PREVEA health

2022
Benefits Guide

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

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 or Certificate of Coverage. If information in this summary differs from the Summary Plan Description or Certificate of Coverage, the Summary Plan Description or Certificate of Coverage is the ruling document.

Welcome to your Benefits!

As a Prevea Health employee, your benefits are an important part of your total compensation package. That's why Prevea is committed to providing a comprehensive and competitive benefits package. On the following pages, you will find an overview of benefits offered to you. You are encouraged to review and become familiar with this information. For more detailed information on each of the plans, please refer to the Summary Plan Descriptions and/or Certificates of Coverage available on https://my.adp.com.

We care about you and are happy to continue to provide a variety of benefits to you and your eligible dependents. Thank you for you continued work and dedication to the Prevea family. If you have questions about your benefits, contact Prevea Human Resources.

Sincerely,

Ashok Rai, MD, President & Chief Executive Officer, Prevea Health

OPEN ENROLLMENT

Prevea's benefit year is January 1 to December 31. Each year you have the opportunity to review your benefit options and make choices based upon your current life situation. The annual open enrollment period occurs during November of each calendar year if making changes or adjustments. All employees working 20 or more hours per week need to enroll or decline the plan offerings by completing the online enrollment process via www.my.adp.com.

BENEFIT RESOURCE INFORMATION

The chart below provides an overview of the benefits and optional coverages offered to you and your eligible dependents. More details about the benefits listed below are outlined in this document.

Benefit	Provider	Phone Number	Website
Medical Plan Benefits	Dean Health Plan Administrative Services	1-877-234-4516	www.deancare.com/aso
Pharmacy Benefits	CVS/Caremark	1-866-818-6911	www.caremark.com
Virtual Care (Online access to medical providers for review of treatment options)	Prevea Virtual Care	N/A	www.prevea.com/virtualcare
Dental Plan Benefits	Delta Dental of Wisconsin	1-800-236-3712	www.deltadentalwi.com
Vision Benefits (Preventive exams are covered as specified in the medical plan)	Dean Health Plan Administrative Services	1-877-234-4516	www.deancare.com/aso
Employee Assistance Program (EAP)	Prevea Behavioral Care	Green Bay: 920-272-1200 Sheboygan: 920-458-5557 Eau Claire: 715-717-5899	www.prevea.com
Group Base Life & AD&D Insurance Voluntary Life and AD&D Insurance	Prudential	1-800-524-0542	www.prudential.com
Short-Term Disability Plan	Prevea Health HR	920-272-1163	N/A
Long Term Disability Insurance	Prudential	1-800-842-1718	www.prudential.com
Health Savings Account	Associated Bank	1-800-270-7719	www.associatedbank.com
Flexible Spending (Medical FSA, Limited Medical FSA, and Dependent Care FSA)	WEX (formerly Discovery Benefits)	1-866-451-3399	www.wexinc.com
Retirement Account	Transamerica	1-800-755-5801	prevea.trsretire.com

401k Plan – Retirement Benefits

Prevea offers a competitive Retirement Plan administered through Transamerica where individuals can contribute to both the 401k plan and/or the Roth 401k plan.

You can contribute up to 90% of your income per check to the 401K plan or the Roth 401K plan. After 1 year of service from your Date of Hire then the following January 1st or July 1st you are eligible for the Employer Match and Discretionary Contribution. Prevea will match your deferral dollar-for- dollar up to 6% plus the additional discretionary contribution which is currently 3%. You must be employed on December 31st and have worked 1000 hours in the year to receive that year's employer contributions. Employer contributions are always placed in your account at Transamerica in March following that plan year.

As a new hire at Prevea, you are automatically enrolled in the Prevea 401k Retirement Plan at a 3% deferral rate. Enrollment is automatic and there are no forms to complete. You will be automatically enrolled in the plan after you become eligible or 45 days after your date of hire, whichever is later. Unless you make an alternative election or opt-out, 3% of your pay will be deducted from your paycheck each pay period on a pre-tax basis and contributed to your 401k account automatically. See the Automatic Enrollment Notice for further information regarding Auto Enroll.

You can make changes to your 401K or Roth 401K at any time throughout the year via Transamerica's website prevea.trsretire.com or contact via phone at 1-800-755-5801.

IRS Plan limits for your Retirement Plan for 2021 (2022 plan limits will be posted on my.adp.com once they are released):

- The elective deferral (contribution) limit for employees who participate in a 401(k) is $19,500.
- The catch-up contribution limit for employees age 50 and over who participate in a 401(k) is $6,500.
- The limitation for defined contribution plans is $58,000 (maximum combined employee and employer contribution).
- The annual compensation limit is $290,000.

TRANSAMERICA®

Paid Time Off (PTO)

Prevea believes everyone should take an annual rest from their duties and therefore provides paid time off to its full-time and part-time employees (*scheduled to work 20 or more hours per week*) who have successfully completed 30 days of employment.

PTO allows you to take paid time off for:

- Vacations
- Holidays
- Personal days
- Weather emergencies
- Family emergencies
- Medical appointments
- Illness or injury

Paid Time Off (PTO) was established as an easier way to track and manage all time away from work.

Paid Time Off (PTO) is an accrued number of hours of paid leave per year based on your length of service with Prevea. PTO is intended to provide you with continued income while you are off work for any number of reasons.

The table below illustrates the accrual rates for a full-time employee working 40 hours per week.

Years of Service	Maximum Yearly Accrual	Accrual Rate
0 - 5	23.5 days (188 hours)	.090385
6 - 7	28.5 days (228 hours)	.109615
8	29.5 days (236 hours)	.113462
9	31.5 days (252 hours)	.121154
10 - 19	33.5 days (268 hours)	.128846
20 - 25	35.5 days (284 hours)	.136538
26+	37.5 days (300 hours)	.144231

PTO Buy-Back

In the spring and fall each year, employees with PTO balances greater than 120 hours, Prevea Health offers a PTO buy-back benefit.

