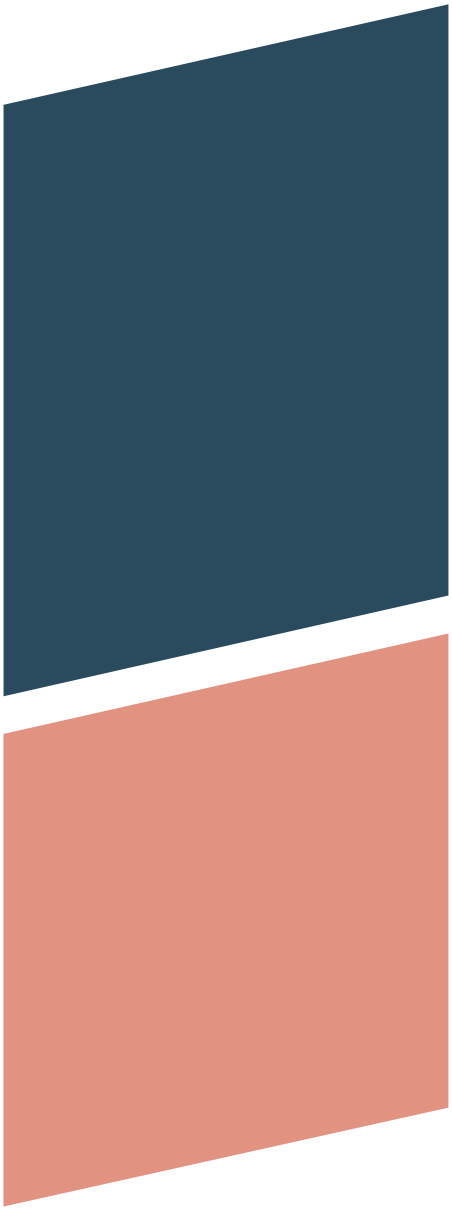
2027
EMPLOYEE BENEFITS

uprisehealth

Table of Contents

Working together is what makes Uprise Health a success, and this teamwork extends to your benefits. We provide options to help support your family's overall wellbeing. This guide provides a detailed overview of your 2027 benefits. If you have questions, please contact People Operations at benefits@uprisehealth.com.

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See **page 35** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to Uprise Health. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Welcome

Dear Uprise Health employee,

You matter to us. So, the things that are important to you matter to us, too. Your physical health is tied to your mental health. That's why we offer comprehensive benefits options for you and your family, including medical, dental, vision, life and disability, and additional benefits coverage. We are committed to excellence in our work and in our offerings for 2027.

This guide includes:

- An overview of your 2027 benefits options
- Explanations of each offering to help you make the best decisions for you and your family
- Contact information for all benefits vendors
- Costs associated with your benefits

Any questions?
We're here to help. Contact People Operations at Benefits@uprisehealth.com.

Eligibility and Enrollment

Uprise Health's benefits are designed to support your unique needs.

Eligibility

If you are a full-time employee of Uprise Health who is regularly scheduled to work at least 30 hours per week, you are eligible to participate in medical, dental, vision, life and disability plans, and additional benefits.

Coverage Dates

Your elections are effective the first of the month following 30 days of employment. Benefits cannot be changed until the next enrollment period unless you experience a Qualifying Life Event.

Dependents

Dependents eligible for coverage include:

- Your legal spouse (or common-law spouse where recognized).
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom you or your spouse have legal guardianship).
- Dependent children 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Note: Verification of dependent eligibility may be required upon enrollment.

Note

You cannot change your benefits, unless you have a Qualifying Life Event, such as marriage or the birth/adoption of a child.

Now's the Time to Enroll!

What are Qualifying Life Events?

You can update your benefits when you start a new job or during Open Enrollment. But changes in your life called Qualifying Life Events (QLEs) determined by the IRS can allow you to enroll in health insurance or make changes outside of these times.

Common QLEs include:

- A change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent)
- A change in a spouse's employment status (resulting in a loss or gain of coverage)
- A change in your legal marital status (marriage, divorce, or legal separation)
- A change in employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- Eligibility for coverage through the Marketplace
- Changes in address or location that may affect coverage
- Entitlement to Medicare or Medicaid

When a Qualifying Life Event occurs, you have 31 days to request changes to your coverage. Your change in coverage must be consistent with your change in status.

Some lesser-known qualifying events are:

- Turning 26 and losing coverage through a parent's plan
- Death in the family (leading to change in dependents or loss of coverage)
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)

Reach out to Uprise Health's People Operations at benefits@uprisehealth.com with questions regarding specific life events and your ability to request changes. Don't miss out on a chance to elect or update your benefits!

Preparing for Enrollment

Uprise Health covers a significant amount of your benefit costs. Your contributions for medical and buy-up dental are deducted on a pre-tax basis, lessening your tax liability. Employee contributions vary depending on the level of coverage you select — typically, the more coverage you have, the higher your portion.

You can choose any combination of medical, dental, and/or vision coverage. You could select medical coverage for yourself and your entire family, but dental and vision coverage only for yourself. The only requirement is that as an eligible employee of Uprise Health, you must elect coverage for yourself in order to elect coverage for dependents. Remember, the base dental, vision, Life, and STD and LTD are at no cost to you.

Enrollment Action Items

Update your personal information.

Ensure you have the most up to date personal details in the ADP system. Beneficiary information is also important for your life coverage.

Double-check covered medications.

Consider how your current prescriptions will be affected under the plan offerings.

Review available plans' deductibles.

Foresee a lot of medical needs this year? You might want a lower deductible. If not, you could switch to a higher deductible plan and enjoy lower premiums.

Consider your HSA or FSA.

An HSA or FSA can help cover healthcare costs, including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with your long-term financial goals.

Check your networks.

Going in-network often saves you money. Check for any plan changes to make sure your go-to providers and pharmacy are still your best bet.

Preventive Care

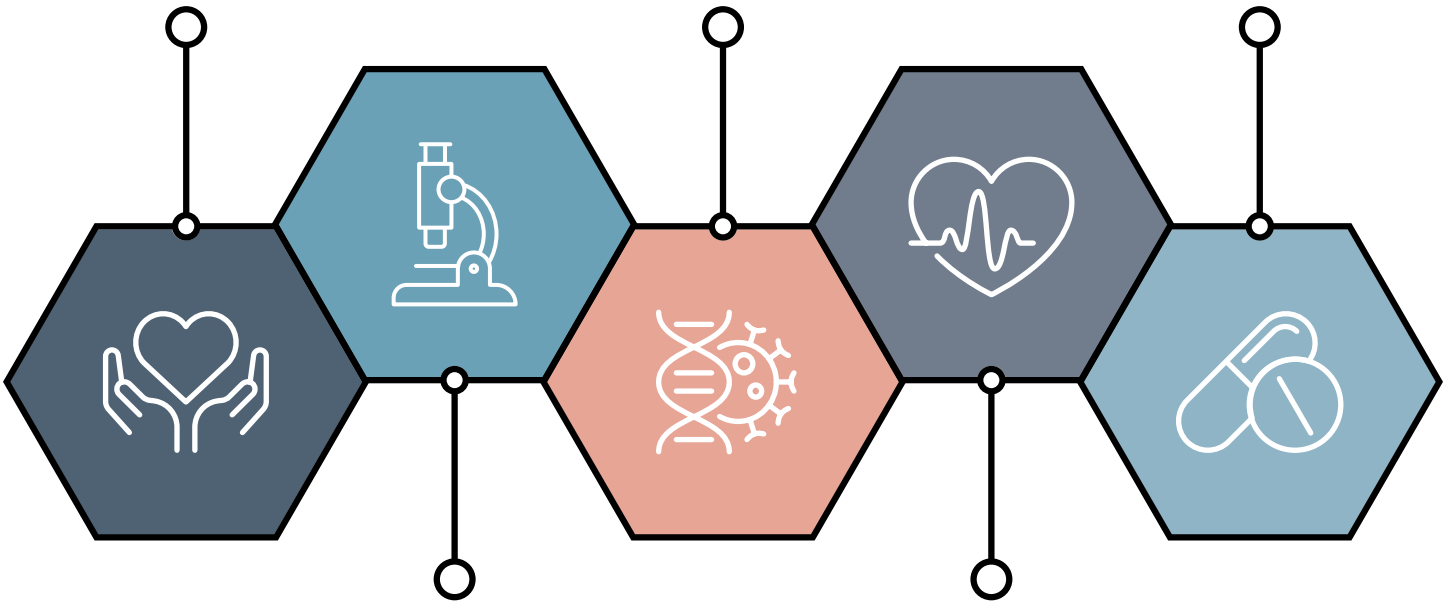
Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance when in-network.

Keep up to date with your primary care physician to stay on top of your overall health. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

Wellness visits, physicals, and standard immunizations

Pediatric screenings for hearing, vision, obesity, and developmental disorders

Iron supplements (for children ages 6 to 12 months at risk for anemia)



Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes

Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women

Don't miss out on these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

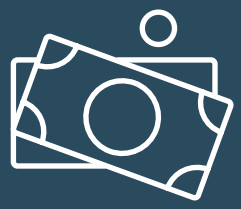
What about the COVID-19 vaccine? The COVID-19 vaccine itself is considered preventive. For individuals who have insurance through Uprise Health, the vaccine will be at no cost.

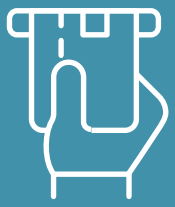
Out-of-Pocket Costs

These are the types of payments you're responsible for:

Copay

The fixed amount you pay for healthcare services at the time you receive them.





Deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

Coinsurance

Your percentage of the cost of a covered service. If your MRI or facility visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.





Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.

Nurse Line

When to Use

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

Types of Care*

Answers to questions regarding:

- Symptoms
- Self-care/home treatments
- Medications and side effects
- When to seek care

Costs and Time Considerations**

- Usually available 24 hours a day, 7 days a week
- Free as part of your medical insurance

Telemedicine

When to Use

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Types of Care*

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

Costs and Time Considerations**

- For the PPO $2,500, and Kaiser plans, visits are covered at the same cost share as in office. For the HDHP $2,900, the cost is subject to your deductible and coinsurance.
- Usually immediate access to care
- Prescriptions through telemedicine or virtual visits not allowed in all states

Primary Care Center

When to Use

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*

- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

Costs and Time Considerations**

- Refer to the Medical Plan Summary for the cost for your selected plan
- Normally requires an appointment
- Usually little wait time with scheduled appointment

Urgent Care Center

When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*

- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

Costs and Time Considerations**

- Cost is usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer (urgency decides order)

Emergency Room

When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*

- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

Costs and Time Considerations**

- Cost is substantially higher than an office visit or urgent care
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- Ambulance charges, if applicable, will be separate and may not be in-network

DO YOUR HOMEWORK

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

*This is a sample list of services and may not be all inclusive.

**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Virtual Medicine

When you're under the weather, there's no place like home. And when you're constantly on the go, scheduling a doctor's appointment can easily move down your priority list. Virtual medicine is a convenient and easy way to connect with a doctor on your time.

We provide a virtual medicine benefit through United Healthcare or Kaiser for you and your covered dependents. Both United Healthcare and Kaiser offer on-demand access to board-certified doctors through online video, telephone, or secure email. General health issues can be addressed at home. Virtual medicine is useful for after-hours non-emergency care, when your primary care doctor is unavailable, if you need prescriptions or refills or if you're traveling. Virtual visits aren't good for conditions requiring exams or tests, complex or chronic problems, or emergencies like sprains or broken bones.

Virtual Care doctors can share information with your primary care physician with your consent. Please note that some states do not allow physicians to prescribe medications via telemedicine.

For the PPO $2,500 and Kaiser plans, virtual doctor visits are at no cost. For the HDHP $2,900, the cost is subject to your deductible and coinsurance.

Virtual Care doctors can treat many medical conditions, including:

- Cold & flu
- Allergies
- Bronchitis
- Bladder infection/ urinary tract infection
- Respiratory infection
- Pink eye
- Sore throat
- Stomachache
- Sinus problems

Access Virtual Visits

Sign in to www.myuhc.com or healthy.kaiserpermanente.org to request a virtual visit. After you register and request an appointment, you'll pay your portion of the service costs (if on HDHP 2,900) and enter a virtual waiting room. During your visit, you can talk to a doctor about your health concerns, symptoms, and treatment options.

Note

A virtual visit or FaceTime directly with your primary care physician might also be an option — and costs the same as an office visit.



Medical Benefits

Medical benefits are provided through United Healthcare and Kaiser. Consider the physician networks, premiums, and out-of-pocket costs for each plan when choosing for you and your family. Keep in mind your choice is effective for the entire 2027 plan year unless you have a Qualifying Life Event.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your biweekly contributions.

	UNITED HEALTHCARE PPO $2,500	UNITED HEALTHCARE HDHP $2,900
BIWEEKLY CONTRIBUTIONS		
EMPLOYEE ONLY	$95.37	$65.40
EMPLOYEE + SPOUSE	$199.95	$201.40
EMPLOYEE + CHILD(REN)	$181.76	$183.09
EMPLOYEE + FAMILY	$272.66	$274.64

	KAISER CALIFORNIA (NORTHERN CALIFORNIA)	KAISER CALIFORNIA (SOUTHERN CALIFORNIA)	KAISER NORTHWEST (OREGON)	KAISER NORTHWEST (SOUTH WASHINGTON)
BIWEEKLY CONTRIBUTIONS				
EMPLOYEE ONLY	$247.17	$297.86	$316.56	$316.56
EMPLOYEE + SPOUSE	$609.52	$719.62	$742.76	$742.76
EMPLOYEE + CHILD(REN)	$524.65	$624.36	$645.28	$645.28
EMPLOYEE + FAMILY	$799.50	$943.91	$1,007.16	$1,007.16

How to Find a Provider

Visit www.myuhc.com or call Customer Care at 866-633-2446 for a list of United Healthcare network providers. **California residents will need to search providers under the Select Plus Network. All others will search under the Choice Plus Network.**

For Kaiser, visit healthy.kaiserpermanente.org or call Customer Care at 800-464-4000. For urgent and emergency care while traveling out of state, Kaiser members now have access to Cigna's PPO Network of providers and facilities for routine, urgent and emergency care. All you will need to get care is your Kaiser ID card. To locate a provider, for coverage information, or for assistance before, during, or after your trip, visit kp.org/travel or call 951-268-3900 for travel support anytime, anywhere.

Note

Preventive care offered by an in-network physician, like well-woman exams or annual physicals, is covered at 100%.

Medical Plan Summary

This chart summarizes the 2027 medical coverage provided by United Healthcare and Kaiser. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations. **New in 2027, the United Healthcare network will be the Core network.**

	UNITED HEALTHCARE PPO $2,500		UNITED HEALTHCARE HDHP $2,900	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE				
INDIVIDUAL	$2,500	$5,000	$2,900	$5,800
FAMILY	$5,000	$10,000	$3,500	$7,000
COINSURANCE (PLAN PAYS)	60%*	50%*	60%*	50%*
ANNUAL OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)				
INDIVIDUAL	$9,000	$18,000	$8,700	$17,400
FAMILY	$18,000	$36,000	$17,400	$34,800
COPAYS/COINSURANCE				
PREVENTIVE CARE	100%	Not covered	100%	Not covered
PRIMARY CARE	$60 copay	50%*	60%*	50%*
SPECIALIST SERVICES	$90 copay	50%*	60%*	50%*
MAJOR DIAGNOSTIC IMAGING	60%*	50%*	Office: 60%* Hospital: 50%*	50%*
INPATIENT	60%*	50%*	$250 copay plus 60%*	$250 copay + 50%*
URGENT CARE	$60 copay	50%*	60%*	50%*
EMERGENCY ROOM	60%*		$300 copay + 60%*	

*After deductible

On the PPO $2,500 Plan, the individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a “per individual” deductible amount will also be applied toward the “per family” deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the “per family” deductible amount. The same typically applies for the out-of-pocket maximum.

For the HDHP $2,900 Plan, each covered individual is not required to meet the individual deductible. The HDHP has an aggregate deductible, meaning the family deductible amount will include all combined eligible expenses that you and your covered dependents incur. The family deductible amount may be satisfied by one member or a combination of two or more members covered under your medical plan. The same typically applies for the out-of-pocket maximum.

	KAISER HMO*** (CALIFORNIA ONLY)	KAISER HMO*** (NORTHWEST OR/S WA)
	IN-NETWORK ONLY	IN-NETWORK ONLY
ANNUAL DEDUCTIBLE		
INDIVIDUAL	$0	$0
FAMILY	$0	$0
COINSURANCE (PLAN PAYS)	100%*	100%*
ANNUAL OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)		
INDIVIDUAL	$1,500	$2,000
FAMILY	$3,000	$4,000
COPAYS/COINSURANCE		
PREVENTIVE CARE	100% covered	100% covered
PRIMARY CARE	$20 copay	$20 copay**
SPECIALIST SERVICES	$35 copay	$30 copay
MAJOR DIAGNOSTIC IMAGING	100% covered	$100 copay
INPATIENT	$250 per admission	$250 per admission
URGENT CARE	$20 copay	$30 copay
EMERGENCY ROOM	$100 copay	$250 copay (waived if admitted) copay

*After deductible
**$5 copay for visits 1-3 and $20 copay for visits 4+
***Inpatient and outpatient hospital services under the Kaiser HMO are subject to the applicable copay. Please see plan summary for more details.

Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through United Healthcare and Kaiser. You will have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at www.myuhc.com for United Healthcare or healthy.kaiserpermanente.org for Kaiser, or by calling the Customer Care number on your ID card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, Non-Preferred, or Specialty Drugs.

	UNITED HEALTHCARE PPO $2,500		UNITED HEALTHCARE HDHP $2,900	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL RX DEDUCTIBLE				
INDIVIDUAL	$350		N/A	
FAMILY	$700		N/A	
RETAIL RX (31-DAY SUPPLY)				
TIER 1	$25 copay*	Not covered	$20 copay*	Not covered
TIER 2	$80 copay*	Not covered	$85 copay*	Not covered
TIER 3	$110 copay*	Not covered	$135 copay*	Not covered
TIER 4	70% to a maximum of $250*	Not covered	75% to a maximum of $250*	Not covered
SPECIALTY	N/A	Not covered	$20/$150/$250*	Not covered
MAIL ORDER RX (90-DAY SUPPLY)				
TIER 1	$62.50 copay*	Not covered	$50 copay*	Not covered
TIER 2	$200 copay*	Not covered	$212.50 copay*	Not covered
TIER 3	$275 copay*	Not covered	$337.50 copay*	Not covered
TIER 4	70% to a maximum of $250*	Not covered	75% to a maximum of $250*	Not covered

*After deductible

	KAISER HMO (CALIFORNIA ONLY)	KAISER HMO (NORTHWEST OR/S WA)
	IN-NETWORK ONLY	IN-NETWORK ONLY
RETAIL RX (30-DAY SUPPLY)		
GENERIC	$10 copay	$10 copay
PREFERRED	$35 copay	$30 copay
NON-PREFERRED	$35 copay	$60 copay
SPECIALTY	20% up to $150	20% up to $250
MAIL ORDER RX	100-DAY SUPPLY	90-DAY SUPPLY
GENERIC	$20 copay	$20 copay
PREFERRED	$70 copay	$60 copay
NON-PREFERRED	$70 copay	$120 copay

Generic Drugs

Want to save money on meds? Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety, and strength. Because they are the same medicine, generic drugs are just as effective as the brand names, and they undergo the same rigid FDA standards. **But generic versions cost 80% to 85% less on average than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Note: Apps like GoodRx and RxSaver let you compare prices of prescription drugs and find possible discounts. Make sure to check the price against the cost through your insurance to get the best deal. Note that these discounts can't be combined with your benefit plan's coverage. **So if you choose to use a discount card from an app such as GoodRx or RxSaver, the amount you pay will not count toward your deductible or out-of-pocket maximum under the benefit plan.**

Healthcare Cost Transparency

There are so many different providers and varying costs for healthcare services — how do you choose? Online services called healthcare cost transparency tools can help. Available through most health insurance carriers, these tools allow you to compare costs for services, from prescriptions to major surgeries, to make your choices simpler. Visit www.myuhc.com or healthy.kaiserpermanente.org to learn more.

