DENBRIGHT™
DENTAL LABS

California Employees Benefits Guide

2025 Plan Year

January 1, 2025 – December 31, 2025

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Important Reminders

- Enroll before the enrollment deadline of November 15th. If you do not make changes to your coverage by **Friday, November 15, 2024**, your current coverage will **NOT** continue for all benefits. If you want to participate in these programs in 2025, you must actively enroll in them during Open Enrollment or you will be defaulted to no coverage.
- **Note:** If you choose to stay with your existing plans, you will still be responsible for any new rates.
- **New employees: Enroll within your eligibility timeframe (within 30 days of hire date).** 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 Denbright, such as basic life insurance.
- **Open Enrollment: Enroll before the enrollment deadline.** If you do not make changes to your coverage within the enrollment time period, your current coverage will **NOT** continue for all benefits except as noted above.
- **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, such as marriage, divorce, birth, adoption, or a change in your or your spouse's employment status that affects your benefits eligibility.

Changes After Open Enrollment

Under section 125 of the Internal Revenue Service (IRS) code, you are allowed to pay for certain group insurance premiums with tax-free dollars. It states that eligible employees may only make elections to the plan during their initial eligibility period or once a year at open enrollment. Pre-tax benefit choices are binding through the end of the plan year. Special Circumstances, often referred to as life event changes, allow you to make plan elections at any time during the year in which they occur. You must inform Human Resources withing 30 days of the event in order to make the qualified change. All other changes will be deferred to open enrollment.

Summary of Benefits and Coverage

The Health section of this guide provides an overview of your medical plan options. You can find detailed information about each plan, including a breakdown of costs, in each plan's Summary of Benefits and Coverage (SBC). The SBCs summarize important information about your health coverage options in a standard format to help you compare costs and features across plans. The SBCs are available on Cendyn Intranet/Human Resources/Employee Resources/United States/Benefit Summaries

A MESSAGE TO OUR EMPLOYEES

At Denbright, our employees are our greatest asset. We believe that by offering one of the most comprehensive benefit packages available, we can attract and retain great people! Our benefits package includes core plans that provide a foundation for your good health and well–being.

We realize that our benefits program can be successful only if it is affordable and meets the needs of our employees. As such, we constantly review our benefits and make changes as necessary. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

For questions regarding your benefits or enrollment options, please refer to the Denbright's Microsite denbrightdentallabs.hrbenefits.net/

EMPLOYEE BENEFITS ENROLLMENT & ELIGIBILITY

If you are a Denbright employee working 30 or more hours per week you are eligible to enroll in the benefits described in this guide. You may also enroll your eligible family members under certain plans you choose for yourself.

Eligible Family Members Include

- Your legally married spouse or qualified domestic partner
- Your children who are your natural children, stepchildren, adopted children, or children for whom you have legal custody (age restrictions may apply). Disabled children aged 26 or older who meet certain criteria may continue your health coverage.

When Does Coverage Begin?

Employees become eligible for benefits the 1st of the month following 60 days of employment. You must complete the enrollment process within 30 days of your date of hire, or the date of your qualifying event.

Choose Carefully!

Due to IRS regulations, you cannot change your elections until the next Open Enrollment period, unless you have a Qualifying Event during the year. The following are examples of the most common qualifying events:

- Marriage, divorce, annulment, or permanent separation from spouse
- Birth of a child;
- Placement of a foster child or child for adoption with you, or assumption of legal guardianship of a child;
- Change in your spouse's or dependent's employment status that affects benefits eligibility, including termination or commencement of employment or change in worksite;
- You or your spouse's return from unpaid leave of absence;
- You or your dependents become eligible or lose eligibility for Medicare or Medicaid;
- The death of your spouse or dependent child
- Court ordered coverage of your child by you or your spouse, allowing you to add or drop the child(ren)'s coverage;
- Change in your employment that affects benefits eligibility (working at least 30 hours per week);
- Loss of eligibility for a dependent; and
- Change in dependent care provider or cost for dependent care FSA.

The change you request must be consistent with the qualifying event. You are required to provide supporting documentation within 30 days of the event.

Important: To make changes to your benefit elections, you MUST notify HR within 30 days of the Qualifying Event (including newborns). Be prepared to show documentation of the event such as a marriage license, birth certificate, or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to make your election changes.

MEDICAL PLANS

KAISER PERMANENTE®

Medical coverage is provided through **Kaiser Permanente**. The medical coverage includes a regional network of physicians, specialists and hospitals. Frontier Dental Labs offers employees medical coverage through Kaiser's Health Maintenance Organization (HMO) plan. Below is a snapshot of what is covered under the plan. To see a full, comprehensive list, please refer to the Summary of Benefits. Plan Costs are communicated separately.

