HALO

Benefits Guide.

This publication contains important information about your employee benefit program.

Please read thoroughly.



At **HALO**, we are committed to a comprehensive employee benefit program to help our employees stay healthy, feel secure, and maintain a work/life balance.

We want you to feel educated and empowered to choose the benefits you and your family need. **HALO** is passionate about the high-quality care and resources we provide our associates and are confident you will find what's right for you.

This guide offers details on the benefits offered, provider contact information, and enrollment instructions. Please review it carefully, so you can feel informed about your options.

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01

Eligibility

HALO

Eligibility

Who is Eligible?

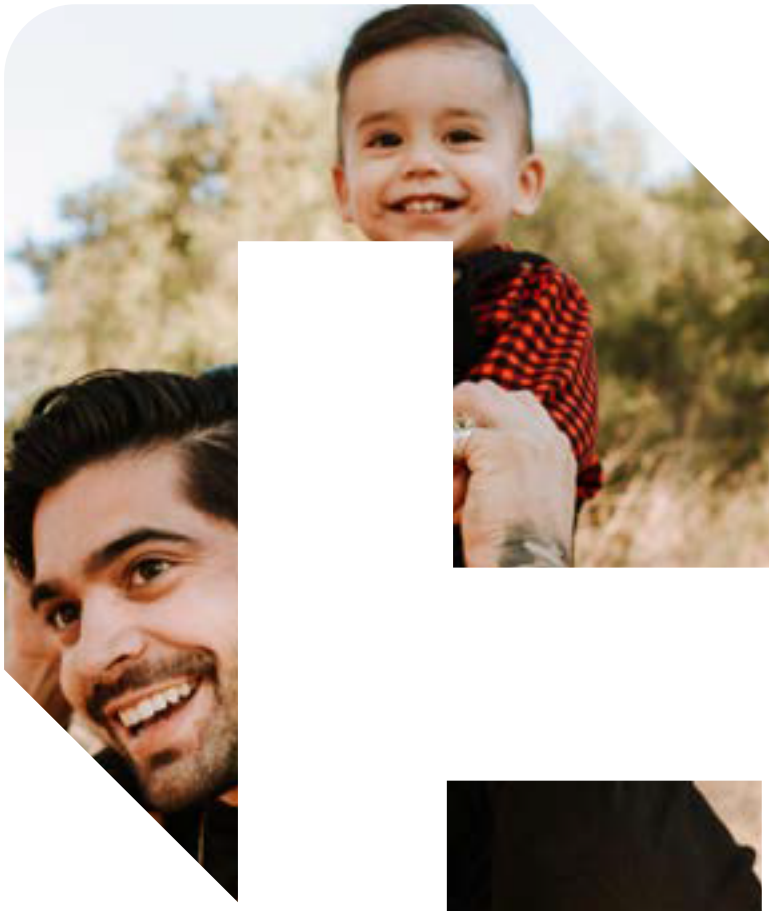
Employee Eligibility

- Actively employed administrative employees scheduled to work a minimum of 30 hours per week.
- Actively employed (commission only) account executives booking a minimum of $40,000 in commissions in the prior calendar year (amount will be estimated or prorated for new hires with mid-year enrollments). The minimum booking threshold is subject to change at the company's discretion every calendar year.

Dependent Eligibility

Legal spouses, civil union, or domestic partners of eligible employees are eligible for benefits.

Children of eligible employees are eligible for coverage in the health/dental/vision plans up to the age 26, regardless of student, marital, or employment status. Coverage will automatically terminate at the end of the month of the dependent's 26th birthday. Supplemental child life coverage terminates at the end of the month of the dependent child's 19th birthday.







When Are You Eligible?

Newly Eligible Employees

Your benefits become effective the first of the month coincident with or following 30 days of employment in an eligible classification. **NOTE: You have 30 days from your date of hire or change to eligible status to enroll in or waive coverage.**

Annual Open Enrollment

You may make changes to your benefit elections during your open enrollment period for a September 1st effective date.

