2022

TRAX INTERNATIONAL

EMPLOYEE BENEFITS GUIDE

FIND WHAT FITS YOU!

Helping you benefit smarter

WELCOME ...

To Your Benefits Enrollment

At TRAX, our success depends on our most vital asset — our people. We also recognize the important role your benefits play in helping you live a healthy, happy, and productive life.

We offer a valuable, comprehensive benefits package designed to advance your overall physical, financial, and emotional well-being. From medical, dental, and vision insurance to life insurance, disability insurance, and retirement savings, your TRAX benefit options can help you thrive at work, at home, and in your community, today — and tomorrow!

Take Action

This guide provides an overview of your 2022 benefit options and explains how to enroll. It's up to you to Benefit Smarter by becoming an informed benefits consumer and using your choices wisely throughout the year! Keep in mind, now is your opportunity to enroll in coverage that fits YOU!

What You Need to Do

LEARN > Use this guide to explore your 2022 TRAX benefit options.

DECIDE > Assess your anticipated needs, and then select a medical plan that fits you and your family best.

ENROLL > Enroll using the Employee Self Service (ESS) during your enrollment period to make elections for medical, dental, vision insurance, and FSAs. Access BenSelect or other site (ID Theft/Legal) to make elections for all voluntary benefits. See page 22.

TABLE OF CONTENTS

WHAT'S INSIDE

YOUR HEALTH

YOUR WEALTH

YOUR ENROLLMENT

YOUR RESOURCES

PLEASE READ THIS IMPORTANT NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare before December 31, 2022, federal law gives you more choices about your prescription drug coverage. Please see the Legal Notices section at the end of this Benefits Guide for more details.

Key Things to Think About

How can you determine whether your medical insurance and other benefits are strong enough? Start by pondering the following questions as they relate to your current benefits coverage:

1. How satisfied are you overall with your medical plan and providers?
2. How well do you take advantage of tax-free savings accounts?
3. How valuable would additional sources of cash be to help pay your expenses?

YOUR HEALTH

MEDICAL PLANS

Medical and prescription benefits from TRAX help you stay well and get the care you and your family need. You have access to an extensive network of quality, lower-cost providers. Your plans also offer many resources and tools to help you maintain a healthy lifestyle.

Your Medical Options

You have a choice of Cigna medical plans: Premier, Basic HSA and Core. For employees located in Alaska, you will have the option of Premier Alaska. All plans offer comprehensive coverage for you and your family. In addition, you pay $0 for in-network preventive care such as annual checkups, cancer screenings, vaccinations, and more. Pharmacy coverage for all plans will continue to be provided by Express Scripts.

FIND A NETWORK PROVIDER

mycigna.com or call
800-CIGNA24

Why In-Network Providers?

Using an in-network provider can work to your advantage through:

- **Peace of mind –** In-network providers agree to meet Cigna's quality-of-care guidelines, so you know that your providers are accountable for the quality of care they provide.
- **Lower costs –** In-network providers charge agreed-upon rates for their services; you cannot be charged more than these rates. Plus, you receive a higher level of benefits from the plan.
- **Convenience –** In-network providers file claims for you, so you have less paperwork when you need care.
- **Extensive network –** You may choose from hundreds of thousands of nationwide providers.

Why you benefit from a primary care physician

You aren't required to select a primary care physician (PCP) with a consumer directed health plan or a preferred provider organization plan, but you may want to. Your PCP does more than just give you a checkup. They get to know you and your medical history, and can help guide your overall care — including specialty care. If you don't have a PCP, visit your plan's website to find one near you.

A CLOSER LOOK AT THE CONSUMER DRIVEN HEALTH PLAN (CDHP) or Basic HSA

The CDHP offers lower contributions in exchange for a higher deductible. It also offers comprehensive medical coverage, such as free in-network preventive care and protection from catastrophic illness or injury. This coverage is paired with a tax-advantaged HSA you may use, grow, and save for current or future health care expenses. To learn more about the HSA, see the next page and find definitions for the terms used here at the end of this guide. How the CDHP Works:

Free In-Network Preventive Care

To emphasize the importance of wellness, preventive care is covered at 100%, if you receive this care from in-network providers.

Deductible

You pay for your initial medical and prescription costs until you meet your annual deductible. This deductible is higher compared with that of the other medical plans. However, you can use your HSA contribution to help cover the higher deductible. Also, if you are covering your family, you will be subject to the family deductible regardless of how many family members have medical expenses. Call Cigna for more information.

Coinsurance

Once the deductible is met, you and TRAX share any further health care costs until you meet the out-of-pocket maximum.

Out-of-Pocket Maximum

The plan limits the total amount you pay each year. Once you meet your out-of-pocket maximum, the plan pays 100% of your eligible in-network expenses for the remainder of the plan year.

HEALTH SAVINGS ACCOUNT (HSA)

TRAX provides a convenient way for you to pay and save for health care now — and in the future. When you enroll in the CDHP, you're eligible to contribute to a tax-free* HSA, which helps you save money on eligible health care expenses for yourself, your spouse, and your tax-dependents.

The Basics of an HSA

1. MONEY GOES IN

The 2022 IRS annual limit on HSA contributions is $3,650 for individual coverage or $7,300 for employee + dependent or family coverage. Note: Those limits include any contributions TRAX makes to your HSA.

2. MONEY COMES OUT

When you have an eligible medical expense, including your plan deductible, you can pay it with the money in your HSA. Note: You can only use money that's already in your account at that time.

