Redhorse Corporation has determined that the prescription drug coverage offered by the Health Plans for the plan year 2025 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, the following options may apply:

- You may stay in the Health Plan and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose Health Plan creditable coverage.
- You may stay in the Health Plan and also enroll in a Medicare prescription drug plan. The Health Plan will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Health Plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Health Plan, you are not able to receive

coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

When Will You Pay a Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Redhorse Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the person listed below for further information.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Redhorse Corporation changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	9/27/2024
Name/Entity of Sender:	Redhorse Corporation
Contact Position/Office:	Human Resources
Address:	1777 N Kent Street, 12th Floor, Arlington, VA 22209
Phone Number:	619-241-4609

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, 2024. Contact your State for more information on eligibility.

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
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
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2
INDIANA – Medicaid
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
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.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

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
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
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
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/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid 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)
WISCONSIN – Medicaid and CHIP
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, 2024, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution – as well as your employee contribution to employment-based coverage – is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Name of Entity/Sender:	Redhorse Corporation
Contact--Position/Office:	Human Resources
Address:	1777 N Kent Street, 12th Floor, Arlington, VA 22209
Phone Number:	619-241-4609

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name Redhorse Corporation		4. Employer Identification Number (EIN) 26-1283951
5. Employer address 1777 N Kent Street, 12th Floor		6. Employer phone number 619-241-4609
7. City Arlington	8. State VA	9. ZIP code 22209
10. Who can we contact about employee health coverage at this job? Human Resources		
11. Phone number (if different from above)	12. Email address humanresources@redhorsecorp.com	

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

- As your employer, we offer a health plan to:
  - ☑ All employees. Eligible employees are:

    Full time employees working 30 or more hours per week
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are:

    Spouse, registered domestic partner, and dependent children up to age 26
  - ☐ We do not offer coverage.

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

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household

income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.
The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $0.00
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16.
If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly