Verus

Employee Benefits Guide
January 1, 2022 - December 31, 2022

Access benefit information online!
www.verusbenefitplans.com

Produced by AssuredPartners

This Benefit Guide is a summary of your benefits as an eligible Verus employee. Each section of this Benefit Guide contains important information, so please read this overview carefully.

Please note that this overview is a summary of benefits. For a complete description of benefit provisions, refer to your certificates of coverage and insurance policies. In the event of a discrepancy between this overview and the official plan documents, benefits will be paid as outlined in the plan documents.

If you have questions about your benefits or need assistance with claims, please contact a Benefit Advocate at MCM. Benefit Advocates are professionals who are available to provide confidential assistance for you and your covered family members. Please see the following page of this overview for more information.

The benefits in this summary are effective:
January 1, 2022 through December 31, 2022

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This plan intends to comply with all federally mandated benefit changes and patient protections required by the federal health care reform law. This Summary of Benefits is based on current interpretations/guidance on health care reform and could change based on future determinations and/or final regulations.

For Assistance

Provider	Benefit	Telephone	Website	Group #
Premera	Medical, Prescription Drug & Basic Vision	1-800-722-1471	www.premera.com	4012885
Connect Your Care	Health Savings Accounts	1-800-941-6121	www.premera.com	4012885
Delta Dental of Washington	Dental	1-800-554-1907	www.deltadentalwa.com	01400
Vision Service Plan (VSP)	Voluntary Vision	1-800-877-7195	www.vsp.com	30087321
Navia Benefit Solutions	Flexible Spending Accounts & Transit Benefit	1-800-669-3539	www.naviabenefits.com	WRT
Unum	Life & Long Term Disability	1-800-421-0344	www.unum.com	710263
Health Advocate through Unum	Employee Assistance Program	1-800-854-1446	www.unum.com/lifebalance	N/A
Assist American through Unum	Travel Assistance	1-800-872-1414	www.unum.com/travelassistance	Reference #: 01-AA-UN-762490

Whom do I call with benefit questions?

If you have a benefit question or problems with a claim payment, Benefit Advocates in the AssuredPartners Employee Service Center (ESC) understand your benefits program and assist you in resolving complex issues such as claims appeals.

The ESC is available Monday through Friday, 7:30 AM to 5:00 PM Pacific Time. There is no cost to you to access the ESC, and all calls and emails are completely confidential. Your Benefit Advocate will track your issue and make sure it is resolved.

Due to HIPAA Privacy regulations, AssuredPartners may need to obtain your written authorization to assist with certain issues. Your Benefit Advocate will provide you with an authorization form, if needed. Please note, the AssuredPartners ESC cannot provide legal representation, legal advice, or medical reviews.

Who is Eligible?

New employees working at least 20 hours per week are eligible to enroll in the medical/prescription drug insurance, vision insurance, dental insurance, flexible spending arrangements, and transit benefits. Employees working at least 30 hours per week will also be automatically enrolled in life and long term disability insurance, which are paid for in full by Verus. Coverage will be effective the first of the month following or coinciding with your date of hire.

Eligible dependents are limited to the following:

- Your spouse, unless legally separated
- Your domestic partner (DP)
- Your child(ren) under age 26. An eligible child is one of the following:
  - A natural offspring of the subscriber and/or spouse/DP
  - A legally adopted child of, or child placed for adoption with, the subscriber and/or spouse/DP
  - A legally placed ward or foster child of the subscriber and/or spouse/DP

Open Enrollment & Election Changes

As an eligible new hire and each year at open enrollment, you have the opportunity to enroll yourself and your eligible dependents in these programs. Please note, if you do not enroll in benefits when initially eligible as a new hire, you will not be able to enroll until the next open enrollment period for a January 1 effective date, unless you or your dependents experience a permitted election change event.

Permitted election change events include, but are not limited to:

- Birth or adoption of a new child
- The death of a dependent
- Marriage, divorce or legal separation
- Spouse loses coverage through his or her employer or gains access to his or her employer's sponsored coverage
- You become eligible for or lose Medicaid coverage

A permitted election change event should be reported to Human Resources within 60 days of the event date.

The above is only a brief description of Verus's eligibility requirements. Please refer to your Certificate of Coverage or see Human Resources for a complete definition of dependent eligibility.