For more on the PTO policy including eligibility, accrual of PTO and buy-back benefits, please refer to the *Prevea Employee Handbook* found on the Prevea Intranet/SharePoint or ADP.

Eligibility

Eligible Employees:

All regular scheduled full-time (who work a minimum of 30 hours per week) and part-time employees (who work a minimum of 20 hours per week) are eligible for benefits. Casual and PRN employees are eligible to contribute to the Retirement plan. Seasonal, flex, interns and temporary colleagues are not eligible for benefits.

Eligible Dependents:

Your eligible dependents can enroll in certain benefits as well. Ultimately, determination of eligibility is based on the terms, conditions and limitations of the plan document or policy as applicable. For more information, contact Human Resources.

Regarding Out-of-Area Dependents and Prevea Health EPO Medical Plan Coverage: We offer coverage for your eligible dependents even if they reside outside the Prevea360 ASO network/service area. The employee or out-of-area dependent must contact Dean Care prior to receiving any services as follows:

1. Call the Dean Customer Care Center at 877-234-4516 (TTY: 711) Monday through Thursday 7:30 am – 5pm and Friday 8:00 am – 4:30 pm.
2. Explain that your dependent is residing out-of-area and provide the address and phone number of the out-of-area dependent.
3. The Customer Care Center will update your dependent's information to indicate that they reside outside of the service area

When Coverage Begins:

The benefit options you choose during the annual Open Enrollment period are effective January 1, through December 31 that following year. For newly hired employees please refer to the insurance eligibility dates chart or Benefit Memo given during new hire orientation.

Making Changes Throughout the Year

Annual Open Enrollment is your opportunity to add/drop dependents, change coverage, drop coverage, or elect additional coverage. However, during your employment, you may update or make changes to your benefit(s) when you experience a qualifying life event or employment change. When you experience a qualified life event, you have 30 days of such event to notify the HR Department as well as providing supporting documentation. If you miss this deadline, you will need to wait until the next annual Open Enrollment period to make benefit changes to your benefits.

You can change your benefit elections mid-year for the following life events: Based on IRS rules, you can generally make changes during the year only if you have a qualifying change in your family or employment status. This includes:

- Marriage or Divorce
- Birth or Adoption
- Change in employment status for you or your dependent when the change affects eligibility
- Loss of eligibility for your child because of marriage, exceeding the plan's limiting age or no longer being disabled
- Death of your spouse or your child
- Change in other medical or dental coverage because of the annual enrollment for the employer of your spouse or eligible child occurring at a different time than Prevea
- Related to Dependent Care FSA; change in day care providers, the hours of which care is needed, or the cost of day care

Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact Human Resources to make these changes.

When you have a qualifying life event change, you have within **30 days** of such event to notify the Human Resources Department at 920-431-1997

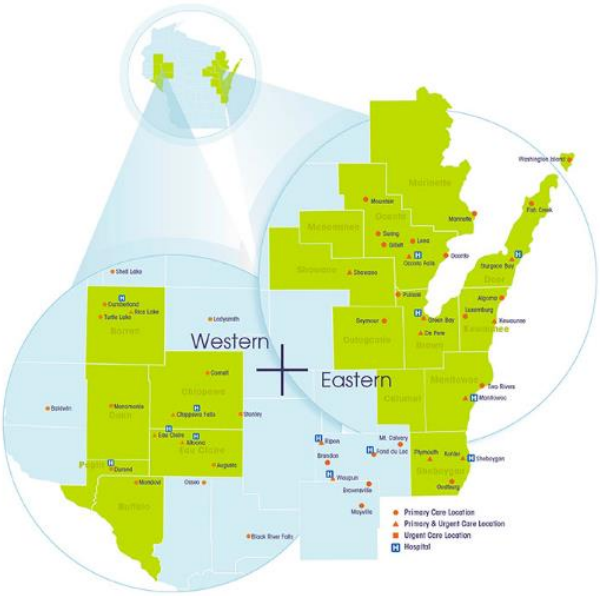
Medical & Pharmacy Plan Options and Features

Prevea Health's medical plans are administered by **Dean Health Plan Administrative Services** (aka Dean Care/ASO) and the pharmacy benefits portion of the medical plan are administered by CVS Caremark.

Effective January 1, 2022, Prevea will offer two medical plan designs to eligible employees who reside within the Prevea360 Provider Service Area. Prevea will continue to offer a HDHP PPO Plan to employees who reside outside the Prevea360 Service Area. All plans offer 100% in-network preventive care benefits. Both of the Prevea High Deductible Health Plans (HDHP) also offer low, to no cost maintenance medications that appear on CVS Caremark *preventive drug list*.

IMPORTANT: After you have enrolled in medical plan coverage, watch your mail as you will receive an ID card. You will need to present this card to obtain medical and prescription drug services. Your ID card acts as both your medical and prescription ID Card.

Network Information (EPO & PPO Medical Plan Options)



Preferred Provider Network – **EPO Medical Plans**

For the Prevea **EPO medical plan designs** (medical plans available to employees residing in the Prevea360 service area), these medical plans use the *Prevea360/ASO* provider network.

How to find an In-Network Prevea360 Provider:

1. Visit www.deancare.com/aso to get started
2. Scroll down and click **See ASO for Members**
3. Scroll down and under *Find a Doctor*, click the link for **Prevea360 ASO Network**
4. Under *Select Plan Type* click **ASO Network**
5. Enter your search criteria

If you have any questions or need assistance, please call the Dean Care Customer Service Center at 877-234-4516

Preferred Provider Network – **PPO Medical Plan** (available if you reside outside the Prevea360 provider network). For the Prevea **PPO Medical Plan**, the medical plan uses the First Health Network.