You pay the full cost of nonpreventive care, including prescriptions, until you meet the plan annual deductible. Think about your typical expenses and consider making pretax* contributions to help cover your deductible if you need it.

3. MONEY LEFT IN ROLLS OVER

Any money left in your account rolls over from year to year and is yours to keep. If you leave TRAX, you take the account with you. You can even use the money to pay medical expenses in retirement.

Growing your savings ...

Amounts above a $1,000 balance threshold can be invested in a range of mutual funds offered by the Cigna Choice Fund HSA.

Remember, the HSA has a **triple tax advantage**: money goes in, grows, and can be withdrawn for medical expenses **tax-free**!*

** Your HSA is free from federal income taxes; however, you may pay state and other taxes, depending on your residence. Talk with your tax advisor for details.*

Plan ahead for expenses

If you have a significant expense early in the year, you may not yet have a sufficient balance to pay that bill from your HSA. If that's the case, you will first have to pay the expense from other sources. However, once your account grows through additional contributions, you can reimburse yourself.

HSA Eligibility Requirements

To be eligible for an HSA, you must meet the following criteria:

- You must be covered by a qualified consumer directed health plan (CDHP).
- You can't be covered by another health plan, including Medicare Parts A or B, or TRICARE.
- You can't be claimed as a dependent on another individual's tax return.
- You or your spouse cannot participate in any traditional health care FSA, even under another employer's plan.
- You cannot have received treatment, other than preventive care, through the U.S. Department of Veterans Affairs within the past three months.

Making Payments with an HSA

Remember, you can only use funds that already have been deposited into your account. Once funds are available, you have three simple ways to pay:

1. **Use the account debit card –** You receive this card after you open an HSA. When you use the card, your expense automatically is paid from available funds in your account.
2. **Be reimbursed –** You can also pay for eligible expenses out of your own pocket. Then, withdraw funds from your HSA to pay yourself back.
3. **Pay online –** Use the online payment feature to pay your health care provider directly from your account.

Understanding dependent status

Thanks to the Affordable Care Act (ACA), adult children can remain on the family health insurance plan, including a CDHP, until age 26. However, tax law only allows parents to claim children as tax dependents until age 19 — or age 24 if the dependent is a full-time student. You also cannot make HSA distributions for anyone who isn't a tax dependent. Therefore, if you aren't claiming your adult child on your taxes, you can't use your HSA funds to pay for their medical expenses — even though they may still be on your medical plan.

MAKE THE MOST OF YOUR PLAN

Optimize Your Health Care with These Tips

Improving or maintaining your health begins with everyday choices. In addition, the choices you make can affect your health — and your wallet — so keep the following in mind.

Stay in-network:

Generally, you pay less when you see an in-network provider. Visit your medical plan provider's website to find a provider today.

Get preventive care:

Annual checkups, certain vaccinations, and other common services are covered at 100% when you obtain them from an in-network provider.

Know where to go for care:

Did you know that the ER might not be the best place to go for simple stitches? Knowing when to access telemedicine, visit an urgent care facility, or make a trip to the ER can potentially save you time and money.

Save with your HSA:

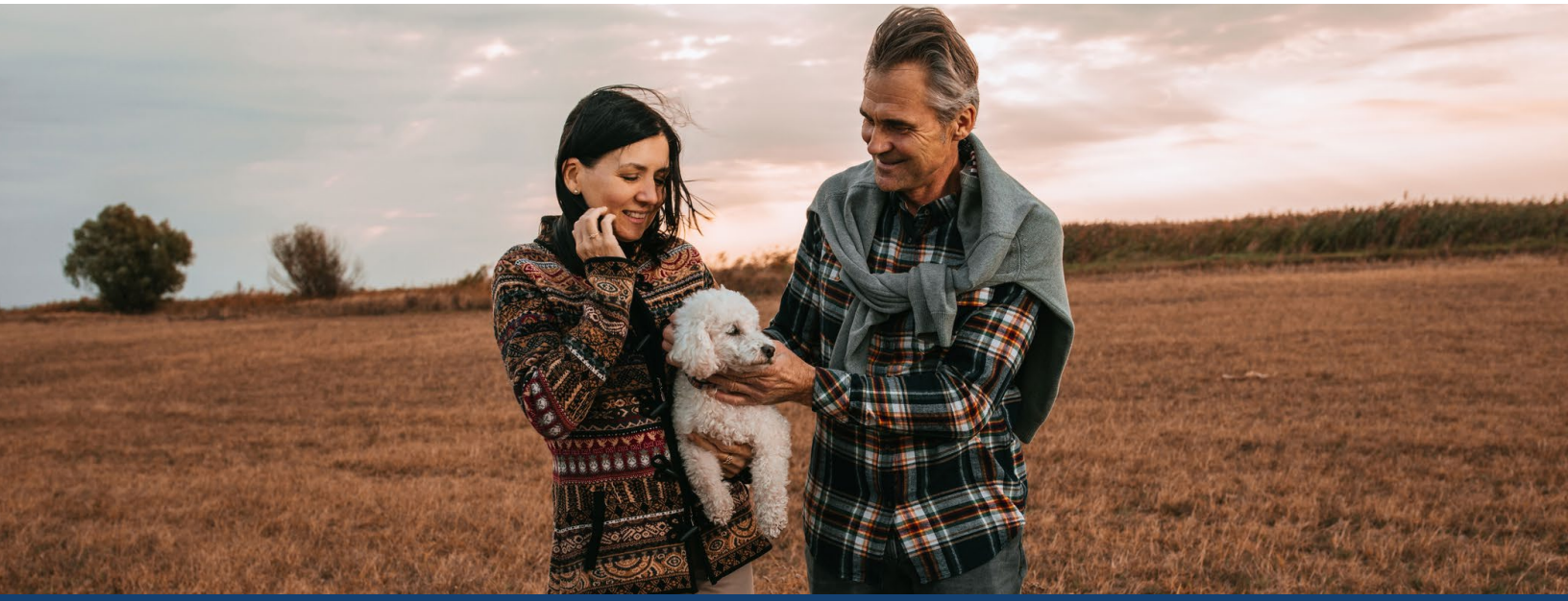
TRAX funds your HSA — and you can, too! Use it to pay your deductible today, or save it for tomorrow's unexpected health care costs or expenses in retirement. You get to decide when and how to use it!.

