Live Well. Be well.

Forge
INDUSTRIAL STAFFING

2024 Benefit Guide

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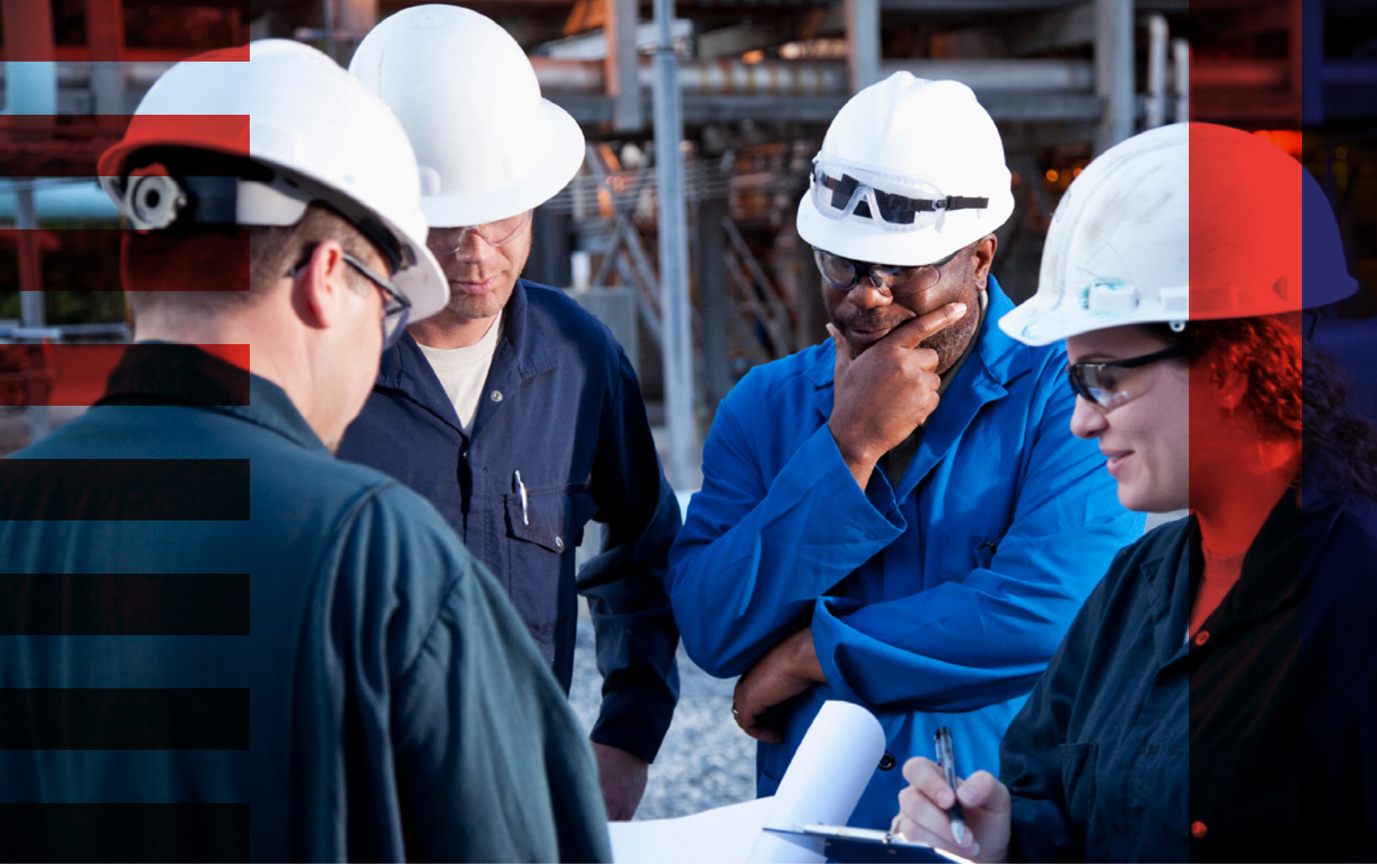
Forge INDUSTRIAL STAFFING

This guide provides an overview of the benefits program. It is not intended to be a complete description of the benefits or official summary plan descriptions for these programs. If there is a conflict between this guide and the official plan documents, the plan documents will govern. Forge reserves the right to modify or terminate any of the described benefits at any time and for any reason. The descriptions of these benefits are not a guarantee of current or future employment or benefits. For information about the specific plans available to you, please contact Human Resources.



Welcome to Your Forge Benefits

Welcome to your 2024 benefits! Use this benefits guide as a resource to compare plans and learn more about the coverages available to you.

If you have questions about your benefits, SISCO is available to help. Call (844) 631-6104 or find more information online at **https://www2.benefitelect.com/be/forge/Home.aspx**.

Eligibility

You're eligible for benefits on the first of the month following 60 days of employment if you are scheduled to work 30 hours or more per week.

Benefits are week-to-week (with a one week offset). Coverage begins the first day of the week following the waiting period. Thereafter, coverage is weekly. If an employee does not work during the week or there is insufficient payroll to take deduction, there will be no coverage the following week (due to one week offset).