Cost of Coverage

The amounts below will be deducted from your paycheck each month if you elect coverage. Premiums are automatically deducted pre-tax unless you instruct HR otherwise.

If you cover a domestic partner (or a domestic partner's children), deductions will be taken on a post-tax basis unless they qualify as dependents under the Internal Revenue Code Section 152. In addition, unless your domestic partner qualifies under IRC Section 152, Verus's contribution to your domestic partner or their children's premium will be included in your taxable income.

The below outlines the monthly premiums to participate in the medical, vision, and dental plans.

Medical, Rx, & Basic Vision: Premera

Option 1: $3,000 High Deductible Medical/Rx + Basic Vision

	You Pay	Verus Pays	Total Premium
Employee Only	$62.86	$565.70	$628.56
Employee & Spouse	$141.43	$1,272.83	$1,414.25
Employee & Child(ren)	$110.00	$989.97	$1,099.97
Employee & Family	$188.57	$1,697.09	$1,885.66

Option 2: $1,000 Low Deductible Medical/Rx + Basic Vision

	You Pay	Verus Pays	Total Premium
Employee Only	$177.83	$630.47	$808.30
Employee & Spouse	$472.85	$1,345.82	$1,818.67
Employee & Child(ren)	$353.64	$1,060.91	$1,414.54
Employee & Family	$654.73	$1,770.19	$2,424.92

Dental: Delta Dental of Washington

	You Pay	Verus Pays	Total Premium
Employee Only	$4.43	$39.83	$44.25
Employee & Spouse	$9.21	$82.89	$92.10
Employee & Child(ren)	$9.89	$89.01	$98.90
Employee & Family	$14.68	$132.12	$146.80

Voluntary Vision: Vision Service Plan (VSP)

	You Pay	Verus Pays	Total Premium
Employee Only	$8.83	$0.00	$8.83
Employee & Spouse	$14.12	$0.00	$14.12
Employee & Child(ren)	$14.41	$0.00	$14.41
Employee & Family	$23.24	$0.00	$23.24

Medical Benefits

We are pleased to provide you with comprehensive medical plans offered through Premera. You will get the highest level of benefits when you receive covered services and supplies from a network provider. If the provider you see does not contract with Premera, you may be responsible for amounts over the allowable charge, in addition to applicable copays, deductibles, coinsurance, etc. Below is a brief description of your medical coverage under this plan.

	Premera	
	Option 1: High Deductible	**Option 2: Low Deductible**
In Network Benefits - Heritage Network		
Deductible Per calendar year	$3,000 Individual $6,000 Family (aggregate)	$1,000 Individual $2,000 Family
Out-of-Pocket Maximum Per calendar year (includes deductible & copays)	$6,000 Individual $12,000 Family	$5,000 Individual $10,000 Family
Preventive Care	No Charge, deductible waived	No Charge, deductible waived
Telehealth Visit (General Medical)	20% coinsurance, after deductible	$10 copay, deductible waived
Office Visit	20% coinsurance, after deductible	$30 copay, deductible waived
Urgent Care Visit	20% coinsurance, after deductible	$30 copay, deductible waived
Chiropractic Services (12 visits Per calendar year)	20% coinsurance, after deductible	$30 copay, deductible waived
Acupuncture (12 visits Per calendar year)	20% coinsurance, after deductible	$30 copay, deductible waived
Outpatient Lab & X-Ray	20% coinsurance, after deductible	20% coinsurance, deductible waived
Outpatient Surgery	20% coinsurance, after deductible	20% coinsurance, after deductible
Inpatient Hospital Services	20% coinsurance, after deductible	20% coinsurance, after deductible
Emergency Room	20% coinsurance, after deductible	$150 copay, then 20% coinsurance, after deductible
Mental Health Benefits	20% coinsurance, after deductible	Office visit / Telehealth visit: $30 copay Inpatient: 20% coinsurance, after deductible
Out of Network Benefits		
Deductible Per calendar year	$6,000 Individual $12,000 Family (aggregate)	$2,000 Individual $4,000 Family
Out-of-Pocket Maximum Per calendar year (includes deductible & copays)	Unlimited	Unlimited
Most Other Services	50% coinsurance, after deductible	50% coinsurance, after deductible

Prescription Benefits

When you enroll in the medical plan, you also receive coverage for prescription drugs. Premera's prescription drug plan gives you coverage for a wide range of prescriptions. The prescription drug coverage is the same, no matter which medical plan you enroll in.

