EMPLOYEE BENEFIT GUIDE

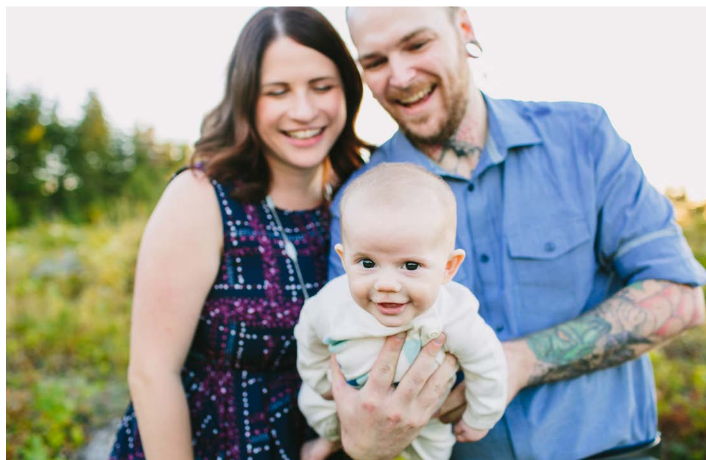
February 1, 2025 – January 31, 2026

This guide contains an overview of the Molecular Epidemiology Inc. benefits program. If there is any discrepancy between this guide and the official plan documents, the official plan documents will govern in all cases.

WELCOME

At Molecular Epidemiology, Inc. (MEI), we recognize our ultimate success depends on our talented and dedicated employees. Our goal is to provide a comprehensive benefits program that meets the needs of you and your family. It is one of the many ways we recognize the value of your contributions.

This Benefit Guide is designed to provide you with information about your benefits so you can make informed choices about your coverage options. Please read it carefully. If you have any questions, please contact the AssuredPartners Employee Service Center at 206-343-4175 or mcm.esc@assuredpartners.com.



Eligibility Rules

MEI employees are eligible for medical coverage in accordance with the Affordable Care Act, as follows:

- If you are expected to average 30 or more hours per week, you may enroll in the health plan on the first day of the month that falls on or after your 60th day of employment.
- If it is not expected (or it is uncertain) that you will average 30 or more hours per week, we will measure your hours over the first 5 months of employment. This is called your initial measurement period. If you average 30 or more hours per week during this time, you will be eligible to enroll for a corresponding 6-month initial stability period.
- Thereafter, MEI monitors eligibility every six months. In general, employees that average 30 or more hours per week in a 6-month measurement period are eligible for a corresponding 6-month stability period.

If you are enrolled in medical coverage, you may also enroll the following family members:

- Your lawful spouse/domestic partner (DP) only if they do not have access to their own employer-sponsored medical and dental insurance. Spouse/DPs exclusion doesn't apply to voluntary life/AD&D insurance.
- You or your spouse/DP's child who is under age 26, including a natural child, stepchild, a legally adopted child, a child placed for adoption, or a child for whom you or your spouse are the legal guardian (foster children are not eligible).
- You or your spouse/DP's unmarried child age 26 or over who is or becomes disabled and dependent upon you.

Importantly, enrolling an ineligible dependent on a MEI medical plan is considered fraud and theft, and may be grounds for termination of employment.

For all other insurance plans including dental, vision, life, and disability, employees must work a minimum of 40 hours per week to be eligible to participate.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please refer to the Medicare Part D Notice at the back of this Guide for more details.

ENROLLING

You have 31 days from the date you first become eligible to enroll in benefits. If you miss this deadline, your next opportunity to enroll will be during Open Enrollment in January. Open Enrollment is the only time during the year you may enroll in or make changes to your benefit elections, unless you experience a qualifying life event.

What You Need to Do:

Open Enrollment through ADP will be from January 13 - 24, 2025.

- If you are currently enrolled in any plans, your current elections will automatically carry over to the new plan year (with the exception of Navia health and dependent care FSA and commuter benefits) unless you make changes in ADP.
- If you want to add a new coverage or make any changes to your existing coverage (such as adding/dropping a dependent, adding/decreasing voluntary life coverage, etc.), you will need to log into ADP to make your changes before January 24, 2025.
- Enrollment for the FSA plans (health & dependent care FSA) or Commuter benefits must be completed online in ADP for the new plan year. Your current plan year elections will NOT carryover.