	Health Maintenance Organization (HMO)		Deductible Health Maintenance Organization (DHMO)	
Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network
Contract Year Deductible	$0 Individual / $0 Family	N/A	$1,000 Individual / $2,000 Family	N/A
After Deductible Plan Pays	N/A	N/A	70%	N/A
Contract Year Out-of-Pocket Maximum (includes Rx)	$3,000 Individual / $6,000 Family	N/A	$5,000 Individual / $10,000 Family	N/A
Lifetime Maximum	Unlimited	N/A	Unlimited	N/A
Preventive Care for Adults & Children	100%	N/A	100%	N/A
Doctors Office Visits Primary Care / Specialist / Urgent Care	$30 Copay / $50 Copay / $30 Copay	N/A	$30 Copay / $50 Copay / $30 Copay	N/A
Inpatient / Outpatient Facility Charges	$500 per Admission / $200 per Procedure	N/A	30% Coinsurance after plan deductible	N/A
Emergency Room Facility Charges*	$100 per Visit	N/A	30% Coinsurance after plan deductible	N/A
Ambulance	$75 per Trip	N/A	$150 per Trip after plan deductible	N/A
Chiropractic Benefits	$15 per Visit	N/A	$15 per Visit	N/A
Independent Labs	N/A	N/A	N/A	N/A

*Out-of-Network Emergency Facility and Professional charges are subject to In-Network Coinsurance and/or Co-pay and Out-of-Network Benefit Year Deductible and Out-of-Pocket.

For more information visit:
denbrightdentallabs.hrbenefits.net/

DENBRIGHT DENTAL LABS

PRESCRIPTION DRUG

When you enroll in a medical plan, you automatically receive prescription drug benefits. Please see the chart below for an overview of the Kaiser prescription drug benefits.

Prescription Drug Benefits

Benefit	HMO Plan	DHMO Plan
Prescription Deductible	N/A	$125 per Individual
Retail Pharmacy (per 30-day supply)		
• Generic	$15 Copay	$15 Copay, Drug deductible does not apply
• Brand / Non-preferred	$35 Copay	$50 Copay, After drug Deductible
• Specialty	20% Coinsurance (not to exceed $250)	$50 Copay, After drug Deductible
Retail and Home Delivery Pharmacy (per 100-day supply)		
• Generic	$30 Copay	$15, Drug deductible does not apply
• Brand / Non-preferred	$70 Copay	$50 Copay, After drug Deductible

MEDICAL PLANS

Medical coverage is provided through **Cigna**. The medical coverage includes a national network of physicians, specialists and hospitals. Frontier Dental Labs offers employees medical coverage through Cigna's Open Access Plus (OAP) Network. Below is a snapshot of what is covered under the plan. To see a full, comprehensive list, please refer to the Summary of Benefits. Plan Costs are communicated separately.

	OAP In-Network Only		Open Access Plus		Open Access Plus HDHP	
Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Contract Year Deductible	$1,000 Individual / $2,000 Family	N/A	$2,000 Individual / $4,000 Family	$4,000 Individual / $8,000 Family	$3,300 Individual / $6,600 Family	$6,400 Individual / $12,800 Family
After Deductible Plan Pays	80%	N/A	80%	60%	90%	60%
Contract Year Out-of-Pocket Maximum (includes Rx)	$4,000 Individual / $8,000 Family	N/A	$5,000 Individual / $10,000 Family	$8,000 Individual / $16,000 Family	$5,000 Individual / $10,000 Family	$10,000 Individual / $20,000 Family
Lifetime Maximum	Unlimited	N/A	Unlimited	Unlimited	Unlimited	Unlimited
Preventive Care for Adults & Children	100%	N/A	100%	60%, after deductible	100%	60%, after deductible
Doctors Office Visits Primary Care / Specialist / Urgent Care	$25 Copay / $60 Copay / $50 Copay	N/A	$30 Copay / $70 Copay / $60 Copay	60%, after deductible	90%, after deductible	60%, after deductible
Inpatient / Outpatient Facility Charges	80%, after deductible	N/A	80%, after deductible	60%, after deductible	90%, after deductible	60%, after deductible
Emergency Room Facility Charges*	$400 Copay, 80%	N/A	$400 Copay, 80%	$400 Copay, 80%	90%, after deductible	90%, after deductible
Ambulance	80%, after deductible	N/A	80%, after deductible	80%, after deductible	90%, after deductible	90%, after deductible
Chiropractic Benefits ($1,500 annual max)	$25 Copay	N/A	$30 Copay	60%, after deductible	90%, after deductible	60%, after deductible
Independent Labs	80%, after deductible	N/A	80%, after deductible	60%, after deductible	90%, after deductible	60%, after deductible

For more information visit:
denbrightdentallabs.hrbenefits.net/

PRESCRIPTION DRUG

When you enroll in a medical plan, you automatically receive prescription drug benefits. Please see the chart below for an overview of the Cigna prescription drug benefits.