How to find an In-Network First Health Provider:

1. Visit www.deancare.com/aso to get started
2. Scroll down and click **See ASO for Members**
3. Scroll down and under *Find a Doctor*, click the link for **First Health**
4. Click **Locate a Provider or Create a Directory**
5. Under *Network Options* click **First Health Network**
6. Select *Provider Type*
7. Enter your search criteria

Prevea Virtual Care services are available – access to low-cost care!

PREVEA Virtual Care
www.prevea.com/virtualcare

Prevea employees and family members (age 2 to 65 years*) covered under the Prevea Health medical plan can attend virtual health care visits with Prevea providers at a cost of $15 per virtual visit attended. No election for this virtual service is needed. You can skip the waiting room and get your diagnosis within one-hour.

Here's how it works:

1. Go to https://www.prevea.com/Virtual-Care log-in from any web-enabled device, anytime, anywhere
2. Complete an online interview questionnaire (most take just 15 minutes to complete)
3. You will receive a diagnosis and treatment plan within an hour**

*Services provided are dependent upon age of the patient and *condition being treated.*

**Diagnosis and treatment plan within an hour during Prevea Urgent Care *hours: 8 a.m. to 8 p.m., Monday through Friday, and weekends and holidays, 8 a.m. to 4 p.m. Visit questionnaires submitted after Prevea Urgent Care hours will be responded to by 9 a.m. the following day.*

Dean Care Member Portal Access – Register at www.deancare.com/aso to get started!

Your Dean Care Member Portal provides a complete dashboard view of your medical and pharmacy plan and self-service tools. The Member Portal keeps your health care information secure and strictly confidential. This site navigation and helpful features go hand in hand with the exceptional customer service you've come to expect from Dean Health Plan.

Features Include:	How to Register:
• View eligibility information • Print a temporary ID card • Search for an in-network doctor or facility • View claims status and history information • Download important forms and documents • View deductible balances • View CVS Caremark pharmacy benefits, including the CVS Caremark drug formulary and preventive drug list	• View **deancare.com/aso** to get started • Click **Member Portal** • Click **Register Now**; read the License Agreement and click **Agree** • Enter your date of birth, ZIP code and Member ID (xxxxxxxxx-xx) • Create a user password (must be at least 8 alphanumeric characters), then enter a secure question and answer

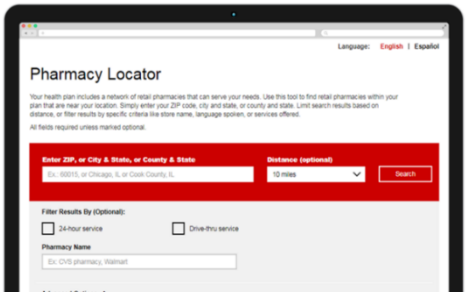
Questions regarding the Member Portal? Please contact the Customer Care Center at **877-234-4516** (TTY: 711)

Prescription Drug Coverage through CVS Caremark

For the medical plans offered by Prevea Health, effective January 1, 2022, pharmacy benefits are administered through CVS Caremark. To obtain reimbursement under the plan for pharmacy related expenses it is important to ensure your using an in-network pharmacy.

How to Find an In-Network Pharmacy

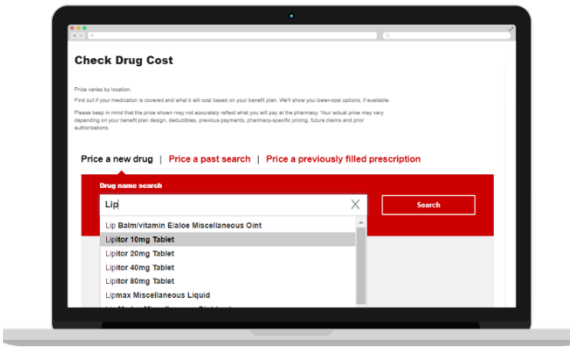
CVS Caremark makes it easy to fill your prescriptions with retail network pharmacies around the United States. Follow these online instructions to locate an in-network pharmacy in your area:



1. Visit www.caremark.com to get started
2. Register and create an account (our member ID as found on your ID card or SSN will be needed)
3. After registering, click Pharmacy Locator in the upper right-hand corner of your dashboard
4. Enter your zip code or city/state to find an in-network pharmacy near you

If you have any specific questions regarding participating pharmacies or other questions related to covered medications, call CVS Caremark Customer Service at 1-866-818-6911 (open 24 hours a day, 7 days a week).

Check Drug Costs and Drug Coverage Information at CVS Caremark



To ensure plan members are spending health care dollars wisely, CVS can help:

- Seach for a drug
- Confirm coverage
- Understand cost
- Explore lower-cost options

Once registered for the www.caremark.com website as mentioned above, enter your drug name, strength and quantity needed to determine if the medication is covered under the plan, and if so, information on the member cost will be shown. If a lower cost covered medication could be an alternative for the original medication that was searched, that information will also be displayed at the bottom of the search results.

CVS Caremark Mail Order Service Available!

Do you take medication every day for diabetes, asthma, or another condition? These are called maintenance medicines. If you take medicine like this, you can get up to a 90-day supply delivered directly to your home. CVS Caremark Mail Service Pharmacy is a fast and convenient way to get the prescription drugs you need. The service is included with your Prevea medical insurance plan. Below are 4 options (choose 1) to get started with CVS mail-order service:

1. Create an account at www.caremark.com and request online a new prescription with mail service from your caremark.com dashboard. Have your prescription and prescriber information available when making your online request.
    - CVS Caremark will then contact your prescriber for a new prescription.
2. Call toll-free number 1-866-818-6911 on or after your benefit effective date
    - Speak with a customer service representative and let them know you would like to get set up with mail service. They will contact your prescriber for a new prescription. Have prescription and prescriber information available when calling.
3. Your prescriber calls toll-free number 1-800-378-5697 or sends new electronic prescriptions to CVS Caremark Mail Service (NCPDP ID: 0322038) on or after your benefit effective date
    - You will still need to contact mail service by phone to setup billing and shipping information.
4. Access www.caremark.com (no account needed)
    - Locate plan forms link in upper right corner. Complete mail order form, print, and mail it in with your hard copy prescription on or after your benefit effective date. Allow at least 14 days for processing.

