

EMPLOYEE BENEFITS GUIDE

COLOURS inc.
AUTOMOTIVE PAINT & SUPPLIES

2026 Benefit Options



**Welcome to Colours Inc.
Enrollment Benefits Guide.**

**We encourage you to read the entire enrollment
guide before you enroll.**

Note: This enrollment is for the period of (03/01/2026-2/28/2027)

This is a summary of your benefits only. Certain restrictions and exclusions apply. For exact terms and conditions, please refer to your Summary Plan Description (SPD) or Certificate of Coverage. If information in this Employee Benefits Guide differs from the legal contract, the legal contract is the ruling document. **SPD's or Certificates of Coverage are available from your Human Resources Department.**

Plan Sponsor is not bound by any typographical errors and/or omissions contained herein.

Your Benefit Choices

Colours Inc. reviews the benefit packages offered to employees to ensure that they remain competitive with the industry.

We recognize that our employees' needs and preferences vary. As a result, we offer a variety of benefit options and coverage levels. These plan options offer you the opportunity to customize your benefits to meet the needs of both you and your family.

Colours Inc. offers the following health & welfare benefits and additional benefits to all regular full time employees and regular part time employees regularly scheduled to work 32 or more hours per week.

In order to receive the highest level of benefits under the Health Insurance Plan, you should use **Blue Cross Blue Shield** facilities and **Blue Cross Blue Shield** physicians for your medical care. However, if you do not use **Blue Cross Blue Shield**, you still have coverage (with differences in copayments and deductibles) depending upon the plan and network used.



Benefit Questions?

Contact:

Highmark
800-241-5704
(Customer Service)

MJL Consulting
MLupole@MJLBenefits.Net
570-280-5479
(Claims & Benefit Questions)

HEALTH & WELFARE BENEFITS

Medical/Rx Coverage/Vision/Dental



AUTOMOTIVE PAINT & SUPPLIES

Welcome to your 2026 open enrollment with Colours Inc.! We are pleased to announce the continuation of our benefits with Highmark Blue Shield, Davis Vision, and Guardian, as well as our ongoing partnership with Revive Health. This is your opportunity to make any changes to your coverage for the upcoming plan year. Life events (Marriage, Birth, Death, Marriage, Divorce, ETC.) during the benefits period allow for changes before next year's open enrollment.

Highmark Blue Cross Blue Shield will continue to offer three plans for you to choose from:

1. **Value Plan:** This plan has the lowest payroll costs but the highest out-of-pocket expenses, as it is a High Deductible Health Plan (HDHP).
2. **Base Plan:** This plan balances payroll costs and out-of-pocket expenses.
3. **Buy-Up Plan:** This plan has the highest payroll costs but the lowest out-of-pocket expenses.

When you enroll in any medical option, Colours Inc. generously provides vision coverage at no cost to our employees and their dependents (if applicable) through Davis Vision.

Guardian will continue to offer Dental, Voluntary Life insurance, and Short-Term Disability coverage at the same rates as 2025. Colours Inc. will also continue to provide \$15,000 in life insurance coverage to all full-time employees.

Revive Health will continue to offer their Urgent Care Services, allowing you to consult with a physician anytime over the phone or online. These providers can also prescribe medication during the call, saving you trips to the ER, urgent care centers, or your provider's office. Also continuing for 2026, Revive Health will offer additional mental health services. Full details of this program can be found on pages 48 and 49 of your guide. Any employee enrolled in medical benefits receives these services free of charge from Colours Inc.

Finally, due to the increased costs we all face daily, Colours Inc. has decided to increase contributions for all medical plans by 2-3%. Please take time to review the new pricing in full and follow up with any questions or concerns you may have. Details on pricing can be found on page 50. If any changes are made, an application for each carrier is required and included in this guide. If you are keeping all benefits the same with no changes, page 50 of this guide must be completed and returned to HR by 2/24/26.

Colours PPO \$250 High Option

Group Number 10510866

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	3/1/2026	
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	\$250	\$6,000
Family	\$500	\$12,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes coinsurance) Once met, the plan pays 100% coinsurance for the rest of the benefit period.		
Individual	None	\$12,000
Family	None	\$24,000
Total Maximum Out-of-Pocket (Includes any medical and prescription drug deductibles, coinsurance, and copays, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$10,600	Not Applicable
Family	\$21,200	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$20 copay	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after \$20 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after \$40 copay	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after \$50 copay	80% after deductible
On-Demand Telemedicine Services (3)	100% after \$15 copay	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Breast Cancer Screenings	100% (deductible does not apply)	80% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	80% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	100% after \$150 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency (6)	100% (deductible does not apply) for emergency services; 100% after deductible for non-emergencies	100% (deductible does not apply) for emergency services; 80% after deductible for non-emergencies
Hospital and Medical / Surgical Expenses (5)		
Hospital Inpatient (including maternity)	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Outpatient Surgery (facility)	100% after deductible	80% after deductible
Surgical Services (professional)	100% after deductible	80% after deductible

Benefit	In Network	Out of Network
Maternity (non-preventive professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	80% after deductible
Therapy Services		
Physical Medicine	100% after \$40 copay limit: 20 visits/benefit period - - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	80% after deductible
Speech Therapy	100% after \$40 copay limit: 12 visits/benefit period - limit does not apply when rehabilitative or habilitative speech therapy services are prescribed for the treatment of mental health or substance abuse	80% after deductible
Occupational Therapy	100% after \$40 copay limit: 12 visits/benefit period - - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Spinal Manipulations	100% after \$40 copay limit: 12 visits/benefit period	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after \$40 copay	80% after deductible
Outpatient Substance Abuse Services	100% after \$40 copay	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100% after deductible	80% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	100% after deductible	80% after deductible
Dental Services Related to Accidental Injury (10)	see service category (i.e. lab, surgery, imaging)	
Diabetes Treatment		
Equipment and Supplies	100% after deductible	80% after deductible
Diabetes Education Program	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after \$75 copay - copay does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Enteral Foods	100% (deductible does not apply)	80% (deductible does not apply)
Home Health Care	100% after deductible	80% after deductible
Home Infusion and Suite Infusion Therapy	100% after deductible	80% after deductible
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment (8) (10)	100% after deductible	80% after deductible
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	100% after deductible limit: 60 days/benefit period	80% after deductible
Therapeutic Injections	100% after deductible	80% after deductible
Transplant Services (10)	100% after deductible	80% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible		
Individual		none
Family		none
Prescription Drug Program (11) SensibleRx Complete	Retail Drugs (31/60/90-day Supply) \$3 / \$6 / \$9 Formulary low cost generic copay	

Benefit	In Network	Out of Network
<p>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</p> <p>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design</p>	<p>\$3 / \$6 / \$9 Non-Formulary low cost generic copay \$15 / \$30 / \$45 Formulary generic copay \$15 / \$30 / \$45 Non-Formulary generic copay \$30 / \$60 / \$90 Formulary brand copay \$50 / \$100 / \$150 Non-Formulary brand copay</p> <p style="text-align: center;">Active Choice</p> <p style="text-align: center;">Maintenance Drugs through Mail Order (90-day Supply)</p> <p style="text-align: center;">\$6 Formulary low cost generic copay \$6 Non-Formulary low cost generic copay \$30 Formulary generic copay \$30 Non-Formulary generic copay \$60 Formulary brand copay \$100 Non-Formulary brand copay</p>	

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Colours PPO Blue \$4000 Base Option

Group Number 10510862

On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	3/1/2026	
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	\$4,000	\$6,000
Family	\$8,000	\$12,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes coinsurance) Once met, the plan pays 100% coinsurance for the rest of the benefit period.		
Individual	None	\$12,000
Family	None	\$24,000
Total Maximum Out-of-Pocket (Includes any medical and prescription drug deductibles, coinsurance, and copays, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$10,600	Not Applicable
Family	\$21,200	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after \$25 copay	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after \$25 copay	80% after deductible
Specialist Office Visits & Virtual Visits	100% after \$50 copay	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after \$50 copay	80% after deductible
On-Demand Telemedicine Services (3)	100% after \$20 copay	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Breast Cancer Screenings	100% (deductible does not apply)	80% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	80% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	100% after \$150 copay (waived if admitted)	
Ambulance - Emergency and Non-Emergency (6)	100% (deductible does not apply) for emergency services; 100% after deductible for non-emergencies	100% (deductible does not apply) for emergency services; 80% after deductible for non-emergencies
Hospital and Medical / Surgical Expenses (5)		
Hospital Inpatient (including maternity)	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Outpatient Surgery (facility)	100% after deductible	80% after deductible
Surgical Services (professional)	100% after deductible	80% after deductible

Benefit	In Network	Out of Network
Maternity (non-preventive professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	80% after deductible
Therapy Services		
Physical Medicine	100% after \$50 copay limit: 20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	80% after deductible
Speech Therapy	100% after \$50 copay limit: 12 visits/benefit period - limit does not apply when rehabilitative or habilitative speech therapy services are prescribed for the treatment of mental health or substance abuse	80% after deductible
Occupational Therapy	100% after \$50 copay limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Spinal Manipulations	100% after \$50 copay limit: 12 visits/benefit period	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	\$50 copay after deductible, 100% thereafter	80% after deductible
Outpatient Substance Abuse Services	\$50 copay after deductible, 100% thereafter	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100% after deductible	80% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	100% after deductible	80% after deductible
Dental Services Related to Accidental Injury (10)	see service category (i.e. lab, surgery, imaging)	
Diabetes Treatment		
Equipment and Supplies	100% after deductible	80% after deductible
Diabetes Education Program	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after \$75 copay - copay does not apply to diagnostic services prescribed for the treatment of mental health or substance abuse	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Mammograms, Medically Necessary	100% (deductible does not apply)	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Enteral Foods	100% (deductible does not apply)	80% (deductible does not apply)
Home Health Care	100% after deductible	80% after deductible
Home Infusion and Suite Infusion Therapy	100% after deductible	80% after deductible
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment (8) (10)	100% after deductible	80% after deductible
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	100% after deductible limit: 60 days/benefit period	80% after deductible
Therapeutic Injections	100% after deductible	80% after deductible
Transplant Services (10)	100% after deductible	80% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible		
Individual	none	
Family	none	
Prescription Drug Program (11) SensibleRx Choice	Retail Drugs (31/60/90-day Supply) \$3 / \$6 / \$9 Formulary low cost generic copay	

Benefit	In Network	Out of Network
<p>Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.</p> <p>Your plan uses the Comprehensive Formulary with an Incentive Benefit Design</p>	<p>\$3 / \$6 / \$9 Non-Formulary low cost generic copay \$25 / \$50 / \$75 Formulary generic copay \$25 / \$50 / \$75 Non-Formulary generic copay \$50 / \$100 / \$150 Formulary brand copay \$70 / \$140 / \$210 Non-Formulary brand copay</p> <p style="text-align: center;">Active Choice</p> <p style="text-align: center;">Maintenance Drugs through Mail Order (90-day Supply)</p> <p style="text-align: center;">\$6 Formulary low cost generic copay \$6 Non-Formulary low cost generic copay \$50 Formulary generic copay \$50 Non-Formulary generic copay \$100 Formulary brand copay \$140 Non-Formulary brand copay</p>	

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Colours PPO Blue HDHP \$6500

Group Number 10510864

This program is a qualified high deductible plan as defined by the Internal Revenue Service. It is designed for use with a Health Savings Account (HSA). On the chart below, you'll see what your plan pays for specific services. You may be responsible for a facility fee, clinic charge or similar fee or charge (in addition to any professional fees) if your office visit or service is provided at a location that qualifies as a hospital department or a satellite building of a hospital.