Prescription Drug Benefits

Benefit	OAP In-Network Plan	OAP Plan	OAP HDHP Plan
Retail Pharmacy (per 30-day supply)			
• Generic	$10 Copay	$10 Copay	10% up to $25 Copay
• Brand	$30 Copay	$30 Copay	10% up to $50 Copay
• Non-Preferred	$50 Copay	$50 Copay	10% up to $75 Copay
• **Specialty**	**$100 Copay**	**$100 Copay**	**10% up to $100 Copay**
Retail and Home Delivery Pharmacy (per 90-day supply)			
• Generic	$20 Copay	$20 Copay	10% up to $50 Copay
• Brand	$60 Copay	$60 Copay	10% up to $100 Copay
• Non-Preferred	$100 Copay	$100 Copay	10% up to $150 Copay

MEDICAL COVERAGE

Cigna Medical – Choosing A Plan

You will see that the three medical plans work a little differently.

- **For the HDHP (HSA)**, all services are subject to the $3,300 per person in-network deductible. After you reach the deductible, the plan will pay 90% of expenses up to a maximum of $5,000 per person. There are no copays on this plan until after you reach the deductible.
- **For the OAP IN & Open Access Plus**, most hospital-based services are subject to the per person in-network deductible, after that you will pay 20% of the cost of care, up to the out-of-pocket maximum. You have copays for office visits and Rx.

Preventive Care – Because Taking Care of yourself is critical

Did you know that our medical plans cover in-network preventive care at no cost to you? No deductible, no copays – the plan covers preventive services and some preventive medications in full. Preventive care includes the following:

- ✓ Annual checkups for adults, including routine screenings and immunizations and routine gynecological exams
- ✓ Routine checkups for children, including routine screenings, assessments, and immunizations
- ✓ Routine prenatal visits and folic acid supplements for pregnant women
- ✓ Breastfeeding pumps and supplies
- ✓ Women's contraception – IUD, contraceptive patch and ring, diaphragm, and the Pill
- ✓ Tobacco cessation medications
- ✓ Risk reducing medications, for those at increased risk for certain cancers

A closer look at the HDHP

The high deductible health plan (HDHP) costs you less from your paycheck, so you keep more of your money. This plan rewards you for taking an active role as a health care consumer and making smart decisions about your health care spending. As a result, you could pay less for your annual medical costs.

Please note – not all brands of medications are covered in full, and limitations do apply. Please contact Cigna for additional details on what is covered under the plan.

MD Live – Convenient Care At A Reduced Cost!

We know that trying to find time to visit a doctor can be tricky. To help you access medical care, both plans offer MD Live. MD Live gives you 24/7/365 access to board-certified doctors via video, or mobile app. And at just a low copayment, depending on your plan (0% after deductible on HSA qualified plan) for medical services, it's an affordable alternative to urgent care or ER visits. MD Live providers can even write and call-in prescriptions for you!

MD Live providers can treat many conditions, such as:

- Cold and flue symptoms and allergies
- Sinus problems
- Ear infection
- Urinary Tract Infection

Money-saving tip

If you enroll in the HDHP, put the money you save through lower paycheck deductions into your tax-free HSA so you'll have money available when you need to pay out-of-pocket costs.

HEALTH SAVINGS ACCOUNT (HSA)

EXCITING NEWS!!! We understand how important it is to have freedom to make your own decisions regarding your health care dollars. Denbright believes strongly in helping employees save for future medical expenses and will **Contribute $500 to your HSA.**
*$250 contribution in January and $250 in July

What Is An HSA?

A Health Savings Account (HSA) is a personal healthcare bank account that you can use to pay out- of-pocket medical expenses with pre-tax dollars. It is designed to give employees more accountability for their healthcare decisions. An HSA allows you to:

- ✓ Be prepared for unexpected healthcare expenses not accounted for in your personal finances.
- ✓ Increase tax savings.
- ✓ Save and "roll over" money if you do not spend it in the calendar year.
- ✓ Carry it with you. The money in your accountis always yours, even if you change health plans or jobs.
- ✓ Create healthcare savings forretirement.

Common Eligible Expenses Include

As long as you have a balance in your HSA, you may use the funds to pay or reimburse yourself for:

- Deductibles, copays and coinsurance
- Eligible prescriptions
- Vision care, including LASIK laser eye surgery
- Dental care, including orthodontia

IRS Publication 502 provides a complete list of eligible expenses and can be found at www.irs.gov.

You Are Eligible To Open An HSA If:

- ✓ You are covered by an HSA-eligible HDHP.
- ✓ You are not covered by other health insurance.
- ✓ Your spouse is not enrolled in a non-tax- qualified medical plan or flexible spending account (FSA).
- ✓ You are not enrolled in Medicare.
- ✓ You are not receiving Social Security benefits.
- ✓ You have not received Veterans Administration benefits.
- ✓ You are not claimed as a dependent on someone else's tax return.