ADP Online Enrollment:

- Sign into your ADP account (workforcenow.adp.com)
- If you don't know your user ID, you can click on the link to recover it on the sign in page. If you don't know your password, you can click on the link to reset your password. If you are unsuccessful after trying both of these options, you can email your payroll representative for assistance:
  - o IEH : iehpayroll@iehinc.com
  - o ESTI: grey.morris@iehinc.com
  - o JLA: jlapayroll@iehinc.com
  - o ASI: nicholas.maris@iehinc.com
  - o MEI, Unitech: henry.mak@iehinc.com
  - o IEH-JL Analytical, IEH-EMA, Microbio, Nautilus: yuliya.perkins@iehinc.com
- Once logged into ADP, click on Myself and then click on Enrollments under Benefits. Click on Start Enrollment to complete the guided enrollment process.
- Note that you will need to add information for any dependents that you plan to enroll in coverage. If you have previously had the dependent(s) enrolled in coverage, you will not be required to provide documentation again. You will only be required to provide documentation for new dependents (see below).

Open Enrollment Webinars:

- **Virtual webinars will be held on Thursday, January 16th at 9:30 AM PST and Wednesday, January 22nd at 1 PM PST.**
- These are optional information webinars, and the same content will be covered in both. The webinars will also be recorded so if you are interested but unable to participate either time, you can email humanresources@iehinc.com after January 22nd to request a copy of the recording.
- Login information for the webinars will be sent out by Monday, January 13th.

Access Your Account Anytime to:

- Review your benefit elections
- Make life event changes (adding/removing dependents) within 30 days of these events:
  - Marriage, divorce, legal separation or annulment
  - Birth, adoption, placement for adoption or legal guardianship of a child
  - A change in your spouse's employment or involuntary loss of health coverage (other than coverage under Medicare or Medicaid programs) under another employer's plan
  - Loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying premiums on a timely basis
  - Your dependent child no longer qualifies as an eligible dependent
  - Any request for a change in coverage must be consistent with the change in your status.
- Review your flexible spending account elections
- Life insurance elections
- And more ...

Please refer to your Summary Plan Description (SPD) for more information on qualifying events.

If You Do Not Enroll ...

If you do nothing, your current elections for 2024-2025 will continue into the 2025-2026 plan year, with the exception of the Navia Health and Dependent care FSA, and Commuter Benefit.

RESOURCES

Coverage	Carrier	Contact
Medical Benefits	UMR Group # 76-413976 Network: UnitedHealthcare Choice Plus	Customer Service: 800-826-9781 www.umr.com
Prescription Drug Benefits	Pharmacy Benefit Dimensions	Member Services Department: 888-878-9172 www.pbdrx.com
Dental Benefits	Delta Dental Group # 09440	Customer Service: 800-554-1907 www.deltadentalwa.com
Vision Benefits	VSP Group # 30002541	Customer Service: 800-877-7195 www.vsp.com
Life and Disability Benefits	The Hartford Group # 877501	Customer Service: 800-423-6789 Claims: 800-243-5860 www.thehartfordatwork.com
Flexible Spending Account Commuter Benefit	Navia Benefit Solutions	Customer Service: 800-669-3539 www.naviabenefits.com
MEI Benefits Website		www.mei-benefits.com

AssuredPartners Employee Service Center

Benefit Advocates in the Employee Service Center can assist with benefit questions and claim issues for you and your covered family members. They are specially trained individuals who can help answer your insurance questions. This is a confidential service provided at no cost to you. All personal health information is confidential.

EMPLOYEE SERVICE CENTER

Phone: 1-888-343-3330 or 206-343-4175

Email: mcm.esc@assuredpartners.com

TTY/TDD: 1-855-877-4726

Translation services available

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.