Benefit	In Network	Out of Network
General Provisions		
Effective Date	3/1/2026	
Benefit Period (1)	Contract Year	
Deductible (per benefit period)		
Individual	\$6,500	\$12,000
Family	\$13,000	\$24,000
Plan Pays – payment based on the plan allowance	100% after deductible	80% after deductible
Out-of-Pocket Limit (Includes any medical and prescription drug coinsurance and copays) Once met, the plan pays 100% coinsurance for the rest of the benefit period.		
Individual	\$250	\$13,100
Family	\$500	\$26,200
Total Maximum Out-of-Pocket (Includes any medical and prescription drug deductibles, coinsurance, and copays, Network only) (2) Once met, the plan pays 100% of covered services for the rest of the benefit period.		
Individual	\$6,900	Not Applicable
Family	\$13,800	Not Applicable
Office/Clinic/Urgent Care Visits		
Retail Clinic Visits & Virtual Visits	100% after deductible	80% after deductible
Primary Care Provider (PCP) Office Visits & Virtual Visits	100% after deductible	80% after deductible
Specialist Office Visits & Virtual Visits	100% after deductible	80% after deductible
Virtual Visit Provider Originating Site Fee	100% after deductible	80% after deductible
Urgent Care Center Visits	100% after deductible	80% after deductible
On-Demand Telemedicine Services (3)	100% after deductible	not covered
Preventive Care (4)		
Routine Adult		
Physical Exams	100% (deductible does not apply)	80% after deductible
Adult Immunizations	100% (deductible does not apply)	80% after deductible
Routine Gynecological Exams, including a Pap Test	100% (deductible does not apply)	80% (deductible does not apply)
Breast Cancer Screenings	100% (deductible does not apply)	80% after deductible
BRCA-Related Genetic Counseling and Genetic Testing	100% (deductible does not apply)	80% after deductible
Colorectal Cancer Screening	100% (deductible does not apply)	80% after deductible
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Routine Pediatric		
Physical Exams	100% (deductible does not apply)	80% after deductible
Pediatric Immunizations	100% (deductible does not apply)	80% (deductible does not apply)
Diagnostic Services and Procedures	100% (deductible does not apply)	80% after deductible
Emergency Services		
Emergency Room Services (5)	100% after deductible	100% after in-network deductible
Ambulance - Emergency and Non-Emergency (6)	100% after deductible	100% after in-network deductible for emergency services; 80% after out-of-network deductible for non-emergencies
Hospital and Medical / Surgical Expenses (5)		
Hospital Inpatient (including maternity)	100% after deductible	80% after deductible
Hospital Outpatient	100% after deductible	80% after deductible
Outpatient Surgery (facility)	100% after deductible	80% after deductible
Surgical Services (professional)	100% after deductible	80% after deductible

Benefit	In Network	Out of Network
Maternity (non-preventive professional services) including dependent daughter	100% after deductible	80% after deductible
Medical Care (including inpatient visits and consultations)	100% after deductible	80% after deductible
Therapy Services		
Physical Medicine	100% after deductible limit: 20 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	80% after deductible
Speech Therapy	100% after deductible limit: 12 visits/benefit period- limit does not apply when rehabilitative or habilitative speech therapy services are prescribed for the treatment of childhood stuttering; limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	80% after deductible
Occupational Therapy	100% after deductible limit: 12 visits/benefit period - limit does not apply when therapy services are prescribed for the treatment of mental health or substance abuse	80% after deductible
Respiratory Therapy	100% after deductible	80% after deductible
Spinal Manipulations	100% after deductible	80% after deductible
Other Therapy Services (Cardiac Rehab, Infusion Therapy, Chemotherapy, Radiation Therapy and Dialysis)	100% after deductible	80% after deductible
Mental Health / Substance Abuse		
Inpatient Mental Health Services	100% after deductible	80% after deductible
Inpatient Detoxification / Rehabilitation	100% after deductible	80% after deductible
Outpatient Mental Health Services (includes virtual behavioral health visits)	100% after deductible	80% after deductible
Outpatient Substance Abuse Services	100% after deductible	80% after deductible
Other Services		
Allergy Extracts and Injections	100% after deductible	80% after deductible
Autism Spectrum Disorder Applied Behavior Analysis (7)	100% after deductible	80% after deductible
Assisted Fertilization Procedures (Limited to Artificial Insemination - 3 attempts per lifetime)	100% after deductible	80% after deductible
Dental Services Related to Accidental Injury (10)	see service category (i.e. lab, surgery, imaging)	
Diabetes Treatment		
Equipment and Supplies	100% after deductible	80% after deductible
Diabetes Education Program	100% after deductible	80% after deductible
Diagnostic Services		
Advanced Imaging (MRI, CAT, PET scan, etc.)	100% after deductible	80% after deductible
Basic Diagnostic Services (standard imaging, diagnostic medical, lab/pathology, allergy testing)	100% after deductible	80% after deductible
Mammograms, Medically Necessary	100% after deductible	80% after deductible
Durable Medical Equipment, Orthotics and Prosthetics	100% after deductible	80% after deductible
Enteral Foods	100% after deductible	80% after deductible
Home Health Care	100% after deductible	80% after deductible
Home Infusion and Suite Infusion Therapy	100% after deductible	80% after deductible
Hospice	100% after deductible	80% after deductible
Infertility Counseling, Testing and Treatment (8) (10)	100% after deductible	80% after deductible
Private Duty Nursing	not covered	not covered
Skilled Nursing Facility Care	100% after deductible limit: 60 days/benefit period	80% after deductible
Therapeutic Injections	100% after deductible	80% after deductible
Transplant Services (10)	100% after deductible	80% after deductible
Precertification/Authorization Requirements (9)	Yes	Yes
Prescription Drugs		
Prescription Drug Deductible Individual Family	Integrated with medical deductible Integrated with medical deductible	
Prescription Drug Program (11) SensibleRx Choice Defined by the National Pharmacy Network - Not Physician Network. Prescriptions filled at a non-network pharmacy are not covered.	Retail Drugs (31/60/90-day Supply) \$3 / \$6 / \$9 Formulary low cost generic copay after in-network deductible \$3 / \$6 / \$9 Non-Formulary low cost generic copay after in-network deductible \$25 / \$50 / \$75 Formulary generic copay after in-network deductible	

Benefit	In Network	Out of Network
Your plan uses the Comprehensive Formulary with an Incentive Benefit Design	<p data-bbox="760 128 1539 218"> \$25 / \$50 / \$75 Non-Formulary generic copay after in-network deductible \$50 / \$100 / \$150 Formulary brand copay after in-network deductible \$70 / \$140 / \$210 Non-Formulary brand copay after in-network deductible </p> <p data-bbox="1068 254 1230 277" style="text-align: center;">Active Choice</p> <p data-bbox="834 285 1463 308" style="text-align: center;">Maintenance Drugs through Mail Order (90-day Supply)</p> <p data-bbox="808 317 1487 340">\$6 Formulary low cost generic copay after in-network deductible</p> <p data-bbox="782 348 1513 371">\$6 Non-Formulary low cost generic copay after in-network deductible</p> <p data-bbox="847 380 1448 403">\$50 Formulary generic copay after in-network deductible</p> <p data-bbox="821 411 1474 434">\$50 Non-Formulary generic copay after in-network deductible</p> <p data-bbox="847 443 1448 466">\$100 Formulary brand copay after in-network deductible</p> <p data-bbox="821 474 1474 497">\$140 Non-Formulary brand copay after in-network deductible</p>	

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SEARCH FOR DOCTORS, HOSPITALS AND MORE



HEALTH TOOLS MAKE COST AND QUALITY CLEARER

Our online health tools help you get the most value from your health plan, and make getting cost and quality information about providers easier so you can make smart health care decisions.

A BETTER SEARCH EXPERIENCE

Our most popular online tool, Find a Doctor, lets you find the right providers for you; from primary care doctors and specialists to hospitals, imaging centers, urgent care centers, pharmacies and more.

You will see which doctors and hospitals are in network for your plan. If your plan has several tiers, you can see which doctors participate at the Preferred, Enhanced or Standard Value Level of Benefits. This will help you save money and avoid higher out-of-pocket costs.

CHOOSING JUST GOT EASIER

Find a Doctor offers a deeper look into the details about each provider, so it's easier to make the right selection. You can use everyday words when you search, like heart disease or pediatrician. The search results will apply to your own health plan. The results can be filtered to find a doctor who meets your own preferences.

A results summary shows all of your options, including:

- Contact information and distance
- Patient ratings
- Blue Distinction® Centers
- Allegheny Health Network-employed providers
- Participation at the Preferred, Enhanced or Standard Value Level of Benefits.

GET THE DETAILS

Each provider profile includes practice details such as location and office hours, physician credentials, plans accepted, and hospital affiliations, plus quality ratings and patient reviews. You can print out the details about the doctors that you find. You can also download a directory of your search results.

Patient Experience Review ratings may appear on each provider search listing as an indicator of other patients' opinions about their experiences. Patient Experience Review lets you read what other people think of the providers and medical facilities you're considering. With Patient Experience Review, you can rate your experiences on a star basis, just like with restaurants and movies.

Overall Patient Ratings

52 Reviews

Experience	★★★★☆
Recommend	👍 (75%) 👎 (25%)
Communication	★★★★☆
Availability	★★★★★
Environment	★★★★★

RATINGS BASED ON FIVE KEY CRITERIA

In a Patient Experience Review, providers are rated on five criteria: experience, communication, availability, environment and recommendation. After your appointment, you can even write and submit your own reviews.

Continued on the back

SHARE YOUR OPINIONS WITH PATIENT EXPERIENCE REVIEWS

QUALITY MATTERS

Cost and convenience are just a few things to think about when choosing providers. Quality and overall experience are also important.

In addition to Patient Experience Review ratings, you'll also see other helpful quality information, including:

- Board certifications
- Accreditations
- Physician Quality Measures ratings
- Participation in quality programs such as Blue Physician Recognition
- Blue Distinction designations

These quality measures draw data from trusted sources such as the Blue Cross and Blue Shield Association (BCBSA), The Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and WebMD®.

Seeing providers' quality measures can help you choose the right providers to fit your needs.



Log in to highmarkbcbs.com to access Find a Doctor.

Find a Doctor is one of our many online health tools that make it easier for you to understand and manage your health care and shop for high-quality, high-value providers.

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, Highmark Benefits Group, Highmark Health Insurance Company or Highmark Select Resources, all of which are independent licensees of the Blue Cross and Blue Shield Association. Health care plans are subject to terms of the benefit agreement.

WebMD Health Services is a registered trademark of WebMD, LLC, an independent and separate company that supports Highmark Blue Cross and/or Blue Shield online wellness services. WebMD Health Services is solely responsible for its programs and services, which are not a substitute for professional medical advice, diagnosis or treatment. WebMD Health Services does not endorse any specific product, service or treatment.

Blue Distinction Centers (BDC) met overall quality measures for patient safety and outcomes, developed with input from the medical community. A Local Blue Plan may require additional criteria for facilities located in its own service area; for details, contact your Local Blue Plan. Blue Distinction Centers+ (BDC+) also met cost measures that address consumers' need for affordable healthcare. Each facility's cost of care is evaluated using data from its Local Blue Plan. Facilities in CA, ID, NY, PA, and WA may lie in two Local Blue Plans' areas, resulting in two evaluations for cost of care; and their own Local Blue Plans decide whether one or both cost of care evaluation(s) must meet BDC+ national criteria. Blue Distinction Total Care (BDTC) providers met BDTC national criteria. National criteria for BDC, BDC+, and BDTC are displayed on www.bcbs.com. Individual outcomes may vary. For details on a provider's in network status or your own policy's coverage, contact your Local Blue Plan and ask your provider before making an appointment. Neither Blue Cross and Blue Shield Association nor any Blue Plans are responsible for non-covered charges or other losses or damages resulting from Blue Distinction or other provider finder information or care received from Blue Distinction or other providers.

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。
请拨打您的身份证背面的号码（TTY：711）。

2026 Preventive Schedule

Effective 1/1/2026

Plan your care: Know what you need and when to get it

Preventive or routine care helps us stay well or finds problems early, when they are easier to treat. As a part of your health plan, you may be eligible to receive some of these preventive benefits with little to no cost sharing when using in-network providers. All benefits for over-the-counter drugs and supplies must be purchased through in-network pharmacy providers in order to be covered.* Make sure you know what is covered by your health plan and any requirements before you receive any services. Recommended annual services are based on a calendar year, which resets on January 1 of every year.

Some services and their frequency may depend on your doctor's advice. That's why it's important to talk with your doctor about the services that are right for your age, gender, and family history. CHIP members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

Questions?



Call Member Service



Ask your doctor



Log in to your account

Adults: Ages 19+







Female










Male

GENERAL HEALTH CARE

 Annual Checkup** (Routine, not a work- or school-related physical)	<ul style="list-style-type: none"> • Ages 19 – 49: Every one to two years • Ages 50 and older: Once a year
 Depression Screening and Anxiety Screening	Once a year
 Illicit Drug-Use Screening	Once a year
 Pelvic and Breast Exam	Once a year

SCREENINGS/PROCEDURES










 Abdominal Aortic Aneurysm Screening	Ages 65 – 75 who have ever smoked: One-time screening
 Ambulatory Blood Pressure Monitoring	To confirm new diagnosis of high blood pressure before starting treatment
 Breast Cancer Genetic (BRCA) Screening (Requires prior authorization)	Those meeting specific high-risk criteria: One-time genetic assessment for breast and ovarian cancer risk
 Cholesterol (Lipid) Screening	<ul style="list-style-type: none"> • Ages 20 and older: Once every five years • High-risk: More often
 Colon Cancer Screening (Including colonoscopy)	<ul style="list-style-type: none"> • Ages 45 and older: Every one to 10 years, depending on screening results • High-risk: Earlier or more frequently
 Colon Cancer Screening (Colonoscopy)	Ages 45 and older: Following a positive result obtained within one year by another mandated screening method
 Certain Colonoscopy Preps With Prescription	<ul style="list-style-type: none"> • Ages 45 and older: Once every 10 years • High-risk: Earlier or more frequently

* For example, if the in-network pharmacy provider is located within a larger retail setting, the drug/supply must be purchased through the pharmacy provider's register (and not the general retail register) in order to be covered.