2025 HSA Limits			
	2025 IRS Limit	Employer Contribution	Your Maximum Contribution *
Individual	$4,300	$500	$3,800
Family	$8,550	$500	$8,050
Age 55+	Contribute an additional $1,000		

*Your maximum contribution is reduced by the match provided by FDL for participating in the HDHP plan

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Denbright offers health care and dependent care flexible spending accounts (FSAs), administered by Flores, which allows you to pay for eligible health and dependent care expenses with pre-tax dollars. The money contributed to your account is deducted from your paychecks before tax is taken out, so you end up with lower taxable income for the year.

Health Care FSA

You can use a Health Care FSA to pay for eligible medical, dental, vision and other out-of-pocket health care expenses that aren't covered by your health plan. You can contribute up to $3,300 for 2025.

Dependent Care FSA

This account can be used to pay for eligible child or adult day care. To be considered an eligible expense, the care must be necessary to enable both you and your spouse or domestic partner, if applicable, to work, look for work or attend school. Eligible dependents include: your children under age 13 or dependent of any age who resides in your home for at least eight hours each day who is physically or mentally incapable of self-care and is dependent on your for at least 50% of their financial support.

You will be able to contribute up to $5,000 for 2025.

Estimate Carefully

Once you have made your FSA election amounts, you cannot make changes during the plan year unless you experience a qualifying family status change.

You cannot use money from your Health Care FSA to pay for dependent care expenses, or vice versa. Keep in mind FSAs are "use-it-or-lose-it" accounts. You will forfeit any funds left in the account at the end of the plan year.

Eligible Expenses

A list of eligible health care expenses can be found in Publication 502 on the IRS website at https://www.irs.gov/pub/irs-pdf/p502.pdf

Eligible dependent care expense information can be found in Publication 503 at https://www.irs.gov/pub/irs-pdf/p503.pdf

COMMUTER

Like a Flexible Spending Account, our commuter benefits program (administered by Flores) gives you the opportunity to pay for certain commuting expenses with pretax payroll deductions.

How the Program Works

You can elect to participate in this program at any time, not just during annual Open Enrollment, and set aside pretax money to cover your commuting costs.

- Parking — Out-of-pocket parking fees for parking meters, garages, and lots. (Parking at or near your home is not eligible.) The IRS Pre-tax limit for 2025 is $325 per month.

- Mass transit/Van Pooling — Transit passes, tokens, fare cards, vouchers or similar items entitling you to ride a mass transit vehicle to or from work. The IRS Pre-tax limit for 2025 is $325 per month.

If you spend more than the monthly IRS limit, that additional amount must be paid by you on an after–tax basis and you would enter your payment method on-line. Any money left in your commuter benefit accounts will transfer into your accounts for the following year!

DENTAL

Denbright dental plan allows you to seek treatment from the dentist of your choice, in or out-of-network.

You will get the most value out of your plan by using Cigna's network providers, who cannot charge more than their negotiated, discounted rate. While the plan covers treatment from out-of- network providers, excess charges may not be covered. The chart below shows how the plan works and how each type of service is covered. This is a brief summary; please refer to your benefit booklet for complete details.

Level of Care	Standard Option PPO		Premium Option PPO	
Benefit	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible Individual / Family	$25 / $75	$25 / $75	$50 / $150	$50 / $150
Max Annual Benefit for Services Applied to preventive, basic and major	$800	$800	$1,600	$1,600
Preventative Care • Periodontal maintenance • Oral exams • Cleaning	100%	100%	100%	100%
Basic Care • Fillings • Simple extractions • X-rays	80%	80%	80%	80%
Major Care • Bridges & dentures • Crowns, Inlays, Onlays • Oral surgery (excluding extractions)	50%	50%	50%	50%
Orthodontia	Not Covered	Not Covered	50%, $1,600 Maximum	50%, $1,600 Maximum

VISION

Denbright vision care benefits include coverage for eye exams, standard lenses and frames, contact lenses and discounts for laser surgery. With Cigna + EyeMed Vision, you can purchase lenses & frames from national retailers, as well as many other providers. You will receive a higher level of benefit if you utilize the services of a provider listed in Cigna's Preferred Provider Directory. To find a provider, simply go to www.cigna.com and use the provider locator tool for a complete list, including door-to-door directions.

The chart below shows how the plan works and how each type of service is covered. This is a brief summary; please refer to your benefit booklet for complete details.

Vision Plan

Feature	In-Network	Out-of-Network
Exam (once a year)	$10 copay	$45 allowance
Frames (once every two years)	$150 allowance	$98 allowance
Lenses (once a year)	$10 copay	$32 to $80 allowance
Contact Lens (once a year)	$150 allowance	$120 allowance

LIFE AND AD&D

Denbright provides life insurance and accidental death and dismemberment benefit (AD&D) for all full- time employees.

- The benefit is a flat $25,000 of coverage.
- Coverage is at the company's expense.
- The coverage may be converted or ported upon termination of active employment.