How to Pick a Plan

What plan is right for you? Consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

How Does a PPO (Preferred Provider Organization) Work?

- You'll pay more in premiums, but perhaps less at the time of service.
- You can choose from a network of providers who offer a fixed copay for office visits.
- If you expect to need more medical care this year or you have a chronic illness, the PPO may be the right choice for you to ensure your healthcare needs are covered.



How Does an HDHP (High Deductible Health Plan) Work?

- You'll pay less in premiums (think less money from your paycheck).
- You'll pay for the full cost of non-preventive medical services until you reach your deductible.
- You can also use a Health Savings Account in conjunction, which provides a safety net for unexpected medical costs and tax advantages.
- If you expect to mostly use preventive care (which is usually covered in full when in-network), this plan could be for you.

How Does an HMO (Health Maintenance Organization) Work? (Kaiser Only)

- In-network services are paid with copays or coinsurance.
- You may seek care from in-network providers only.
- In-network providers are contracted with the insurance company to provide services at a discounted fee.
- Out-of-network services are not covered.
- You need a referral to see a specialist.
- Coverage is limited to a select network of healthcare providers.
- Staying in one health system can lead to coordinated care between your doctors.

Note

The cost of an MRI can vary between $500 and $4,000 — even within your area.

United Healthcare Programs

If you are enrolled in one of the United Healthcare medical plans, the following programs are available to you at no additional cost.

United Healthcare Rewards

United Healthcare Rewards is a next-level program that brings the best of UHC's wellness options into a digital experience built for a healthier lifestyle and rewards.

United Healthcare Rewards is included in your UHC health plan at no additional cost and participation allows you to earn up to $300. With UHC Rewards, a variety of actions — including many things you may already be doing — lead to rewards. The activities you aim for are up to you — same goes for ways to spend your earnings. Here are some ways you can earn:

Reach Daily Goals

- Track 5,000 steps or 15 active minutes each day, or double it for an even bigger reward
- Track 14 nights of sleep

Complete One-Time Reward Activities

- Go paperless
- Get a biometric screening
- Take a health survey
- Connect a tracker

Get Started, Visit www.myuhc.com or Download the United Healthcare App

- Sign in or register
- Select UHC Rewards
- Activate UHC Rewards
- Choose reward activities that inspire you and start earning
- Though not required, connect a tracker and get access to even more reward activities

United Healthcare Real Appeal Weight Loss Program

Get Healthier, At No Additional Cost to You

Real Appeal on Rally Coach is a proven weight management program designed to help you get healthier and stay healthier. It's available to you and eligible family members at no additional cost as part of your UHC benefits.

Small Steps Toward Healthier Habits

Set achievable nutrition, exercise, and weight management goals that keep you motivated to create lasting change. Track your progress from your daily dashboard, too.

Support and Community Along the Way

Feel supported with personalized messages, online group sessions led by coaches, and a caring community of members.

Get a Success Kit Delivered Right to Your Door

Make the most of tools and resources like weight, and food scales, a portion plate, and more. Your Success Kit will be delivered after you attend your first live group session.

To enroll in Real Appeal, visit enroll.realappeal.com.

Mental Health and Employee Assistance Program

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. But your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help? Whether you need assistance with work-life balance or anxiety, there are resources available to help you out.

Unum Employee Assistance Program

We're here for you when you need help. Our Employee Assistance Program (EAP) helps manage your and your family's total health, including mental, emotional, and physical. And there's no cost to you — whether or not you're enrolled in a company-sponsored medical plan.

Through the EAP, you have access to mental health assistance and legal and financial help from professionals. You also have 24-hour access to helpful resources by phone, and the EAP benefit includes three face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with Uprise Health. You may access information, benefits, educational materials, and more by phone at 800-854-1446 or online at unum.com/lifebalance.

The Program provides referrals to help with:

- Emotional health and wellbeing
- Alcohol or drug dependency
- Marriage or family problems
- Job pressures
- Stress, anxiety, depression
- Grief and loss
- Financial or legal advice

Mental Health and Your Medical Plan

In addition to the Employee Assistance Program (EAP), the medical plan covers behavioral and mental health services.

An important aspect of your overall wellbeing is emotional wellness — the ability to successfully adapt to changes and challenges as they arrive and handle life's stresses. These five actions have been shown to improve emotional wellness.

The Big Five of Emotional Wellness

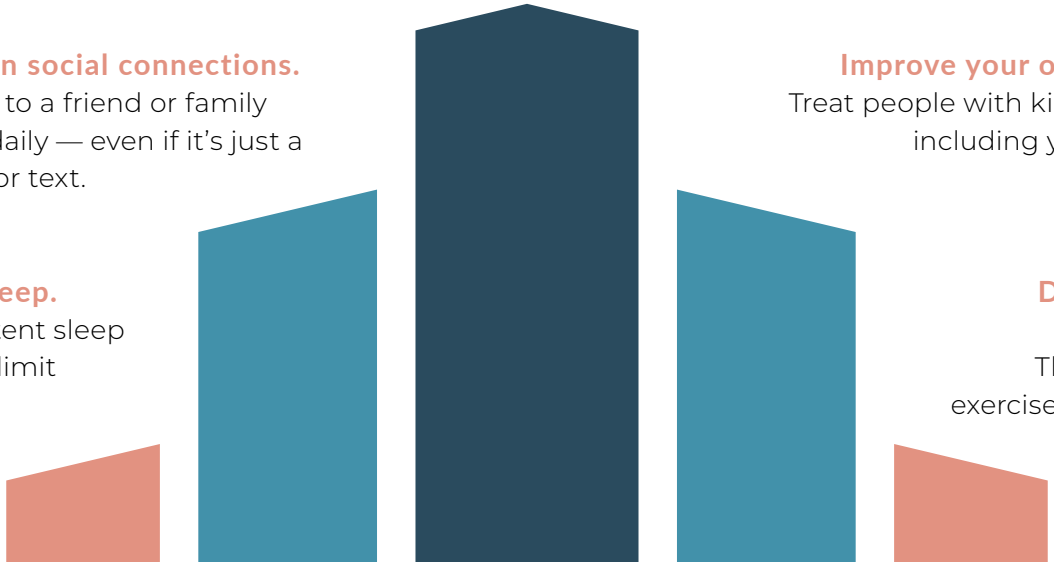
Practice mindfulness.
Practice deep breathing, enjoy a stroll, and stay present in each moment.