	Premera	
	Option 1: High Deductible	**Option 2: Low Deductible**
In Network Benefits - Heritage Network		
Deductible Per calendar year	Combined with medical	None
Out-of-Pocket Maximum Per calendar year	Combined with medical	Combined with medical
Retail Pharmacy 30 day supply limit	20% coinsurance, after deductible	$15/$30/$50 copay
Mail Order Pharmacy 90 day supply limit	20% coinsurance, after deductible	$37/$75/$125 copay

The High Deductible Plan uses Premera's Open A1 prescription drug list, while the Low Deductible Plan uses Premera's Preferred B3 prescription drug list. Drug tiers do not apply on the Open A1 drug list; all drugs are subject to deductible and coinsurance as outlined above. The Preferred B3 drug list categorizes prescription drugs into three tiers based on their value. The costs shown above are Generic/Preferred Brand/Non-Preferred Brand. Drugs can change tiers during the year; you can check what tier your drug is in at www.premera.com

Certain prescription drugs may have limitations or requirements. Contact Premera for more information.

Basic Vision Benefits *(included in Medical/Rx plan)*

When you enroll in the medical plan, you also receive coverage for vision care through Premera. Coverage includes benefits for routine eye exams and vision hardware. For a more comprehensive vision plan option, refer to the VSP vision plan on page 10.

		Premera	
	Frequency	**Option 1: High Deductible**	**Option 2: Low Deductible**
Vision Exam	Per calendar year	$25	$25
Vision Hardware	Every 2 calendar years	Up to $150 allowance	Up to $150 allowance
Pediatric Vision Exam	Per calendar year	$25	$25
Pediatric Vision Hardware	Per calendar year	One pair of glasses (frames and lenses) or a 12 month supply of contacts covered in full	One pair of glasses (frames and lenses) or a 12 month supply of contacts covered in full

Premera Tools and Resources

Premera Website

Register with www.premera.com for online access to your benefits. Once you have registered you will be able to:

- Find a network doctor of facility
- Track claims and expenses for your family
- Plan ahead for tests and treatments

Premera Mobile App

Premera's mobile app lets you easily access your health care information and gives you tools to access the NurseLine, contact customer service, and find providers- anytime and anywhere. It's built to be your go-to health care resource when you're on the go. Download the Premera mobile app to your Apple or Android smartphone or tablet, you can:

- Find nearby providers, hospitals, and pharmacies
- View and share your ID card
- View discounts on hearing aids, gym memberships, health coaching, and more.

Premera Virtual Care

The Premera virtual health network provides easy-to-access, board-certified, quality care that saves you money and time. This network- as well as in-network brick-and-mortar telemedicine- are available as part of your plan.

- Get everything from fast diagnosis and treatment of common ailments to routine checkups and ongoing monitoring of chronic conditions anytime with 98point6 and Doctor On Demand.
- With Talkspace and Doctor On Demand, you get specialized psychiatric treatment from a licensed prescriber- all from the comfort of your home.
- Boulder Care includes video visits and text messaging with a therapist for treatment of opioid use disorder and alcohol use disorder.
- WorkIt Health includes live chat and video with a therapist for treatment of opioid use disorder and alcohol use disorder.

Get convenient access on the Premera mobile app.

Premera's Wellness Tools

It's the little choices that matter. Whether it's choosing an apple over a donut, taking the stairs instead of the elevator, or even walking at lunch, it all adds up. Sure, these choices can be simple, but making lifestyle changes can be hard. Premera is here to help. When you choose Premera as your health plan, you gain access to Premera's Wellness Tools.

Online Health Assessment

The online Health Assessment is an easy-to-complete survey that gauges your physical and emotional health based on risk factors and current lifestyle habits. With these results, you can gain an understanding of lifestyle changes that will positively impact your overall health.

myStrength Interactive Self Care

An interactive computerized cognitive behavioral therapy (CCBT) program to help you tackle common issues such as stress, depression, anxiety, and insomnia, anywhere, anytime.