Qualified Change in Status

Your benefit elections will remain in effect for the entire year unless you experience a qualifying life event. You may make benefit changes within 30 days of a qualified event. Examples of qualifying life events include: marriage, civil union, divorce, birth, adoption, death of a dependent, or loss of other coverage, such as spouse/partner losing coverage as a result of a job loss or change. Note: This is only a summary of the benefit plans; refer to the Summary Plan Descriptions or Certificates for each benefit to view full details on coverage, maximums, limitations, and exclusions. If there is any conflict between this document and the official plan documents, the official plan documents govern the plan.

What Benefits Are Available?

As you consider your plans for the year, refer to this chart of coverage and enrollment information for the various benefit programs offered through HALO.

Reminder: Coverage begins the first of the month coincident with or following 30 days of employment in an eligible classification.

Note:
Your basic life and AD&D, short term disability, and long term disability insurance will only be provided by HALO if you elect medical coverage.

- **If you do not enroll in medical coverage, but want to enroll in these benefits, you will pay 100% of the cost.**

Benefit Plan	Vendor	Do I Need to Enroll?
Health Plans		
Medical	Blue Cross Blue Shield of Illinois	Yes
Prescription Drug Coverage	CVS Caremark	Included with enrollment in BCBS IL Plans
Dental	Delta Dental of Illinois	Yes
Vision	Blue Cross Blue Shield of Illinois (EyeMed)	Yes
Life and AD&D Insurance		
Basic Life and AD&D Insurance	New York Life	Enrolled in medical: No Not enrolled in medical: Yes
Voluntary Life (for you and your dependents)	New York Life	Yes
Disability Insurance		
Short Term Disability	New York Life	Enrolled in medical: No Not enrolled in medical: Yes
Long Term Disability	New York Life	Enrolled in medical: No Not enrolled in medical: Yes
Voluntary Options		
Critical Illness	Cigna	Yes
Hospital Indemnity	Cigna	Yes
Accident	Cigna	Yes
Additional Programs		
401(k) Savings Plans	BOK Financial	No
Health Savings Account	HealthEquity	Yes
Flexible Spending Accounts	WEX	Yes
Cancer Navigation	Cancer Experts Now	No

02

Staying Healthy

HALO

Staying Healthy

Medical Highlights—HDHP

HALO offers two medical plans with access to a Participating Provider Organization (PPO) to cover your medical needs from preventive care to emergency situations. With a High Deductible Health Plan (HDHP), you will have a higher deductible to meet, but you will pay a lower monthly premium. With the HDHP, you must meet your deductible before coinsurance begins. If you meet your out-of-pocket maximum, you will not pay any more for the cost of your care for the rest of the year.

Note: Your deductible and out-of-pocket maximum renew on a calendar year basis.

How the Family Deductible and Out-of-Pocket Maximums Work (HDHP Only)

- The plan will not begin cost sharing for any family member until the family deductible is met
- Any combination of one or more family members can incur expenses to meet the family deductible
- All family members' out-of-pocket expenses count towards the family deductible
- The family out-of-pocket maximum must be met by any combination of one or more family members before plan will begin to cover in-network expenses at 100%

Plan Features	HDHP Plan	
	In-Network	Out-of-Network
Coinsurance	80%	60%
Deductible		
Individual	$1,600	$4,800
Family	$3,200	$9,600
Account Funding (HSA)		
Individual	$500	
Family	$1,000	
Out-of-Pocket Max (includes deductible)		
Individual	$4,750	$14,250
Family	$9,100	$27,300
Covered Services		
Preventive Care	100%	Deductible and coinsurance
Office visit	Deductible and coinsurance	Deductible and coinsurance
Specialist	Deductible and coinsurance	Deductible and coinsurance
Urgent Care	Deductible and coinsurance	Deductible and coinsurance
Emergency Room	Deductible and coinsurance	Same as in-network
Prescription Drug		
Generic	$10 Copay, After Deductible	Same as in-network
Preferred	$30 Copay, After Deductible	
Non-Preferred	$50 Copay, After Deductible	
Speciality	$200 Copay, After Deductible	