General Medical Plan Design Information

High Deductible Health Plan (HDHP)

An HDHP typically allows for lower insurance premiums and is the only way to **qualify for a tax-advantaged Health Savings Account (HSA)**. All medical plan covered services are subject to the plan's annual deductible amount (before the plan reimburses claims), except for in-network preventive care and maintenance medications on a preventive drug list as mentioned earlier. Once you have satisfied your deductible for the calendar year, you will be responsible for a portion of the bill, called coinsurance, until you have satisfied the plan's annual out-of-pocket maximum. Most services are subject to coinsurance after you satisfy your deductible amount. This type of design can have higher out-of-pocket costs for those plan members with high medical expenses. However, amounts accrued in an HSA account can be used to offset out-of-pocket costs by plan members.

Traditional EPO /Co-pay Plan (non-HSA qualified)

A traditional EPO plan usually has higher premiums than a HDHP. This type of design can have lower co-payments that apply to certain services versus being subject to the plan's annual deductible amount. Unless co-pays apply, regarding services subject to the plan's deductible, once you have satisfied your deductible for the calendar year, you will be responsible for a portion of the bill, called coinsurance, until you have satisfied the plan's annual out-of-pocket maximum. **If covered under this type of plan design, plan members are not eligible to contribute into a tax-advantaged HSA.**

2022 Prevea Health Medical Plans Available to Employees

The below is a brief outline of the medical plan designs offered to eligible employees. Please refer to the summary plan description for complete plan details.

Plan Highlights	Dean Health Plan, Inc. HDHP EPO Plan (HSA Qualified)		Dean Health Plan, Inc. Traditional EPO Plan (non Qualified HSA)		Dean Health Plan, Inc. HDHP PPO Plan (HSA Qualifed) Out of Area Participants Only - Please see zip code list for eligibility	
Benefits Coverage	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible						
Individual	$2,000	Not covered	$1,000	Not covered	$2,000	$4,000
EE +1	$4,000 combined	Not covered	$2,000 combined	Not covered	$4,000 combined	$8,000 combined
Family	$4,000 combined	Not covered	$2,000 combined	Not covered	$4,000 combined	$8,000 combined
Coinsurance	80%	Not covered	80%	Not covered	80%	60%
Annual Maximum Out-of-Pocket Amount						
Individual	$3,000	Not covered	$2,000	Not covered	$3,000	$6,000
Family	$6,000	Not covered	$4,000	Not covered	$6,000	$12,000
Additional Coverage Details						
Primary Care	80% after deductible	Not covered	Office Visit: $25 copay All other services 80% after deductible	Not covered	80% after deductible	60% after deductible
Specialty Care	80% after deductible	Not covered	Office Visit: $50 copay All other services 80% after deductible	Not covered	80% after deductible	60% after deductible
Urgent Care	80% after deductible	Not covered	$15 Prevea Virtual Care $25 Prevea Urgent Care	Not covered	80% after deductible	60% after deductible
Emergency Room	80% after decutible		80% after deductible		80% after deductible	
Adult Periodic Exams & Well-Child Care	100%	Not covered	100%	Not covered	100%	100%
X-ray, Lab, Radiology	80% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	60% after deductible
Inpatient Charges	80% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	60% after deductible
Outpatient and Surgical Charges	80% after deductible	Not covered	80% after deductible	Not covered	80% after deductible	60% after deductible
Pharmacy Benefits – ***Note:*** *Plan member prescription out-of-pocket amounts track toward the annual deductible and annual out-of-pocket amounts for the HDHP Plan designs. Plan member prescription co-payments that apply to the Traditional Plan design track toward the annual out-of-pocket amount only (and not the annual deductible amount).*						

Plan Highlights	Dean Health Plan, Inc. HDHP EPO Plan (HSA Qualified)		Dean Health Plan, Inc. Traditional EPO Plan (non Qualified HSA)		Dean Health Plan, Inc. HDHP PPO Plan (HSA Qualifed) Out of Area Participants Only - Please see zip code list for eligibility	
Benefits Coverage	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Retail Pharmacy (30 Day Supply or up to 90 day Supply for maintenance medications) ACA/Preventive Drug List applies to HDHP plan options* See plan for details						
Generic (Tier 1)	20% after deductible	Not covered	$5 copay	Not covered	20% after deductible	Not covered
Preferred Brand (Tier 2)	20% after deductible	Not covered	$25 copay	Not covered	20% after deductible	Not covered
Non-Preferred Brand (Tier 3)	20% after deductible	Not covered	$40 copay, then 20%	Not covered	20% after deductible	Not covered
Preferred Specialty (Tier 4)	20% after deductible	Not covered	20%	Not covered	20% after deductible	Not covered
Mail Order Pharmacy (90 Day Supply) ACA/Preventive Drug List applies to HDHP plan options* See plan for details						
Generic (Tier 1)	20% after deductible	Not covered	$12.50 copay	Not covered	20% after deductible	Not covered
Preferred Brande (Tier 2)	20% after deductible	Not covered	$62.50 copay	Not covered	20% after deductible	Not covered
Non-Preferred Brand (Tier 3)	20% after deductible	Not covered	$100 copay, then 20%	Not covered	20% after deductible	Not covered
Preferred Specialty (Tier 4)	20% after deductible	Not covered	20%	Not covered	20% after deductible	Not covered