Health Savings Accounts

When you enroll in the high deductible health plan, you can also open a health savings account (HSA) through Connect Your Care. This account can help you fund your deductible, coinsurance, and other qualified medical expenses. When you successfully open the account, you may choose to make contributions to the account directly from your paycheck. All employees who elect the HSA will receive $37.50 per paycheck deposited into their account from Verus from their eligibility date through their last paycheck of the year. For employees who are enrolled for the full year, this is a total employer contribution of $900.

What is a qualified High Deductible Health Plan?

A qualified high deductible health plan (HDHP) is the only type of plan that allows you to make contributions to a tax-advantaged HSA. With the exception of preventive care, all medical and pharmacy expenses are your responsibility until you meet the annual deductible. After you meet the deductible, coinsurance may apply until you meet your out of pocket maximum.

What is a Health Savings Account?

An HSA is a tax-advantaged account you can use to pay for medical expenses incurred by you, a spouse or a tax dependent. Contributions, investment earnings and qualified withdrawals are all exempt from federal income tax, FICA tax and most state income tax (excludes California)*.

You may make contributions through payroll deduction up to IRS limits. The annual limit depends upon whether you are enrolled in the qualified HDHP with self-only coverage or with dependents, as well as how much of the year you are covered by a qualified HDHP.

Please be conservative when contributing towards the HSA mid-calendar year, as contribution limits are prorated based on the number of months you are enrolled in a qualified HDHP. The IRS imposes a penalty on excess contributions in the form of an income tax and a 6% additional tax on the excess contribution amount. You are responsible for tracking your contributions to ensure you don't exceed the maximum allowable contribution. See 2022 limits on the bottom of page 10.

Who qualifies for an HSA?

All employees eligible for health benefits may enroll in the HDHP option, but under strict IRS rules, not everyone is eligible to contribute to or receive contributions to a HSA. To be an eligible individual and qualify for an HSA, you must meet the following requirements:

- You must be covered under a qualified HDHP on the first day of the month.
- You have no other health coverage except what is permitted (e.g. a limited-purpose health FSA or HRA).
- You are not enrolled in Medicare (including Medicare Part A).
- You cannot be claimed as a dependent on someone else's tax return (except your spouse's).

Under the IRS's last-month rule, you are considered to be an eligible individual for the entire year if you are an eligible individual on the first day of the last month of your tax year (December 1 for most taxpayers), as long as you remain an eligible individual for at least 13 months.

Who can use the HSA?

You do not pay taxes on the funds you use to pay for qualified health care expenses. The following individuals can use HSA funds:

1. You and your spouse.
2. All dependents you claim on your tax return.
3. Any person you could have claimed as a dependent on your return except that:
   - The person filed a joint return,
   - The person had gross income of $3,700 or more, or
   - You, or your spouse if filing jointly, could be claimed as a dependent on someone else's tax return.

What are Eligible Medical Expenses?

You can use your HSA to pay for a wide range of eligible medical expenses for yourself, your spouse or tax dependents. Funds used to pay for eligible medical expenses are always tax-free, and you can continue to use your HSA funds even if you're not covered by an HSA-compatible plan.

- Deductibles, coinsurance
- Dental care – braces, dentures
- Vision care – glasses, contacts, Lasik surgery
- Medical equipment
- COBRA premiums
- Long Term Care insurance
- Prescription medications

For additional information, please refer to IRS publication 502, "Medical and Dental Expenses."

Funds used to pay for qualified medical expenses, referred to by the IRS as distributions, are tax free (certain state income taxes apply). If you use your HSA to pay for an ineligible expense, you must report it on your federal income tax return and pay the related taxes, plus a penalty. (After age 65, the penalty does not apply.)

HSA Perks

- Money put in your HSA is tax free and earns interest tax free (excludes California).*
- Money left in your account at the end of the plan year rolls over to the next year.
- You own the money in your HSA so you keep it even if you change plans or jobs.

HSA Limits

- 2022 contribution limits, as established by the IRS, are $3,650 for employee only coverage and $7,300 if you cover at least one dependent.
- Verus's contribution counts toward these maximums.
- An additional $1,000 "catch-up" contribution is allowed for individuals over age 55.