Staying Healthy

Medical Highlights—PPO

A Preferred Provider Organization (PPO) plan offers a lower deductible, but has higher monthly premiums. You will also have copays for some services if you stay in-network. If you or your dependents utilize specialists frequently or require hospitalization, a PPO may be better for you.

How the Family Deductible and Out-of-Pocket Maximums Work (PPO Only)

- A single member of a family does not have to meet the full family deductible before the after-deductible benefits kick in
- Individual family members only need to meet the individual deductible for the after-deductible benefits to kick in
- The money that is paid toward the individual deductible and out-of-pocket maximums is also credited toward the family deductible and out-of-pocket maximums
- Once several different family members have each paid enough in individual deductibles that meet the family deductible in total, benefits will begin to be paid for the entire covered family
- When family members have paid enough in out-of-pocket maximums to complete the family out-of-pocket maximum, the plan will begin covering in-network expenses at 100%

Plan Features	PPO Plan	
	In-Network	Out-of-Network
Coinsurance	80%	60%
Deductible		
Individual	$750	$3,000
Family	$1,500	$6,000
Out-of-Pocket Max (includes deductible)		
Individual	$3,400	$13,600
Family	$6,800	$27,200
Covered Services		
Preventive Care	100%	Deductible and coinsurance
Office visit	$20	Deductible and coinsurance
Specialist	$40	Deductible and coinsurance
Urgent Care	$50	Deductible and coinsurance
Emergency Room	80%	
Prescription Drug		
Generic	$10	Same as in-network
Preferred	$30	
Non-Preferred	$50	
Speciality	$200	

Staying Healthy

Rx benefit through CVS

Effective September 1, 2023, CVS Caremark in partnership with VPS Rx Solutions will provide prescription drug coverage, for those enrolled in the BCBS IL Medical Plans. You will be automatically enrolled in prescription drug coverage with CVS Caremark if you enroll in a BCBS IL Medical Plan. CVS Caremark will be the Pharmacy Benefits Manager, which includes coverage for Mail-Order & Specialty Prescription

- **While CVS is the Pharmacy Benefits Manager, that does not mean that you can only refill your medication through CVS.**
- **You will use your BCBS IL Medical ID, for your prescription benefits.**

Two new key program highlights:

Specialty Copay Assistance Program

If you take a specialty medication, VPS Rx Solutions will provide you with support in accessing copay assistance programs that are available for your medication through the manufacturer. In order to take advantage of the manufacturer's copay assistance, 2023, your copay will be 30% (after deductible, if applicable) of the price on specialty prescriptions. While this may appear to significantly increase your copay, the manufacturer copay assistance will cover most, if not all, of your out-of-pocket expenses for your specialty medication.

As a result, your out-of-pocket costs for a 30-day supply will in most cases be less than what you are paying today.

Patient Assistance Program

Through Specialty Patient Assistance programs, you may be able to acquire select medication directly from the manufacturer at no cost. Because these programs are difficult to qualify for, an outside vendor (ImpaxRx) will work with you as a patient advocate to complete the application process, work with the physician and get final approval for the manufacturer.

If you or a covered family member are eligible for either program, you will receive communications from the vendor. It is your responsibility to work with the vendor, to take advantage of the programs.

Want to learn more? Email **Benefits@halo.com.**

Staying Healthy

Cost for Medical Coverage

The cost you pay for Medical insurance is based on a variety of factors, including your compensation, wellness classification, & tobacco status.

- Administrative Employees are classified based on your annual salary, as of 7/1/2024.