Voluntary Life/AD&D

You're able to purchase additional amounts of life/AD&D coverage to meet your individual needs. Voluntary Life/AD&D is available for employees, spouses and children. The benefit reduces by 65% at age 65, and 40% at age 70 for employees and spouses. The coverage may be continued or ported upon termination of active employment.

Voluntary Life Insurance Coverage			
Coverage Options	Benefit	Guaranteed Issue (GI)	Evidence of Insurability (EOI) Requirements
Employee Only	Coverage is available up to 5x earnings to $500,000 in $10,000 increments	5x earnings or $300,000	Required in amounts excess of $300,000
Spouse	Coverage is available up to 50% of the employee election or $250,000 in $5,000 increments	$30,000	Required in amounts excess of $30,000
Child(ren)	$10,000 Children are covered to age 26.	Full Benefit	N/A

Amounts over the guaranteed issue limit require Evidence of Insurability* and approval before these amounts are effective.

* For the 2025 open enrollment prior voluntary life amounts can be rolled over with no evidence of insurability needed. You need to elect the amount for the new plan year.

For more information visit:
denbrightdentallabs.hrbenefits.net/

SHORT TERM DISABILITY

In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. This coverage is paid by Denbright and is employee coverage only. Disability benefits must be approved by a physician and the disability provider.

Denbright provides this coverage to you at no cost. Short-term disability is designed to replace a portion of your income for a short period of time while you are unable to work. If you qualify for benefits, they are taxable to you. An overview of the coverage is provided below. Please refer to the contract for complete plan details.

	Employer Paid Short-Term Disability
Benefit Provided	Up to 60% of your weekly salary
When do Benefits Begin	After the 7th day of an illness or an injury
Maximum Benefit Duration	13 weeks
Maximum Weekly Benefit	$500

If you live in a state with mandated statutory leave benefits, STD coverage may not be appropriate for you.

LONG TERM DISABILITY

In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. This coverage is paid by the employee. Disability benefits must be approved by a physician and the disability provider.

Long Term Disability

Long Term Disability (LTD) is an employee paid benefit that provides partial income protection if you are unable to work due to an illness or injury. Your benefit covers a portion of your monthly salary up to 24 weeks. Benefits begin on the 15th day of disability and are not taxable income to you.

Benefits	Employer Paid LTD	Employee Paid LTD
Benefit Provided	Up to 50% of your monthly salary	Up to 60% of your monthly salary
Maximum Benefit Duration	Until you're no longer considered disabled or you reach normal retirement age, whichever comes first.	Until you're no longer considered disabled or you reach normal retirement age, whichever comes first.
Maximum Monthly Benefit	$5,000	$10,000
Waiting Period	90 days	90 days

Long Term Disability Premium

Your premium amount will be shown when you enroll through Paylocity. If you'd like to estimate your premium, follow these steps:

(Monthly earnings/$100) x rate (.82) x 12/26 = Bi-weekly premium max. of $16,667/mo.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Denbright offers a comprehensive Employee Assistance Plan (EAP) through Lincoln Financial Group, at no cost to you. EmployeeConnect offers professional, confidential services to help you and your loved ones improve your quality of life.

The Employee Assistance Program helps you and your eligible dependents balance the demands of work,life, and personal issues. This **confidential** service provides access to professional counseling and guidance to address stressful life events.

Employees and their eligible dependents can speak to a trained professional who will help assess their needs and provide referrals to local resources including psychologists, legal and financial consultants, marriage/family therapists, and substance abuse counselors.

You and your eligible dependents have unlimited telephonic access to the EAP and up to five face-to-face counseling sessions per issue.

Take Advantage of EmployeeConnect

For more information, visit GuidanceResources.com, download the GuidanceNow mobile app, or call 888-628-4824.

GuidanceResources.com Login Credentials:

Username: LFGSupport Password: LFGSupport1

VOLUNTARY BENEFITS

Denbright offers plans to provide you additional protections against unexpected events. Through Cigna, you may purchase Critical Illness, Accident and/or Hospital Indemnity policies. Benefits are paid directly to the policyholder regardless of other insurance. These plans are designed to help with your out-of-pocket costs related to health events.

For many Americans, a home, 401(k) plan and college fund make up the majority of their savings. However, these are not sensible sources of cash for medical emergencies. They represent cash saved for the long haul — not for a few months of recovery along the way.

Critical Illness

Cigna Critical Illness insurance can help with the treatment of costs of covered critical illnesses, such as cancer, a heart attack, or a stroke. More importantly, the plan helps the colleagues focus on getting better (instead of the distraction and stress over the cost of medical and personal bills). This insurance provides a lump-sum benefit to help with out-of-pocket medical expenses and the living expenses that can accompany a covered critical illness. Consider the potential costs of care/recovery and the financial shortfalls that could impact your family if an injury or sickness occurs.