Save the ER for True Emergencies

You'll save a lot of money and time if you seek care through telemedicine or an urgent care clinic for non-life-threatening conditions. See the next page for tips on how to receive the right care at the right time.

Save with your FSA:

The health care FSA lets you pay for eligible medical, prescription, dental, and vision expenses with pretax dollars, which means you pay less in taxes.



RIGHT CARE, RIGHT TIME

Telemedicine vs. Urgent Care vs. Emergency Room – How Do You Choose?

If it's not a true emergency, skip the emergency room. Emergency room copays are expensive, and the average wait time is 4.5 hours! Telemedicine services and urgent care centers provide quality care, and you can save hundreds of dollars and hours of time in the waiting room for non-life-threatening issues.

How to Decide Where to Receive Care

Telemedicine	Urgent Care Center	Emergency Room
Use it for ... A non-life-threatening condition when your primary care doctor isn't available.	**Use it for ...** A condition that needs immediate care but is not life- or limb-threatening.	**Use it for ...** A life-threatening or potentially crippling condition that needs immediate care.
Examples: • Headache and fever • Cold and flu symptoms • Cough and sore throat • Skin irritation or rash	**Examples:** • Broken bone, severe sprain or strain • Cut requiring stitches • Earache and minor infections • Allergic reaction, mild asthma • Back and joint pain	**Examples:** • Sudden weakness, dizziness, or loss of consciousness • Uncontrollable bleeding • Chest pain, difficulty breathing • Head injury or major trauma • Severe allergic reaction
Average price:* $ Varies by plan but typically less than $50	**Average price:* $$** $182	**Average price:* $$$** $645 (minor); $2,419 (moderate); $5,176 (severe)
Average wait time: Immediate Available anytime, anywhere from your mobile device.	**Average wait time:** 20–30 min. (wait times will vary) Typically not open 24 hr.	**Average wait time:** 40 min. to 1 hr. (will vary according to hospital and condition)

**Average prices are from healthcarebluebook.com. Costs vary from provider to provider, and from different facilities. Contact your health insurance plan for specific costs.*

HOW THE MEDICAL PLANS WORK

Plan Features	Premier	Basic HSA	Premier Alaska	Core
	In-Network	In-Network	In-Network	In-Network
HSA Funding				
Employer HSA Funding (Individual/Family)	N/A	$250/$500	N/A	N/A
What the Plan Pays				
Preventive Care	Covered at 100%			
What You Pay				
Deductible (per calendar year)				
Individual/Family	$1,500/$4,500	$2,000/$4,000	$1,500/$4,500	$6,000/$12,000
Out-of-Pocket Maximum (per calendar year)				
Individual/Family	$4,500/$9,000	$4,000/$8,000	$4,500/$9,000	$6,000/$12,000
Covered Services				
Office Visits (primary care physician/specialist)	$35/$50	20% after ded	25%	0% after ded
Emergency Room	$250 + 25%	20% after ded	$250	0% after ded
Urgent Care Facility	$45	20% after ded	25%	0% after ded
Inpatient Hospital Stay	$500 + 25%	20% after ded	$500 + 25%	0% after ded
Outpatient Surgery	25%	20% after ded	25%	0% after ded
Most Other Services	25%	20% after ded	25%	0% after ded
Prescription Drugs (generic/preferred/nonpreferred)				
Retail Pharmacy (30-day supply)	$11/30%/30%	$9/30%/30% after ded	$11/30%/30%	$9/30%/30% after ded
Mail Order (90-day supply)	$22/30%/30%	$18/30%/30% after ded	$22/30%/30%	$18/30%/30% after ded

Coinsurance percentages and copay amounts shown above represent what the member is responsible for paying.

Save on prescription drug costs

- Buy generic over brand-name medications. Generally, generic drugs are just as effective and typically cost 30% to 70% less.
- Take advantage of mail order (home delivery) to buy a 90-day supply of maintenance drugs at a discount over retail.
- Register at **express-scripts.com** or download the Express Scripts **mobile app** to use the online pricing tool to compare prescription prices.

DENTAL PLANS

TRAX's dental benefits offer you and your family affordable options for maintaining your overall health. You can choose from two Cigna Dental PPO plans.

Cigna Dental PPO*

You get to select your provider with this plan. The plan covers diagnostic and preventive care at 100%. See the chart below for coverage details. In addition to the Base DPPO plan, you have the option to purchase a $0 deductible Buy-Up plan.