HEALTH AND WELLNESS

Medical Benefits

MEI provides a medical plan through UMR. UMR is a third-party administrator, which means they process our claims and provide members access to United Healthcare's network of providers and facilities. UMR is owned by United Healthcare but operates separately. The plan provides the highest level of coverage when you visit doctors and hospitals that are part of the UnitedHealthcare Choice Plus network.

UMR		
Plan	**PPO Plan**	
Provider Network	**In Network**	**Out of Network**
Deductible Per plan year*	$1,500 Individual $3,000 Family	$3,000 Individual $6,000 Family
Out-of-Pocket Maximum Per plan year* Includes deductible and copays**	$3,500 Individual $7,000 Family	No limit
Coinsurance***	20%	50%
Office Visits	Primary: $20 copay Specialist: $40 copay deductible waived	50%
Virtual Visits	Covered in full after $10 copay	
Preventive Care Visits	Covered in full	50%
Emergency Room	Covered in full after $300 copay	
Urgent Care	$50 copay	50%
Outpatient Lab/X-ray Covered 100% if part of preventive visit	20% coinsurance	50%
Outpatient Hospital Care	20% coinsurance	50%
Inpatient Hospital Care	20% coinsurance	50%
Outpatient Rehabilitation Services Physical, speech, occupation therapy – *combined 20 visit limit, pre-authorization required* Cardiac therapy – *unlimited visits*	$25 copay	50%

*The plan year runs from February 1, 2025 through January 31, 2026.

**Prescription drug coinsurance does not apply towards the medical out of pocket maximum.

***The coinsurance reflects the member's percentage of cost after the deductible.

Preventive Care Services

MEI covers preventive care services in full for adults and children when they are received from an in-network provider and billed as routine preventive services. This includes healthy diet and physical activity counseling to prevent cardiovascular disease, blood pressure screening, cholesterol checks, and breast cancer screenings.

Remember! During your preventive exam, your physician may discover an issue or problem that requires further testing or screening for an accurate diagnosis. Additional diagnostic tests often require you to pay a share of the costs. However, diagnostic and supplemental breast exams and imaging, after a mammogram will now be covered at 100% in-network.

HEALTH AND WELLNESS

Prescription Drug Benefits

When you enroll in the medical plan, you also receive coverage for prescription drugs through Pharmacy Benefit Dimensions. The prescription drug plan gives you coverage for a wide range of prescriptions, as well as access to prescription discounts.

In Network Benefits	In Network	Out of Network
Deductible	No deductible applies	Not Covered
Out of Pocket Maximum	Unlimited	
Tier 1 - Generics Retail 30-day supply / Mail Order 90-day supply	20% coinsurance	
Tier 2 - Preferred Brand Name Retail 30-day supply / Mail Order 90-day supply	30% coinsurance	

Prescription Mail Order

You can get a 90-day supply of your medications shipped to you at no additional cost through Wegmans Mail Order Pharmacy Services or ProAct Pharmacy Services. *Express shipping is available for an additional charge.*

First Time Registration

You will have to register with the mail order pharmacy of your choice. Please have your member ID number available:

- Mail: fill out the registration form for the mail order of your choice. Forms are available online in the "Members" section at www.pbdrx.com or by calling PBD's Member Service Department at 1-888-878-9172

- Online:
  - Wegmans Mail Order Pharmacy Services: www.wegmans.com/pharmacy
  - ProAct Pharmacy Services: www.proactpharmacyservicespbd.com

- Phone:
  - Wegmans Mail Order Pharmacy Services: 1-888-205-8573 (TTY: 1-877-409-8711)
  - ProAct Pharmacy Services: 1-888-425-3301 (TTY: National 711 Relay Service)

Obtaining Prescriptions

You will first need a new prescription for your doctor. Request a 90-day supply, plus refills for up to one year (if applicable).

- Please note: after placing your initial order, it can take up to 2 weeks to receive your first shipment.
- Your may easily pay your prescriptions using credit card, check, or money order.