Accident

This coverage provides cash benefits to help offset medical expenses resulting from accidents. Also includes supplemental AD&D coverage.

Hospital Indemnity

Cigna Hospital Indemnity insurance helps deliver financial security for the unexpected – allowing you to help protect your budgets against unforeseen expenses if you suffer an accidental injury or sickness. You can use the cash benefits from this coverage to help meet copayments, to pay for recovery expenses or in any way you see fit.

For more information visit:
denbrightdentallabs.hrbenefits.net/

IDENTITY THEFT PROTECTION

We're committed to the physical, emotional and financial well-being of those we serve. That's why Cigna teamed up with IdentityForce, a top-rated provider of identity theft protection.[4]

We'll help protect your Cigna medical plan subscribers and their children against ID theft and help fix any identity theft compromises – at no additional cost for eligible members

TWO WAYS TO ENROLL:

1. IdentityForce will **email an enrollment link to registered myCigna customers**. (remember to register on myCigna [3])
2. Cigna members can visit our dedicated IdentityForce website https://cigna.identityforce.com/starthere or phone line

   (**833-580-2523**) to get started

Once enrolled, customers can access **IdentityForce** directly through the **IdentityForce** app or website

1. Every two seconds, there's a new identity theft victim.[1]
2. 15 billion consumer credentials are circulating on the dark web.[2]

1. Sadler, AT. "There's a new victim of identity theft every two seconds: Here's the best way to protect yourself online." Clark.com. April 3, 2017. https://clark.com/technology/theres-a-new-victim-of-identity-theft-every-twoseconds-heres-the-best-way-to-protect-yourself-online/ 2. Forbes. "New Dark Web Audit Reveals 15 Billion Stolen Logins From 100,000 Breaches." https://www.forbes.com/sites/daveywinder/2020/07/08/new-dark-webaudit-reveals-15-billion-stolen-logins-from-100000-breaches-passwords-hackerscybercrime/?sh=6e53c5bf180f. July 8, 2020. 3. Customers under age 13 (and/or their parent/guardian) will not be able to register at myCigna.com. 4. White, A. "Best identity theft protection services of September 2021." CNBC.com. August 27, 2021. https://www.cnbc.com/select/best-identity-theft-protection-services/. Frankel, RS. "Best Identity Theft Protection Services Of 2021." Forbes Advisor. June 10, 2021. https://www.forbes.com/advisor/personal-finance/best-identity-theftprotection-services/.

Benefit Resource Center (BRC)

Access all your benefits details while on the go!

The Benefit Resource Center (BRC) is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you. This confidential service is offered to you at no cost.

The specialists in the Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time via phone 855-874-0835 or via email BRCSouth@usi.com . If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or email message by the end of the following business day.

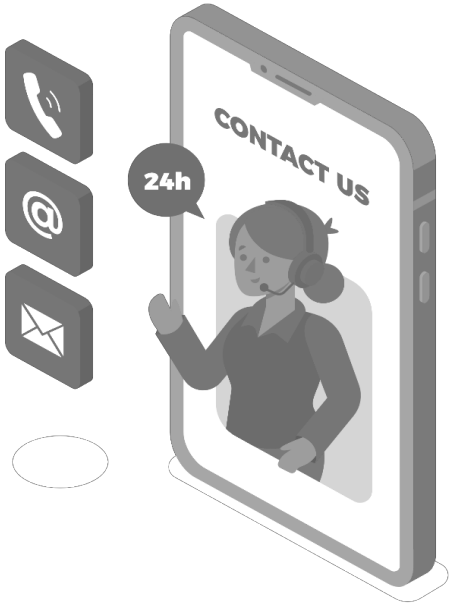
Our Benefits Specialists can help you with:

- Deciding which plan is the best for you
- Benefit plan & policy questions
- Eligibility & claim problems with carriers
- Information about claim appeals & process
- Allowable family status election changes
- Transition of care when changing carriers
- Claim escalation, appeal & resolution

Benefit Resource Center (BRC)

BRCSouth@usi.com | Toll Free: 855-874-0835

Monday – Friday | 8:00am to 5:00pm EST



FREQUENTLY ASKED QUESTIONS

When Do I Pay A Copayment?

Expect to pay a copayment for doctor's visits, emergency room visits and urgent care center visits.

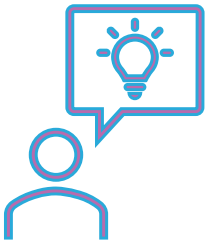
How Do I Know When To Go To An Urgent Care Center Vs. The Emergency Room?

If you need medical care when your regular doctor is not available, think about going to an urgent care center. The urgent care center should be used for minor emergencies (fever, cough, pain, etc.), when your physician's office is closed and your symptoms are too severe to wait until the office reopens, or when you are out-of-town. The copayment is less for the urgent care center than the ER and getting care at the urgent care center will most certainly be faster than an ER visit. Emergency rooms should only be used for true emergencies such as broken bones, vigorous bleeding or severe pain.