If you and/or your spouse/domestic partner are a tobacco user, you will be required to pay a surcharge on your medical premiums. This surcharge can be removed by participating in a Cessation program.

To learn more about your classification or cost, please contact **benefits@halo.com**

Bi-Weekly Smoker Surcharge	
1 Smoker	$17.31
2 Smokers	$34.62

Medical Plan Contributions

HDHP Bi-Weekly Contributions				
Salary Bracket	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
Over $200,000				
Wellness	$109.75	$321.53	$229.09	$397.04
Non-Wellness	$174.43	$477.68	$341.10	$588.14
Over $100,000				
Wellness	$92.19	$264.42	$192.58	$333.77
Non-Wellness	$147.88	$400.82	$284.85	$494.68
Over $60,000				
Wellness	$76.50	$231.42	$168.27	$293.99
Non-Wellness	$129.96	$352.28	$254.33	$445.66
Under $60,000				
Wellness	$62.35	$200.63	$154.25	$277.42
Non-Wellness	$108.72	$310.49	$223.84	$399.02
Commision Based				
Wellness	$109.75	$321.53	$229.09	$397.04
Non-Wellness	$174.43	$477.68	$341.10	$588.14

PPO Bi-Weekly Contributions				
Salary Bracket	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
$200,000				
Wellness	$149.47	$403.91	$297.78	$526.46
Non-Wellness	$217.51	$551.56	$405.29	$711.25
Over $100,000				
Wellness	$122.36	$325.78	$245.32	$433.71
Non-Wellness	$184.41	$462.82	$338.45	$593.94
Over $52,000				
Wellness	$103.76	$283.45	$212.53	$382.16
Non-Wellness	$162.54	$410.23	$304.76	$538.68
Under $52.000				
Wellness	$90.48	$258.14	$198.76	$360.69
Non-Wellness	$136.11	$364.92	$273.25	$491.32
Commision Based				
Wellness	$149.47	$403.91	$297.78	$526.46
Non-Wellness	$217.51	$551.56	$405.29	$711.25

Staying Healthy

MyHealthyHALO Employee Wellness Program

- The rate you pay for Medical insurance is based on a variety of factors, including completion of HALO's Wellness Program. You will have access to MyHealthyHALO, if you are Medically enrolled.
- Employee's completing the program requirements for the Plan Year starting 9/1/2023, will receive the Premium Incentive Discount.
- Failure to complete the program requirements as outlined in the program guide, results in you paying the Non-Compliant Premium.
- Requirements for the 1/1/2026 Premium Incentive will be communicated, following the upcoming Open Enrollment.
  - If your medical coverage starts for the first time with HALO as of 9/1/2024 and after, you are not subject to the program requirement to receive the premium discount.
- In addition to the Premium Incentive, MyHealthyHALO gives you the opportunity to earn Break Through Points by completed a variety of activities.



Getting Started:

- **www.myhealthyhalo.com**
- **Program Guide**
- **Download the Navigate Mobile App**

Staying Healthy

Tools and resources with BCBSIL

Virtual Visits with MDLIVE!

Speak With a Physician or Therapist—Anytime, Anywhere

MDLIVE allows you to access board-certified physicians or therapists 24/7/365 from any location, whether you are on the road, at work or in the comfort of your own home. This service is available for both physical and behavioral health visits. You may access MDLIVE by mobile app, online video or over the phone. Getting sick after hours or on the weekends used to mean a long, costly trip to the emergency room or urgent care center. But with your virtual visits benefit provided by Blue Cross Blue Shield of Illinois and powered by MDLIVE, you may access care at a location convenient to you. Virtual visits are for non-emergency situations such as:

- Allergies
- Anxiety
- Asthma
- Cold/flu
- Depression
- Ear infections
- Pink eye
- Rashes
- Stress management

If needed, through MDLIVE, you can get a prescription called into your local pharmacy.