Key Dental Benefits	Cigna Dental Base PPO	Cigna Dental Buy-Up PPO
	In- and Out-of-Network	In- and Out-of-Network
What the Plan Pays Benefit Maximum (per calendar year; basic, and major services combined)		
Per Individual	$1,500	$2,000
Orthodontia Lifetime Maximum	$1,500	$2,500
What You Pay Deductible (per calendar year)		
Individual/Family	$50/$150	$0/$0
Preventive and Diagnostic Care	0%, no deductible	0%, no deductible
Basic Care	20% after deductible	20% after deductible
Major Care	50% after deductible	50% after deductible
Orthodontia	50%, no deductible Children only	50%, no deductible Adults and children

**If you live in Texas, please contact Corporate HR.*

Cigna®

FIND A NETWORK PROVIDER

mycigna.com or call
800-CIGNA24

Dental health matters

As many as 120 systemic diseases can be visible in your mouth. Regular dental checkups can reveal the signs of disease before other symptoms are noticeable and help lower your risk of stroke and heart disease.

VISION PLAN

TRAX offers you vision benefits through VSP to ensure that you and your family have access to quality eye care. You have the ability to select from two vision plan options, both of which let you select your provider. Keep in mind, you can maximize your benefits and reduce your out-of-pocket costs when you receive care from a VSP network provider.

If you prefer to shop online, use your vision benefits on Eyeconic® – the VSP preferred online retailer.

Key Vision Benefits	Base Plan	Easy Options Buyup
WellVision Exam	You: $10 copay (in-network) Every calendar year	You: $10 copay (in-network) Every calendar year
Frames • $150 allowance for a wide selection of frames • $170 allowance for feature frames • 20% savings on the amount over your allowance • $80 Walmart®/Costco® frame allowance	Included in prescription glasses Every calendar year	Included in prescription glasses Every calendar year
Lenses • Single vision, lined bifocal, and lined trifocal • Polycarbonate lenses for dependent children	Included in prescription glasses Every calendar year	Included in prescription glasses Every calendar year
Lens Enhancements • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20–25% on other lens enhancements	You: $0 $95-$105 $150-$175 Every calendar year	You: $0 $95-$105 $150-$175 Every calendar year
Contacts (instead of glasses) • $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60 Every calendar year	Up to $60 Every calendar year
Easy Options Feature	N/A	Choose of the below upgrades: • An additonal $100 frame allowance • Fully covered premium or custom progressive lenses • Fully covered anti-glare coating Every calendar year

VSP® Vision care for life

FIND A NETWORK PROVIDER

vsp.com or call **800-877-7195**

FLEXIBLE SPENDING ACCOUNTS (FSAs)

FSAs are great ways to save because they let you set aside pretax payroll deductions to pay for out-of-pocket health care expenses such as deductibles, copays, and coinsurance, as well as dependent care expenses. Because that portion of your income is not taxed, you pay less in federal income, Social Security, and Medicare taxes — giving you more take-home pay.

TRAX offers two different FSAs administered through TRI-AD.

Health Care FSA

- Pay for eligible health care expenses, such as plan deductibles, copays, and coinsurance.
- Contribute up to $2,850 in 2022.

Note: If you are a participant in a health savings account (HSA), you are not eligible for the health care FSA.

Dependent Care FSA

This account is available to all benefits-eligible TRAX employees, regardless of medical plan enrollment.

- Pay for eligible dependent care expenses such as preschool, summer day camp, before- and after-care school programs, or child daycare and adult daycare so you and/or your spouse can work, look for work, or attend school full time.
- Contribute up to $5,000 in 2022, or $2,500 if you are married and filing separately.*

* This is a household maximum, so a couple can elect any amount up to $5,000.

FSA Rules to Keep in Mind

You must enroll each year to participate. Keep in mind, FSAs are "use-it-or-lose-it" accounts. Unused money does not carry over at the end of the year.

Health Care FSA – You can submit claims up to March 31 of the following year. You forfeit any remaining money.

Dependent Care FSA – Unused funds will NOT be returned to you or carried over to the following year.

New HSA enrollees – Please be advised that if you enroll in the Basic HSA for 2022, you are NOT eligible to enroll in the Healthcare FSA.

Identifying eligible expenses

Health Care FSA – Plan deductibles, copays, coinsurance, and other health care expenses. To learn more, see IRS Publication 502 at **www.irs.gov**.

Dependent Care FSA – Child day care for children under the age of 13, afterschool programs, home care for dependent elders, and related expenses. To learn more, see IRS Publication 503 at **www.irs.gov**.

COMPARE ACCOUNTS: HSA VS. FSAs

	HSA	Health Care FSA	Dependent Care FSA
Available with these plans	Cigna Basic HSA	Cigna Premier, Premier Alaska or Core	Any medical plan (or no TRAX medical plan)
Debit Card use available	Yes	Yes	Yes
Change your contribution amount anytime	Yes	No	No
Access only funds that have been deposited	Yes	No	Yes
Use the money for	All eligible health care expenses	All eligible health care expenses	Eligible dependent care expenses, including child daycare for children up to age 13 and care for dependent adults
Access to entire elected amount at the beginning of the plan year	No	Yes	No
"Use it or lose it" at year-end	No	Yes	Yes
Documentation required	For tax-filing and IRS audit purposes only	For submission with reimbursement request	For submission with reimbursement request

Make sure you're using the right account

Important! The dependent care FSA is NOT used for health care expenses for your dependents. It is for dependent child or adult day care only.

Similarly, the health care FSA debit card cannot be used to pay for dependent care FSA expenses.