2022 Medical Plan Employee Contributions (Bi- Weekly)		
HDHP EPO Plan (HSA Qualified)	Full-Time	Part-time
Employee	$61.45	$126.32
Employee +1	$126.11	$259.23
Family	$168.64	$346.65
Traditional EPO Plan (non-Qualifed HSA)	Full-Time	Part-time
Employee	$88.36	$158.31
Employee +1	$181.89	$325.89
Family	$243.29	$435.89
HDHP PPO Plan (Out of Area Only)	Full-Time	Part-time
Employee	$61.45	$126.32
Employee +1	$126.11	$259.23
Family	$168.64	$346.65

Dental Insurance

Effective January 1, 2022, Prevea Health will offer voluntary dental insurance through Delta Dental of Wisconsin. Eligible employees can choose from three plan designs, to best fit the health needs of you and your family. All three plans cover preventive care at 100% with no deductible.

All three dental plan designs come equipped with two of the nation's largest dental networks**, Delta PPO** and **Delta Premier**. You may use any dentist for your dental services; however, using an in-network Delta Dental provider will reduce your out-of-pocket costs.

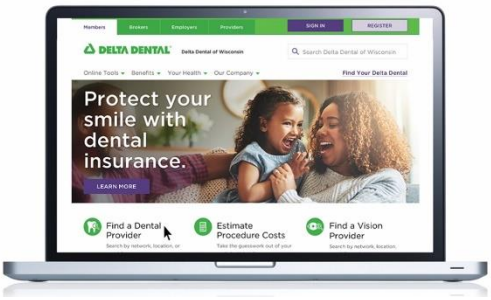
So, what's the difference between the two networks?

- The Delta Dental **PPO network** has deeper discounts than the Premier network. Not only does it save you money, but fewer dollars are going toward your annual maximum.
- The Delta Dental **Premier network** is the larger of the two networks; however, the discounts aren't as deep. Seeing a Delta Dental Premier dentist will still save you money, just not as much as if you saw a Delta Dental PPO dentist.

It's important to note that Delta Dental has no control over what an out-of-network dentist charges, so you may be responsible for additional fees which exceed Delta Dental's maximum plan allowance, if treating out-of-network.

How to locate a participating Delta Dental PPO or Premier Network Provider

It's easy to check whether your current dentist is in-network or to search for an in-network dentist:



- Visit www.deltadentalwi.com and select ***Find a Network Provider*** found in the middle of the screen.
- Once you are at "Find a Network Provider," you can search based on Network – Delta Dental PPO or Delta Dental Premier – and then search by location (enter an address or just a zip code).
- If you'd like, you can narrow your search criteria based on distance from you, specialty, language, and even office hours.

Important: Your Delta Dental coverage comes with an Evidenced-Based Integrated Care Program (EBICP) which provides additional cleanings and/or fluoride treatment to individuals with specific medical conditions that have oral implications. For more information, please call Delta Dental at 800-236-3712. Please refer to the Delta Dental summary plan description for complete plan details.

Hearing Discounts Available Through Delta Dental and Amplifon!

- Free hearing screening
- 60-day no-risk trial
- Lowest price guarantee
- No interest financing
- 3-year warranty

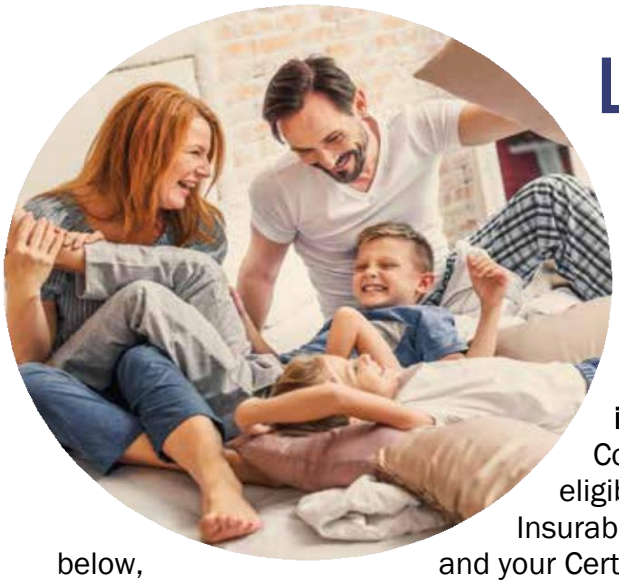
To activate your discount call 1-888-901-0132 today!

Prevea Dental Plans Available to Employees

The below is a brief outline of the dental plan designs offered to eligible employees. As mentioned earlier, **Delta Dental has no control over what an out-of-network dentist charges, so you may be responsible for additional fees which exceed Delta Dental's maximum plan allowance, if treating out-of-network**. Refer to pg. 12 of this guide for directions on locating an in-network Delta Dental provider. Please also refer to the Delta Dental certificate of coverage for complete plan details.