** A routine checkup could include health history; physical; height, weight, and blood pressure measures; body mass index (BMI) assessment; counseling for obesity, fall prevention, skin cancer, and safety; depression screening; alcohol and drug abuse, and tobacco use assessment; age-appropriate guidance, and intimate partner violence screening and counseling for reproductive age women.

** United States Preventive Services Task Force (USPSTF)-mandated routine labs

SCREENINGS/PROCEDURES

	Diabetes Screening	Ages 40 and older who are at high risk: Once every three years
	Hepatitis B Screening	<ul style="list-style-type: none"> Once per lifetime for adults High-risk: More often
	Hepatitis C Screening	Ages 18 – 79
	Latent Tuberculosis Screening	High-risk
	Lung Cancer Screening (Requires use of authorized facility)	Ages 50 – 80 with 20-pack per year history: Once a year for current smokers, or once a year if currently smoking or quit within past 15 years
	Mammogram	<ul style="list-style-type: none"> Ages 40 and older: Once a year, including 3D Screening, follow-up MRI, or ultrasound: Per doctor's advice
	Osteoporosis Screening (Bone Mineral Density)	Ages 65 and older: Once every two years, or younger if at risk as recommended by physician
	Pap Test (Cervical Cancer Screening)	<ul style="list-style-type: none"> Ages 21 – 65: Every three years, or annually, per doctor's advice Ages 30 – 65: Every five years if HPV only or combined Pap and HPV are negative Ages 65 and older: Per doctor's advice
	Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)	<ul style="list-style-type: none"> Sexually active males and females HIV screening for adults to age 65 in the general population and those at risk, then screening over age 65 with risk factors




IMMUNIZATIONS**

	Chicken Pox (Varicella)	Adults with no history of chicken pox: One two-dose series
	COVID-19 Vaccine	Per doctor's advice
	Diphtheria, Tetanus (Td/Tdap)	One dose Tdap, then Td or Tdap booster every 10 years
	Flu (Influenza)	Every year
	Haemophilus Influenzae Type B (Hib)	For adults with certain medical conditions to prevent meningitis, pneumonia, and other serious infections; this vaccine does not provide protection against the flu and does not replace the annual flu vaccine
	Hepatitis A	At-risk or per doctor's advice: One two-, three-, or four-dose series
	Hepatitis B	<ul style="list-style-type: none"> Ages 19 – 59: Two to four doses per doctor's advice Ages 60 and older: High-risk per doctor's advice
	Human Papillomavirus (HPV)	<ul style="list-style-type: none"> Up to age 26: One three-dose series Ages 27 – 45, at-risk or per doctor's advice
	IPV Polio Vaccine	Adults never vaccinated or with incomplete vaccination history
	Measles, Mumps, Rubella (MMR)	One or two doses
	Meningitis*	At-risk or per doctor's advice







* Meningococcal B vaccine per doctor's advice.

** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

IMMUNIZATIONS**

	Pneumonia	High-risk or ages 50 and older: One or two doses, per lifetime
	RSV Vaccine	<ul style="list-style-type: none"> • Ages 60 and older • Pregnant women
	Shingles	<ul style="list-style-type: none"> • Shingrix — Ages 50 and older: Two doses • Ages 19 – 49: Immunocompromised per doctor’s advice


PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR’S PRESCRIPTION

	Aspirin	Pregnant women at risk for preeclampsia
	Folic Acid	Women planning or capable of pregnancy: Daily supplement containing .4 to .8 mg of folic acid
	Chemoprevention drugs such as raloxifene, tamoxifen, or aromatase inhibitors***	At risk for breast cancer, without a cancer diagnosis, ages 35 and older
	Tobacco Cessation (Counseling and medication)	Adults who use tobacco products
	Low-to-Moderate Dose Select Generic Statin Drugs for Prevention of Cardiovascular Disease (CVD)	Ages 40 – 75 years with one or more CVD risk factors (such as dyslipidemia, diabetes, hypertension, or smoking) and have calculated 10-year risk of a cardiovascular event of 10% or greater
	Select PrEP Drugs and Certain Related Services for Prevention of HIV Infection	Adults at risk for HIV infection, without an HIV diagnosis




** Must get at your PCP’s office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

*** Aromatase inhibitors when the other drugs can’t be used such as when there is a contraindication or they are not tolerated.


PREVENTIVE CARE FOR PREGNANT WOMEN

 <p>Screenings, Procedures, and Counseling</p>	<ul style="list-style-type: none"> • Gestational diabetes screening • Hepatitis B screening and immunization, if needed • HIV screening • Syphilis screening • Smoking cessation counseling • Depression screening and anxiety screening during pregnancy and postpartum • Depression prevention counseling during pregnancy and postpartum 	<ul style="list-style-type: none"> • Rh typing at first visit • Rh antibody testing for Rh-negative women • RSV vaccine per CDC guidelines • Tdap with every pregnancy • Urine culture and sensitivity at first visit • Alcohol misuse screening and counseling • Nutritional counseling for pregnant women to promote healthy weight during the pregnancy
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PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE

 <p>Adults with BMI 25 to 29.9 (overweight) and 30 to 39.9 (obese) are eligible for:</p>	<ul style="list-style-type: none"> • Additional annual preventive office visits specifically for obesity and blood pressure measurement • Additional nutritional counseling visits specifically for obesity 	<ul style="list-style-type: none"> • Recommended lab tests: <ul style="list-style-type: none"> – ALT – AST – Hemoglobin A1c or fasting glucose – Cholesterol screening
 <p>Adults with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome</p>	Nutritional counseling	
 <p>Adults with BMI 40 and over</p>	Nutritional counseling and fasting glucose screening	

ADULT DIABETES PREVENTION PROGRAM (DPP)

 <p>Applies to Adults</p> <ul style="list-style-type: none"> • Without a diagnosis of diabetes (does not include a history of gestational diabetes) • Overweight or obese (determined by BMI) • Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140-199mg/dl 	Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss
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2026 Preventive Schedule

Plan your child's care: Know what your child needs and when to get it

Preventive or routine care helps your child stay well or finds problems early, when they are easier to treat. Most of these services may not have cost sharing if you use the plan's in-network providers. Make sure you know what is covered by your health plan and any requirements before you schedule any services for your child.

Services include Bright Futures recommendations. CHIP members may have additional preventive services and coverage. Please check the CHIP member booklet for further details of CHIP coverage of preventive services.

It's important to talk with your child's doctor. The frequency of services, and schedule of screenings and immunizations, depends on what the doctor thinks is right for your child.

Questions?



Call Member Service



Ask your doctor



Log in to your account

Children: Birth to 30 Months¹

GENERAL HEALTH CARE	BIRTH	1M	2M	4M	6M	9M	12M	15M	18M	24M	30M
Annual Checkup* (Routine, not preschool- or daycare-related physical)	●	●	●	●	●	●	●	●	●	●	●
Hearing Screening	●										
SCREENINGS											
Autism Screening									●	●	
Critical Congenital Heart Disease (CCHD) Screening With Pulse Oximetry	●										
Developmental Screening						●			●		●
Hematocrit or Hemoglobin Anemia Screening							●				
Hepatitis C Screening			Per MD recommendation with material exposure during pregnancy								
Lead Screening**							●			●	
Newborn Blood Screening and Bilirubin	●										
IMMUNIZATIONS											
Chicken Pox							Dose 1				
COVID-19 Vaccine	Per doctor's advice										
Diphtheria, Tetanus, Pertussis (DTaP)			Dose 1	Dose 2	Dose 3			Dose 4			
Flu (Influenza)***					Ages 6 months to 30 months: 1 or 2 doses annually						
Haemophilus Influenzae Type B (Hib)			Dose 1	Dose 2	Dose 3		Dose 3 or 4				
Hepatitis A							Dose 1		Dose 2		
Hepatitis B	Dose 1	Dose 2			Dose 3						
Measles, Mumps, Rubella (MMR)							Dose 1				
Pneumonia			Dose 1	Dose 2	Dose 3		Dose 4				
Polio (IPV)			Dose 1	Dose 2	Ages 6 months to 18 months: Dose 3						
Rotavirus			Dose 1	Dose 2	Dose 3						
RSV Vaccine	Per MD recommendation following CDC guidelines										

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance. Additional: Instrument vision screening to assess risk for ages 1 and 2 years.

** Per Bright Futures. Refer to state-specific recommendations as needed.

*** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

Children: 3 Years to 18 Years¹

GENERAL HEALTH CARE	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
Routine Checkup* (This exam is not the preschool- or day care-related physical)	●	●	●	●	●	●	●	●	Once a year from ages 11 – 18			
Ambulatory Blood Pressure Monitoring**												●
Anxiety Screening						Once a year from ages 8 – 18						
Depression Screening									Once a year from ages 12 – 18			
Illicit Drug-Use Screening												●
Hearing Screening***		●	●	●		●		●		●	●	●
Visual Screening***	●	●	●	●		●		●		●	●	
SCREENINGS												
Hematocrit or Hemoglobin Anemia Screening			Annually for females during adolescence and when indicated									
Lead Screening	When indicated (Please also refer to your state-specific recommendations)											
Cholesterol (Lipid) Screening							Once between ages 9 – 11 and ages 17 – 21					
IMMUNIZATIONS												
Chicken Pox		Dose 2										
COVID-19 Vaccine	Per doctor's advice											
Dengue Vaccine							9 – 16 years living in dengue endemic areas in U.S. Territories AND have laboratory confirmation of previous dengue infection					
Diphtheria, Tetanus, Pertussis (DTaP)		Dose 5										
Flu (Influenza)****	Ages 3 – 18: 1 or 2 doses annually											
Human Papillomavirus (HPV)							Provides long-term protection against cervical and other cancers. 2 doses when started ages 9 – 14. 3 doses, all other ages.					
Measles, Mumps, Rubella (MMR)		Dose 2										
Meningitis*****									Dose 1		Age 16: One-time booster	
Pneumonia	Per doctor's advice											
Polio (IPV)		Dose 4										

* Routine checkup could include height and weight measures, behavioral and developmental assessment, and age-appropriate guidance; alcohol and drug abuse, and tobacco use assessment.

** To confirm new diagnosis of high blood pressure before starting treatment.

*** Hearing screening once between ages 11 – 14, 15 – 17, and 18 – 21. Vision screening covered when performed in doctor's office by having the child read letters of various sizes on a Snellen chart. Includes instrument vision screening for ages 3, 4, and 5 years. A comprehensive vision exam is performed by an ophthalmologist or optometrist and requires a vision benefit.

**** Must get at your PCP's office or designated pharmacy vaccination provider. Call Member Service to verify that your vaccination provider is in the Highmark network.