Pharmacy Benefit Dimensions' Member Service Department: 1-888-878-9172

HEALTH AND WELLNESS

Dental Benefits

MEI offers you dental benefits through Delta Dental. You may seek care from any licensed provider; however, there is no deductible if you see a Delta Dental PPO Dentist.

Delta Dental			
Provider Network	**PPO Dentist**	**Premier Dentist**	**Non-participating Dentist**
Deductible Per plan year*	No deductible	$50 Individual $150 Family	$50 Individual $150 Family
Class 1 – Preventive Exams, x-rays, etc.	Covered in full (deductible waived)		
Class 2 – Restorative** Periodontics, surgery, etc.	20%		
Class 3 – Restorative** Crowns, dentures, etc.	50%		
Annual Maximum Per plan year For all services combined	$1,000 per person		

*The plan year runs from February 1, 2025 through January 31, 2026.

**The coinsurance reflects the member's percentage of cost after the deductible.

Looking for a Delta Dental PPO Dentist?

1. Go to www.deltadentalwa.com
2. Click on the Patients tab
3. Click on Find a Dentist
4. Select Delta Dental PPO as the network

Vision Benefits

MEI provides vision benefits through Vision Service Providers (VSP). You will receive greater benefits if you see an in network provider.

VSP		
Provider Network	**In Network**	**Out of Network**
Eye Exam Once every 12 months	$10 copay, then covered 100%	$50 allowance
Contact Evaluation and Fitting Once every 12 months	Up to $60 copay, then covered 100%	$150 allowance
Lenses* Once every 12 months	$25 copay, then covered 100%	$50–$125 allowance depending on lenses
Frames Once every 24 months	$200 allowance	$70 allowance
Contact Lenses Once every 12 months In lieu of lenses and frames	$200 allowance	$105 allowance (combined allowance for evaluation, fitting, and contacts)

*Lenses include single, lined bifocal, and lined trifocal. There are additional out of pocket costs for progressive lenses.

MONTHLY EMPLOYEE CONTRIBUTIONS

Up to $30,000	Medical/Pharmacy	Dental	Vision
Employee	$75.00	$17.00	$7.33
Employee + Spouse	$382.00	$64.00	$11.72
Employee + Child	$135.00	$36.00	$11.98
Employee + Children	$183.00	$36.00	$11.98
Employee, Spouse, & Child	$452.00	$87.00	$19.31
Employee, Spouse, & Children	$555.00	$87.00	$19.31

$30,001 to $45,000	Medical/Pharmacy	Dental	Vision
Employee	$104.00	$17.00	$7.33
Employee + Spouse	$420.00	$64.00	$11.72
Employee + Child	$160.00	$36.00	$11.98
Employee + Children	$226.00	$36.00	$11.98
Employee, Spouse, & Child	$498.00	$87.00	$19.31
Employee, Spouse, & Children	$611.00	$87.00	$19.31

$45,001 to $65,000	Medical/Pharmacy	Dental	Vision
Employee	$128.00	$17.00	$7.33
Employee + Spouse	$459.00	$64.00	$11.72
Employee + Child	$185.00	$36.00	$11.98
Employee + Children	$262.00	$36.00	$11.98
Employee, Spouse, & Child	$544.00	$87.00	$19.31
Employee, Spouse, & Children	$668.00	$87.00	$19.31

$65,001 to $85,000	Medical/Pharmacy	Dental	Vision
Employee	$150.00	$17.00	$7.33
Employee + Spouse	$497.00	$64.00	$11.72
Employee + Child	$210.00	$36.00	$11.98
Employee + Children	$297.00	$36.00	$11.98
Employee, Spouse, & Child	$590.00	$87.00	$19.31
Employee, Spouse, & Children	$724.00	$87.00	$19.31

$85,001 to $110,000	Medical/Pharmacy	Dental	Vision
Employee	$168.00	$17.00	$7.33
Employee + Spouse	$536.00	$64.00	$11.72
Employee + Child	$235.00	$36.00	$11.98
Employee + Children	$333.00	$36.00	$11.98
Employee, Spouse, & Child	$636.00	$87.00	$19.31
Employee, Spouse, & Children	$780.00	$87.00	$19.31