To set up an account, you may:

- Call MDLIVE at **866.676.4204**
- Go to **www.MDLIVE.com/BCBSIL**
- Text BCBSIL to **635.483**
- Download the MDLIVE app

Virtual Primary Care with Teledoc

BCBS works with Teladoc Health to provide virtual primary care as a part of the benefit plan. Members get access to the following services:

- General Medical: Diagnosis and treatment for cold/flu, allergies, sinus infections and more as well as prescriptions sent to your local pharmacy
- Behavioral health services for depression, anxiety, stress and more with a therapist or psychiatrist
- Dermatology services for diagnosis and treatment of skin conditions including eczema, psoriasis, acne, rosacea, and skin infections

You can access services through the following:

- Visit **teladoc.com/bcbsil**
- Call **800-TELADOC 835.2362**
- Download the Teladoc app

Virtual Visits are a cost-effective and convenient way to get medical care. The information below will provide you with details related to the cost of virtual care under both programs. When trying to understand which program to utilize, it is important to understand the MDLIVE is for acute care. Virtual Primary Care will provide convenient virtual primary care services, with the bonus of offering acute care, like MDLIVE.

PPO:

- **MDLIVE:** Health & Acute Care + Behavioral Health: $0 Copay
- **Virtual Primary Care:** Acute Care + Behavioral Health: $0 Copay
- **Virtual Primary Care & Dermatology:** $20 Copay

HDHP:

- **MDLIVE:** Health & Acute Care + Behavioral Health: $0 after deductible has been met
- **Virtual Primary Care:** Acute Care + Behavioral Health: $0 after deductible has been met
- **Virtual Primary Care:** Virtual Primary Care + Dermatology: 20% after deductible has been met

Before Deductible:

- **MDLIVE / Virtual Primary Care:** Health Visit: $44-$55
- **MDLIVE / Virtual Primary Care:** Behavioral Health Visit: $90 - $250
- **Virtual Primary Care:** PCP Initial and Annual Visit: $165
- **Virtual Primary Care:** PCP Follow-Up: $99
- **Virtual Primary Care:** Dermatology: $85

Staying Healthy

Digital Accounts for Medical & Pharmacy Benefits

Staying Connected to your Medical (BAM)

Save time with self-service support tolls and health and wellness resources available through a convenient and secure website.

Through BAM (Blue Access for Members) you can:

- Check claims and claims history
- View, save or print Explanation of Benefits (EOBs)
- Sign up for electronic EOBs, and save paper
- View benefits and covered dependents
- Check coverage details and benefit information
- Manage mobile and texting preferences
- Request new ID cards or print temporary ID cards
- Access health and wellness information and guides
- Get details on wellness, discounts, 24/7 Nurseline
- Use Provider Finder® to find in-network doctors and hospitals

Getting Started:
Visit **www.bcbsil.com/member** and use the information on your ID card to create an account

BCBSIL App for Mobile Devices

To download the app, go to Google Play, the App Store or text* BCBSILAPP to33633

Staying Connected to your Pharmacy

Easily manage your prescriptions through **Caremark.com**.

Here, you can sign up to get notifications about your prescriptions, ways to save, status updates, and more.

- Request Refills quickly
- Explore Rx Savings options
- Find out if your Rx is covered or if you could pay less for it
- Manage Rx Mail Order for convenience and savings
- Email a pharmacist for questions
- Manage Rx Mail Order for convenience and savings
- Email a Pharmacist for questions

Getting Started:
Visit **https://www.caremark.com/** and use the information on your BCBS ID card to create an account.
Specialty Medications? Manage your Specialty Medications on **https://www.cvsspecialty.com/**.

Staying Healthy

A Healthier You

Trying to become healthier versions of ourselves can be very difficult without any help. That is why HALO has partnered with BCBS of IL to offer some of the great benefits below.