***There are a few states that do not conform with federal tax rules regarding HSAs. In California and New Jersey, HSA contributions and earnings are subject to state income taxes. In New Hampshire, interest and dividend earnings are taxable above a certain dollar amount. Please consult your personal tax advisor for additional information.**

Dental Benefits

We are pleased to offer you a dental plan through Delta Dental of Washington. This is a Delta Dental PPO Preferred Provider plan. You can choose any dentist; however, if you select a dentist who is part of the Delta Dental PPO network, your benefits will be paid at a higher level, and your out-of-pocket expenses will likely be lower.

	Delta Dental of Washington	
	Preferred PPO Dentist	**Participating (Premier) or Non-Participating Dentist**
Deductible Per calendar year	$50 Individual $150 Family	$50 Individual $150 Family
Individual Benefit Maximum Per calendar year	$1,000	$1,000
Class 1 - Diagnostic & Preventive Exams, prophys, x-rays, fluoride, & sealants (does not apply to Individual Benefit Maximum)	No charge	20% coinsurance, deductible waived
Class 2 - Restorative Services Restorations, endodontics, periodontics, oral surgery	20% coinsurance, after deductible	30% coinsurance, after deductible
Class 3 - Major Services Crowns, dentures, partials, bridges, implants	50% coinsurance, after deductible	60% coinsurance, after deductible
TMJ - Surgical and Non-Surgical Treatment $1,000 annual maximum, $5,000 lifetime maximum	50% coinsurance, after deductible	50% coinsurance, after deductible

Balance Billing: If you visit a non-participating dentist, you may be responsible for charges that exceed the plan's maximum reimbursement levels, in addition to the deductible and plan cost share.

Pre-Treatment Estimate: If your dental work will be extensive, you should have your dentist submit the proposed treatment plan to Delta Dental before you begin treatment. Delta Dental will provide you with a summary of the plan's coverage and your estimated out-of-pocket costs.

Find a Dentist: You can find a participating dentist in your area by visiting the Delta Dental of Washington website. Be sure to select the appropriate plan- ***Delta Dental PPO***- and follow the prompts.

MySmile Personal Benefits Center: To get the most from your benefits, register for MySmile on deltadentalwa.com. Whether you need to check benefits, find a dentist, or have general questions, you'll find the answers you need.

At MySmile Personal Benefits Center you can:

- Check your coverage
- Print ID cards
- Check claim status or retrieve prior claim information
- Find a dentist
- View your dental activity
- Compare average dental costs in your location

Voluntary Vision Benefits

If you are looking for more comprehensive vision coverage than what is provided through the Premera medical plan, you can also enroll in coverage for vision care through Vision Service Plan (VSP). Coverage includes in and out of network benefits for routine eye exams and vision hardware. As a VSP member, you may receive extra discounts and savings on laser vision correction, prescription glasses and contacts.

	VSP Choice Provider	
	Frequency	**You pay**
Vision Exam	Every 12 Months	$10 copay
Prescription Glasses		$25 copay
Basic Lenses*	Every 12 Months	Included in glasses copay
Premium Lenses**		Premium progressive lenses: $80- $90 Custom progressive lenses: $120- $160 Average savings of 35- 40% on other lens enhancements
Frames	Every 24 Months	Included in glasses copay up to: $130 allowance for a wide selection of frames $150 allowance for featured frame brands 20% savings on the amount over your allowance $70 Costco frame allowance
Contact Lenses (contacts and exam)	Every 12 Months in lieu of Prescription Glasses	Up to $60 for exam Lenses covered up to $130 Copay does not apply

* Basic lenses include single vision, lined bifocal, lined trifocal, and basic progressive lenses. Basic lenses also include polycarbonate lenses for dependent children.
** Premium lenses include premium and custom progressive lenses, and all other lens enhancements.

Extra savings:

- Average savings of 35-40% on lens enhancements (such as anti-reflective coating and scratch-resistant coating).
- Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details.
- 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam; or get 20% from any VSP provider within 12 months of your last WellVision Exam.
- No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.
- Average 15% off the regular price or 5% off the promotional price of laser vision correction; discounts only available from contracted facilities.