$110,001 +	Medical/Pharmacy	Dental	Vision
Employee	$168.00	$17.00	$7.33
Employee + Spouse	$536.00	$64.00	$11.72
Employee + Child	$235.00	$36.00	$11.98
Employee + Children	$333.00	$36.00	$11.98
Employee, Spouse, & Child	$636.00	$87.00	$19.31
Employee, Spouse, & Children	$780.00	$87.00	$19.31

INCOME PROTECTION BENEFITS

Basic Life/AD&D Insurance

MEI provides Basic Life/Accidental Death & Dismemberment (AD&D) insurance to all eligible employees through The Hartford. This benefit is provided at no cost to you. The amount of your life insurance is equal to one times your annual salary, to a maximum benefit of $100,000. The minimum benefit is $50,000. Benefit reductions due to age begin at age 70.

Long Term Disability Insurance

MEI provides Long Term Disability (LTD) insurance to all eligible employees through The Hartford. This benefit is provided at no cost to you. In the event of disability, you would receive 66 2/3% of your base monthly salary, to a maximum monthly benefit of $10,000. Benefits begin on the 91st day of a qualifying disability due to a non-work-related illness or injury, and continue up to your Social Security Normal Retirement Age, as long as your condition continues to meet the definition of disability under the terms of the plan. A 12-month waiting period applies for pre-existing conditions treated within 3 months of your effective date of coverage.

You have the option to elect a tax-free LTD benefit. Since MEI pays the LTD premium, any disability benefits you may receive would be subject to taxation, resulting in a reduced benefit. Because disability often results in financial hardship, MEI has established a Tax Choice option to provide a tax-free benefit. If you elect the Tax Choice option, your LTD benefit would not be taxable. The employer-paid premium would, however, be included in your taxable income. Tax on the LTD premium would be deducted from your last paycheck of the year. Please make the appropriate selection in ADP when completing your enrollment. If you do actively select the Tax Choice option, you will be enrolled int the default option (meaning any LTD benefits received will be taxed).

Supplemental Life/AD&D Insurance

MEI provides you the opportunity to purchase Supplemental Life and Supplemental Accidental Death & Dismemberment (AD&D) insurance for yourself and your spouse/domestic partner (DP) through The Hartford. Supplemental Life is also available for your dependent children. You can elect coverage in increments of $10,000 up to $500,000 for yourself. You may also elect spouse/DP coverage in increments of $5,000 up to $100,000, not to exceed 50% of your amount. Supplemental Life for your dependent children is available at the flat amount of $10,000 for children from birth to 26 years.

The guarantee issue amount is $140,000 for you, $30,000 for your spouse/domestic partner (DP), and $10,000 for your children. If you apply for amounts of coverage over the guarantee issue amount and/or enroll for the first time after your initial eligibility period, you will need to complete an Evidence of Insurability form to provide proof of good health (look for an email from The Hartford).

Supplemental Life Rates

Age Band	per $1,000 of benefit
Under 25	$0.049
25-29	$0.058
30-34	$0.078
35-39	$0.087
40-44	$0.097
45-49	$0.145
50-54	$0.223
55-59	$0.417
60-64	$0.640
65-69	$1.231
70-74	$1.996
75+	$1.996
Child(ren)	$0.200

*Spouse/Domestic Partner rates are based on the employee’s age.

Voluntary AD&D Rates

	AD&D cost per	Monthly Rate
Employee	$1,000	$0.020
Spouse/DP	$1,000	$0.020
Child(ren)	$1,000	$0.020

INCOME PROTECTION BENEFITS

Voluntary Short Term Disability

MEI also offers you the opportunity to purchase Voluntary Short-Term Disability insurance through The Hartford. You can elect a benefit amount equal to 50% of your basic weekly earnings up to $1,500 per week. Benefits begin on the 15th day following your non-work-related illness or injury and may continue for up to 11 weeks. Premiums are deducted after taxes from your paycheck, making this a tax-free benefit to you in the event of your disability. A pre-existing condition limitation applies from the date you become eligible for coverage. Benefits will only be paid for up to 4 weeks for disabilities caused by a pre-existing condition. If you apply for amounts of coverage over the guarantee issue amount and/or enroll for the first time after your initial eligibility period, you will need to complete an Evidence of Insurability form to provide proof of good health (look for an email from The Hartford).