Hinge Health

Conquer back or joint pain without drugs or surgery. As a member of Blue Cross and Blue Shield of Illinois, you get access to a new digital program for back, knee, hip, shoulder, and neck pain at no cost to you!

The program, provided by Hinge Health, includes:

- A tablet computer and wearable sensors
- Unlimited 1-on-1 health coaching
- Personalized exercise therapy

For more information, call the number on the back of your member ID card.

Wondr Health

Ready to lose weight, gain energy, sleep better, and improve your mind and body? Wondr is here to help and is available at no cost to you!

Wondr is a skills-based digital weight loss program that teaches you how to enjoy the foods you love to improve your overall health. No points, plans, or counting calories!

To learn more and join the waitlist, visit: **wondrhealth.com/BCBSIL**

Questions? Visit **support.wondrhealth.com** or download that app in the App Store or on Google Play.

Livongo®

Livongo helps those recently diagnosed with high blood pressure, by offering a FREE blood pressure management program. The program includes an advanced blood glucose meter, a blood pressure monitor, and coaching. You will also receive:

- Unlimited strips & lancets
- Personalized tips with each check
- Support when you need it most
- Set reminders on when to check your blood pressure
- Easily share reading with your doctor

Get Started:

- **go.livongo.com/BCBSIL-HEALTH**
- Member Support Call Center: (800) 945-4355
- Registration code: BCBSIL-HEALTH

Mental Health

Do you suffer from depression, anxiety, substance use, or any other condition that makes you not feel yourself? Taking the first step isn't easy. But you don't have to take it alone. If you're facing a mental health issue, BCBSIL has experts who can help you learn about your condition and treatment options. Your personal health details won't be shared with your employer. BCBSIL can also help you find a provider and understand your mental health benefits.

Don't be afraid to reach out – call the Customer Service or behavioral health number on the back of your member ID card.

Staying Healthy

Access Your Maternity and Family Benefits—BCBSIL

Ovia Health provides maternity and family apps to support enrolled members through your entire parenthood journey. These apps are included in your health plan benefits, offered through Blue Cross and Blue Shield of Illinois (BCBSIL).

Follow These Easy Steps to Download Ovia and Launch Your Account:

01 Download the app that's right for you

- Ovia Fertility—Health & Fertility
- Ovia Pregnancy—Pregnancy & Postpartum
- Ovia Parenting—Family & Working Parents

02 When signing up, choose "I have Ovia Health as a benefit" before tapping "Sign up" and make sure to select BCBSIL as your health plan and enter your employer name (optional).

03 Already have an Ovia app on your phone?

- Open your app and tap "Health" to take the Ovia Health Assessment.
- Tap "Update my healthcare information" and select BCBSIL as your health plan and enter your employer name (optional).

If You Do Not Indicate BCBSIL As Your Health Plan, You'll Only Be Able To Access Some Of The Features Available To You:

- Health and menstrual cycle tracker
- Pregnancy calendar & daily baby updates
- Child's development checklist
- Daily health and wellness content
- Data & symptom feedback

With Ovia Health, You'll Have Access to Enhanced, Personalized Health and Wellness Features:

Health Assessment and Symptom Tracking

Receive alerts and predictive, personal coaching when Ovia detects a potential medical issue.

Over Fifty Physician-Developed Clinical Programs to Help You be as Healthy As Possible

Engage with personalized health and wellness programs to help you navigate infertility, sexual health, birth planning, preterm delivery, mental health, breastfeeding, and more.

Unlimited 1-on-1 Coaching

Message instantly with Registered Nurse health coaches to ask all your questions.

Career and Return-to-Work Programs

Find coaching and career advice for preparing for maternity leave, returning to work, and being a working parent.

Staying Healthy

You and your immediate family have access to Cancer Support, at no cost!