The next time you are faced with deciding where to go, be sure to evaluate all your options and choose the setting that best suits your illness or injury. Of course, in a true emergency, seek the appropriate care without delay.

What Is An Explanation Of Benefits (EOB)?

An EOB is a description the insurance company sends to you explaining the health care charges that you incurred and the services for which your doctor has requested payment. You should compare your EOB to the bill you receive from the doctor. All data on your EOB should match the information that appears on the statements you receive from your doctor. If it doesn't, contact the doctor's office immediately.



What Is Preventive Care?

Preventive care is proactive, comprehensive care that emphasizes prevention and early detection. This care includes physical exams, immunizations, well woman and well man exams. Be sure your child gets routine checkups and vaccines as needed, both of which can prevent medical problems (and bills) down the road. Also, adults should get preventive screenings recommended for their age to detect health conditions early. Remember all preventive care benefits are covered 100% under your medical plan.

What Is The Difference Between Generic And Brand Name Drugs?

The difference between generic and brand name medications lies in the name of the drug and the cost. Generic drugs cost much less than brand name drugs, save you and your employer money, and provide the same health benefits as brand name drugs.

What Is The Benefit Of Mail Order Drugs?

Mail order drugs are perfect for patients who take medication on an ongoing basis. Examples are high blood pressure medication, high cholesterol medication, insulin, and birth control. Mail Order drugs are convenient because they are delivered to your doorstep, which relieves the stress of standing in line at the pharmacy.

What Should I Ask My Doctor?

Amazingly, many patients do not ask their doctor basic questions. "How much will my treatment cost?" "Can I be treated another way that is equally effective but less costly?" "What are the risks?" "What are the side effects?" Having a dialogue with your physician can help you better understand how his or her care decisions affect your health plan costs. It will also help your doctor get to know you better and consequently prescribe treatment that is more effective.

GLOSSARY

1095-C – The health care law outlining which employers must offer health insurance to their employees. The law refers to them as "applicable large employers," or ALEs. A company or organization is an ALE if it has at least 50 full-time employees or full-time equivalents. It also provides information needed to do a federal tax return.

COINSURANCE – A type of health insurance in which the insured individual contributes a specified percentage of the total cost of the medical expense after the deductible has been reached.

COPAY – The fixed amount paid by the insured for health care services or prescriptions received.

DEDUCTIBLE – The amount the insurer pays for health care services before the health insurance begins to pay its portion. A deductible may not apply to all services, including preventive care.

EMPLOYEE CONTRIBUTION – The amount paid by an employee for insurance coverage.

EXPLANATION OF BENEFITS (EOB) – A statement sent by a health insurance company to
covered individuals explaining what medical treatments and/or services were paid for on their behalf.

IN-NETWORK – Discounted rates for healthcare services provided by doctors, hospitals, and other providers that contract with the insurance company.

OUT-OF-NETWORK – Out-of-network providers are doctors, hospitals and other providers that do not offer their health services at a discounted rate because they are not contracted with the insurance company.

OUT-OF-POCKET MAXIMUM – The total you will pay for covered health care services during the plan year (typically a 12-month period) before the health insurance or plan starts to pay 100% of the allowed amount. This does not include the monthly premium or services not covered by the plan.

OVER-THE-COUNTER (OTC) MEDICATIONS – Medications available without a prescription.

PRESCRIPTION MEDICATIONS – Doctor-prescribed medications. The medications costs are determined by their specified tier: Generic, Preferred, Non-Preferred or Specialty.

SUMMARY OF BENEFITS AND COVERAGE (SBC) – Documents required through health care reform, an easy-to-follow summary of theinsurance carrier or plan benefits and plan coverage offered.

WHO TO CONTACT

Carrier Customer Service			
Benefits Plan	**Carrier**	**Phone Number**	**Website**
Medical & Rx	Cigna	800-997-1654	www.cigna.com
Medical & Rx (California Only)	Kaiser	888-901-4636	www.healthy.kaiserpermanente.org
Dental	Cigna	800-997-1654	www.cigna.com
Vision	Cigna	866-939-3633	cignaeyemedconference.com
Flexible Spending Accounts (FSAs)	Flores	800-532-3327	www.flores247.com
Life and AD&D Insurance	Lincoln Financial Group	800-423-2765	www.lincolnfinancial.com
Short & Long-Term Disability	Lincoln Financial Group	800-423-2765	www.lincolnfinancial.com
Accident Insurance	Cigna	800-997-1654	www.cigna.com
Critical Illness Insurance	Cigna	800-997-1654	www.cigna.com
Hospital Care Insurance	Cigna	800-997-1654	www.cigna.com
Employee Assistance Program (EAP)	Lincoln Financial Group	800-423-2765	www.lincolnfinancial.com