***** Meningococcal B vaccine per doctor's advice.

CARE FOR PATIENTS WITH RISK FACTORS	3Y	4Y	5Y	6Y	7Y	8Y	9Y	10Y	11Y	12Y	15Y	18Y
BRCA Mutation Screening (Requires prior authorization)					Per doctor's advice							
Cholesterol Screening	Screening will be done based on the child's family history and risk factors											
Fluoride Varnish (Must use primary care doctor)	Ages 5 and younger											
Hepatitis B Screening									Per doctor's advice			
Hepatitis C Screening												●
Latent Tuberculosis Screening												High-risk
Sexually Transmitted Disease (STD) Screenings and Counseling (Chlamydia, Gonorrhea, HIV, and Syphilis)									For all sexually active individuals HIV routine check, once between ages 15 – 21			
Tuberculin Test	Per doctor's advice											

Children: 6 Months to 18 Years¹

PREVENTIVE DRUG MEASURES THAT REQUIRE A DOCTOR'S PRESCRIPTION

Oral Fluoride For ages 6 months to 16 years whose primary water source is deficient in fluoride

PREVENTION OF OBESITY, HEART DISEASE, DIABETES, AND STROKE

Children with a BMI in the 85th to 94th percentile (overweight) and the 95th to 98th percentile (obese) are eligible for:

- Additional annual preventive office visits specifically for obesity
- Additional nutritional counseling visits specifically for obesity
- Recommended lab tests:
 - Alanine aminotransferase (ALT)
 - Aspartate aminotransferase (AST)
 - Hemoglobin A1c or fasting glucose (FBS)
 - Cholesterol screening

Age 18 with a diagnosis of Hypertension, High Blood Pressure, Dyslipidemia, or Metabolic Syndrome Nutritional counseling

ADULT DIABETES PREVENTION PROGRAM (DPP) AGE 18



Applies to Adults 18+

- Without a diagnosis of diabetes (does not include a history of gestational diabetes)
- Overweight or obese (determined by BMI)
- Fasting Blood Glucose of 100-125 mg/dl or HGBA1c of 5.7% to 6.4% or Impaired Glucose Tolerance Test of 140-199mg/dl

Enrollment in certain select CDC-recognized lifestyle change DPP programs for weight loss



Women’s Health Preventive Schedule

SERVICES

Contraception (Birth Control) Methods and Discussion*	All women planning or capable of pregnancy
Well-Woman Visits (Includes: Preconception and first prenatal visit, urinary incontinence screening)	Up to four visits each year for developmentally and age-appropriate preventive services

SCREENINGS/PROCEDURES

Anxiety Screening	The Women’s Preventive Services Initiative recommends screening for anxiety in adolescent girls and adult women, including those who are pregnant or postpartum.
Breast Cancer Diagnostic Screening for Women at Average Risk	Age 40 and older breast mammogram, MRI, ultrasound, biopsy when there is no diagnosis of breast cancer
Breastfeeding (Lactation) Support and Counseling, and Costs for Equipment	During pregnancy and/or after delivery (postpartum)
Diabetes Screening	Screen for diabetes in pregnancy at first prenatal visit or at weeks 24 – 28 and after pregnancy in women with a history of gestational diabetes and no diagnosis of diabetes.
HIV Screening and Discussion	<ul style="list-style-type: none"> • All sexually active women: Once a year • Ages 15 and older, receive a screening test for HIV at least once during their lifetime • Risk assessment and prevention education for HIV infection beginning at age 13 • Screen for HIV in all pregnant women upon initiation of prenatal care with rescreening during pregnancy based on risk factors
Human Papillomavirus (HPV) Screening Testing	Beginning at age 30: Every three years
Intimate Partner and Domestic Violence Screening and Counseling (Provide or refer to intervention services)	Adolescent and adult women
Navigation Services**	Services for Cervical and Breast Cancer Screening
Nutritional Counseling	Ages 40 – 60 with normal BMI and overweight BMI
Sexually Transmitted Infections (STI) Discussion	All sexually active women: Once a year

* FDA-approved contraceptive methods may include sterilization and procedures as prescribed. One or more forms of contraception in each of the 18 FDA-approved methods, as well as any particular service or FDA approved, cleared or granted contraceptive product that an individual’s provider determines is medically appropriate, are covered without cost sharing. Exception Process: Your provider may request an exception for use of a prescribed nonformulary contraception drug due to medical necessity by completing the online request form. When approved, the prescribed drug will then be made available to you with zero-dollar cost share. Note: On page 2 of the form under the title Prior Authorization reads “Contraceptives require a statement of medical necessity only”. The following link works for all states. [<https://content.highmarkprc.com/Files/Region/PA/Forms/MM-056.pdf>] Only FDA approved contraception apps, which are not part of the 18 method categories, and are available for download to a cell phone are reimbursable through the paper claim process with a prescription. Members need to submit three documents to obtain reimbursement; 1) completed the paper Claim Form: [https://www.highmarkbcbs.com/redesign/pdfs/mhs/Medical_Claim_Form.pdf] Under section DIAGNOSIS OR NATURE OF ILLNESS OR INJURY – write “contraception app purchase” 2) receipt of payment for the FDA approved contraception app, 3) provider prescription for the FDA approved contraception app.

** Navigation Services can be found in the My Highmark App, online at www.highmark.com, or by calling the number on the back of your ID card.

In-Network Benefits – Non-Voluntary		Designer Advantage V	
Frequency – Once Every:			
Eye Examination (including dilation when professionally indicated)		12 months	
Spectacle Lenses		12 months	
Frame		12 months	
Contact Lenses (in lieu of eyeglass lenses)		12 months	
Copayments			
Eye Examination		\$0	
Spectacle Lenses		\$0	
Contact Lens Evaluation, Fitting & Follow-Up Care		n/a	
Eyeglass Benefit - Frame		Average Retail Value	
Non-Collection Frame Allowance (Retail):		Up to \$130	
Davis Vision Frame Collection¹ (in lieu of Allowance):		Up to \$120	
- Fashion level		Up to \$125	
- Designer level		Up to \$175	
- Premier level		Up to \$225	
Eyeglass Benefit - Spectacle Lenses		Average Retail Value	
Clear plastic single-vision, lined bifocal, trifocal or lenticular lenses (any Rx)		\$60-\$120	
Oversize Lenses		\$20	
Tinting of Plastic Lenses		\$20	
Scratch-Resistant Coating		\$25-\$40	
Scratch Protection Plan Single Vision		\$60 - \$120	
Scratch Protection Plan Multifocal		\$60 - \$120	
Polycarbonate Lenses ²		\$60-\$75	
Ultraviolet Coating		\$25-\$30	
Standard Anti-Reflective (AR) Coating		\$50-\$70	
Premium AR Coating		\$65-\$90	
Ultra AR Coating		\$100-\$125	
Standard Progressive Lenses		\$150-\$195	
Premium Progressives (Varilux®, etc.)		\$195-\$225	
Ultra Progressive Lenses		\$225-\$300	
Intermediate-Vision Lenses		\$150-\$175	
High-Index Lenses		\$90-\$150	
Polarized Lenses		\$95-\$110	
Plastic Photosensitive Lenses		\$95-\$150	
Contact Lens Benefit (in lieu of eyeglasses)		Member Charges	
Non-Collection Contact Lenses: Materials Allowance		Up to \$120	
- Evaluation, Fitting & Follow-Up Care – Standard Lens Types		Not Covered	
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types		Not Covered	
Collection Contact Lenses/¹ (in lieu of Allowance): Materials		Covered In Full	
- Disposable		Covered In Full	
- Planned Replacement		Included	
- Evaluation, Fitting & Follow-up Care			
Medically Necessary Contact Lenses (with prior approval)		Included	
- Materials, Evaluation, Fitting & Follow-Up Care			
Out-of-Network Reimbursement Schedule: up to			
Eye Examination: \$30	Single Vision Lenses: \$25	Trifocal Lenses: \$45	Elective Contact Lenses: \$75
Frame: \$30	Bifocal/Progressive Lenses: \$35	Lenticular Lenses: \$60	Medically Necessary CL: \$225

¹Collection is available at most participating independent provider offices. Collection is subject to change. Collection is inclusive of select torics and multifocals.

²Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

One-year eyeglass breakage warranty included

Name: _____ Title: _____ Date: _____



ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY
IN **BLUE** OR **BLACK** INK.
DO NOT USE PENCIL OR HIGHLIGHTER.

ENROLLING
(Complete sections I, II, IV, and V)

WAIVING
(Complete sections I and III)

I EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer/Group Name Colours Inc.		Group Number	Payroll Location
First Name	MI	Last Name	Social Security Number (If no SS#, write N/A)	
Address				
City	State	Zip	County	Home/Cell Phone
Marital Status (Please check one): <input type="checkbox"/> Single/Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced		Enrollment Status <input type="checkbox"/> Active Employee <input type="checkbox"/> COBRA Continuant Start Date ____ / ____ / ____ <input type="checkbox"/> Rehired Employee <input type="checkbox"/> HIPAA Life Event (Please attach a copy of COBRA Election Notice or HIPAA Certificate to support eligibility.)		
Full-Time Hire (or Rehire) Date (Month/Day/Year) ____ / ____ / ____	Hours Worked Per Week	Job Title		
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) ____ / ____ / ____	Age	Product Selection(s) <input type="checkbox"/> Medical Product Name: _____ <input type="checkbox"/> Vision <input type="checkbox"/> Dental	
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Are you an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

II DEPENDENT INFORMATION (If enrolling more than four dependents, please attach a separate sheet.)

SPOUSE/DOMESTIC PARTNER				
First Name	MI	Last Name	Only fill out if adding a spouse *Must also fill out Spouse Medical Plan Surcharge Relationship to You? <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner [†]	
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) ____ / ____ / ____	Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental				
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Spouse/DP an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Note: If spouse's last name differs from the contract holder above, please attach a copy of your marriage certificate.

[†]If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

DEPENDENT CHILD				
First Name	MI	Last Name	Only fill out if adding a child Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*	
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) ____ / ____ / ____	Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental				
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Dependent Status if Age 26 or Older <input type="checkbox"/> Disabled <input type="checkbox"/> Act 4**	
			Is Child an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.



DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / / Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental		Dependent Status if Age 26 or Older <input type="checkbox"/> Disabled <input type="checkbox"/> Act 4**	
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? <input type="checkbox"/> Child <input type="checkbox"/> Step-child <input type="checkbox"/> Adopted* <input type="checkbox"/> Other*
Social Security Number (If no SS#, write N/A)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (Month/Day/Year) / / Age
Product Selection(s): <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental		Dependent Status if Age 26 or Older <input type="checkbox"/> Disabled <input type="checkbox"/> Act 4**	
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

**If your employer offers Act 4 adult dependent coverage, complete and attach an Act 4 Dependent Verification Form.

III WAIVER OF COVERAGE (Complete this section ONLY if you are declining coverage(s) offered to you AND/OR your family members.)

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:

- For myself
- For family members **ONLY**:
- For myself and **ALL** family members
- For the following family members:

REASON FOR DECLINING MEDICAL COVERAGE:

- Insured under spouse. Please provide spouse's employer and insurance carrier names:

- Other:

VISION

I HEREBY DECLINE VISION COVERAGE:

- For myself
- For family members **ONLY**
- For myself and **ALL** family members
- For the following family members:

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

- For myself
- For family members **ONLY**
- For myself and **ALL** family members
- For the following family members:

I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer and that I have declined coverage for myself and/or my dependents as noted above. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment (described below) occurs before coverage will be offered.

Employee/Contract Holder Signature

Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 31 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

IV OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier		Group Number	Effective Date / /		Name of Policyholder
Policyholder Date of Birth / /	Relationship to Policyholder	Policy Number		Policyholder Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired Date of Retirement: / /	

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No

V IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

To the best of my knowledge and belief, the information provided on this application is true and correct.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

Colours Inc.

Print Employee/Contract Holder Name

Print Employer/Group Name

Employee/Contract Holder Signature

Date

For New Group Business: Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and all supporting documentation) to the appropriate Highmark Small Group Sales Contact.

For Ongoing Enrollment: If adding new employees/contract holders/or dependents to an existing group, please fax/send Enrollment/Waiver Forms to one of the following addresses:

Fax (800) 290-3301

Membership Department
P.O. Box 535193
Pittsburgh, PA 15253-5193

Insurance or benefit administration may be provided by Highmark Blue Cross Blue Shield, First Priority Life Insurance Company (FPLIC) or First Priority Health (FPH). Information is issued by Highmark Blue Cross Blue Shield on behalf of these companies, which are independent licensees of Blue Cross and Blue Shield Association.

Highmark Blue Cross Blue Shield, FPLIC and FPH do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

We are committed to providing outstanding services for our applicants and members. If you require special assistance, including accommodations for disabilities or limited English proficiency, please call the number on the back of your member ID card to request these free services (TTY/TDD users may call 711).

Estamos comprometidos a ofrecer servicios excepcionales a nuestros solicitantes y miembros. Si usted necesita ayuda especial, incluyendo acomodaciones para discapacidades o dominio limitado del inglés, por favor llame al número que aparece en su tarjeta de identificación para solicitar este servicio gratuito. Usuarios de TTY con problemas de audición pueden llamar al 711 para recibir ayuda de forma gratuita.

我們致力於為我們的申請人和會員們提供卓越的服務。如果您需要特殊協助，如英語能力有限，請撥打您證件上的號碼，來要求這些免費服務。如您有聆聽障礙需要TTY免費服務，請致電711。

May pananagutan kaming magbigay ng bukod-tanging mga serbisyo para sa aming mga aplikante at mga miyembro. Kung kailangan mo ng espesyal na tulong, kabilang ang akomodasyon para sa limitadong kahusayan sa wikang Ingles pakitawagan ang numero sa iyong ID card para hilingin ang libreng serbisyong ito. Ang mga gumagamit ng TTY para sa mga may kapansanan sa pagdinig ay maaaring tumawag sa 711 para makatanggap ng libreng tulong.