2022 Dental Plan Options:	Delta Dental Basic Plan	Delta Dental Standard Plan	Delta Dental Plus Plan
Annual Deductible			
Individual	$50	$50	$50
Family	$150	$150	$150
Waived for Preventive Care?	Yes	Yes	Yes
Dental Plan Annual Maximum			
Per Individual	$1,000	$1,250	$1,250
Preventive: Exams (2x/year), Cleanings (2x/year), Fluoride treatments (2x/year to age 19), X-rays (bitewings every 12 months & full mouth every 5 years), Space maintainers, Sealants (once per tooth to age 19)	100%	100%	100%
Basic: Emergency treatment to relieve pain, Fillings (silver & composite), Root canals, Treatment of gum disease, Extractions (surgical & non-surgical), Repairs & adjustments to bridges & dentures	50% after deductible	80% after deductible	80% after deductible
Major: Crowns, inlays, onlays, Bridges & dentures, Implants	Not covered	Not covered	50% after deductible
Orthodontia			
Benefit Percentage	Not covered	Not covered	50%
Adults & covered dependents to age 26	Not covered	Not covered	Covered
Lifetime Maximum	N/A	N/A	$1,000

2022 Dental Dental Employee Contributions (Bi- Weekly)	
Basic Plan	
Employee	$10.20
Employee +1	$25.81
Family	$34.66
Standard Plan	
Employee	$14.03
Employee +1	$34.01
Family	$45.91
Plus Plan	
Employee	$22.65
Employee +1	$54.81
Family	$68.90



Life and AD&D

Prevea Health automatically enrolls eligible employees under basic **life and accidental death and dismemberment** (AD&D) coverage through Prudential, at no cost to you. Employee AD&D coverage will mirror employee's base life insurance coverage amount.

You can also purchase additional **Optional Life and AD&D insurance** for yourself, your spouse and/or dependents. Coverage is contingent on all those covered, meeting the plan's eligibility requirements. Coverage may be subject to Evidence of Insurability and benefit amounts reduce starting at age 65. Please see below, and your Certificate of Coverage for more information.

Life Insurance Coverages and Prevea Health's Annual Open Enrollment

During Prevea Health's annual enrollment period, employees may be able to increase existing voluntary life insurance coverage. Dependent on the level of coverage requested, Evidence of Insurability may be required. The cost of voluntary life insurance coverages can be found on https://my.adp.com. Please refer to your Certificate of Coverage or contact Human Resources for more information.

Important Reminder!

You must designate a beneficiary for both Basic and Voluntary Life insurance on my.adp.com

EMPLOYEE LIFE AND AD&D INSURANCE	
100% employer-paid Base annual earnings are rounded to the next higher $1,000 No evidence of insurability required	Full-Time Employees working 30 or more hours per week: **1 x base annual earnings to $50,000** (minimum of $20,000) Part-Time Employees working 20-29 hours per week: **½ x base annual earnings to $50,000** (minimum of $20,000) Employee AD&D coverage will mirror employee's Base Life Insurance coverage amount. *New hires please refer to the Benefit Memo given during new hire orientation (if applicable) &/or your amounts can be found on ADP*

EMPLOYEE OPTIONAL LIFE AND AD&D INSURANCE	
100% employee-paid *Evidence of insurability required above $200,000	Can elect increments of $10,000 to a maximum of $500,000* Voluntary Employee AD&D may also be elected at the same coverage levels as applies to Optional Employee Life Insurance

DEPENDENT VOLUNTARY LIFE INSURANCE AND AD&D	
100% employee-paid *Evidence of insurability required above $30,000	**Spouse:** $10,000 increments to maximum of $250,000* **Child(ren):** $250 – birth to 6 months, $10,000 – 6 months to age 19 (*25 if a full-time student*) Optional Dependent AD&D may also be elected at the same coverage levels as applies to Optional Dependent Life Insurance Note: You (the Prevea employee) are automatically the named beneficiary of any voluntary Spouse or Child(ren) Life Insurance coverage.

Short-Term Disability

Short Term Disability (STD) is a company-paid benefit provided to all eligible full-time employees. Coverage is available at 70% of your base wage *times* scheduled work hours. Employee may use Paid Time Off (PTO) to supplement the 30% of the STD benefit does not cover. However, one cannot receive greater than 100% of their regular base wage with the combination of STD and PTO.

STD benefits begin after 5 consecutive scheduled workdays or 40 consecutive scheduled work hours, whichever is less. This time is referred to as the elimination period. PTO may be used for this elimination/waiting period but is not required. The maximum benefit duration is 13 weeks as allowed for under the Plan. Please refer to the STD Income Protection Summary of Benefits for more information.

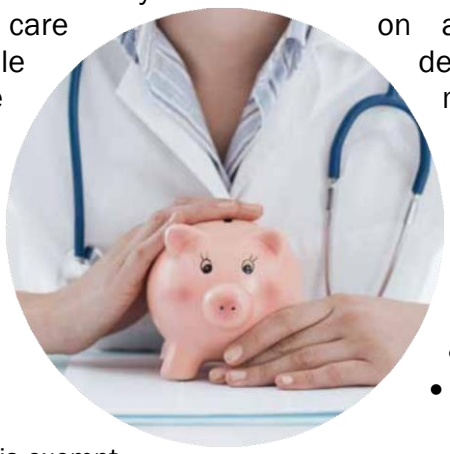
Long-Term Disability Insurance

Long Term Disability (LTD) acts as a continuing source of income if you are unable to work due to long-term injury or illness that takes you past Short-Term Disability coverage. Coverage through Prudential is available at 66.67% of your total monthly earnings (*as defined by the Policy and your applicable Class*) up to a maximum benefit $15,000 (to all eligible full-time employees). LTD benefits begin after a 3-month elimination period and is available as outlined in the LTD Policy insured through Prudential. The cost of this benefit is paid entirely by Prevea Health and benefits if received are fully taxable to the employee. Prevea employees are automatically enrolled in this benefit.

Health Savings Account (HSA)

When you are enrolled in a Qualified High Deductible Health Plan (QHDHP) and meet the eligibility requirements, the IRS allows you to open and contribute to an HSA Account.

What is a Health Savings Account (HSA)?
An HSA is a tax-sheltered bank account that you own to pay for eligible health care expenses for you and/or your eligible dependents for current or future healthcare expenses. The Health Savings Account (HSA) is yours to keep, even if you change jobs or medical plans. There is no "use it or lose it" rule; your balance carries over year to year. Plus, you get extra tax advantages with an HSA because:



- Money you deposit into an HSA is exempt from federal income taxes
- Interest in your account grows tax free; and
- You don't pay income taxes on withdrawals used to pay for eligible health expenses. (If you withdraw funds for non-eligible expenses, taxes and penalties apply).
- You also have a choice of investment options which earn competitive interest rates, so your unused funds grow over time.