SUPPLEMENTAL MEDICAL PLANS

We know life doesn't always go as expected, which is why TRAX provides you with access to supplemental medical plans designed to protect you and your family from the financial impact of a covered critical illness, injury, or hospital stay.

Review the chart below to understand the voluntary supplemental medical benefit choices available to you.

	Accident Insurance	Critical Illness Insurance	Hospital Indemnity Insurance
What it is	Pays cash benefits you can use for anything. Ideally, you would use the benefits to offset out-of-pocket medical expenses related to a covered accident.	Pays cash benefits you can use for anything. Ideally, you would use the benefits to offset out-of-pocket medical expenses related to a covered critical illness.	Pays cash benefits you can use for anything. Ideally, you would use the benefits to offset out-of-pocket medical expenses related to a covered hospital stay.
What it covers	Hospitalization, injuries, surgical procedures, physical therapy, ambulance, and more	Some cancers, heart attack, stroke, coma, kidney failure, major organ transplant, and more	First-day hospital confinement; daily hospital confinement; intensive care unit (ICU) confinement
Benefit amount	Choose from two plan options. Both pay on a schedule according to the covered injury or occurrence.	You may elect a $10,000 benefit or a $20,000 benefit; your spouse may receive up to 100% of your coverage amount; dependent children may receive $10,000 coverage.	Choose from two plan options. Plans pay either $500 or $1,000 for your initial confinement and a preset per diem of $100 or $200 for every day as an inpatient, up to 90 days.
How it works	Lump-sum payment directly to you; you decide how to spend the benefit*		

** Guidelines dictate benefit payment for each covered illness and circumstances under which it's paid.*

THE HARTFORD

FIND A NETWORK PROVIDER

thehartford.com/benefits/enroll or call **855-396-7655**

Get a financial safety net when it's most important!

Life is unpredictable, and even the best medical insurance will not cover everything — leaving you with out-of-pocket expenses.

These voluntary benefit options can offer additional peace of mind by ensuring that you have help paying high, unanticipated out-of-pocket expenses.

The lump sum you receive also can be used to pay for non-health care expenses: groceries, housing, car payments, utilities, childcare, or whatever you decide!

EMPLOYEE ASSISTANCE PROGRAM (EAP)

TRAX wants you and your family to live well in all aspects of life, whether you're at home or at work. That means taking care of your total health — physical, financial, and emotional. For that reason, we provide an employee assistance program (EAP), through ComPsych Guidance Resources, at no cost to you. This service connects you with the best mental health and counseling services. All provided services are confidential and outcomes will not be shared.

Whether you're interested in work/life resources, mental health assistance, or legal and financial advice, the EAP service can connect you and members of your household with a variety of professionals. With just one phone call, at any hour of the day or night, you can speak with helpful resources.

Turn to the EAP When You Need Assistance with:

- Emotional problems, stress, anxiety, depression
- Child care, schooling concerns, elder care services
- Alcohol or drug dependency, tobacco cessation program
- Grief and loss
- Continuing education and college planning
- Marriage or family relationship problems
- Relocation guidance and neighborhood analysis
- Financial or legal advice
- Adoption information, parental leave coaching
- Work relationships
- Travel and expatriate information
- Referrals to local service providers

CONNECT WITH THE EAP

http://guidanceresources.com
Organization Web ID: HLF902
Company Name: TRAX
800-327-1850

ID THEFT COVERAGE

TRAX International is offering identity protection to employees through ID Watchdog®. Now more than ever, it is important to better protect your identity as fraudsters are taking advantage of consumers' increased digital dependence to steal personal and financial information.

With ID Watchdog®, you have an easy and affordable way to help better protect and monitor your identity. You'll be alerted to potentially suspicious activity and enjoy the peace of mind that comes with the support of dedicated identity resolution specialists. Plus, the family plan helps you better protect your loved ones of all ages. ID Watchdog® offers more features that help protect family members than any other provider.

idwatchdog

Enroll at

idwatchdog.com/myplan/trax
or call **866-513-1518**

LEGAL COVERAGE

TRAX International is offering legal coverage through LegalShield. During these unprecedented times, it is not only important to safeguard our physical health, but our financial health and legal rights, too.

With LegalShield, a legal protection plan, you can protect your legal rights at an affordable rate. LegalShield provides you and your family direct access to a dedicated law firm who can provide legal consultation and advice, review and preparation of legal documents (such as wills), and can assist you with other personal legal matters such as speeding tickets, neighbor disputes and family related matters such as adoption, divorce, child custody and support orders.

LegalShield®

Enroll at

benefits.legalshield.com/trax
or call **888-807-0407**

YOUR WEALTH

LIFE AND AD&D INSURANCE

Life and Accidental Death and Dismemberment (AD&D) Insurance are useful solutions to help preserve your family's quality of life and financial future.

Basic Life/AD&D (Company-paid)

TRAX's life insurance program through The Hartford provides valuable financial protection to your named beneficiary(ies) in the event of your death or accidental injury — at no cost to you. Your coverage is effective on the first day of the month after your date of hire. You must be actively at work for your life insurance coverage to become effective. Enrollment is automatic — you don't have to do anything to receive this coverage.

Basic Life & AD&D	Benefits
Benefit Amount	$20,000
Age Reduction	Age 65: Reduced by 35% Age 70: Reduced by 50%

** Reductions will be applied to the original amount.*

Voluntary Term Life/AD&D (Employee-paid)

You also can purchase additional voluntary term life insurance through The Hartford for yourself and your eligible family members. You must be actively at work on the effective date of your coverage.