You may enroll your eligible dependents in the same plans you choose for yourself. Eligible dependents include your legal spouse or registered domestic partner and your children up to age 26.

When to Enroll

Your hours will be tracked to determine eligibility upon starting your first assignment. Once you meet the hours required by ACA, you will receive a postcard notification which explains that you qualify for health insurance from Forge. You will have two weeks to accept or decline the coverage. **If no action is taken, you will be automatically enrolled into the Default Plan**. You may update to a different plan or waive coverage; however, this must be done during the two-week period.

How to Enroll

Online enrollment for you and your dependents is available at **https://www2.benefitelect.com/be/forge/Home.aspx**.

Returning Users:

1. Enter your username and password.
2. Follow the prompts to enroll.

New Users:

1. Click “Register” and complete the registration process.
2. Click “Open Enrollment Site.”
3. Update your personal information on the “About You” page. Click “Continue.”
4. Update dependent information on the “About your Dependents” page. Click “Continue.”
5. On the “Enrollment” page, enroll or waive coverage for yourself and your dependents. Make sure to update your beneficiary information!

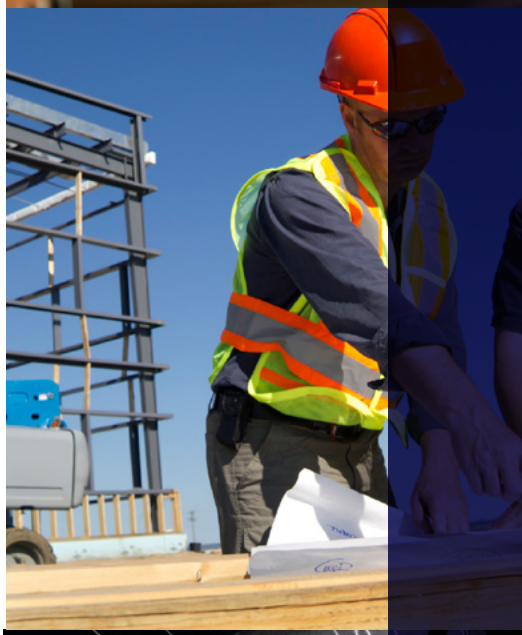
Review your information on the Enrollment Summary. A confirmation statement will also be generated.

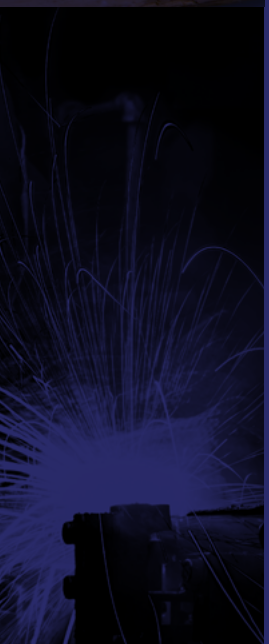
To enroll over the phone, call the SISCO Call Center at (855) 447-4726 ext. 4483.

Making Changes

The choices you make when you are first eligible are in effect for the remainder of the plan year which ends on December 31. Once you enroll, you must wait until the next Open Enrollment period to change your benefits or add or remove coverage for dependents, unless you have a qualified change in family status as defined by the IRS. The following are a few examples:

- Marriage, divorce, legal separation, annulment, or death of spouse
- Birth, adoption, or placement for adoption
- Change in your residence or workplace (if your benefit options change)
- Loss of other health coverage
- Change in your dependent’s eligibility status because of age, student status, or any similar circumstance





Helpful Benefit Terms & Definitions

To better understand your coverage, it's helpful to be familiar with benefits vocabulary. Take a moment to review these terms, which may be referenced throughout this guide.

Balance Bill – When a health care provider bills a patient for the difference between what the patient's health insurance reimburses and the provider charges.

Copay – A fixed dollar amount you pay the provider at the time of service; for example, a $20 copay for an office visit or a $12 copay for a generic prescription.

Coinsurance – The percentage paid for a covered service, shared by you and the plan. Coinsurance can vary by plan and provider network. Review the plans carefully to understand your responsibility. You are responsible for coinsurance until you reach your plan's out-of-pocket maximum.

Deductible – The amount you pay each calendar year before the plan begins paying benefits. Not all covered services are subject to the deductible. For example, the deductible does not apply to preventive care services.

Emergency Room Care – Care received at a hospital emergency room for life-threatening conditions.

In-Network Care – Care provided by contracted doctors within the plan's network of providers. This enables participants to receive care at a reduced rate compared to care received by out-of-network providers.

Out-of-Network Care – Care provided by a doctor or at a facility outside of the plan's network. Your out-of-pocket costs may increase, and services may be subject to balance billing.

Out-of-Pocket Maximum – The maximum amount you pay per year before the plan begins paying for covered expenses at 100%. This limit helps protect you from unexpected catastrophic expenses.

Premium – The complete cost of your plans. You share this cost with the company and pay your portion through regular payroll deductions.