Monthly Rates per $10 of Covered Weekly Benefit

Age Band	California	All Other States
Under 25	$0.071	$0.500
25-29	$0.056	$0.520
30-34	$0.049	$0.250
35-39	$0.034	$0.260
40-44	$0.023	$0.130
45-49	$0.029	$0.160
50-54	$0.029	$0.190
55-59	$0.060	$0.230
60-64	$0.082	$0.270
65+	$0.046	$0.300

For employees in states with paid leave benefits through the state (including but not limited to California, Colorado, Maryland, New Jersey, Oregon, Rhode Island, and Washington), please keep in mind that if you qualify both STD benefits through The Hartford and benefits through these state-run programs, the amount you receive from The Hartford will be reduced by any benefit payments you receive from the applicable state-run program.

Ability Assist Counseling Services

Each person's life includes its own unique set of challenges. To help you cope with these challenges, we offer The Hartford's Ability Assist Counseling Services, offered by ComPsych. Enrollment is automatic for eligible employees and MEI pays the full cost for your coverage. Service includes six face-to-face emotional or work-life counseling sessions per occurrence per year.

By telephone: 1-800-964-3577

Online: Visit www.guidanceresources.com to create your own personal username and password. First time users will be asked to provide the following information on the profile page:

- In the Company/Organization field, use: HLF902
- Then, create your own confidential user name and password
- Finally, in the Company Name field at the bottom of personalization page, use: abili

Services include:

- Emotional or work-life counseling
- Financial information and resources
- Legal support and resources

FLEXIBLE SPENDING ACCOUNTS

MEI sponsors a Flexible Spending Account (FSA) through Navia Benefit Solutions. An FSA allows you to pay for eligible health care and dependent care expenses with pre-tax dollars. We offer two FSA options:

1. Health Care FSA – covers medical, prescription drug, dental and vision expenses.
2. Dependent Care Assistance Program (DCAP) – covers day care expenses for dependent children under age 13 or adult dependents (such as your parent or spouse) who are physically or mentally incapable of self-care. Dependent care expenses are for services that allow you to work, attend school full-time or look for work.

Here is how it works:

Estimate your expenses for health care and/or dependent care for the coming plan year and enroll in an FSA for that amount. The amount you contribute is prorated over each paycheck you receive during the year or the remaining paychecks in the plan year at the time you enroll. Your contribution will be deducted out of your paycheck on a pre-tax basis, so you don't pay FICA, Federal Income Tax, or state income tax (in most states). This means you reduce your taxable income, and therefore, your income tax.

Health Care FSA

You can contribute a minimum of $360, up to a maximum of $3,300, per year to your Health Care FSA. You must submit claims no later than 90 days after the end of the Plan Year. The 2025-2026 plan year has a rollover provision, which allows you to roll over up to $660 of unused Health Care FSA dollars to the subsequent year. Any Health Care FSA funds in excess of $660 will be forfeited. This provision is not available on balances from DCAPs.

Dependent Care Assistance Program (DCAP)

You and your spouse may contribute up to a combined total of $5,000 each year. If you choose to have dependent care expenses reimbursed by your Dependent Care FSA, those same expenses cannot be claimed for a dependent care tax credit on your federal income tax return. Consult a tax advisor for more information.

FSA RULES

In return for the tax advantages, the IRS has strict rules:

- You cannot stop or change the amount you contribute to either account until the next plan year, unless you experience an event that permits a mid-year change (e.g. marriage, divorce, birth or adoption).
- Transfers of money from one account to the other are not allowed.
- "Use It or Lose It" – Any money left in a Health Care FSA in excess of the $660 roll over allowance or DCAP at the end of the plan year will be forfeited.
- If you terminate employment, only expenses incurred before you terminated are eligible for reimbursement from your FSA, unless you elect to continue your Health Care FSA through COBRA.