Voluntary Term Life/ AD&D	Benefits*	Guaranteed Issue
Employee	Increments of $10,000 up to $200,000 max.	$200,000 when newly eligible
Spouse	Increments of $10,000 up to 100% of employee amount or $200,000, whichever is less	$50,000 when newly eligible
Child(ren)	$10,000	No EOI required

** Your benefit will be reduced by 35% at age 65 and 50% at age 70. Reductions will be applied to the original amount..*

What is AD&D Insurance?

Should you lose your life, sight, hearing, speech, or use of a limb in a covered accident, AD&D provides additional cash payments. AD&D benefits are paid as a percentage of your coverage amount — usually 50% to 100% — depending on the type of loss. AD&D benefits are available for you but not for your dependents.

Name Someone to Receive Benefits?

You should designate a primary and/or secondary beneficiary who receives benefits in the event of your death. You can change a beneficiary at any time.

No health questions at certain enrollment times

If you enroll for voluntary term life within 31 days of employment, no proof of good health (EOI) is necessary if the coverage amount is within the guaranteed issue amount. If you wait to enroll until after the eligibility period, you will need to complete a Statement of Health form. Also, a physical exam, regardless of the coverage amount you select, may be required.

DISABILITY INSURANCE

If you have to miss work due to childbirth, injury, or illness, TRAX's disability program through The Hartford helps ensure that you still collect a part of your income until you can return to work or you reach retirement age.

The key is to remember that you will still have expenses, separate from the medical expenses related to your disability. For example, disability coverage can help ensure you have money to pay for basic needs such as housing (mortgage or rent), utilities, food, transportation, childcare, and more.

Short-Term Disability (Company paid)	
Benefit Percentage	66.67% of earnings
Weekly Benefit Maximum	$500
When Benefits Begin	8 days injury/8 days sickness
Maximum Benefit Duration	26 weeks

Long-Term Disability	
Benefit Percentage	66.67% of earnings
Monthly Benefit Maximum	$5,000; minimum of $100 or 10% of the benefit
When Benefits Begin	After 180 day of disability
Maximum Benefit Duration	Social Security Normal Retirement Age or 3.5 years, whichever is greater

Enroll without evidence of good health

The best time to enroll for Voluntary LTD coverage is during your initial eligibility period. During this period, you automatically will be approved for the benefit(s) as long as you were not hospitalized within the past 90 days.

Meet the match!

Try to contribute at least up to what your match is — don't leave free money on the table!

RETIREMENT SAVINGS PLAN

Financial security is an important part of your total well-being. TRAX is committed to helping you plan for the future by offering an easy way to build savings for retirement.

Your Contributions

As a newly eligible employee you are automatically enrolled at 6% in the plan on the following dates closest to your hire date: October 1, January 1, April 1, or July 1. You may contribute 2% to 100% of your salary on a pretax and/or after-tax (Roth) basis, subject to IRS limits. The maximum in 2022 is $20,500. However, if you're age 50 or older, you are eligible to contribute an additional catch-up contribution up to $6,500.

Company Match

TRAX International may make match contributions.

Your Funds Are Vested

Vesting refers to how much of the company matching contribution you own if you leave TRAX. You are always 100% vested in your own contributions, and company matching contributions, including any investment gains or losses.

YOUR ENROLLMENT

ELIGIBILITY

You are eligible for benefits if you are a full time employee who works 30 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse.
- Your children, including biological children, stepchildren, adopted children, and children for whom you have legal custody or guardianship. Children may be covered until age 26 (unless the child is disabled). Disabled children may be covered beyond age 26.
- If you and your spouse both work for TRAX, each must take their own coverage for medical and dental. Anyone considered as a TRAX employee cannot be covered as a dependent of another TRAX employee.

WHEN COVERAGE BEGINS

New Hires – You must complete the enrollment process within 30 days of your date of hire. If you enroll on time, coverage is effective on the first day of the month after your date of hire.

IMPORTANT REMINDERS

- **New employees: Enroll within 30 days from your date of hire.** If you don't enroll within this time period, you will not have benefits coverage, except for plans and programs that are fully paid by TRAX, such as basic life, basic accidental death & dismemberment, STD and the employee assistance program.
- **After your enrollment opportunity ends, you will not be able to make changes to your benefits** until the next Open Enrollment, unless you experience a qualifying life event.

Cover only eligible dependents

Knowingly adding or not removing ineligible individuals from your TRAX medical, dental, and vision plans is considered insurance fraud. For questions regarding benefits eligibility, contact Corporate HR at **702-216-4455**.

When you enroll a new dependent, you may be asked to provide evidence that your dependent meets eligibility requirements. Acceptable proof may include any of the following:

- Marriage license
- Birth certificate
- Formal court designation

For more information contact your local HR representative.

ENROLLMENT CHECKLIST

Be informed and take action. This is your opportunity to select coverage so you can get the most out of your benefit programs in 2022.

- ☐ **Read this guide.** It describes your plans, coverage details, and costs for 2022.
- ☐ **Evaluate your current coverage and determine if:**
  - Your spouse has access to another plan.
  - Your dependents are eligible for TRAX medical coverage.
  - You need life or disability insurance coverage.
  - You need to name your beneficiaries.
- ☐ **Gather eligibility documentation for new dependents.**
- ☐ **Take advantage of the FSAs or the HSA.**
- ☐ **Get the coverage that fits YOU.**

CHANGING YOUR BENEFITS

Qualifying Life Events

You typically cannot receive or change benefits outside of Open Enrollment without a qualifying life event (QLE).