Preventive Care – Routine health care, including annual physicals and screenings, to prevent disease, illness, and other health complications. In-network preventive care is covered at 100%.

Urgent Care – Visit urgent care for sudden illnesses or injuries that are not life-threatening. Urgent care centers are helpful when care is needed quickly to avoid developing more serious pain or problems.

Benefit Acronyms

AD&D = Accidental Death & Dismemberment

FSA = Flexible Spending Account

CDHP = Consumer Driven Health Plan

HDHP = High Deductible Health Plan

HMO = Health Maintenance Organization

HRA = Health Reimbursement Account

HSA = Health Savings Account

LTD = Long-Term Disability

OOPM = Out-of-Pocket Maximum

PPO = Preferred Provider Organization

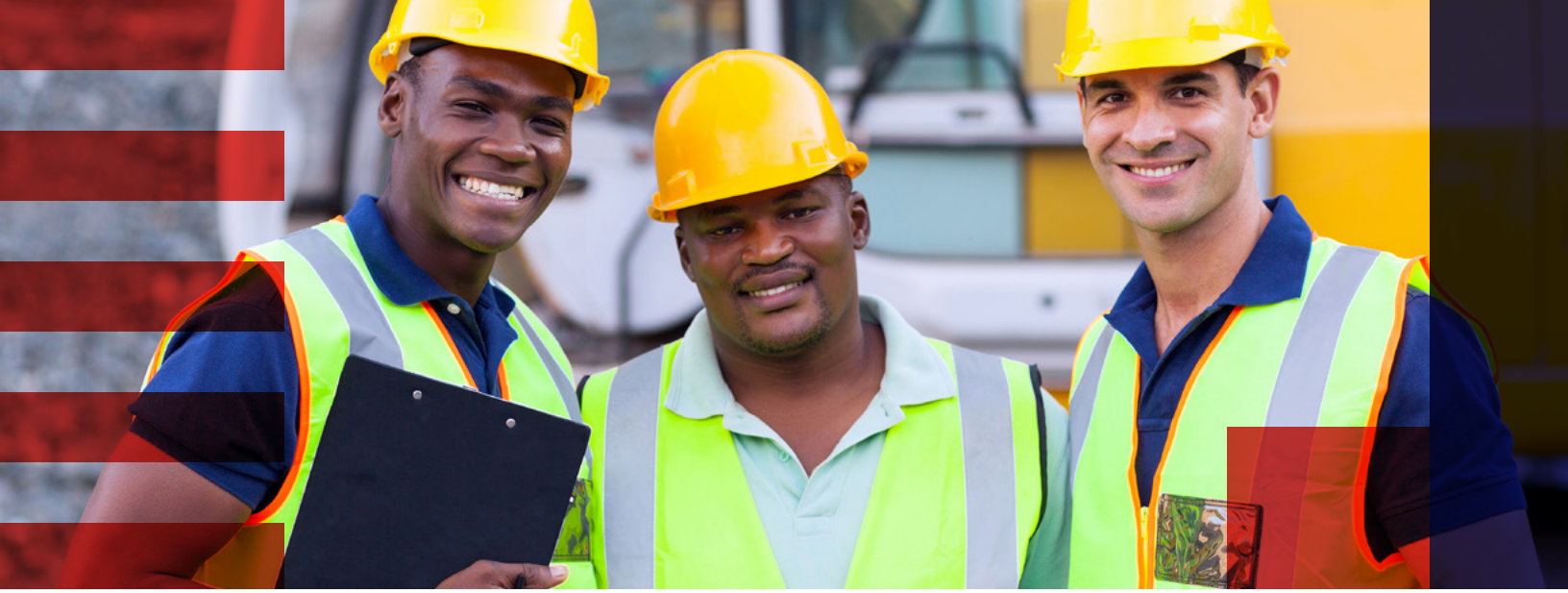
STD = Short-Term Disability

Medical Coverage You Can Count On

Take great care of your health through annual preventive care visits with your doctor. Review the medical plan options below to choose the plan that's best for you based on your medical needs and expenses in the upcoming plan year. Eligible employees who do not make an election will be enrolled into the Base Low Plan by default.