Commuter and Transit Benefit

For associates working in Seattle and New Jersey, new Commuter Benefit Ordinances gives you the opportunity to make pre-tax elections for mass transit and parking expenses. In 2025, the IRS contribution limits are $325 for parking expenses and $325 for mass transit expenses. The money you set aside is not included in your taxable income. We will deduct the amount you elect from your pay and forward it to Navia Benefits Solutions. Unused amounts carry over from month to month.

Please refer www.navia.com for information on how to access your commuter funds.

IMPORTANT INFORMATION

PERMITTED MID-YEAR ELECTION CHANGES

In most cases, once you have made your benefit elections for the plan year, you cannot change them until the next annual open enrollment period, unless you experience a permitted election change event. These include, but are not limited to:

- Change in legal marital status (marriage, divorce, legal separation)
- Gain or loss of eligibility by one of your dependents
- Birth, adoption, or placement for adoption
- Loss of other health coverage by employee, spouse, or dependent(s)
- Gain or loss of eligibility for Medicaid or the Children's Health Insurance Program (CHIP)
- Change in coverage under another employer health plan

If you experience an event that allows you to make changes to your benefit elections, you must notify Human Resources within 31 days (60 days for events related to Medicaid or CHIP). You may need to provide proof of the change, such as a marriage or birth certificate. For more information regarding permitted mid-year election changes, please contact Human Resources.

REQUIRED ANNUAL NOTICES

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 Molecular Epidemiology, Inc. 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. Molecular Epidemiology, Inc. has determined that the prescription drug coverage offered by Molecular Epidemiology, Inc. 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 15 through December 7.

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 Molecular Epidemiology, Inc. coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current Molecular Epidemiology, Inc. 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 Molecular Epidemiology, Inc. 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 Molecular Epidemiology, Inc. changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: 2/1/2025
Name of Entity/Sender: Molecular Epidemiology, Inc.
Contact--Position/Office: Human Resources
Address: 15300 Bothell Way NE, Lake Forest Park, WA 98155

NOTICE OF SPECIAL ENROLLMENT RIGHTS

You may be eligible to participate in Molecular Epidemiology, Inc.'s Group 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 31 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 31 days after the marriage or within 60 days after 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.

All questions about the plan's special enrollment provision should be directed to Human Resources.

PPACA NOTICE OF GRANDFATHERED PLAN STATUS

This group health plan believes this PPO Medical Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Human Resources, 15300 Bothell Way NE, Lake Forest Park, WA 98155, (206) 522-5432). You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers . This website has a table summarizing which protections do and do not apply to grandfathered health plans.

NOTICE OF PRIVACY PRACTICES

Effective Date: 2/1/2025

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 Human Resources at (206) 522-5432, 15300 Bothell Way NE, Lake Forest Park, WA 98155.

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.

ile 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 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.

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

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

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

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

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

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

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

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

FLORIDA – Medicaid

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

GEORGIA – Medicaid

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

INDIANA – Medicaid

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

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid
ServicesMedicaid Phone: 1-800-338-8366
Hawki Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
Health & Human Services: iowa.gov
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

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

KENTUCKY – Medicaid

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

LOUISIANA – Medicaid

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

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

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

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA-Medicaid

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

NEVADA – Medicaid

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

NEW HAMPSHIRE-Medicaid

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

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

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

NORTH CAROLINA – Medicaid

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

NORTH DAKOTA – Medicaid

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

OKLAHOMA-Medicaid and CHIP

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

OREGON-Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-90759075

PENNSYLVANIA-Medicaid and CHIP

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children’s Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND-Medicaid and CHIP

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

SOUTH CAROLINA-Medicaid

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

SOUTH DAKOTA-Medicaid

Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS-Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH-Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT-Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA-Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium- assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium- assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON-Medicaid
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA-Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

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

Share this Employee Benefits Guide with your family.

AssuredPartners

1325 Fourth Avenue, Suite 2100
Seattle, WA 98101
206.343.2323 | 800.347.2303 (toll-free)
assuredpartners.com