When you visit a VSP doctor, tell them you have VSP. There is no ID card necessary. If you'd like a card for reference, you can print one on VSP.com.

Prefer shopping online? Use your VSP benefits at www.eyeconic.com, VSP's preferred online eyewear store.

Flexible Spending Accounts

Navia Benefit Solutions administers our Health Care, Limited Purpose Health Care, and Dependent Care Flexible Spending Accounts (FSAs). The money you elect to contribute will be deducted out of your paychecks on a pre-tax basis, enabling you to pay less in taxes and have more disposable income.

Health Care FSA

Verus Contributes: $300
Your Annual Contribution Maximum: $2,850

Allows you to pay for qualified medical, dental or vision out-of-pocket health care expenses.

Limited Purpose Health Care FSA

Your Annual Contribution Maximum: $2,850

Specifically for those members enrolled in an HSA medical plan. Allows you to pay for out-of-pocket dental and vision expenses only.

Dependent Care FSA

Your Annual Contribution Maximum: $5,000 (per household)

Allows you to pay for daycare expenses for children under age 13, dependent elder care, or care for other tax dependents unable to care for themselves while both you and your spouse work or go to school full time. Discuss with a tax consultant whether it is better for you to participate in the Dependent care FSA or claim a deduction on your taxes.

Note: If you have a traditional Health Care FSA and move to the high deductible plan, your traditional Health Care FSA will be terminated without a grace period prior to your first day in the high deductible plan due to IRS regulations.

Grace Period & Runout Period

There is a grace period, which gives you extra time to incur more claims after the end of the plan year that can be applied to your prior year's FSA balance. All receipts for eligible expenses are due by the dates shown below.

Due Dates

	2021 Plan Year	2022 Plan Year
Incur Claims Until	December 31, 2022	March 15, 2023
Receipts are Due	December 31,2022	March 31, 2023

Note: The 2021 plan year grace period was extended due to COVID-19; the 2022 plan year is expected to revert back to a 2.5 month grace period with 16 days after the end of the grace period to submit claims.

FSA Rules

Specific IRS rules govern the operation of FSAs, including the following:

- "Use It or Lose It"- You will forfeit any money left in an FSA at the end of the runout period.
- Only expenses incurred before the end of the month in which you terminate employment are eligible for reimbursement, unless you continue your FSA via COBRA.
- All caregivers using the Dependent Care FSA must have a tax ID or Social Security number. This information must be included on your federal tax return.

How much should I contribute?

Before you enroll in the FSA, use this worksheet to estimate your out-of-pocket expenses for the calendar year.

Medical	
Deductibles	$
Coinsurance	$
Office Visit Copays	$
Prescription Drug Copays	$
Dental	
Deductibles	$
Coinsurance	$
Vision	
Copays	$
Examinations	$
Lenses	$
Contact Lenses	$
Miscellaneous	
Other Qualified Medical Expenses	$
ANNUAL TOTAL	**$**

GoNavia Commuter Benefits

The GoNavia Commuter program allows you to pay for your work-related transit expenses using pre-tax dollars. Once registered on the website (www.naviabenefits.com) you can place an order for your monthly transit needs. The order amount will be deducted from your paycheck pre-tax and loaded onto a Navia Benefits Card. You can then use the Navia Benefits Card in place of a personal debit or credit card to purchase services at any transit or parking facility that accepts MasterCard. There is no claim filing required, and there is no open enrollment period for this program. Employees can join for any month.

Life Insurance Benefits

Eligible employees are automatically enrolled in life insurance through Unum at no cost to you. Your life insurance benefit is equal to 2 times your annual earnings to a maximum of $500,000. Any amount over $450,000 is subject to medical underwriting. Benefit reductions begin at age 65.

Long Term Disability Insurance Benefits

Verus provides eligible employees with long term disability insurance through Unum, which replaces a portion of your income if you were to become sick or injured and unable to work.

Your benefits begin after a 180 day elimination period of continuous disability from the date of your disabling condition. The plan will pay 66 2/3% of your covered pre-disability earnings up to a maximum monthly benefit of $15,000. How long you are eligible for benefits is determined by the extent of your disability and ability to work. The plan will not pay benefits for a disability that results from a pre-existing condition for your first 12 months of coverage.