Plan Features	Base Low Plan	Advantage Plan		Value Plan
	In-Network Only	In-Network	Out-of-Network	In-Network Only
Network	PHCS Healthy Directions	Multiplan		Multiplan
Lifetime Plan Maximum	Unlimited	Unlimited		Unlimited
Annual Deductible Individual/Family	$0/$0	$0/$0	$500/$1,000	$0/$0
Annual Out-of-Pocket Maximum Individual/Family	$0/$0	$3,000/$12,700 (includes deductible)	Unlimited	$7,150/$14,300 (includes deductible)
	You pay:	**You pay:**	**You pay:**	**You pay:**
Preventive Care Visit	Covered in full	Covered in full	40% after deductible	Covered in full
Primary Care Visit	$20 copay 4 visits per year	$15 copay	40% after deductible	$15 copay
Specialist Visit	$30 copay 2 visits per year	$25 copay	40% after deductible	$25 copay
Diagnostic Lab & X-ray	Not covered	$50 copay*	40% after deductible*	$50 copay*
Imaging (CT, PET Scans, MRIs)	Not covered	$400 copay*	40% after deductible*	Not covered
Urgent Care	Not covered	$50 copay	40% after deductible	$50 copay
Emergency Room	Not covered	$500 copay up to $1,500 maximum*		$500 copay*
Outpatient Services	Not covered	Not covered		Not covered
Inpatient Hospital	Not covered	Not covered**		$1,000 copay, then 80%**
Inpatient Surgery	Not covered	Not covered**		$1,000 copay, then 80%**
Transplant Services	Not covered	Not covered**		$1,000 copay, then 80%**
Retail Rx Benefit (30 day supply) Tier 1 prescriptions only	$12 copay 15 fills per year	$15 copay 20 fills per year		$40 copay
Mail Order Rx Benefit	Not covered	Not covered		Not covered

*All services rendered in the emergency room are limited to a $1,500 maximum
**150% of Medicare allowable



Limited Benefit Health Plans

To supplement your medical plan, you have the option to enroll in the limited benefit health plan. The Limited Benefit Plan is included in the Base Low Plan.

Limited Benefit Health Plans		
Benefit	**Benefit payable per day**	**Maximum # of days payable per benefit year**
Daily In-Hospital Indemnity Benefit	$250	10 days
Initial Hospital Admission Indemnity Benefit	$500	1 day
Outpatient Diagnostic X-Ray and Lab Benefit	$50	1 day
Emergency Room Indemnity Benefit	$100	1 day
Ambulance Service Indemnity Benefit	$100	1 day

Dental Coverage

Good dental care improves your overall health. Our dental plans help you maintain a healthy smile through regular preventive dental care and offers coverage to fix problems as soon as they occur. To find an in-network provider near you, visit **http://www.dentemax.com/**.

Dental Plan	
Services	**Modified Essentials**
Deductible Per Individual	$50 contract year
Type 1 Preventive Services **Oral exams, cleanings (2 per 12 months), bitewing x-rays**	80%
Type II Basic Services **Space maintainers, fillings, pain treatment, sealants, full mouth x-rays**	80%
Type III Major Services* **Anesthesia, endodontics, simple and surgical extractions**	50%
Maximums	$750 per contract year
Takeover Benefit**	Preferred

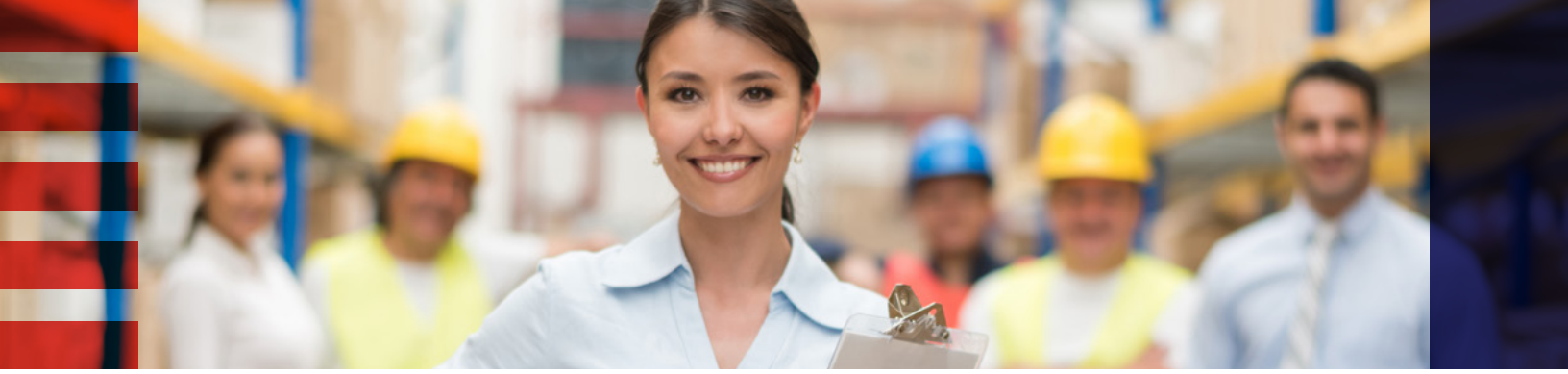
*There is a 12 month waiting period for major services.

**Preferred Takeover – The waiting period(s) for existing employees, including those who weren't on the prior plan will be waived. The prior group dental plan must have been in effect continuously for at least 12 months prior to the effective date of this plan. All waiting periods will apply to future new employees.

Vision Coverage

Keep your vision clear and your eyes in good health with regular eye exams. The vision plan offers an extensive network of optometrists and vision care specialists. Don't forget, you'll save money by visiting in-network providers. To find an in-network provider near you, visit **https://eyemed.com/en-us**.