Nihinaanish niizhónigo bee nihiká' adiilwofigñ binahj' ts'Idá yéego bidiilkaal, nihí naaltsoos nidahonifigñ dóo Bee Atah 'idfinigñ nihit hada'dit' éhigñ nihá. T'áá hait' éego da nint' ago níká' iidoowof, dñ Bilagána Bizaad doo hózhq bik'í'diitiingó, ei Bik'isindáago bee nééhózinigñ béesh bee hane' é bikáá', t'áá jík'eh áká'aná'áwo', éi bich'j' hodñilni. Doo hazhó'ó azhdiits'a'gó éi TTY chodayoof'ingñ 711 bich'j' hodñilnih, t'áá jík'eh níká'iidoowof.

Network providers—The Davis Vision provider network is being used through a contractual arrangement between Davis Vision and Highmark. Davis Vision is an independent company that manages a network of licensed vision providers in both private practice and retail locations. Network providers are reviewed and credentialed to ensure that standards for quality and service are maintained.

Network retail locations—In order to provide you with the greatest amount of flexibility and convenience, the network includes a number of retail establishments. Benefits at the retail locations may vary slightly from other locations, as noted in this benefit description. However, your value is comparable.

Locating a network provider—To find a network provider, go to www.highmarkbcbs.com and click on “Find a Doctor or Rx.” Click on “Find an Eyecare Provider”. Enter your zip code and mile radius then click on “Search” to see the most current listing of providers that will accept your vision plan.

Receiving services from a network provider:

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Highmark member, or eligible dependent, in a vision plan administered by Davis Vision.
- Provide the office with your identification (ID) number (located on your Highmark ID card), and the name and birth date of the covered dependent receiving services. It's that easy! The provider's office will verify your eligibility for services. No claim forms are required!

Frame benefit—You may choose from 'The Collection' in most independent network provider offices or a program allowance will be applied toward a network provider's own frames. Many Collection frames are covered in full or have a nominal copayment which helps you select high-quality frames, while minimizing out-of-pocket expenses. Network retail providers typically do not display the Collection. You will instead be given a program allowance toward your frame purchase. If the chosen frame exceeds the allowance, you will be responsible for any remaining balance.

Contact lenses benefit—Contact lenses may be selected in lieu of eyeglass lenses. No copayment applies towards the initial supply of formulary contact lenses (many of the most popular standard, soft daily wear; disposable or planned replacement) including fitting/follow-up charges. A program allowance will be applied toward contact lenses from the provider's own supply (which may or may not include fitting/follow-up charges). At a network retail location, you will receive an allowance toward the cost of lenses from the retailer's supply. With prior approval, medically necessary contact lenses will be covered in full at all network provider locations.

Low vision services—You and your covered dependents are entitled to a comprehensive low vision evaluation once every five years and low vision aids up to the plan maximum. Up to four follow-up visits will be covered during the five-year period.

Exclusions—This vision program excludes coverage for certain items and services, including: medical treatment of eye disease or injury; vision therapy; special lens designs or coatings other than those previously described; replacement of lost or stolen eyewear; non-prescription (Plano) lenses; and services not performed by licensed personnel.

VALUE-ADDED FEATURES

Replacement contact lens program—Highmark offers a contact lens replacement program to members. This mail order program exclusively allows you to enjoy the guaranteed lowest prices on contact lens replacement materials. Visit www.davisvisioncontacts.com or call 1-855-589-7911 with a current prescription. Every order comes with a complimentary starter kit.

Information about laser vision correction services—You and your covered dependents can receive substantial discounts on laser correction procedures. You are entitled to savings of up to 25% off the provider's usual and customary fees, or a 5% discount on any advertised special through a network of credentialed physicians affiliated with Eye Centers of Excellence. (Some centers provide a flat fee equating to these discount levels.)

Call Member Service Monday through Friday, 8:00 am to 5:00 pm, Eastern Standard Time (EST) at 1-800-223-4795 (TTY users call 1-800-523-2847) to find a network provider, ask benefit questions, verify eligibility or request an out-of-network provider reimbursement form.

For information prior to enrolling, call 1-800-223-4795.



Summary of Benefits

Dental Benefit Summary

Group ID:	00498363	Coverage Type:	Voluntary
Group Name:	COLOURS INC	Class:	0003 ALL OTHER ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following date of hire		

Plan Information

Your dental networks is: Dental - DentalGuard Pref - Philadelphia, Pa

Coverage Information

	Dental - DentalGuard Pref - Philadelphia, Pa	
What's the most cost-effective way to use dental insurance?	With your PPO plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.	
	In Network	Out of Network
Calendar year deductible	\$50, Once the annual deductible is met by each of three family members, no further deductibles apply.	\$50, Once the annual deductible is met by each of three family members, no further deductibles apply.
Preventive	Waived	Waived
Basic	Not Waived	Not Waived
Major	Not Waived	Not Waived
Calendar Year Maximum Benefit	The amount shown in the out of network field is your combined Calendar Year maximum for both in and out of network services.	\$1,000
Maximum rollover	Yes	Yes
Monthly Switch	Not Available	Not Available
	How much does the plan pay?	How much does the plan pay?(as a percentage of fee schedule.)
Office Visit Co-pay (one office visit may cover multiple services)	None	None
Preventive Care:	100%	100%
Bitewing X-Rays	100%	100%
Full Mouth X-Rays	100%	100%
Cleaning	100%	100%
Oral Exams	100%	100%
Sealants (per tooth)	100%	100%
Basic Care:	100%	80%
Fillings (one surface)	100%	80%
General Anesthesia ¹	100%	80%
Scaling & Root Planing (per quadrant)	100%	80%
Simple Extractions	100%	80%
Major Care:	60%	50%
Dentures	60%	50%
Single Crowns	60%	50%
Orthodontia	Not Available	Not Available

General Exclusions

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred PPO plans:

This policy provides dental insurance only. Coverage is limited to charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury.

Deductibles apply.

The plan does not pay for:

- Oral hygiene services (except as covered under preventive services),
- Orthodontia (unless expressly provided for),
- Cosmetic or experimental treatments (unless they are expressly provided for).
- Any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment.

The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DEN -16 et al.

Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000



¹ Restrictions apply and may be subject to medical necessity.

This Benefit Summary is for illustrative purposes. Your benefits booklet will show exactly what is covered and/or excluded under your plan. If there is a discrepancy between this Benefit Summary and your benefit booklet, the benefit booklet prevails.

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Summary of Benefits

Basic Life Benefit Summary

Group ID:	00498363	Member Coverage Type:	Non Contributory
Group Name:	COLOURS INC	Class:	0003 ALL OTHER ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following date of hire	As of Date:	

Coverage Information

Employee Volume Amount	Flat \$15,000
Maximum Amount	\$15,000
Cutbacks	35% at age 65 60% at age 70 75% at age 75 85% at age 80

Plan Information

When is my policy effective?	Coverage is effective after you satisfy any waiting period required by your employer. Coverage will not begin until Guardian has approved any amount subject to medical underwriting.
Do I have to answer medical questions as part of purchasing insurance?	No
Can I take the policy with me if I leave the company?	Yes, you can convert this coverage to an individual policy if you terminate employment with the company or the policy ends. (Some restrictions apply; see certificate of benefits for more information.)

Basic Life and General Exclusions

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.

Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.



Summary of Benefits

Voluntary Life Benefit Summary

Group ID:	00498363	Member Coverage Type:	Voluntary
Group Name:	COLOURS INC	Class:	0003 ALL OTHER ELIGIBLE EMPLOYEES
Waiting Period:	1st of the month following date of hire	As of Date:	

Coverage Information

Employee Volume Amount

Increments of \$10,000 to a Maximum of \$250,000

\$10,000	\$110,000	\$210,000
\$20,000	\$120,000	\$220,000
\$30,000	\$130,000	\$230,000
\$40,000	\$140,000	\$240,000
\$50,000	\$150,000	\$250,000
\$60,000	\$160,000	
\$70,000	\$170,000	
\$80,000	\$180,000	
\$90,000	\$190,000	
\$100,000	\$200,000	

Spouse Volume Amount

Minimum Amount of \$10,000 and Increments of \$5,000 to a maximum of \$250,000

Child Volume Amount

Ages 14 Days to 6 Months Minimum of \$1,000 and Increments of \$1,000 to a maximum of \$10,000

Ages 6 Months to 26 Years Minimum of \$1,000 and Increments of \$1,000 to a maximum of \$10,000

Member Guaranteed Issue

Ages 15-64 \$150,000

Ages 65-69 \$50,000

Ages 70 and up \$10,000

Spouse Guaranteed Issue

Spouse's Age 15-64 \$25,000

Spouse's Age 65 and up \$10,000

Child Guaranteed Issue

There is no guaranteed issue. All amounts are approved.

Cutbacks

35% at age 65

60% at age 70

75% at age 75

85% at age 80

Plan Information

When is my policy effective?

Coverage is effective after you satisfy any waiting period required by your employer. Coverage will not begin until Guardian has approved any amount subject to medical underwriting.

Do I have to answer medical questions as part of purchasing insurance?

If you decide to purchase more than the amount guaranteed by Guardian or enroll after the open enrollment period, you must answer some medical questions to help us assess your insurability.

Answering "yes" to any of the questions will not necessarily prevent you from obtaining coverage.

Can I take the policy with me if I leave the company?

You may be able to port this coverage to a group trust plan.

Yes, you can convert this coverage to an individual policy if you terminate employment with the company or the policy ends. (Some restrictions apply; see certificate of benefits for more information.)

Voluntary Life and General Exclusions

Spouse coverage is based on employee age and terminates at age 70.

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.

Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.

Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to policy booklet for full plan description.

Dependent coverage will not take effect if a dependent, other than a newborn is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex. (may vary by state).

Accelerated Life Benefit is not paid to an employee under the following circumstances: one who is required by law to use the benefit to pay creditors; is required by court order to pay the benefit to another person; is required by a government agency to use the payment to receive a government benefit; or loses his or her group coverage before an accelerated benefit is paid.

We pay no benefits if the insured's death is due to suicide within two years from the insured's original effective date. This two year limitation also applies to any increase in benefit. This exclusion may vary according to state law.

The group policy or individual certificate cannot be contested after it, or any rider or amendment subsequently added to it, has been in force for a period of two years. If the age or any other relevant factor of the insured has been misstated, GIAC will use the true fact in determining whether insurance is in force under the terms of the certificate and in what amounts.



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Benefit Summary - Short Term Disability

Group name	Group ID	Class	Contribution type	Waiting period
COLOURS INC	00498363	0003 ALL OTHER ELIGIBLE EMPLOYEES	Voluntary	1st of the month following date of hire

Coverage Information

Weekly Volume	60% of weekly earnings
Guaranteed Issue	There is no guaranteed issue. All amounts are approved.
Maximum Amount	\$1,200
Waiting Periods (Benefits begin on ...)	Accident: Day 8 Illness: Day 8
Maximum Payment Period	13 weeks

Plan Information

When is my policy effective?	Coverage is effective after you satisfy any waiting period required by your employer. Coverage will not
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begin until Guardian has approved any amount subject to medical underwriting.

How are my earnings defined?

Earnings means your weekly earnings excluding expense accounts, and any other extra compensation. Earnings include the average of your bonuses & commissions for the previous 12 months. If you are a partner, earnings means your partnership earnings that are reported on your IRS Form 1040 Schedule E for the prior calendar or tax year.

Can I take the policy with me if I leave the company?

No.

Do I have to answer medical questions as part of purchasing insurance?

No.

Can I return to work part time while I'm disabled?

Yes, you may return to work part time and still be considered disabled. Some restrictions apply.

Short Term Disability General Limitations and Exclusions

We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces); committing a felony or taking part in any riot or other

civil disorder; or intentionally injuring themselves or attempting suicide while sane or insane, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed.

We do not pay benefits for any job-related or on-the-job injury, or conditions for which Workers' Compensation benefits are payable.

We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss or earnings is not solely due to disability.

This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", "medical" insurance as defined by the New York State Insurance Department.

Employees must be legally working in the United States in order to be eligible for coverage.

Underwriting must approve coverage for employees on temporary assignment:

- a. exceeding one year; or
- b. in an area under travel warning by the US Department of State, subject to state specific variations.

If the plan is new (not transferred): This STD plan limits benefits to two weeks for a disability relating to a pre-existing condition. A pre-existing condition includes any condition for which an employee, in the three month period prior to coverage under this plan, consults with a physician, receives treatment, or takes prescribed drugs.

Contract #'s GP-1-STD2K-1.0 et al., GP-1-STD07-1.0 et al., Contract # GP-1-STD-15-1.0 et al.

Acts of war etc.

Disability benefits do not cover any disability caused by

1. war or any act of war, including service in the armed forces;
2. committing a crime or taking part in a riot or civil disorder;
3. intentionally injuring yourself or attempting suicide while sane or insane;
4. confined to a correctional facility, or

5. receiving treatment outside US.