Strengthen social connections.
Reach out to a friend or family member daily — even if it's just a video call or text.

Improve your outlook.
Treat people with kindness, including yourself.

Get quality sleep.
Keep a consistent sleep schedule and limit electronic use before bed.

Deal with your stress.
Think positively, exercise regularly, and set priorities.



Other Mental Health Resources

No matter your problem, whether you're a manager or entry-level employee, don't be afraid to ask for help. There are resources available 24/7.

988 Suicide & Crisis Lifeline Dial 988 to be connected with 24/7/365 emotional support. Free, confidential crisis counseling, including appropriate follow-up services, is available no matter where you live in the United States.

Crisis Text Line Text "HOME" to 741741 Send a text 24/7 to the Crisis Text Line to speak with a crisis counselor who can provide support and information. Standard text messaging rates may apply.

War Vet Call Center Veterans and their families call 877-WAR-VETS (877-927-8387) to talk about their military experience and/or readjustment to civilian life.

Call 911 if you or someone you know is in immediate danger or go to the nearest emergency room.

Note

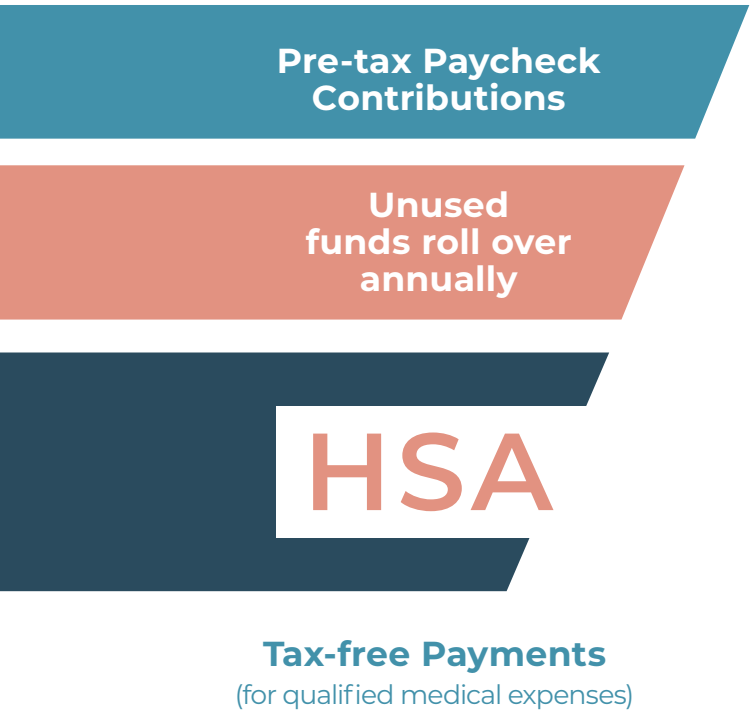
According to the American Psychological Association, 61% of adults say they could have used more emotional support in 2020.

Health Savings Account

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in an HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

WEX will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.



Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse's or parent's non-HDHP.
- You or your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care (service-related care will not be taken into consideration).)

You Own Your HSA

Your HSA is a personal bank account that you own and administer. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements (you own all contributed HSA funds immediately) or forfeiture provisions.

Note

Because HSA funds never expire, contributing your annual maximum to your HSA can help you save to pay for healthcare expenses tax-free after retirement.

How to Enroll

To enroll in Uprise Health's HSA, you must elect the HDHP with Uprise Health. Submit all HSA enrollment materials and choose the amount to contribute on a pre-tax basis. Uprise Health will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with WEX. The money in your HSA (including interest and investment earnings) grows tax-free. When the funds are used for qualified medical expenses, they are spent tax-free.*

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax. This is why it's important to know what medical expenses qualify for HSA use and to keep track of where you spend your HSA funds.

*State income taxes are also waived on HSA contributions in almost all states.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2027, contributions are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$4,500
FAMILY	$9,000
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

HSA contributions over the IRS annual contribution limits ($4,500 for individual coverage and $9,000 for family coverage for 2027) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed but won't have to pay a penalty tax.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The Uprise Health HSA is established with WEX. You may be able to roll over funds from another HSA. For more enrollment information, contact People Operations or visit www.WEXinc.com.

Flexible Spending Accounts

Take control of your spending! A Flexible Spending Account (FSA) provided through WEX is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to $3,500 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Note

The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.



Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $7,500 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent daycare expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or daycare provider
- Before- and after-school care
- Day camp
- In-house dependent daycare

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Using the FSA Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

If you incur an eligible expense for which you do not use your FSA debit card, you can submit a claim form along with the required documentation. Contact WEX with reimbursement questions. If you need to submit a receipt, WEX will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges in case you need to prove an expense was eligible. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2027 plan year.
- Funds cannot be transferred between FSAs.
- You are not permitted to claim the same expenses on both your federal income taxes and Dependent Care FSA.
- You must “use it or lose it” — any unused funds will be forfeited.
- Up to $700 may be rolled over to the next plan year at the end of 2027 for Healthcare FSAs.
- You cannot change your FSA election in the middle of the plan year without a Qualifying Life Event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $160,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

FSA vs HSA

Flexible Spending Accounts		Health Savings Account
Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	OWNERSHIP	You own your HSA. It is a savings account in your name, and you always have access to the funds, even if you change jobs.
You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	ELIGIBILITY & ENROLLMENT	You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
FSA contributions are tax-free via payroll deduction. Funds are spent tax-free when used for qualified expenses.	TAXATION	HSA contributions are tax-free; the account grows tax-free; and funds are spent tax-free on qualified expenses.
You can contribute up to $3,500 in 2027 to an FSA.	CONTRIBUTIONS	You can contribute up to $4,500 in 2027 (up to $9,000 for families). Ages 55+ can make an annual $1,000 "catch-up" HSA contribution.
Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	PAYMENT	Many HSAs include a debit card to pay for qualified expenses directly. Alternatively, you can save funds for future expenses or retirement.
Any unclaimed funds at the end of the year are forfeited. Exceptions might include an additional 2.5-month grace period for expenses to be incurred and reimbursed, or an allowed rollover amount.	ROLLOVER OR GRACE PERIOD	HSA funds roll over from year to year. The account is portable and may be used for future qualified expenses — even in retirement years.
Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
Dependent Care FSA (pre-tax dollars can be used for elder or child dependent care).	OTHER TYPES	There is only one type of HSA.