Vision Plan		
Benefit	**In-Network**	**Out-of-Network**
Exam (every 12 months)		
Exam with Dilation as Necessary	$10 copay	$35 allowance
Contact Lens Fit and Follow-Up (Contact lens fitting and two follow-up visits available once a comprehensive eye exam has been completed)		
Standard	$0 copay	$40 allowance
Premium	$0 copay, 10% off retail, then apply $55 allowance	$40 allowance
Standard Plastic Lenses (every 12 months)		
Single	$10 copay	$25 copay
Bifocal	$10 copay	$40 copay
Trifocal	$10 copay	$55 copay
Lens Options		
UV Coating	$15 copay	n/a
Tint (Solid and Gradient)	$15 copay	n/a
Standard Scratch Resistant Coating	$15 copay	n/a
Standard Polycarbonate	$40 copay	n/a
Standard Anti-Reflective Coating	$40 copay	n/a
Standard Progressive (Add-on to Bifocal)	$65 copay	n/a
Other Add-Ons and Services	29% off retail	n/a
Contact Lenses – Materials Only (Every 12 months)		
Conventional	$0 copay, $80 allowance, 15% off balance over allowance	$64 allowance
Disposable	$0 copay, $80 allowance, 15% off balance over allowance	$64 allowance
Medically Necessary	Covered-in-full	$200 allowance
Frames (every 24 months)		
Any available frame at provider location. Benefit is not available on those frames where the manufacturer prohibits a discount.	$100 allowance, 20% of balance over allowance	$45 allowance



Basic Life

As an eligible employee, you receive Basic Life insurance in the amount of $10,000. Basic Life is provided by the company at no cost to you.

Voluntary Life and AD&D Insurance

In addition to Basic Life and AD&D, you may buy voluntary Life and AD&D coverage at a discounted rate. The chart below describes the amount of coverage you can buy for yourself, your spouse, and your child(ren).

Benefit Features	Voluntary Life and AD&D Options		
	Employee	Spouse	Dependent Child(ren)
Voluntary Coverage Amount	$20,000	$5,000	$2,500
Guaranteed Issue Period	Within 30 days of benefits eligibility or a qualifying life event		

Voluntary Critical Illness Insurance

Critical Illness insurance helps protect you from the expense of a serious health issue such as a stroke, heart attack, or cancer. To enroll in coverage, you select a lump-sum benefit which is paid directly to you at the first diagnosis of a covered condition. How you choose to use the cash benefit is up to you.

First Ever Occurrence Benefit: Provides a lump sum payment when for the first time in his/her lifetime and while covered under this policy, the Insured has undergone the specific procedure or been diagnosed with the specific condition included in the covered illnesses.

Reoccurrence Benefit: Pays when a covered critical illness for which a benefit has already been paid reoccurs. The two occurrences must be separated by at least 12 months or, for cancer, at least 12 months treatment free. Up to two reoccurrences of any critical illness may be payable.

Additional Occurrence Benefit: Pays an additional benefit upon the diagnosis of a covered Condition for which benefits previously have not been paid. In the case of two different critical illnesses, the latest occurrence must be separated by at least six months (at least six months treatment free for cancer) from any prior occurrence. The Maximum Benefit Amount payable under this policy is three times the policy face amount.

Reduction Formula: If a Covered Person is Age 60 on the Policy Effective Date, or when the Covered Person reaches Age 60, the Benefit Amount will be reduced by 25%. If a Covered Person is age 65 or more on the Policy Effective Date, or when the Covered Person reaches Age 65, the Benefit Amount will be reduced by an additional 25% (collectively a “Benefit Reduction Due to Age”).

Short-Term Disability (STD)

Short-Term Disability coverage provides you with a portion of income replacement if you are unable to work due to a non-occupational illness or injury.

STD benefits may be offset by benefits you receive from the state-mandated disability plans in California, New Jersey, New York, Rhode Island or the Commonwealth of Puerto Rico

Short-Term Disability (STD)			
Percent of Earnings	**Weekly Maximum**	**Elimination Period**	**Maximum Duration**
60%	$150	8 days	26 weeks