Disability benefits are not paid for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces); committing a felony or taking part in any riot or other civil disorder; or intentionally injuring themselves or attempting suicide while sane or insane, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed.

Disability benefits are not paid during any period in which you are confined to a correctional facility, you are not under the care of a doctor, you are not receiving treatment outside of the US or Canada, and or your loss of earnings is not due solely to disability.

You will receive a certificate of coverage after you enroll which contains a complete list of exclusions. If there is a difference between this booklet and the certificate of coverage, the certificate of coverage prevails.

Other

When applicable, this coverage will integrate with any mandated state disability plans.

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Child/Dependent 1: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 3: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: () -	<input type="checkbox"/> Add <input type="checkbox"/> Drop	Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check as applicable) <input type="checkbox"/> Student (post high school) <input type="checkbox"/> Disabled <input type="checkbox"/> Non standard dependent

<p>Drop Coverage:</p> <p><input type="checkbox"/> Drop Employee/Member <input type="checkbox"/> Drop Dependents/Family Members</p> <p>The date of withdrawal cannot be prior to the date this form is completed and signed.</p> <p>Last Day of Coverage: ____ - ____ - ____</p> <p><input type="checkbox"/> Termination of Employment <input type="checkbox"/> Retirement</p> <p>Last Day Worked: ____ - ____ - ____</p> <p><input type="checkbox"/> Other Event: _____</p> <p>Date of Event: ____ - ____ - ____</p>	<p>Coverage Being Dropped:</p> <p><input type="checkbox"/> Dental <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Basic Term Life</p> <p><input type="checkbox"/> Voluntary Term Life <input type="checkbox"/> Employee/Member <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)</p> <p><input type="checkbox"/> Short Term Disability</p>
<p>Loss Of Other Coverage:</p> <p>I and/or my dependents were previously covered under Loss of coverage was due to:</p> <p><input type="checkbox"/> Termination of Employment: ____ - ____ - ____</p> <p><input type="checkbox"/> Divorce/Separation ____ - ____ - ____</p> <p><input type="checkbox"/> Death of Spouse ____ - ____ - ____</p> <p><input type="checkbox"/> Termination/Expiration of Coverage ____ - ____ - ____</p> <p>Coverage Lost <input type="checkbox"/> Dental</p>	<p>I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:</p> <p><input type="checkbox"/> Covered under another insurance plan</p> <p><input type="checkbox"/> Other _____</p> <p>(additional information may be required)</p>

<p>Dental Coverage: You must be enrolled to cover your dependents/family members. Check only one box.</p>				
Your Bi-weekly Premium	Employee/Member Only	Employee/Member & Spouse	Employee/Member & Dependent/Child(ren)	Employee/Member, Spouse & Dependent/Child(ren)
PPO	<input type="checkbox"/> \$13.90	<input type="checkbox"/> \$29.79	<input type="checkbox"/> \$35.80	<input type="checkbox"/> \$53.29
<p><input type="checkbox"/> I do not want Dental Coverage because (Check as applicable):</p> <p><input type="checkbox"/> I am covered under another Dental plan</p> <p><input type="checkbox"/> My spouse is covered under another Dental plan</p> <p><input type="checkbox"/> My dependents/family members are covered under another Dental plan</p>				

Basic Life Coverage with Accidental Death and Dismemberment (AD&D):

Benefit reductions apply. Please see plan administrator.

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Policy Amount

Employee/Member Only

\$15,000

The Guarantee Issue Amount is \$15,000.

* If Employee/Member is 65+ benefit reductions may apply which may change the GI amount. Please see enrollment materials for details.

This portion must be filled out.



Employee/Member Name your beneficiaries: (Primary beneficiary percentages must total 100%)

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name: _____ Social Security Number: _____ %

Date of Birth (mm-dd-yy): ____ - ____ - ____

Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Name: _____ Social Security Number: _____ %

Date of Birth (mm-dd-yy): ____ - ____ - ____

Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Contingent Beneficiary: _____ Social Security Number: _____

Date of Birth (mm-dd-yy): ____ - ____ - ____

Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer/Planholder maintains beneficiary information.)

Dependents/Family Members – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. Yes No

If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): _____

Date of Birth (mm-dd-yyyy) (if an individual): ____ - ____ - ____

Address/City/State/Zip: _____

Phone: () - _____

If this Basic Life coverage will replace your existing life insurance coverage through your current Employer/Planholder, provide the amount of the previous policy \$ _____

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

If Yes, fill our EOI form questions 1-4

LIFE INSURANCE *continued*

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D): You must be enrolled to cover your dependents/family members. *Benefit reductions apply. Please see plan administrator.*

The amount of life insurance coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Employee/Member

Policy Amount

Check one box only

- | | | | | | |
|------------------------------------|------------------------------------|-------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$20,000 | <input type="checkbox"/> \$30,000 | <input type="checkbox"/> \$40,000 | <input type="checkbox"/> \$50,000 | <input type="checkbox"/> \$60,000 |
| <input type="checkbox"/> \$70,000 | <input type="checkbox"/> \$80,000 | <input type="checkbox"/> \$90,000 | <input type="checkbox"/> \$100,000 | <input type="checkbox"/> \$110,000 | <input type="checkbox"/> \$120,000 |
| <input type="checkbox"/> \$130,000 | <input type="checkbox"/> \$140,000 | <input type="checkbox"/> \$150,000* | <input type="checkbox"/> \$160,000 | <input type="checkbox"/> \$170,000 | <input type="checkbox"/> \$180,000 |
| <input type="checkbox"/> \$190,000 | <input type="checkbox"/> \$200,000 | <input type="checkbox"/> \$210,000 | <input type="checkbox"/> \$220,000 | <input type="checkbox"/> \$230,000 | <input type="checkbox"/> \$240,000 |
| <input type="checkbox"/> \$250,000 | | | | | |

\$150,000 or more, you must fill our EOI form

Guarantee Issue up to: Employee Less than age 65 \$150,000*, 65-69 \$50,000, 70+ \$10,000. The Health History section must be completed if any amount above the Guarantee Issue Amount is elected.

I do not want this coverage

Add Voluntary Life for Spouse

Policy Amount

- | | | | | | |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$15,000 | <input type="checkbox"/> \$20,000 | <input type="checkbox"/> \$25,000* | <input type="checkbox"/> \$30,000 | <input type="checkbox"/> \$35,000 |
| <input type="checkbox"/> \$40,000 | <input type="checkbox"/> \$45,000 | <input type="checkbox"/> \$50,000 | <input type="checkbox"/> \$55,000 | <input type="checkbox"/> \$60,000 | <input type="checkbox"/> \$65,000 |
| <input type="checkbox"/> \$70,000 | <input type="checkbox"/> \$75,000 | <input type="checkbox"/> \$80,000 | <input type="checkbox"/> \$85,000 | <input type="checkbox"/> \$90,000 | <input type="checkbox"/> \$95,000 |
| <input type="checkbox"/> \$100,000 | <input type="checkbox"/> \$105,000 | <input type="checkbox"/> \$110,000 | <input type="checkbox"/> \$115,000 | <input type="checkbox"/> \$120,000 | <input type="checkbox"/> \$125,000 |
| <input type="checkbox"/> \$130,000 | <input type="checkbox"/> \$135,000 | <input type="checkbox"/> \$140,000 | <input type="checkbox"/> \$145,000 | <input type="checkbox"/> \$150,000 | <input type="checkbox"/> \$155,000 |
| <input type="checkbox"/> \$160,000 | <input type="checkbox"/> \$165,000 | <input type="checkbox"/> \$170,000 | <input type="checkbox"/> \$175,000 | <input type="checkbox"/> \$180,000 | <input type="checkbox"/> \$185,000 |
| <input type="checkbox"/> \$190,000 | <input type="checkbox"/> \$195,000 | <input type="checkbox"/> \$200,000 | <input type="checkbox"/> \$205,000 | <input type="checkbox"/> \$210,000 | <input type="checkbox"/> \$215,000 |
| <input type="checkbox"/> \$220,000 | <input type="checkbox"/> \$225,000 | <input type="checkbox"/> \$230,000 | <input type="checkbox"/> \$235,000 | <input type="checkbox"/> \$240,000 | <input type="checkbox"/> \$245,000 |
| <input type="checkbox"/> \$250,000 | | | | | |

Guarantee Issue up to: Spouse Less than age 65 \$25,000*, 65-69 \$10,000, \$0.

**The amount may not be more than 100% of the employee amount for Voluntary Life.*

I do not want this coverage

You must answer if not desiring coverage.

Add Voluntary Life for Dependent/Child(ren)

Policy Amount

- | | | | | | |
|----------------------------------|----------------------------------|----------------------------------|------------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> \$1,000 | <input type="checkbox"/> \$2,000 | <input type="checkbox"/> \$3,000 | <input type="checkbox"/> \$4,000 | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$6,000 |
| <input type="checkbox"/> \$7,000 | <input type="checkbox"/> \$8,000 | <input type="checkbox"/> \$9,000 | <input type="checkbox"/> \$10,000* | | |

**Guarantee Issue Amount*

**The amount may not be more than 10% of the employee amount for Voluntary Life.*

I do not want this coverage

You must answer if not desiring coverage.

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form.

Only fill out if adding additional life insurance

LIFE INSURANCE *continued*

Employee/Member Only Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life or Voluntary Term Life, please name below.

If additional space is needed, please attach a separate sheet of paper with this information along with your enrollment form. Be sure to sign and date (mm-dd-yyyy) the paper and keep a copy for your records.

Primary Beneficiaries:

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Name: _____ Social Security Number: _____ - _____ - _____ % _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

Contingent Beneficiary: _____ Social Security Number: _____ - _____ - _____

Date of Birth (mm-dd-yy): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____ Relationship to Employee/Member: _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer/Planholder maintains beneficiary information.)

Spouse and dependent/child(ren) – If the intended beneficiary is to be someone other than the Employee/Member, please complete the Beneficiary Designation form.

Attention: If any of the beneficiaries named above is a minor (a person under the age of 18 or 21, depending on their state of residency), state law may limit Guardian's ability to pay life insurance proceeds directly to them for as long as they remain a minor. State Uniform Transfers to Minors Act (UTMA) laws, where applicable, may allow for the normal course of payment of these proceeds, or a portion thereof, to the minor beneficiary's designated Custodian to manage on the minor's behalf until they reach adult age. At that time, the proceeds are turned over to the adult child, who can use the proceeds in any way he or she chooses.

Are any of the beneficiaries identified above considered a minor in the state in which they reside? Check one box only. Yes No
If you answered "Yes", please name the legally designated UTMA Custodian for all minor beneficiaries you have designated:

Custodian to Minor Beneficiaries:

Name: _____ Social Security Number (or FEIN/TIN # if a corporate entity): _____ - _____ - _____

Date of Birth (mm-dd-yyyy) (if an individual): _____ - _____ - _____ Address/City/State/Zip: _____

Phone: () - _____

Short-Term Disability (STD) Coverage:

The amount of STD coverage you select may be either a specific dollar amount or an amount that is a multiple of your salary and may be subject to certain reductions.

Weekly Benefit

60% of salary to a maximum of \$1,200

I do not want this coverage.

If yes, fill out EOI Form questions 1-5

Signature

- I understand that my dependents/family members cannot be enrolled for a coverage if I am not enrolled for that coverage.
- LIFE ONLY: I understand that life insurance coverage for a dependent/family member, other than a newborn child, will not take effect if that dependent/family member is confined to a hospital or other health care facility, or is home confined, or is unable to perform two or more Activities of Daily Living (ADL's).
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- I understand that plan design limitations and exclusions may apply. For complete details of coverage, please refer to the plan documents or enrollment materials. State limitations may apply.