For Additional Resources and Notices please Visit Our Benefits Site:
denbrightdentallabs.hrbenefits.net/

Denbright Dental Labs

Important Legal Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 35 for more details

USI

Important Legal Notices Affecting Your Health Plan Coverage

FIXED INDEMNITY NOTICE

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

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

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

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

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

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

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

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

- Kaiser HMO: Deductible - $0 Individual / $0 Family; Coinsurance – N/A
- Kaiser DHMO: Deductible - $1,000 Individual / $2,000 Family; Coinsurance – 70%

- Cigna OAP In-Network Only: Deductible - $1,000 Individual / $2,000 Family; Coinsurance – 80%
- Cigna Open Access Plus: Deductible - $2,000 Individual / $4,000 Family, Coinsurance – 80%
- Cigna Open Access Plus HDHP: Deductible - $3,200 Individual / $6,400 Family, Coinsurance – 90%

NEWBORNS ACT DISCLOSURE – FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

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

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

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

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

ADA NOTICE REGARDING WELLNESS PROGRAMS

GoPivot is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive such as i rewards that could include gift cards, merchandise

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Brittany Lazar at 980-285-7072

Protections from Disclosure of Medical Information

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Brittany Lazar at 980-285-7072

HIPAA WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at Brittany Lazar at 980-285-7072 and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

PATIENT PROTECTION MODEL DISCLOSURE

Kaiser or Cigna generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Kaiser at 888-901-4636 or Cigna at 800-997-1654.

You do not need prior authorization from Kaiser or Cigna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Kaiser at 888-901-4636 or Cigna at 800-997-1654.

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce your Rights

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

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

Assistance with your Questions

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

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Brittany Lazar
1101 Investment Blvd, Suite 100
El Dorado Hills, California United States 95762
980-285-7070
blazar@frontierdentallab.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully****.*

Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

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

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

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

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

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

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

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

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

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

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

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

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

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

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

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

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

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.

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

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

Changes to the Terms of this Notice

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

MODEL INDIVIDUAL CREDITABLE COVERAGE DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

Important Notice from Denbright Dental Labs About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Denbright Dental labs and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

When Can You Join A Medicare Drug Plan?

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

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

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

- You may stay in the Kaiser HMO, Kaiser DHMO, Cigna OAP In-Network Only, Cigna Open Access Plus, Cigna Open Access Plus HDHP and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose Kaiser HMO, Kaiser DHMO, Cigna OAP In-Network Only, Cigna Open Access Plus, Cigna Open Access Plus HDHP creditable coverage.
- You may stay in the Kaiser HMO, Kaiser DHMO, Cigna OAP In-Network Only, Cigna Open Access Plus, Cigna Open Access Plus HDHP and also enroll in a Medicare prescription drug plan. The Kaiser HMO, Kaiser DHMO, Cigna OAP In-Network Only, Cigna Open Access Plus, Cigna Open Access Plus HDHP will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the Kaiser HMO, Kaiser DHMO, Cigna OAP In-Network Only, Cigna Open Access Plus, Cigna Open Access Plus HDHP and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the Kaiser HMO, Kaiser DHMO, Cigna OAP In-Network Only, Cigna Open Access Plus, Cigna Open Access Plus HDHP, you are not able to receive coverage through the plan unless and

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Denbright Dental Labs changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	1/1/2025
Name/Entity of Sender:	Denbright Dental Labs
Contact Position/Office:	HR Business Partner
Address:	1101 Investment Blvd, Suite 100, El Dorado Hills, CA 95762
Phone Number:	980-285-7070

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

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

Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

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

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

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

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE – Medicaid

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

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

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

NORTH DAKOTA – Medicaid

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

OKLAHOMA – Medicaid and CHIP

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

OREGON – Medicaid and CHIP

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

PENNSYLVANIA – Medicaid and CHIP

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

RHODE ISLAND – Medicaid and CHIP

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

SOUTH CAROLINA – Medicaid

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

SOUTH DAKOTA – Medicaid

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

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid

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

VIRGINIA – Medicaid and CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

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

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

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

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

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 Denbright Dental Labs			4. Employer Identification Number (EIN) 68-03555156
5. Employer address 1101 Investment Blvd, Suite 100			6. Employer phone number 950-255-7070
7. City El Dorado Hills		8. State CA	9. ZIP code 95762
10. Who can we contact about employee health coverage at this job? Brittany Lazar HR Business Partner			
11. Phone number (if different from above)	12. Email address blazar@frontierdentallab.com		

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☐ Some employees. Eligible employees are:
    As defined in the certificate of coverage and summary plan description
- With respect to dependents:
  - ☐ We do offer coverage. Eligible dependents are:
    As defined in the certificate of coverage and summary plan document
  - ☐ We do not offer coverage.

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

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

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

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

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

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

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

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16. What change will the employer make for the new plan year?
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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