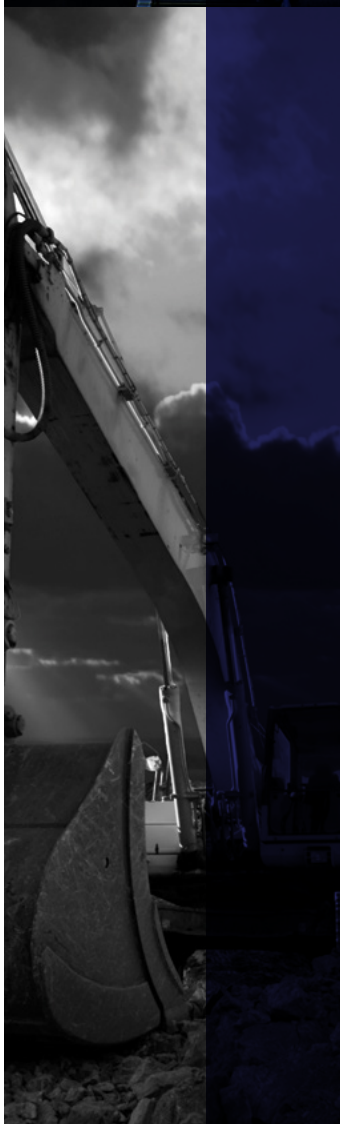
Your 2024 Cost for Coverage

Medical Plan Payroll Deductions			
Benefit Tier	**Base Low Plan You pay:**	**Advantage Plan You pay:**	**Value Plan You pay:**
Employee Only Monthly/Weekly	$105.33 / $24.31	$104.67 / $24.15	$110.49 / $25.50
Employee + Spouse Monthly/Weekly	$154.75 / $35.71	$238.32 / $55.00	Not available
Employee + Children Monthly/Weekly	$128.42 / $29.64	$268.67 / $62.00	$1,729.07 / $399.02
Family Monthly/Weekly	$176.55 / $40.74	$407.54 / $94.05	Not available

Dental Plan Payroll Deductions	
Benefit Tier	**You pay:**
Employee Only Monthly/Weekly	$23.52 / $5.43
Employee + Spouse Monthly/Weekly	$43.32 / $10.00
Employee + Children Monthly/Weekly	$43.19 / $9.97
Family Monthly/Weekly	$62.93 / $14.52

Vision Plan Payroll Deductions	
Benefit Tier	**You pay:**
Employee Only Monthly/Weekly	$9.37 / $2.16
Employee + Spouse Monthly/Weekly	$17.69 / $4.08
Employee + Children Monthly/Weekly	$20.93 / $4.83
Family Monthly/Weekly	$27.85 / $6.43

Short Term Disability Payroll Deductions	
Benefit Tier	**You pay:**
Employee Only Monthly/Weekly	$27.00 / $6.23



Your 2024 Cost for Coverage (cont.)

Critical Illness Payroll Deductions		
Age	**Employee Only** You pay (monthly/weekly):	**Employee + Dependent** You pay (monthly/weekly):
18-24	$1.80/$0.42	$3.15/$0.73
25-29	$2.20/$0.51	$3.85/$0.89
30-34	$3.30/$0.76	$5.78/$1.33
35-39	$5.50/$1.27	$9.63/$2.22
40-44	$8.80/$2.03	$15.40/$3.55
45-49	$13.20/$3.05	$23.10/$5.33
50-54	$19.80/$4.57	$34.65/$8.00
55+	$26.40/$6.09	$46.20/$10.66

Voluntary Life and AD&D* Payroll Deductions		
Age	**$20,000 Employee Coverage** You pay (monthly/weekly):	**$5,000 Spouse Coverage** You pay (monthly/weekly):
Under 30	$2.00/$0.46	$0.50/$0.12
30-34	$2.20/$0.51	$0.55/$0.13
35-39	$2.60/$0.60	$0.65/$0.15
40-44	$3.40/$0.78	$0.85/$0.20
45-49	$5.20/$1.20	$1.30/$0.30
50-54	$9.00/$2.08	$2.25/$0.52
55-59	$13.20/$3.05	$3.30/$0.76
60-64	$25.00/$5.77	$6.25/$1.44
65-69	$38.80/$8.95	$9.70/$2.24
70+	$71.20/$16.43	$17.80/$4.11
$2,500 Child(ren) Coverage You pay (monthly/weekly):		
$6.25/$1.44		

*AD&D coverage is equal to the Voluntary Life amount.

Important Notices

Health and Welfare Benefits Annual Notice Packet

Medicare Part D Creditable Coverage Notice

Important Notice from Forge Industrial Staffing 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 Forge Industrial Staffing 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. **Forge Industrial Staffing has determined that the prescription drug coverage offered by the Employer Advantage Plan - Forge 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 while enrolled in Forge Industrial Staffing coverage as an active employee, please note that your Forge Industrial Staffing coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Forge Industrial Staffing coverage as a former employee.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Forge Industrial Staffing and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Forge Industrial Staffing 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.

Health and Welfare Benefits Annual Notice Packet

Medicare Part D Creditable Coverage Notice Continued

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).

Name of Entity/Sender: Forge Industrial Staffing
Contact--Position/Office: Americo Teran, HR Manager
Address: 5011 28th St Suite B, Grand Rapids, MI 49512
Phone Number: 616-285-6860

Health and Welfare Benefits Annual Notice Packet

HIPAA Special Enrollment Rights Notice

If you are declining enrollment in Forge Industrial Staffing group health coverage 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.

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

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.

Forge Industrial Staffing ("Forge") sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Forge, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

1. your past, present or future physical or mental health or condition;
2. the provision of health care to you; or
3. the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Forge, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact the Forge HIPAA Privacy Officer or:

Forge Industrial Staffing
Attention: HIPPA Privacy Officer
5011 28th St Suite B
Grand Rapids, MI 49512

Effective Date

This notice as revised is effective November 8, 2024.