Important Tip! Act quickly – A QLE triggers a 30-day "special enrollment period" that will allow you to apply for benefits or change coverage. You must change your benefits within 30 days of the official QLE date. Proof of the QLE will be required, and the date you enter must match the documents you provide.

Not Qualifying Life Events

Qualifying Life Event		Example of Documentation Needed
Change in marital status	Marriage	Copy of marriage certificate
	Divorce/Legal Separation	Copy of divorce decree, legal separation agreement or certified copy of court order/decree
	Death	Copy of death certificate
Change in number of dependents	Birth or adoption	Copy of birth certificate with parents' names listed, hospital birth record, adoption certificate or certified court order/decree
	Stepchild	Copy of birth certificate with spouse name listed, plus a copy of the marriage certificate between employee and spouse
Change in employment	Change in spouse or dependent's employment status	Notification of spouse's employment status change that results in a loss or gain of coverage
Gaining or losing other coverage	You, your spouse or dependent loses other coverage	Letter from insurance carrier or COBRA verifying end of coverage with end date listed
	You, your spouse or dependent gains other coverage	Letter from insurance carrier or COBRA verifying new coverage with start date listed

HOW AND WHEN TO ENROLL

PART ONE – REQUIRED: ESS – Benefits Enrollment

Use the **ESS** to make elections for medical, dental, vision insurance and FSAs

- **Login to** Time & Expense → Self Service → Payroll & Benefits → Benefits Enrollment at **https://traxintl.okta.com**
- **Current Elections —** First, you will view a summary of your current benefit elections. Click "continue" to move through each screen.
- **Benefits —** You will then move through each of the benefits available to you and make your 2022 elections. Plan Summaries are available by clicking on the Plan Name (a hyperlink).
- **Voluntary Life and AD&D Insurance and Voluntary Benefits —** You will be directed to BenSelect or other site (ID Theft/Legal) to make your elections and update your beneficiary designation information.
- **FSAs —** You will enter the total amount you'd like to contribute for the year or the amount you wish to contribute per paycheck for the Health Care and/or the Dependent Care FSA.
- **Summary —** Review the summary to ensure your elections are accurate and click "Submit." You will then receive a confirmation email, and the summary page will indicate that your enrollment elections are "Confirmed."

PART TWO – VOLUNTARY: The Hartford/BenSelect

Access BenSelect to make elections for all voluntary benefits (accident insurance, critical illness insurance, and hospital insurance, long-term disability and supplemental life).

When you're ready to enroll, click on the **BenSelect** link in ESS or visit: **https://enroll.thehartfordatwork.com/Enroll/Login.aspx**

- **User ID:** Your user ID is the first letter of your first name and the first letter of your last name followed by the last four digits of your Social Security number (SSN). **For example:** John Smith's SSN is 987-65-4321. His login ID is js4321.
- **Password:** Your password is the first letter of your first name and the first letter of your last name, followed by your date of birth (MMDDYYYY). Your password is case sensitive. Therefore, you will need to use lowercase initials. You will be required to reset your password during your initial login. **For example:** John Smith's birth date is February 25, 1963. His password is js02251963.

YOUR RESOURCES

TERMS TO KNOW

Beneficiary – The person you designate to receive your life insurance proceeds in the event of your death. Please make sure to complete your beneficiary designation.

COBRA – A federal law that allows workers and dependents who lose their medical, vision, dental, or flexible spending account coverage to continue any group coverage for a specified length of time.

Coinsurance – Your share of the cost of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service, typically after you meet your deductible.

Copayment – The fixed amount, as determined by your insurance plan, you pay for health care services received.

Deductible – The amount you must pay out of your own pocket before the plan begins to pay benefits and share the cost of care with you.

Employee Contribution – The amount you pay for your insurance coverage.

Evidence of Insurability – An application process in which you provide information on the condition of your health or your dependent's health in order to be considered for certain types of insurance coverage.

Network – A group of doctors and hospitals that offer discounts on services based on their relationship with a particular medical carrier.

Out-of-Pocket Maximum – The most you will pay out of your own pocket for services during the year. Once you reach your out-of-pocket maximum, the plan pays 100% of the cost for eligible services for the rest of the plan year.

Review your Summary Plan Description (SPD)

Please refer to the SPD to find specific details about your benefit plans. This document explains the fundamental features of an employer-sponsored benefit plan, including eligibility requirements, contribution formulas, vesting schedules, benefit calculations, distribution options, and more.

CONTACTS

Benefit Plan	Provider	Phone Number	Website
Medical	Cigna	800-CIGNA24	mycigna.com
Prescription Drugs	Express Scripts	800-596- 5920	express-scripts.com
Health Savings Account (HSA)	Cigna	800-CIGNA24	mycigna.com
Dental	Cigna	800-CIGNA24	mycigna.com
Vision	VSP	800-877-7195	vsp.com
Flexible Spending Accounts (FSAs)	TRI-AD	888-844-1372	www.tri-ad.com
Supplemental Medical (Critical Illness, Accident, Hospital Indemnity) Enrollment Claims		855-396-7655 866-547-4205	http://thehartford.com/benefits/enroll http://thehartford.com/mybenefits
Life and AD&D Enrollment Claims	The Hartford	855-396-7655 888-563-1124	http://thehartford.com/benefits/enroll http://thehartford.com/mybenefits
Disability Enrollment Claims	The Hartford	855-396-7655 800-549-6514	http://thehartford.com/benefits/enroll http://thehartford.com/mybenefits
Retirement Savings Plan	Principal	800-547-7754	http://www.principal.com
Employee Assistance Program (EAP)	ComPsych Guidance	800-327-1850 Web ID: HLF902	http://guidanceresources.com Organization Web ID: HLF902 Company Name: TRAX
ID Theft Coverage	ID Watchdog	866-513-1518	idwatchdog.com/myplan/trax
Legal Coverage	Legal Shield	888-807-0407	benefits.legalshield.com/trax

QUESTIONS?