- Your coverage will not be effective until approved by a Guardian or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements.
- I agree that my employer/planholder may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

SIGNATURE OF EMPLOYEE/MEMBER X _____

DATE _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

PO Box 14319
Lexington, KY 40512

Please complete this form in ink. As a convenient alternative, for Life and Disability coverages, this form can be completed at www.guardiananytime.com/eoi

Planholder Name (Company Name) Colours Inc.				Group Plan No. 00498363			
Complete the following information for each person to be underwritten:							
Name (Last, First, Middle Initial)			Sex	Birthdate	Height	Weight	Full time Student
Employee:			<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee Home Address:				Preferred Method of Contact:		Employee Telephone Number:	
Date of Hire: / /		Cell Phone:		E-mail Address:			
Spouse:			<input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Height	Weight	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:			<input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Height	Weight	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:			<input type="checkbox"/> M <input type="checkbox"/> F	Birthdate	Height	Weight	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee's Social Security Number:			Date of Marriage: / /		Employee's Place of Birth (State):		
Employee Amount of Insurance Currently Inforce:			Spouse Amount of Insurance Currently Inforce:		Child Amount of Insurance Currently Inforce:		
Employee's Insurance Amount Elected:			Spouse Insurance Amount Elected:		Child Insurance Amount Elected:		
Section I: IF APPLYING FOR LIFE INSURANCE, questions 1-4 must be answered by each person applying for coverage. However, if applying for coverage for a child, the Employee must complete questions 1-4 for the child applying for coverage. IF APPLYING FOR DISABILITY INSURANCE, questions 1-5 must only be answered by the Employee.							
1. In the past 10 years, has any proposed insured been treated for or diagnosed as having any of the following: a) any disorder or condition of the heart; liver, kidney(s); lung or respiratory system; b) any disorder or condition of your digestive system including your esophagus, stomach, or intestines; c) any mental, nervous, emotional or neurological disorder or condition; d) auto immune disorder; e) diabetes; f) cancer; or g) a stroke?;						Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No
						Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No
						Child	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past 5 years, has any proposed insured: used any illegal drugs; used prescription medication other than as prescribed; been treated for alcoholism or drug use or dependency; or been advised to seek treatment for alcoholism, drug abuse or drug dependency?						Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No
						Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No
						Child	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has any proposed insured ever tested positive for HIV (Human Immunodeficiency Virus) antibodies?						Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No
						Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No
						Child	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past year, has any proposed insured: (a) consulted or been examined by or treated by a physician, practitioner or specialist for any illness or injury, disease or disorder NOT listed in the questions above (including routine physicals only when there is an existing or newly diagnosed medical condition); or (b) sought treatment or a consultation in a hospital or other health care facility for observation, diagnosis, treatment or an operation; undergone any diagnostic testing including but not limited to X ray, blood work, ultrasound, an MRI, a CT scan, or PET scan with abnormal findings; or been prescribed medication(s) – (other than for colds, flu or allergies)?						Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No
						Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No
						Child	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. If applying for disability coverage, please complete these additional questions:						Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No
(a) In the past 5 years, has any proposed insured been treated for any disorder or condition of the back, neck, spine; arthritis; or any muscular skeletal disorder or condition?						Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No
(b) Are you currently pregnant?						Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please retain a copy for your records and submit this form to Guardian

For each "yes" answer to question 1 through 5 give details below. (Continue on reverse side if additional space is needed.)					
Question #	Name	Test, Injury, Illness, Disease, Operation or Complication	Date of		Full Details (including Doctors' Names and Addresses)
			Onset	/ Recovery	

Please retain a copy for your records and submit this form to Guardian

Representations of the Proposed Insured(s) and Authorization Please read and sign below.

Part I. Representations of the Proposed Insured

Those parties who sign below hereby represent that the statements and answers to the question(s) are, to the best of the knowledge and belief of the party signing below, full, complete, true and correctly recorded. Those parties who sign below understand that they will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required. When used in this Part I, "I" refers to the person applying for insurance signing below.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (except in the case of a late entrant, it is not at the Company's expense), that any proposed insured be examined by an accredited medical examiner selected by the Company; (2) no Group Insurance will be binding or in force until satisfactory evidence of insurability is submitted, approved by the Company and the required premiums are received by the Company; and: (a) I am actively at work on a full-time basis (as defined in the Group Plan) for full pay on the date my Group Insurance becomes effective; otherwise, (b) I become insured on the date I do return to work and satisfy a waiting period (as defined in the Group Plan) of full-time service; (3) coverage for my dependents will not take effect if a dependent other than a newborn is: (a) confined to the hospital or other health care facility; or (b) is unable to perform the normal activities of someone of like age and sex; (4) no person, except the President, a Vice President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company's requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (5) the employer is hereby named the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company. In the event the Company receives premiums in excess of the appropriate amount for the coverage provided, the Company will only be liable for the overpaid premiums plus applicable interest.

Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment or may lead to rescission of any coverage issued based on this Evidence of Insurability Form.

Part II. Authorization to Obtain Information (Medical Records and other information)

I authorize my physician, medical practitioner, hospital, clinic, other health facility, practitioner, mental health professional, pharmacy or pharmacy benefit manager, laboratory, the MIB, Inc., insurance or reinsurance company, group policyholder, benefit plan administrator, employer, other organization, institution or person that has any records or knowledge of the Proposed Insured or his/her health, business associate, other person or organization to release any and all medical and non-medical information in its possession about me, to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, pharmaceutical history, and all past and present physical, mental, drug and alcohol condition, or treatment of me. Non-medical information includes employment history, job duties, and any wage or earnings information. I understand that the information released could contain reference to or results of HIV Antibody (AIDS) testing, and may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric, and psychological conditions, and drug or alcohol abuse.

I understand that Guardian will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. I further understand that if I refuse to sign this authorization, the Company may not be able to process my application, or pay a claim in the case of coverage which is already in force. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the MIB, Inc., or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may fully authorize. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulations governing privacy (such as the HIPAA Privacy Rule).

By my signature below, I authorize the Company or its legal representatives to make a brief report of my personal health information to the MIB, Inc.

I know that I may revoke this authorization in writing, at any time, by sending a written request for revocation to the Guardian Corporate Secretary at 7 Hanover Square, New York, NY 10004-2616. I understand that a revocation is not effective to the extent that the Company and/or any of the entities listed above has already relied on this authorization, or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I know that I may request and receive a copy of this authorization.

I agree that a photocopy of this authorization will be as valid as the original. I agree that this authorization will be valid for two and one half years from the date shown below.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the Fraud Warning Statements page below.

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

By my signature below,

1. I agree with all of the terms, conditions, statements, and representations stated above in Part I. Representations of the Proposed Insured; and
2. I agree and consent to the Company obtaining and disclosing the information as stated above in Part II. Authorization to Obtain Information (Medical Records and Other Information) and with all other terms and conditions stated therein.

Signature of Employee

Date

Signature of Spouse

Date

Please retain a copy for your records and submit this form to Guardian

Insurance Information Practices Please read and detach for your records

Thank you for choosing The Guardian Life Insurance Company of America ("Guardian"). This notice is given to you at the time you apply for life or disability insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential, except as authorized by you, or as required by law. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to: The Privacy Office, The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-4025.

MIB, Inc. Pre-Notice: Information regarding your insurability will be treated as confidential. Guardian, or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc. member company for life, health or disability insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc., at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of the information in your MIB, Inc. file, you may contact MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc., information office is 50 Braintree Hill Park, Suite 400, Braintree MA 02184-8734.

Guardian, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life, health, or disability insurance, or to whom a claim for benefits may be submitted.

Medical Records: We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian's staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.

Please retain a copy for your records and submit this form to Guardian

Fraud Warning Statements

The laws of several states require the following statements to appear on the evidence of insurability form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Kansas, Nebraska, Oregon, and Vermont: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Please retain a copy for your records and submit this form to Guardian

welcome to revive.

Eligible employees can talk to a doctor 24/7 by phone or video-chat at no cost or co-pays!

- ✓ 24/7 nationwide access to Board-Certified physicians
- ✓ Consults available anytime, anywhere
- ✓ Prescriptions sent to your preferred local pharmacy
- ✓ Avoid overcrowded waiting rooms and long wait times
- ✓ NO copays, deductibles, or surprise statements



getting started.

1. Head to member.myrevive.health and select 'Register Now'
2. Complete the required fields, inclusive of your enrollment code: **CLRS17**

You will also receive a welcome email with instructions to complete your activation.

Access care via our mobile app!



conditions we treat

Allergies and Rashes, Arthritis Pain, Back Pain or Injury, Cold Sores, Diarrhea, Earache, Conjunctivitis or Pink Eye, Fever and Flu, Headache, Insect Bites and Stings, Lymes Disease, Sinusitis, Sore Throat, Stomach Ache and Nausea, Upper Respiratory Infections, Urinary Tract Infections, Vomiting, Your Individual Concerns

Revive does not replace your PCP managing chronic conditions. Revive health doctors don't prescribe controlled or psychiatric medications, and certain other medications subject to abuse.

mental health.

Asking for help can be scary.
Our expert mental health care isn't.

Discover mental healthcare tailored to you. With expert guidance and personalized mental wellness plans.



No claims/copays | Consults in 1-3 days | Nationwide coverage | Provider matching

member benefit.

You have 6 mental health therapy visits per member per year.

- 24/7 mental health support (ages 12+)
- Connect with a master's level clinician
- Rapid appointments available for urgent needs
- Scheduled appointments available for your convenience
- Stay on track with regular follow-ups and check-ins to keep making goal progress
- Your mental health is personal, and we keep it that way



conditions treated.

included but not limited to:

- Alcohol and drug dependency
- Anxiety
- Burnout
- Child or elder care matters
- Codependency
- Daily stress
- Depression
- Eating disorders
- Physical, emotional, or sexual abuse
- Relationship concerns
- Work conflicts

Please call (866) 270-0762 to schedule a therapy session.

Throughout the calendar year, you will be notified of how many appointments you have remaining.

Please use this weblink to fill out this form

COLOURS, INC

PENNSYLVANIA, NEW YORK, NEW JERSEY, MARYLAND, MAINE,
DELAWARE, MASSACHUSETTS, WEST VIRGINIA, NEW HAMPSHIRE,
SOUTH DAKOTA, ILLINOIS, IOWA, MINNESOTA, NEBRASKA

Colours Enrollment Form

2026-2027 Benefits Enrollment Form

Plan Year Start Date: March 1, 2026

Plan Year End Date: February 28, 2027

Open enrollment is the only time when you can make enrollment changes, drop coverage, or add/delete dependent(s) from your coverage, unless a qualified change in family status occurs. All elections remain in effect for the duration of the plan year. **IMPORTANT: If you're NOT making any changes to your benefits for the new plan year then you do NOT need to fill out this form. If you are making ANY changes or are new to the plan, please fill out below.**

EMPLOYEE NAME: _____ Hire Date: _____ Store #: _____

Bi-Weekly Contributions:

COVERAGE LEVEL	HIGHMARK Buy-Up Plan	HIGHMARK Base Plan	Highmark Value Plan	GUARDIAN DENTAL	
Individual	\$174.00	\$135.00	\$65.00	\$13.90	
Employee/Spouse	\$363/\$408	\$296/\$357	\$510/\$765	\$29.78	
Employee/Child/ren	\$189.00	\$148.00	\$204.00	\$35.80	
Employee/Family	\$316.00	\$260.00	\$357.00	\$53.29	
SECTION 125 ELECTION: PRE TAX: ___ POST TAX: ___					
Guardian Life Insurance			Short Term Disability		
Units	Cost	Total Cost	ST Units	ST Cost	Total Cost
TOTALS		*ONLY Complete For Changes or New To The Plan* This form needs to be completed AND returned to your Manager no later than 2/24/2026 so it can be forwarded to our main office. If you are enrolling for the first time or making any changes to your plan you will be required to complete an application (Enclosed) for each applicable carrier.			
Medical	\$				
Dental	\$				
Voluntary Life	\$				
Short-Term Disability	\$				
Total	\$				

Printed Name: _____ Signature: _____ Date: _____

WAIVER OF HEALTH INSURANCE COVERAGE

I acknowledge that Colours is offering me affordable coverage that meets all requirements of the Affordable Care Act. I understand that I have the opportunity to accept or waive the coverage options listed above.

If declining these options, I have indicated below the reason(s) for my waiver of coverage:

- _____ I have coverage through my spouse's employer
- _____ I have other coverage
- _____ I have Medicare coverage
- _____ I do not wish to enroll myself in any type of medical coverage at this time
- _____ I do not wish to enroll my ___ spouse ___ Child(ren) in any type of medical coverage at this time

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may, under certain circumstances in the future, enroll yourself or your dependents in the company's plan prior to the next open enrollment period. To do this, you must have involuntarily lost your other coverage and we must receive your enrollment application within 30 days after your other coverage ended. 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 dependents, provided we receive your completed application within 60 days after the marriage, birth, adoption, or placement for adoption.

Printed Name: _____ Signature: _____ Date: ___/___/___

SPOUSE MEDICAL PLAN SURCHARGE AFFIDAVIT

To be completed if you are enrolling your spouse in your employer medical plan (PPO Plan or HDP, including retiree PMD/MPD). If you are NOT enrolling your spouse in your employer medical plan this form is not needed. If you fail to complete this form or are late turning it in, an additional monthly surcharge will be assessed. More information about the spouse surcharge is found on the next page.

Please print.

Employee/Retiree Name _____ Last 4 Digits of SSN _____

Spouse Name _____ Last 4 Digits of SSN _____

Form due date

Annual Enrollment Form is due by March 1, 2026.

Newly-hired Form is due within 14 days of your hire date.