Health and Welfare Benefits Annual Notice Packet

HIPAA Notice of Privacy Practices Continued

Our Responsibilities

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above or on our intranet at [insert intranet address]. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment
We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment
We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations
We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates
We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law
We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety
We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors
For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Health and Welfare Benefits Annual Notice Packet

HIPAA Notice of Privacy Practices Continued

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation
If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans
If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation
We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks
We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities
We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes
If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement
We may disclose your protected health information if asked to do so by a law enforcement official—

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct; and
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors
We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities
We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Health and Welfare Benefits Annual Notice Packet

HIPAA Notice of Privacy Practices Continued

Special Situations Continued

Inmates
If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research
We may disclose your protected health information to researchers when:

1. the individual identifiers have been removed; or
2. when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits
We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You
When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.
We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives
We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

1. you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
2. treating such person as your personal representative could endanger you; or
3. in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members
With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations
Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Health and Welfare Benefits Annual Notice Packet

HIPAA Notice of Privacy Practices Continued

Your Rights
You have the following rights with respect to your protected health information:

Right to Inspect and Copy
You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend
If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures
You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years (three years for electronic health records) or the period Forge has been subject to the HIPAA Privacy rules, if shorter.

Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions
You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Health and Welfare Benefits Annual Notice Packet

HIPAA Notice of Privacy Practices Continued

Your Rights Continued
You have the following rights with respect to your protected health information:

Right to a Paper Copy of This Notice
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see Your Rights Under HIPAA.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. 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/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

Health and Welfare Benefits Annual Notice Packet

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, 2023. 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**
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	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

Health and Welfare Benefits Annual Notice Packet

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) Continued

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremiumassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA - Medicaid	**NEBRASKA - Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

Health and Welfare Benefits Annual Notice Packet

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) Continued

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.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. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
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	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**
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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	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	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
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

Health and Welfare Benefits Annual Notice Packet

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP) Continued

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, 2023, 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

Health and Welfare Benefits Annual Notice Packet

Women's Health Cancer Rights Act (WHCRA) Notice

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a 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. If you would like more information on WHCRA benefits, contact your plan administrator at 616-285-6860

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

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 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).

Model General Notice of COBRA Continuation Coverage Rights
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.

Health and Welfare Benefits Annual Notice Packet

Model General Notice of COBRA Continuation Coverage Rights Continued

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;
- or
- 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: HR Manager at 616-285-6860

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:
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.

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Model General Notice of COBRA Continuation Coverage Rights Continued

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.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

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/agencies/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.

Plan contact information
HR Manager
616-285-6860

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Medicare Part D Non-Creditable Coverage Notice

Important Notice from Forge Industrial Staffing 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 Forge Industrial Staffing 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Forge Industrial Staffing has determined that the prescription drug coverage offered by the Employer Advantage Plan - Forge is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered **Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Employer Advantage Plan - Forge. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.**
3. You can keep your current coverage from Employer Advantage Plan - Forge. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan while enrolled in Forge Industrial Staffing coverage as an active employee, please note that your Forge Industrial Staffing coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits may be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Forge Industrial Staffing coverage as a former employee.

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

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under Employer Advantage Plan - Forge is not creditable, you may pay a penalty to join a Medicare drug plan depending on how long you go without creditable prescription drug coverage. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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Medicare Part D Non-Creditable Coverage Notice Continued

For More Information about This Notice or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. NOTE: You will 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 Forge Industrial Staffing 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).

Date: November 8, 2023
Name of Entity/Sender: Forge Industrial Staffing
Contact--Position/Office: Americo Teran, HR Manager
Address: 5011 28th St Suite B, Grand Rapids, MI 49512
Phone Number: 616-285-6860

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HIPAA Notice of Availability of Notice of Privacy Practices

The Forge Industrial Staffing Plan (Plan) maintains a Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's Notice of Privacy Practices, please contact HR Manager at 616-285-6860

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?
When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:
Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - » Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - » Cover emergency services by out-of-network providers.
  - » Base what you owe the provider or facility (cost-sharing) on what it would pay an in□network provider or facility and show that amount in your explanation of benefits.
  - » Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