Are you eligible to open a Health Savings Account (HSA)?

Although everyone is able to enroll in the Qualified High Deductible Health Plan, not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in a Qualified High Deductible Health Plan (QHDHP)
- You must not be covered by another non-QHDHP health plan, such as a spouse's PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person's tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse's FSA. (Enrollment in a limited purpose health care FSA is allowed).

2022 HSA Contributions

You can contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS has established the following maximum HSA contributions:

FOR THE 2022 TAX YEAR:

- Individual $3,650
- Family $7,300
- If you are age 55 and over, you may contribute an extra $1,000 catch up contribution.

To begin making pre-tax contribution through Prevea Health payroll deduction you must first open your account. HSA Funds are not available until your account is opened. Purchases made prior to your HSA account opening are not eligible. You can change your HSA election amount (payroll deduction) on a bi-weekly basis if it does not exceed IRS limits.

How do I get reimbursed for my eligible expenses?

The easiest way to use your HSA dollars is by using your Associated Bank HSA Debit Card at the time you incur an eligible expense. Or you can withdraw money from an ATM. But keep your receipts! You must be able to prove that you were reimbursing yourself for an eligible expense in the event that you are audited. If you use your HSA funds for non-eligible expenses, you will be charged a 20% penalty tax (if under age 65) as well as federal income taxes. Associated Bank provides helpful information about your HSA, including online calculators to help you add up your tax savings and see your HSA's possible future growth. For additional guidelines, please go online at www.associatedbank.com or call Associated Bank at 1-800-270-7719.

Flexible Spending Accounts

Full Medical FSA & Limited Purpose FSA

A full Medical flexible spending account (FSA) allows you to set aside up to $2,750 in pre-tax money to pay for eligible out of pocket expenses (including deductibles, copays, and coinsurance) for medical, dental or vision expenses. The FSA plan year is **January 1 – December 31**. Our FSA plans are administered by **Wex, Inc.**

For employees who do not contribute into an HSA account, Prevea Health sponsors a **full (FSA)** to help pay for everyday expenses (medical, dental and vision) on a pre-tax basis.

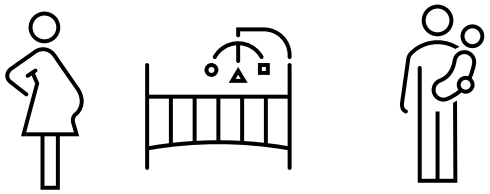
For employees with an HSA account, Prevea Health sponsors a **limited purpose** flexible spending accounts (FSA) to help you pay for everyday dental and vision expenses only on a pre-tax basis.

Contributions for either the full FSA or limited purpose FSA cannot be changed unless a qualifying life event occurs and must be made within 30 days of the event. All components of "use it or lose it" apply to both plans except for being able to rollover up to $550 to the next plan year. Participants must enroll annually during the designated open enrollment period.

Why enroll in an FSA Account?

- Contributions are payroll deducted throughout the year, and are contributed on a pre-tax basis, thereby lowering your taxable income.
- Elected FSA contributions are available first day of the plan year or effective date of coverage.
- Convenient use of a Benefits Card – can be used like a debit card at most provider offices, retail stores, dental or vision offices.
- You can use the account for your eligible health care expenses and those of your legal spouse and for your dependent child(ren) up to age 26 (subject to any and all IRS rules).
- Check out this video for more information: https://youtu.be/L9V59QJ2z1o

WEX card example:



Dependent Care Accounts

Wex, Inc. also administers dependent care accounts for Prevea Health. You may contribute up to $5,000 *($2,500 if you are married and file a separate income tax return from your spouse)* on a pre-tax basis to your dependent care spending account this year to help pay yourself back with pre-tax dollars for the cost of eligible daycare for your dependent(s) while you work. Convenient use of a **Benefits Card/debit card** is also available. Participants must enroll annually during the designated open enrollment period or during a qualified life event. Note: dependent care contributions into your dependent care account are available only as the amounts are contributed to your account via payroll deduction.

Prevea Health Discounts & Rewards!

NEW for 2022! – BenefitHub

BenefitHub is a benefits and rewards portal that offers the widest variety of discounted leisure, health, and financial benefits, which are personalized to the individual. There are hundreds of benefits that may help with you and your family member(s) everyday lives.

- One stop shopping – everything in one place
- Expanded range of benefits, including direct bill voluntary benefits
- Amazing deals on thousands of brands including restaurants, tickets, cars, apparel, electronics, tickets/entertainment, beauty and spa, travel and more

Great local deals

- Designed for mobile use, you can shop anywhere
- Employees can save money each year

It's more than just a place to get discounts on shopping and entertainment. It's your go-to for saving on voluntary insurance plans, too. BenefitHub works with carriers and voluntary insurance providers to offer you the best deal for the coverage you need for such coverages as:

- Identity Theft Protection
- Pet Insurance
- Long Term Care

It's easy to access and start saving!

1. Visit https://prevea.benefithub.com
2. Create an account
3. Register using referral code: YJFAQ3
4. Start saving!!

Questions? If you have any questions about or need assistance with the Benefits Hub website, you can contact Support at 1-866-664-4621 or email customercare@benefithub.com

This brochure summarizes the benefit plans that are available to Prevea Clinic, Inc. eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

REQUIRED NOTIFICATIONS

Important Legal Notices Affecting Your Health Plan Coverage

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

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

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

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

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

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

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

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

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

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

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

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce your Rights

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

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $156 per day (up to a $1,566 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: the Human Resources/Benefits Department, P.O. Box 19070, Green Bay, Wisconsin United States 54307, 920-431-1997

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

Your Information. Your Rights. Our Responsibilities.