Please refer to your summary plan description or plan certificate for your plan's specific FSA or HSA benefits.

Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. Uprise Health offers two plan options from MetLife for routine care and beyond.

Stay in Network

If your dentist doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit MetLife at mybenefits.metlife.com.

ID Card

MetLife does not provide physical ID cards. Your provider will need the employee's Social Security number and date of birth to confirm benefits. If you would like to request an ID card, you may download the MetLife mobile app.

Dental Premiums

Dental premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your biweekly premium.

Dental Plan Summary

This chart summarizes the dental coverage provided by MetLife for 2027.

	DENTAL BASE		DENTAL BUY-UP	
BIWEEKLY CONTRIBUTIONS				
EMPLOYEE ONLY	$3.32		$10.85	
EMPLOYEE + SPOUSE	$6.61		$21.60	
EMPLOYEE + CHILD(REN)	$7.16		$26.07	
EMPLOYEE + FAMILY	$11.16		$39.66	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE				
INDIVIDUAL	$50	$50	$50	$50
FAMILY	$150	$150	$150	$150
ANNUAL MAXIMUM				
PER PERSON	$1,000	$1,000	$2,000	$2,000
COVERED SERVICES				
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, X-rays, Fluoride Applications, Sealants, Space Maintainers	100%	100%	100%	100%
BASIC SERVICES Fillings, Root Canal Therapy, Periodontics, Extractions	80%*	80%*	90%*	90%*
MAJOR SERVICES Crowns, Dentures, Bridges	50%*	50%*	60%*	60%*
ORTHODONTICS Adult and Child(ren)	N/A		50%	
ORTHODONTIC LIFETIME MAXIMUM	N/A		$2,000	

*After deductible

Note

Oral health is linked to your overall health — keeping your mouth healthy can protect you from cardiovascular disease, pregnancy complications, and pneumonia.

Vision Benefits

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through VSP at no cost to you.

Vision Plan Summary

This chart summarizes the vision coverage provided by VSP for 2027. Please note, you will not receive a vision card from VSP. Your vision provider can verify your benefits by calling VSP at 800-877-7195.

	VSP VISION	
BIWEEKLY CONTRIBUTIONS		
EMPLOYEE ONLY	$0.00	
EMPLOYEE + SPOUSE	$0.00	
EMPLOYEE + CHILD(REN)	$0.00	
EMPLOYEE + FAMILY	$0.00	
	IN-NETWORK	**FREQUENCY**
EXAMS		
COPAY	$10 copay	Once per calendar year
LENSES		
SINGLE VISION	$25 copay	Once per calendar year
BIFOCAL	$25 copay	
TRIFOCAL	$25 copay	
LENTICULAR	$25 copay	
CONTACTS (IN LIEU OF LENSES AND FRAMES)		
FITTING AND EVALUATION*	Up to $60 fee	Once per calendar year
ELECTIVE	$150 allowance	
MEDICALLY NECESSARY	$25 copay	
FRAMES		
COPAY	$25	Once every other calendar year
ALLOWANCE	$150	

*Fitting and Evaluation fee applied to contact lens allowance.

Out-of-Network Coverage

Get the most out of your benefits and greater savings with a VSP network doctor. Log in to www.VSP.com for out-of-network plan details.

Note

Early detection of vision conditions like diabetic retinopathy leads to more effective treatment and cost savings.

Survivor Benefits

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection in the event of an unexpected event.

Basic Life and Accidental Death & Dismemberment Insurance

Uprise Health provides employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage at no cost through UNUM, which guarantees that your spouse or other designated survivor(s) continue to receive benefits after death.

Your Basic Life and AD&D insurance benefit is **2x salary, up to $1,000,000**. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you waive other coverage.

Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death under the UNUM insurance.

Name a primary and contingent beneficiary to make your intentions clear. Indicate their full name, address, Social Security number, relationship, date of birth, and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact People Operations or your own legal counsel with any questions.

Voluntary Life and AD&D Insurance

You may wish for extra coverage for more peace of mind. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

BASIC EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	2x salary
WHO PAYS	Uprise Health
MAXIMUM BENEFIT	$1,000,000
GUARANTEED ISSUE	$750,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	If you elect more than the Guaranteed Issue amount upon initial eligibility or elect any amount outside of initial enrollment opportunity
VOLUNTARY EMPLOYEE LIFE	
COVERAGE AMOUNT	1–6 times salary, in increments of $10,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$500,000
GUARANTEED ISSUE	$300,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	If you elect more than the Guaranteed Issue amount upon initial eligibility, or elect any amount outside of initial enrollment opportunity
VOLUNTARY SPOUSE LIFE	
COVERAGE AMOUNT	Increments of $10,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$250,000, not to exceed 100% of employee's approved amount
GUARANTEED ISSUE	$30,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	If you elect for your spouse more than the Guaranteed Issue amount upon initial eligibility, or elect any amount outside of initial enrollment opportunity
VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	$10,000
WHO PAYS	Employee
MAXIMUM BENEFIT	$10,000
VOLUNTARY AD&D	
COVERAGE AMOUNT	Matches Voluntary Life benefit
WHO PAYS	Employee

VOLUNTARY LIFE INSURANCE

RATES/$1,000 (BIWEEKLY)			
AGE (AS OF 01/01/2027)	EMPLOYEE	AGE (AS OF 01/01/2027)	SPOUSE
15-24	$0.025	15-24	$0.025
25-29	$0.028	25-29	$0.028
30-34	$0.037	30-34	$0.037
35-39	$0.049	35-39	$0.049
40-44	$0.073	40-44	$0.073
45-49	$0.119	45-49	$0.119
50-54	$0.183	50-54	$0.183
55-59	$0.257	55-59	$0.257
60-64	$0.310	60-64	$0.310
65-69	$0.586	65-69	$0.586
70-74	$0.951	70-74	$0.951
75+	$0.951	75+	$0.951

VOLUNTARY AD&D INSURANCE

RATES/$1,000 (BIWEEKLY)
$0.009

VOLUNTARY CHILD LIFE INSURANCE

RATES/$1,000 (BIWEEKLY)
$0.092

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

$	÷ 1,000 =	$	x Age Based Rate =	$
Benefit Elected				Premium

Income Protection

You and your loved ones depend on your regular income. That's why Uprise Health offers disability coverage at no cost to the employee to protect you financially in the event you cannot work as a result of a debilitating injury. A portion of your income is protected until you can return to work or you reach retirement age.