We're here to help. If you have additional questions about your benefits, you may also contact **Corporate HR** at **702-216-4455.**

LEGAL NOTICES

Important Notice to Employees from TRAX International About Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the TRAX International medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2021. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2021 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with TRAX International and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of Creditable Coverage
You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the TRAX International prescription drug plans, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2021. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the TRAX International plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop TRAX International coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the TRAX International plan, assuming you remain eligible.

You should know that if you waive or leave coverage with TRAX International and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this TRAX International coverage changes, or upon your request.

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. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Corporate Human Resources Department
Benefits Administration
(702) 216-4455

Notice of Special Enrollment Rights for Health Plan Coverage
As you know, if you have declined enrollment in TRAX International's health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plans without waiting for the next open enrollment period, provided that you request enrollment within 30 days after your other coverage ends. 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 eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

TRAX International will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 30 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the TRAX International group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another plan.

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

• All stages of reconstruction of the breast on which the mastectomy was performed;

• Surgery and reconstruction of the other breast to produce a symmetrical appearance;

• Prostheses; and

• Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at 702-216-4455 (Corporate Human Resources Department – Benefits Administration).

Newborns' and Mothers' Health Protection Act Notice
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 702.216.4455 (Human Resources Department – Benefits Administration).

CHIP/MEDICAID NOTICE
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, 2021. 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: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website:Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecov ery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Website: 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/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840

MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
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
NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Website: http://dhcfp.nv.gov Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
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: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ 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, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor U.S.
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

TRAX International HIPAA Privacy Notice
Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by TRAX International health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: TRAX International Welfare Benefit Plan. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you
The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not TRAX International as an employer — that's the way the HIPAA rules work. Different policies may apply to other TRAX International programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information
The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.

- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance

resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with TRAX International

The Plan, or its health insurer or HMO, may disclose your health information without your written authorization to TRAX International for plan administration purposes. TRAX International may need your health information to administer benefits under the Plan. TRAX International agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Corporate Human Resources, Finance and Payroll are the only TRAX International employees who will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and TRAX International, as allowed under the HIPAA rules:

- The Plan, or its insurer or HMO, may disclose "summary health information" to TRAX International, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.

- The Plan, or its insurer or HMO, may disclose to TRAX International information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option or HMO offered by the Plan.

In addition, you should know that TRAX International cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by TRAX International from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health in-formation is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protective services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if in-forming you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tis-sue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project

Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health in-formation is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights
You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse
You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information
If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information
With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete
With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing

your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

Right to receive an accounting of disclosures of your health information
You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.

You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice
The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on January 1, 2020. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice via email.

Complaints
If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, please call 702-216-4455 (Corporate Human Resources Department – Benefits Administration).

Contact
For more information on the Plan's privacy policies or your rights under HIPAA, contact the Corporate Human Resources Department – Benefits Administration at 702-216-4455

New Health Insurance Marketplace Coverage Options and Your Health Coverage
PART A: General Information
To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.78% for 2020 or 9.83% for 2021 of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact 702-216-4455 (Corporate Human Resources Department – Benefits Administration).

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

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: TRAX INTERNATIONAL CORP	**4. Employer Identification Number (EIN):** 85-0277228	
5. Employer address: 8337 West Sunset Road, Suite 250	**6. Employer phone number:** 702-216-4455	
7. City: Las Vegas	**8. State:** NV	**9. Zip code:** 89113
10. Who can we contact about employee health coverage at this job? 702-216-4455		

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:

☐ Some employees. Eligible employees are:

With respect to dependents:
☑ We do offer coverage. Eligible dependents are: Spouses and dependent children

☐ 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.

ACA Section 1557 Notice, Statement and Taglines
For translated versions of the following ACA Section 1557 notices, please see the HHS website, here: https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

MODEL NOTICE
Discrimination is Against the Law
TRAX International complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability or sex. TRAX International does not exclude people or treat them differently because or race, color, national origin, age, disability or sex.

• TRAX International provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters

- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is no English, such as:

- Qualified interpreters

- Information written in other languages

If you need these services, contact Corporate HR Benefits Administration

If you believe that TRAX International has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Corporate HR Benefits Administration; 8337 West Sunset Road; Ste 250; Las Vegas, NV 89113; 702-216-4455You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Corporate HR Benefits Administration is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Rom 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

NONDISCRIMINATION STATEMENT
TRAX International complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Model COBRA Continuation Coverage General Notice
Model General Notice of COBRA Continuation Coverage Rights
****Continuation Coverage Rights Under COBRA****

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

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

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

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

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

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

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

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, 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[2], you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

• The month after your employment ends; or

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

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

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

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

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

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
Corporate Human Resources Benefits Administration ; 702-216-4455

While every effort has been made to ensure accuracy of this benefits guide, the plan documents and contracts will prevail in case of discrepancy between this guide and the plan documents and contracts. In addition, TRAX International reserves the right to modify or terminate any benefit plans at any time.

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