1. IS YOUR SPOUSE EMPLOYED?

- Yes Employer Name _____ Employer Phone _____
- No If NO, skip questions 2 and 3. Sign, date and return this form to Human Resources.

2. IF YOUR SPOUSE IS EMPLOYED, IS HE/SHE ELIGIBLE TO RECEIVE MEDICAL INSURANCE OFFERED BY HIS/HER EMPLOYER?

- Yes
- No If NO, skip question 3. Sign, date and return this form to Human Resources.

3. IF YOUR SPOUSE'S EMPLOYER OFFERS MEDICAL INSURANCE AND YOUR SPOUSE IS ELIGIBLE FOR THAT INSURANCE, IS YOUR SPOUSE ENROLLED IN HIS/HER EMPLOYER MEDICAL PLAN?

- Yes Name of Insurance Carrier _____
- If YES, you must attach proof of spouse enrollment in spouse's employer plan (ID card, coverage confirmation page, or employer documentation printed on employer's letterhead). With proof of enrollment, you will not be assessed a monthly Spouse Medical Plan Surcharge if your spouse is enrolled in both the spouse's employer plan and your medical plan (dual coverage). IRS rules do not allow for enrollment in a high deductible health plan (HDHP) and a traditional plan (like a PPO) at the same time. Sign, date and return this form to Human Resources.
- No If NO, you will be assessed a monthly Spouse Medical Plan Surcharge in addition to your insurance premium when you enroll your spouse in your medical plan. Sign, date and return this form to Human Resources.
-

CERTIFICATION

I certify the information I provided on this form is true and correct. I acknowledge that falsification of any information may lead to disciplinary action, up to and including employment termination, and that I may be held responsible for funds paid to providers on my spouse's behalf. I will notify my employer's Human Resources Department if my spouse gains or loses other employer medical coverage (a qualified change in status event) and turn in required paperwork to the Human Resources Department within 31 days of the event. I further understand a spouse surcharge may be terminated at the first of the month following timely notification. Spouse surcharge refunds for late notification are not allowed.

Employee Signature _____ Date _____

Information about the Spouse Medical Plan Surcharge

Regardless of the medical plan you select, you could pay more for coverage if you enroll your spouse in your medical plan. A spouse surcharge will not apply if your spouse enrolls in both your spouse's employer plan and your employer plan. If your spouse does not enroll in his/her employer medical plan, you will pay more to enroll your spouse in your employer's medical plan. Review your specific situation before you enroll your spouse. Reference to the PPO Plan includes Retiree PMD/MPD Plans for a non-Medicare spouse enrolled in the PPO Plan.

The spouse surcharge will apply if:

1. Your spouse's employer offers a medical plan and your spouse is eligible for coverage under that plan and did not enroll in that plan; and
2. You cover your spouse in your employer PPO medical plan or HDP; then
3. A monthly spousal surcharge will apply to the cost of covering your spouse on your employer medical plan (active employees - deducted from payroll).
4. The surcharge will also apply if you fail to complete or were late turning in the required Spouse Medical Plan Surcharge Affidavit. Spouse surcharge refunds are not retroactive, and are not allowed for failure to turn in the form or turning the form in late.

The spouse surcharge will NOT apply if:

1. Your spouse is enrolled in his/her employer medical plan (proof of enrollment required) and your employer PPO medical plan or HDP; or
2. Your spouse does not work outside the home and has no access to employer coverage; or
3. Your spouse's employer does not offer medical coverage or your spouse is not eligible for that coverage; or
4. Your spouse's other coverage is Medicare, Medicaid, TRICARE or care received at a VA facility; and
5. You turned in the required Spouse Medical Plan Surcharge Affidavit on time.

Required time-sensitive enrollment action

During annual enrollment each year, any employee who covers his/her spouse must sign a Spouse Medical Plan Surcharge Affidavit attesting to your spouse's access to employer medical plan coverage through his/her employer, regardless if he/she enrolled in that coverage.

If you are newly-hired and you enroll a spouse in your employer medical plan, you must turn in the Spouse Medical Plan Surcharge Affidavit within 14 days of your hire date. If you experience a qualified change in status event, you must notify the Human Resources Department and complete required paperwork within 31 days of the event. Provided the change is an eligible event, the change will become effective the first day of the month following timely notification.

Spouse's employer enrollment period

While many plans are calendar-year plans, some are not. If your spouse's employer plan is not a calendar year plan, and your spouse did not enroll in his/her employer plan during your spouse's annual enrollment, your spouse should check with his/her employer to see if it is still possible to enroll. If the employer's plan rules do not allow enrollment, then the spouse surcharge applies until your spouse's employer coverage is effective.

Cost considerations

It is important that you consider each of the following items to determine if you wish to enroll your spouse in your employer plan. Monthly premium is not the only item you should evaluate.

1. Monthly premium cost under each plan (single coverage with spouse's plan, employee plus spouse/family coverage in your employer plan) with and without the surcharge.
2. Plan design differences (deductibles, out-of-pocket maximum, copays and coinsurance).
3. Type of plan (IRS rules do not allow coverage in a high deductible plan and any other medical plan (like a PPO Plan) at the same time).
4. If both you and your spouse are enrolled in the HDP, consider the impact of employer seed money (if any) to your HSA if applicable.

Medical Plan

For purposes of this affidavit, a medical plan is an affordable plan with minimum essential coverage (MEC) offered through an employer as defined by the Affordable Care Act (ACA).

Information about the Spouse Medical Plan Surcharge

Regardless of the medical plan you select, you could pay more for coverage if you enroll your spouse in your medical plan. A spouse surcharge will not apply if your spouse enrolls in both your spouse's employer plan and your employer plan. If your spouse does not enroll in his/her employer medical plan, you will pay more to enroll your spouse in your employer's medical plan. Review your specific situation before you enroll your spouse. Reference to the PPO Plan includes Retiree PMD/MPD Plans for a non-Medicare spouse enrolled in the PPO Plan.

The spouse surcharge will apply if:

1. Your spouse's employer offers a medical plan and your spouse is eligible for coverage under that plan and did not enroll in that plan; and
2. You cover your spouse in your employer PPO medical plan or HDP; then
3. A monthly spousal surcharge will apply to the cost of covering your spouse on your employer medical plan (active employees - deducted from payroll).
4. The surcharge will also apply if you fail to complete or were late turning in the required Spouse Medical Plan Surcharge Affidavit. Spouse surcharge refunds are not retroactive, and are not allowed for failure to turn in the form or turning the form in late.

The spouse surcharge will NOT apply if:

1. Your spouse is enrolled in his/her employer medical plan (proof of enrollment required) and your employer PPO medical plan or HDP; or
2. Your spouse does not work outside the home and has no access to employer coverage; or
3. Your spouse's employer does not offer medical coverage or your spouse is not eligible for that coverage; or
4. Your spouse's other coverage is Medicare, Medicaid, TRICARE or care received at a VA facility; and
5. You turned in the required Spouse Medical Plan Surcharge Affidavit on time.

Required time-sensitive enrollment action

During annual enrollment each year, any employee who covers his/her spouse must sign a Spouse Medical Plan Surcharge Affidavit attesting to your spouse's access to employer medical plan coverage through his/her employer, regardless if he/she enrolled in that coverage.

If you are newly-hired and you enroll a spouse in your employer medical plan, you must turn in the Spouse Medical Plan Surcharge Affidavit within 14 days of your hire date. If you experience a qualified change in status event, you must notify the Human Resources Department and complete required paperwork within 31 days of the event. Provided the change is an eligible event, the change will become effective the first day of the month following timely notification.

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While many plans are calendar-year plans, some are not. If your spouse's employer plan is not a calendar year plan, and your spouse did not enroll in his/her employer plan during your spouse's annual enrollment, your spouse should check with his/her employer to see if it is still possible to enroll. If the employer's plan rules do not allow enrollment, then the spouse surcharge applies until your spouse's employer coverage is effective.

Cost considerations

It is important that you consider each of the following items to determine if you wish to enroll your spouse in your employer plan. Monthly premium is not the only item you should evaluate.

1. Monthly premium cost under each plan (single coverage with spouse's plan, employee plus spouse/family coverage in your employer plan) with and without the surcharge.
2. Plan design differences (deductibles, out-of-pocket maximum, copays and coinsurance).
3. Type of plan (IRS rules do not allow coverage in a high deductible plan and any other medical plan (like a PPO Plan) at the same time).
4. If both you and your spouse are enrolled in the HDP, consider the impact of employer seed money (if any) to your HSA if applicable.

Medical Plan

For purposes of this affidavit, a medical plan is an affordable plan with minimum essential coverage (MEC) offered through an employer as defined by the Affordable Care Act (ACA).

Compliance

Consolidated Omnibus Budget Reconciliation Act (COBRA)

Disability extension of 18-month period of COBRA continuation coverage:

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

Second qualifying event extension of 18-month period of continuation coverage:

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

If you have questions:

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes:

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Notice of Opportunity to Enroll in Connection with Extension of Dependent Coverage to Age 26:

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage) under a group health plan or health insurance coverage because, under the terms of the plan or coverage, the availability of dependent coverage of children ended before the attainment of age 26. The enrollment opportunity must continue for at least 30 days, regardless of whether the plan or coverage offers an open enrollment period and regardless of when any open enrollment period might otherwise occur. This enrollment opportunity must be presented not later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010 (which is the applicability date of PHS Act section 2714). Coverage must begin no later than the first day of the first plan year (in the individual market, policy year) beginning on or after September 23, 2010.

Model Language Notice Lifetime Limit No Longer Applies and Enrollment Opportunity:

Plans and issuers are required to give written notice that the lifetime limit on the dollar value of all benefits no longer applies and that an individual, if covered, is once again eligible for benefits under the plan. Additionally, if the individual is not enrolled in the plan or health insurance coverage, or if an enrolled individual is eligible for but not enrolled in any benefit package under the plan or health insurance coverage, then the plan or issuer must also give such an individual an opportunity to enroll that continues for at least 30 days (including written notice of the opportunity to enroll). The notices and enrollment opportunity must be provided beginning not later than the first day of the first plan year beginning on or after September 23, 2010. For individuals who enroll under this opportunity, coverage must take effect not later than the first day of the first plan year beginning on or after September 23, 2010.

Compliance

Medicare continued...

Medicare Part A (Hospital Insurance)

Part A covers inpatient hospital stays, care in a skilled nursing facility, hospice care, and some home health care.

Medicare Part B (Medical Insurance)

Part B covers certain doctors' services, outpatient care, medical supplies, and preventive services.

Medicare Part D (prescription drug coverage)

Part D adds prescription drug coverage to:

These plans are offered by insurance companies and other private companies approved by Medicare. Medicare Advantage Plans may also offer prescription drug coverage that follows the same rules as Medicare Prescription Drug Plans.

Preventive Services and the Affordable Care Act

Under the Affordable Care Act, you and your family may be eligible for some important preventive services which can help you avoid illness and improve your health—at no additional cost to you.

What this means for you:

If your plan is subject to these new requirements, you would not have to pay a co-payment, co-insurance, or any deductible to receive preventive health services, such as recommended screenings, vaccinations, and counseling.

For example, depending on your age, you may have free access to such preventive services as:

- Blood pressure, diabetes, and cholesterol tests;
- Many cancer screenings, including mammograms and colonoscopies;
- Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression, and reducing alcohol use;
- Routine vaccinations against diseases such as measles, polio, or meningitis;
- Flu and pneumonia shots;
- Counseling screening, and vaccines to ensure healthy pregnancies
- Regular well-baby and well-child visits, from birth to age 21

Some Important Details:

- If your health plan uses a network of providers, be aware that health plans are only required to provide these preventive services through an in-network provider. Your health plan may allow you to receive these services from an out-of-network provider, but may charge you a fee.
- Your doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that your plan can require you to pay some costs of the office visit, if the preventive service is not the primary purpose of the visit, or if your doctor bills your for the preventive services separately from the office visit.
- To know which covered preventive services are right for you—based on your age, gender, and health status—ask your health care provider.

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)**.

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	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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+)	FLORIDA – Medicaid
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	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
<p>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</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfp/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>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</p>	<p>Website: www.medicicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>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/ofa/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/mashealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfnv.gov Medicaid Phone: 1-800-992-0900	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	NEW YORK – Medicaid
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)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	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	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	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	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

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

Important Notice from Colours About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Colours 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. Colours has determined that the prescription drug coverage offered by Colours 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.

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 **Colours** 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 at (800) 624-6374. **NOTE:** You'll get this notice each year. 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:	March 1, 2026
Name of Entity/Sender:	Colours
Contact--Position/Office:	Amy Wolsieffer
Address:	1137 Hanover St Hanover TWP PA 18706
Phone Number:	(570) 208-5655