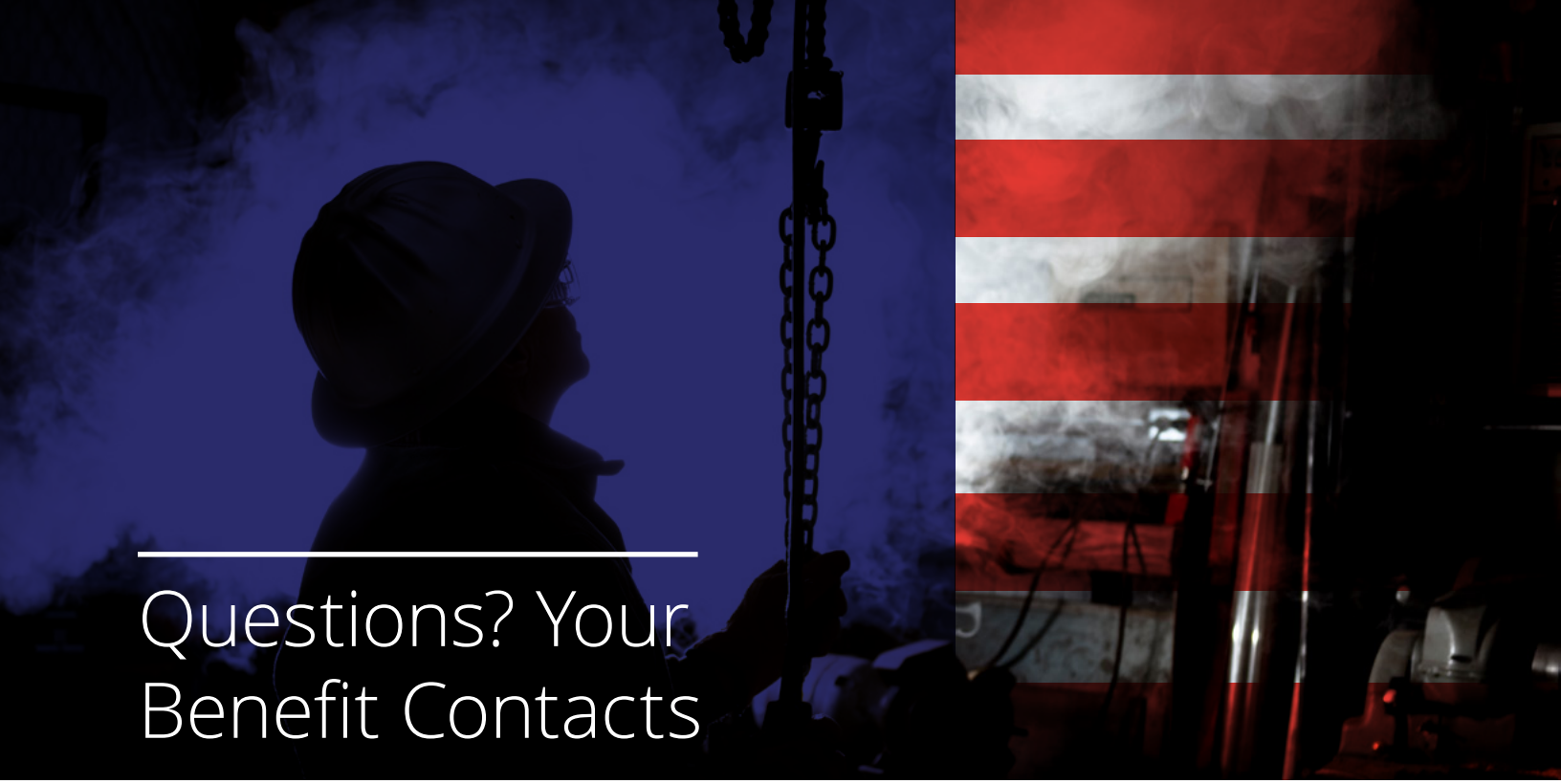
Health and Welfare Benefits Annual Notice Packet

Your Rights and Protections Against Surprise Medical Bills Continued

If you believe you've been wrongly billed, the following information and resources are available to help you understand your rights:

Assistance by telephone – You may contact the U.S. Department of Health & Human Services at (800) 985-3059 to discuss whether you may have any surprise billing protection rights for your situation.

Available online assistance – You can also visit the U.S. Centers for Medicare & Medicaid Services website to learn more about protections from surprise medical bills and for contact information for the state department of insurance or other similar agency/resource in your state to learn if you have any rights under applicable state law. Please click on your state in the map for contact information to appear.



Questions? Your Benefit Contacts

Benefit	Contact	Phone	Website
General Benefits Information	SISCO Call Center	(844) 631-6104	N/A
Online Enrollment	BenefitElect	(844) 631-6104	**https://www2.benefitelect.com/be/forge/Home.aspx**
Medical	SISCO Call Center	(844) 631-6104	**https://www2.benefitelect.com/be/forge/Home.aspx**
Medical Indemnity	SISCO Call Center	(844) 631-6104	**https://www2.benefitelect.com/be/forge/Home.aspx**
Prescription Drug	CastiaRx Pharmacy Solutions	(866) 516-2121	**www.CastriaRx.com**
Voluntary Dental	SISCO Call Center	(844) 631-6104	**http://www.dentemax.com/**
Voluntary Vision	SISCO Call Center	(844) 631-6104	**https://eyemed.com/en-us**
Basic Life and AD&D	SISCO Call Center	(844) 631-6104	**www.companionlife.com**
Voluntary Life and AD&D, Short-Term Disability, and Critical Illness	SISCO Call Center	(844) 631-6104	**www.companionlife.com**
Accident	IHC	-	**www.ihcgroup.com**
COBRA	SISCO Call Center	(844) 631-6104	

This communication highlights your benefit plans. Your actual rights and benefits are governed by the official plan documents. If any discrepancy exists between this communication and the official plan documents, the plan documents will prevail. Your employer reserves the right to change any benefit plan without notice. Benefits are not a guarantee of employment.

Forge INDUSTRIAL STAFFING