Basic Short Term Disability (STD) Insurance

Short Term Disability (STD) benefits are available at no cost. This insurance replaces 60% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or People Operations for details.

WEEKLY MAXIMUM BENEFIT	60%, up to $1,500
ELIMINATION PERIOD	7 days
MAXIMUM BENEFIT PERIOD	12 weeks

Basic Long Term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are available at no cost. This insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or People Operations for details.

MONTHLY MAXIMUM BENEFIT	60%, up to $5,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

Supplemental Health Benefits

Uprise Health offers several ways to supplement your medical plan coverage. This additional insurance can help cover unexpected expenses, regardless of any benefit you may receive from your medical plan. Coverage is available for yourself and your dependents and offered at discounted group rates.

Accident Coverage

You can't always prevent accidents, but you can be prepared for them, including readying for any financial impact. Accident coverage through MetLife provides benefits for you and your covered family member for expenses related to an accidental injury that occurs outside of work. Health insurance helps with medical expenses, but this coverage is an additional layer of protection that can help pay deductibles, copays, and even typical day-to-day expenses such as a mortgage or car payment. Benefits are payable to you to use as you wish.

Please review the summary of benefits for more information.

BIWEEKLY CONTRIBUTIONS	
EMPLOYEE ONLY	$3.78
EMPLOYEE + SPOUSE	$7.57
EMPLOYEE + CHILD(REN)	$8.93
EMPLOYEE + FAMILY	$10.67

Critical Illness Coverage

Critical Illness coverage through MetLife pays a lump-sum benefit if you are diagnosed with a covered disease or condition. You can use this money however you like. Examples include helping pay for expenses not covered by your medical plan, lost wages, childcare, travel, home healthcare costs, or any of your regular household expenses.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
  - Employee: Increments of $10,000 up to $40,000
  - Spouse and Child(ren): 100% of employee's benefit
- Pre-Existing Conditions: This plan does NOT have a pre-existing condition exclusion; however, your date of diagnosis must be on or after the effective date of your policy for benefits to be paid.

Covered Benefits

Paid at 100% of your elected benefit amount unless otherwise noted; refer to plan summary:

- Heart Attack
- Stroke
- Coronary Artery Bypass (50%)
- Invasive Cancer
- Skin Cancer (5%)
- Benign Brain Tumor
- Kidney Failure
- Major Organ Transplant
- Alzheimer's Disease
- Coma
- Complete Blindness
- Complete Loss of Hearing
- Infectious Disease (25%)
- Amyotrophic Lateral Sclerosis (ALS)
- Parkinson's Disease

NON-TOBACCO COVERAGE BIWEEKLY CONTRIBUTION PER $1,000 OF COVERAGE

ATTAINED AGE	EMPLOYEE ONLY	EMPLOYEE PLUS SPOUSE	EMPLOYEE PLUS CHILDREN	EMPLOYEE PLUS FAMILY
<25	$0.17	$0.34	$0.40	$0.57
25 - 29	$0.20	$0.40	$0.43	$0.63
30 - 34	$0.24	$0.48	$0.48	$0.72
35 - 39	$0.30	$0.60	$0.54	$0.83
40 - 44	$0.41	$0.81	$0.64	$1.04
45 - 49	$0.57	$1.13	$0.80	$1.36
50 - 54	$0.78	$1.62	$1.02	$1.85
55 - 59	$1.06	$2.28	$1.29	$2.51
60 - 64	$1.45	$3.18	$1.68	$3.42
65 - 69	$2.00	$4.45	$2.23	$4.68
70 - 74	$2.73	$6.02	$2.96	$6.25
75+	$3.90	$8.36	$4.14	$8.59

TOBACCO COVERAGE BIWEEKLY CONTRIBUTION PER $1,000 OF COVERAGE

ATTAINED AGE	EMPLOYEE ONLY	EMPLOYEE PLUS SPOUSE	EMPLOYEE PLUS CHILDREN	EMPLOYEE PLUS FAMILY
<25	$0.21	$0.42	$0.44	$0.65
25 - 29	$0.26	$0.51	$0.49	$0.74
30 - 34	$0.34	$0.66	$0.57	$0.90
35 - 39	$0.46	$0.88	$0.69	$1.11
40 - 44	$0.66	$1.26	$0.89	$1.50
45 - 49	$0.94	$1.85	$1.17	$2.08
50 - 54	$1.34	$2.74	$1.57	$2.97
55 - 59	$1.84	$3.92	$2.07	$4.15
60 - 64	$2.53	$5.55	$2.76	$5.78
65 - 69	$3.50	$7.81	$3.73	$8.05
70 - 74	$4.73	$10.48	$4.97	$10.71
75+	$6.62	$14.29	$6.85	$14.52

TO CALCULATE HOW MUCH YOUR COVERAGE WILL COST:

$	÷ 1,000 =	$	x Age Based Rate =	$
Benefit Elected				Monthly Premium

Hospital Indemnity Coverage

Hospital Indemnity coverage through MetLife pays you cash benefits directly if you are admitted to the Hospital or an Intensive Care Unit (ICU) for a covered stay. You can use the benefits to help pay for your medical expenses such as deductibles and copays, travel cost, food and lodging, or everyday expenses such as groceries and utilities.

Plan Highlights

- Guaranteed Issue Coverage (no medical questions)
- Pre-Existing Conditions: This plan does NOT have a pre-existing condition exclusion. Benefits are payable for hospitalizations that occur on or after the effective date of your policy.

BENEFIT AMOUNT	
INITIAL CONFINEMENT BENEFIT FOR HOSPITAL OR CRITICAL CARE UNIT (UP TO 4 TIMES PER CALENDAR YEAR)	$1,000
DAILY BENEFIT FOR HOSPITAL CARE (30 DAYS PER CALENDAR YEAR)	$200
DAILY BENEFIT FOR CRITICAL CARE (ADDITIONAL 15 DAYS PER CALENDAR YEAR)	$200
DAILY BENEFIT FOR NEWBORN NURSERY CARE (2 DAYS PER CONFINEMENT)	$50

BIWEEKLY CONTRIBUTIONS	
EMPLOYEE ONLY	$12.45
EMPLOYEE + SPOUSE	$22.26
EMPLOYEE + CHILD(REN)	$18.52
EMPLOYEE + FAMILY	$28.32

Prepaid Legal Coverage

MetLife offers low-cost access to attorneys for personal legal services. Payments are made conveniently through payroll deductions. It's like having your own attorney on retainer to assist you with:

- Estate planning, wills, and trusts
- Real-estate matters
- Identity-theft defense
- Financial matters, such as debt-collection defense
- Traffic offenses
- Document review
- Family law, including adoption and name change
- Advice and consultation on personal legal matters
- Divorce

Coverage is available for $12 biweekly and covers you and your dependents.