Recipients of the notice are encouraged to read the entire notice. Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

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

Your Choices

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

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

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research

- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

Help manage the health care treatment you receive
We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

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

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

Run our organization

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

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

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

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

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

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

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

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

Our Responsibilities

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

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

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

Other Instructions for Notice

- Effective Date of this Notice: January 1, 2022
- Should you have any questions regarding this notice, please contact Prevea Health at: Human Resources/Benefits Department, P.O. Box 19070, Green Bay, Wisconsin United states 54307, 920-431-1997.

Important Notice from Prevea Clinic, Inc.
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 Prevea Clinic, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Prevea Clinic, Inc. has determined that the prescription drug coverage offered by the Prevea Clinic, Inc. is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Prevea Clinic, Inc. coverage will not be affected. You can keep your Prevea Clinic, Inc. coverage and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Prevea Clinic, Inc. coverage, be aware that you and your dependents will be able to get this coverage back at the next open enrollment.

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 [Insert Name of Entity] and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact Human Resources/Benefits Department, P.O. Box 19070, Green Bay, Wisconsin United States 54307, 920-431-1997. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Prevea Clinic, Inc. changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	October 1, 2021
Name of Entity/Sender:	Prevea Clinic, Inc.
Contact--Position/Office:	Human Resources/Benefits Department
Address:	P.O. Box 19070, Green Bay, Wisconsin United States 54307,
Phone Number:	920-431-1997

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 **877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

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

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

ALABAMA – Medicaid	**ARKANSAS – Medicaid**
Website: **http://myalhipp.com/** Phone: 1-855-692-5447	Website: **http://myarhipp.com/** Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	**CALIFORNIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: **http://myakhipp.com/** Phone: 1-866-251-4861 Email: **CustomerService@MyAKHIPP.com** Medicaid Eligibility: **http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx**	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid – Medicaid and CHIP (Hawki)**
Health First Colorado Website: **https://www.healthfirstcolorado.com/** Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+:**https://www.colorado.gov/pacific/hcpf/child-health-plan-plus** CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562

FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
GEORGIA – Medicaid	**KENTUCKY – Medicaid**
Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp** Phone: 678-564-1162 ext. 2131	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov**/agencies/dms/member/Pages/kihipp.aspx** Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
INDIANA – Medicaid	**LOUISIANA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: **http://www.in.gov/fssa/hip/** Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**NEVADA – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 800-977-6740 TTY: Main relay 711	Medicaid Website: **http://dhcfp.nv.gov/** Medicaid Phone: 1-800-992-0900
MASSACHUSETTS – Medicaid and CHIP	**NEW HAMPSHIRE – Medicaid**
Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840	Website: **https://www.dhhs.nh.gov/oii/hipp.htm** Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
MINNESOTA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/** Medicaid Phone: 609-631-2392 CHIP Website: **http://www.njfamilycare.org/index.html** CHIP Phone: 1-800-701-0710
MISSOURI – Medicaid	**NEW YORK – Medicaid**
Website: **http://www.dss.mo.gov/mhd/participants/pages/hipp.htm** Phone: 573-751-2005	Website: **https://www.health.ny.gov/health_care/medicaid/** Phone: 1-800-541-2831
MONTANA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP** Phone: 1-800-694-3084	Website: **https://medicaid.ncdhhs.gov/** Phone: 919-855-4100

NEBRASKA – Medicaid	NORTH DAKOTA – Medicaid
Website: **http://www.ACCESSNebraska.ne.gov** Phone: 1-855 632-7633 Lincoln: 402 473-7000 Omaha: 402 595-1178	Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/** Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: **http://www.insureoklahoma.org** Phone: 1-888-365-3742	Medicaid Website: **https://medicaid.utah.gov/** CHIP Website: **http://health.utah.gov/chip** Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT – Medicaid**
Website: **http://healthcare.oregon.gov/Pages/index.aspx** **http://www.oregonhealthcare.gov/index-es.html** Phone: 1-800-699-9075	Website: http://greenmountaincare.org**/** Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://www.coverva.org/hipp/ https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: **http://www.eohhs.ri.gov/** Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: **https://www.scdhhs.gov** Phone: 1-888-549-0820	Website: **http://mywvhipp.com/** Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: **http://dss.sd.gov** Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: **http://gethipptexas.com/** Phone: 1-800-440-0493	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, 2021**, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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

Updated: 8/24/2021

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(Expires 6-30-2023)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment–based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one–stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost–sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.1

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer–offered coverage. Also, this employer contribution –as well as your employee contribution to employer–offered coverage– is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after–tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

1 An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name **Prevea Clinic, Inc.**	4. Employer Identification Number (EIN) **39-1839349**	
5. Employer address **2710 Executive Drive**	6. Employer phone number **920-431-1997**	
7. City **Green Bay**	8. State **Wisconsin**	9. ZIP code **54304**
10. Who can we contact about employee health coverage at this job? **Prevea Clinic, Inc., Human Resources/Benefits Department**		
11. Phone number (if different from above)	12. Email address Shari.Baer1@prevea.com	

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

- As your employer, we offer a health plan to:

  ☐ All employees. Eligible employees are:

  ✓ Some employees. Eligible employees are:

  All regular employees working 20+ hours per week.

- With respect to dependents:

  ✓ We do offer coverage. Eligible dependents are:

  Legally married spouses and biological child(ren), stepchild (ren), adopted child(ren), legal ward, or a child placed with the employee for adoption (by court order, a licensed county agency, a Wisconsin child welfare agency, or a child welfare agency licensed by another state), up to age 26.

  ☐ We do not offer coverage.

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

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

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

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)