Travel Assistance Program

Also, through your life insurance coverage, you, your spouse, and your dependent children have access to worldwide travel assistance services through Assist America. Whenever you travel 100 miles or more from home, be sure to keep this service in mind. Add the number to your cell phone contacts so it's always close at hand, or download the Assist America Mobile App. Whether traveling for business or pleasure, just one phone call can connect you and your family to these medical and other important services 24 hours a day:

- Hospital admission assistance
- Emergency medical evacuation
- Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Emergency message services
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance

Employee Assistance Program (EAP) and Work/Life Balance Services

Verus provides a completely confidential Employee Assistance Program (EAP) and Work/Life Balance Services through Health Advocate for all employees who are eligible for the Unum LTD plan. These services are available to all employees who are eligible for the Unum LTD plan, their spouse or domestic partner, dependent children, parents, and parents-in-law. Expert support is available 24/7 over the phone or online.

Employee Assistance Program (EAP)

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor. You can get up to three visits, available at no cost to you, per issue per year.

A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Anger, grief, loss
- Job stress, work conflicts
- Family and parenting problems
- And more

Work/Life Balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and a Work/Life Specialist can answer your questions and help you find resources in your community.

Ask your Work/Life Specialist about:

- Child care and elder care
- Financial services, debt management, credit report issues
- Identity theft
- Legal questions
- Reducing your medical or dental bills
- And more

Annual Notices

SURPRISE MEDICAL BILLING

COVID-19 relief legislation addresses "surprise" medical bills sent to consumers when they receive unplanned medical care from certain providers, such as out-of-network emergency facilities, out-of-network care received at in-network facilities, and air ambulance transportation. When services fall within the surprise billing protections, cost-sharing is restricted to in-network levels and balance billing (i.e., seeking to collect from the patient more than the applicable cost-sharing amount) is prohibited. Explanations of Benefits (EOB) will include a notice of these balance billing requirements and protections.

NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2022

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.**

If you have any questions about this notice, please contact Mellisa Ingraham at 206-622-3700 or mingraham@verusinvestments.com.

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 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, and we may say "no" if it would affect your care.

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 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 on page 1.
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/ocr/privacy/hipaa/complaints/. 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 unable 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.

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.

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.

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/ocr/privacy/hipaa/understanding/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/ocr/privacy/hipaa/understanding/consumers/noticepp.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 and we will mail a copy to you.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

You may be eligible to participate in the Verus Health Plan. A federal law called HIPAA requires that we notify eligible participants about the right to enroll in the plan under its "special enrollment provision."

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or obtain more information, contact **Mellisa Ingraham at 206-622-3700.**

NOTICE OF THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

This notice is being sent to you as required by the Women's Health and Cancer Rights Act of 1998, which states you must be advised annually of the presence of benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry of the breasts, prostheses and complications resulting from a mastectomy. Please refer to your medical benefit booklet for additional information. Benefits for these services may be subject to annual deductibles and coinsurance consistent with those established for other benefits.

NOTICE OF CREDITABLE PRESCRIPTION DRUG COVERAGE
MEDICARE PART D – YOUR PRESCRIPTION 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 Verus 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. Verus has determined that the prescription drug coverage offered by Verus 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 through 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 Verus coverage may be affected.

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

Please contact the Human Resources Department or your Benefit Advocate for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

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 Verus 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 November 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 ABC COMPANY 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.

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).

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).

Date: 01/01/2022
Name of Entity/Sender: Verus
Contact--Position/Office: Mellisa Ingraham/Benefits Manager
Address: 800 Fifth Ave, Suite 3900, Seattle, WA 98104
Phone Number: 206-622-3700

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help

pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility –

To see if any other states have added a premium assistance program since July 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
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

ALABAMA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy- program HIBI Customer Service: 1-855-692-6442
FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a- to-z/hipp HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid
Website: https://www.maine.gov/dhhs/ofi/applications-forms 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/info-details/masshealth- premium-assistance-pa Phone: 1-800-862-4840
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
NEBRASKA – Medicaid
Medicaid Website:http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid and CHIP
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: https://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP
Website:http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website:https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

VERMONT– Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid
Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website:https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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 1/31/2023)

Notes

Share this Employee Benefits Guide with your family

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