Pet Insurance

Your pets are also loved ones. We offer pet insurance through the ASPCA. You will receive the benefit of lower rates being with Uprise Health. For more information, please visit www.aspcapetinsurance.com/uprise (priority code: EBUPRISE) or call 877-343-5314.

Glossary

Balance Billing – When you are billed by an out-of-network provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

High Deductible Health Plan (HDHP) Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.



Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- **Healthcare FSA –** A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Dependent Care FSA –** A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.
- **Limited Use FSA –** Designed to complement a Health Savings Account, a Limited Use FSA allows for reimbursement of eligible dental and vision expenses.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your tax-free dollars to pay for qualified medical expenses. You must be enrolled in an HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network –** Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network –** Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating –** Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.



Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred, or specialty.

- **Generic Drugs –** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs –** Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs –** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs –** Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- **Prior Authorization –** A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice From Uprise Health About Your Prescription Drug Coverage and Medicare Under the United Healthcare and Kaiser Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Uprise Health 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. Uprise Health has determined that the prescription drug coverage offered by the United Healthcare and Kaiser plan(s) 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, your current Uprise Health coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Uprise Health 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 at the end of these notices 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 Uprise Health 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 Medicare Part D 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:	January 1, 2027
Name of Entity/Sender:	Uprise Health
Contact—Position/Office:	People Operations
Address:	2 Park Plaza, Suite 1200 Irvine, CA 92614
Phone Number:	800-395-1616

Women's Health and Cancer Rights Act

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. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact People Operations at 800-395-1616.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact People Operations at 800-395-1616.

HIPAA 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 later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact People Operations at 800-395-1616.

Illinois Essential Health Benefit (EHB) Listing

Employer Name: Uprise Health

Employer State of Situs: California

Name of Issuer: United Healthcare

Plan Marketing Name: PPO $2,500 and HDHP $2,900

Plan Year: 2027

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

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

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
1	Accidental Injury – Dental	Ambulatory	Pgs. 10 & 17	Yes
2	Allergy Injections and Testing		Pg. 11	Yes
3	Bone Anchored Hearing Aids		Pgs. 17 & 35	Yes
4	Durable Medical Equipment		Pg. 13	Yes
5	Hospice		Pg. 28	Yes
6	Infertility (Fertility) Treatment		Pgs. 23 - 24	No
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Pg. 21	Yes
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)		Pgs. 15 - 16	Yes
9	Private-Duty Nursing		Pgs. 17 & 34	No
10	Prosthetics/Orthotics		Pg. 13	Yes
11	Sterilization (Vasectomy Men)		Pg. 10	Yes
12	Temporomandibular Joint Disorder (TMJ)		Pgs. 13 & 24	Yes
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency Services	Pg. 7	Yes
14	Emergency Transportation/Ambulance		Pgs. 4 & 17	Yes
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Yes
16	Breast Reconstruction After Mastectomy		Pgs. 24 – 25	Yes
17	Reconstructive Surgery		Pgs. 25 – 26, & 35	Yes
18	Inpatient Hospital Services (e.g., Hospital Stay)		Pg. 15	Yes
19	Skilled Nursing Facility		Pg. 21	Yes
20	Transplants – Human Organ Transplants (Including Transportation & Lodging)		Pgs. 18 & 31	Yes

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	EHB Benefit	EHB Category	Benchmark Page # Reference	
21	Diagnostic Services	Laboratory Services	Pgs. 6 & 12	Yes
22	Intranasal Opioid Reversal Agent Associated with Opioid Prescriptions	MH/SUD	Pg. 32	Yes
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)		Pgs. 8 – 9, 21	Yes
24	Opioid Medically Assisted Treatment (MAT)		Pg. 21	Yes
25	Substance Use Disorders (Including Inpatient Treatment)		Pgs. 9 & 21	Yes
26	Tele-Psychiatry		Pg. 11	Yes
27	Topical Anti-Inflammatory Acute and Chronic Pain Medication		Pg. 32	Yes
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See All Kids Pediatric Dental Document	No
29	Pediatric Vision Coverage		Pgs. 26 – 27	No
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Yes
31	Outpatient Prescription Drugs	Prescription Drugs	Pgs. 29 – 34	Yes
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Yes
33	Contraceptive/Birth Control Services		Pgs. 13 & 16	Yes
34	Diabetes Self-Management Training and Education		Pgs. 11 & 35	Yes
35	Diabetic Supplies for Treatment of Diabetes		Pgs. 31– 32	Yes
36	Mammography – Screening		Pgs. 12, 15, & 24	Yes
37	Osteoporosis – Bone Mass Measurement		Pgs. 12 & 16	Yes
38	Pap Tests/Prostate-Specific Antigen Tests/Ovarian Cancer Surveillance Test		Pg. 16	Yes
39	Preventive Care Services		Pg. 18	Yes
40	Sterilization (Women)		Pgs. 10 & 19	Yes
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 – 13	Yes
42	Habilitative and Rehabilitative Services		Pgs. 8, 9, 11, 12, 22, & 35	Yes

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

Important Contacts

MEDICAL, PHARMACY, AND TELEMEDICINE

United Healthcare
866-633-2446
www.myuhc.com
Policy #: 925984

Kaiser
800-464-4000
healthy.kaiserpermanente.org
Policy #:
Southern California: 235692
Northern California: 607340
Oregon and S Washington: 24567

DENTAL

MetLife
800-438-6388
mybenefits.metlife.com
Policy #: 5392340

VISION

VSP
800-877-7195
www.vsp.com
Policy #: 30107362

FLEXIBLE SPENDING ACCOUNT AND HEALTH SAVINGS ACCOUNT

WEX
866-451-3399
customerservice@WEXhealth.com

LIFE/AD&D AND DISABILITY

UNUM
800-858-6843
www.Unum.com/Employees
Basic Life and Disability Policy #: 947045
Voluntary Life and AD&D Policy #: 947046

EMPLOYEE ASSISTANCE PROGRAM

UNUM
800-854-1446
unum.com/lifebalance
Policy #: 947045

SUPPLEMENTAL HEALTH (Accident, Critical Illness, Hospital Indemnity, Legal)

MetLife
800-438-6388
mybenefits.metlife.com
Policy #: 5392340

PET INSURANCE

ASPCA
877-343-5314
www.aspcapetinsurance.com/uprise
Priority code: EBUPRISE

UPRISE HEALTH PEOPLE OPERATIONS

benefits@uprisehealth.com

Notes

uprisehealth