- Cancer Expert Now provides completely free, virtual access to the world's top cancer experts. You will speak over an audio or video call with an expert who specializes in your cancer type. During the call, you can ask questions and receive guidance on your treatment options, prognosis and/or diagnosis.
- Access to Cancer Expert Now is a benefit offered to you and your spouse/domestic partner, children, parents, and parents in-law. HALO pays the full cost of this confidential service, regardless of your enrollment.
- There is no limit to how much you or a family member can utilize the service.

  Together, we can make a difference; let's raise awareness, encourage early detection, and support those affected by cancer.

When you are speaking with the expert, you can ask anything. There is no question too big or small. Ask about...

- A screening
- A new or existing diagnosis
- A procedure or upcoming surgery
- A treatment plan
- Medications
- Survivor protocols
- A condition requiring a specialist

Monthly Webinar Series

Each month Cancer Expert Now hosts a 30-minute educational webinar with a leading oncologist. We cover topics like who is at risk for specific cancers, their signs, symptoms, treatment options and more.

These are LIVE and always include a live Q&A portion for attendees to ask their questions.

Want to be invited to all Cancer Expert Now Webinars? Share your contact information and you will automatically be invited to all upcoming webinars!

Opt-in using the QR code below!

HALO

Getting Started:

Step 1: Contact Cancer Experts Now (CEN)

Reach out to CEN using one of the three contact methods below. After contacting CEN, your care navigator will reach out and guide you through the next steps.

- **Call 1-855-946-5735**
- **Visit cancerexpertnow.com/access, using access code HALO.**
- **Email carenavigator@onviv.com**

Step 2: Connect with a Care Navigator

Your Care Navigator will provide a smooth and personalized experience by:

- Addressing all your questions or concerns about the process
- Helping upload your medical records to our secure,
- HIPAA-compliant portal
- Scheduling your 30-minute meeting with the expert

Step 3: Speak with the expert!

- When it is time for your meeting with the expert, your care navigator will send you a virtual meeting link. Simply click the link and then chat with the expert!
- After the meeting, you will receive a detailed summary of your conversation for your records. You may share this information at future visits with your treating physician(s).

Our Values Are In Our Name

Cancer
is complex and personal; we service our users with commitment, humility, and respect

Expert
knowledge deserves to be accessible to all people, we offer a direct line to a global network of experts

Now
is the time to share rapid, expert intelligence; we provide results that exceed expectations

Staying Healthy

Dental Plan Highlights

There are two dental plans available for you to choose from, the Low Plan and the High Plan. As a reminder, getting care from an in-network provider will be lower cost for you than if you were to visit an out-of-network provider. For more details, see the dental plan summaries.

Plan Design	High Plan	Low Plan
Individual Deductible	$50	$100
Family Deductible	$150	$300
Maximum	$1,250	$1,000
Preventive	100%	90%
Basic	80%	70%
Major	50%	50%
Orthodontia	50%	N/A
Orthodontia Eligibility	Children under 19	N/A
Orthodontia Lifetime Maximum	$2,000	N/A

Pay Less by Using an In-Network Provider

Click here to find an in-network provider near you.

You will receive in-network benefits from Delta Dental PPO and Delta Dental Premier network dentists. You will save the most money by using a Delta Dental PPO network. See how.

Dental Coverage Reminders

- Two routine dental cleanings per benefit year
- Annual maximum is the most your plan will pay towards your dental services in the calendar year
    - Applies to each covered person on the plan
- Orthodontia limit of $2,000 on the High Plan is a lifetime maximum
    - This is the most your plan will pay for orthodontia services per member per lifetime
    - Does not "reset" each year like your annual maximum

Dental Plan Contributions

Delta Dental IL Bi-Weekly Contributions		
Coverage Tier	**High Plan**	**Low Plan**
Single	$12.81	$10.62
EE + Spouse	$23.05	$19.12
EE + Child(ren)	$37.25	$26.22
Family	$50.05	$36.85

Staying Healthy

Vision Plan Highlights

Your vision coverage is offered through BCBSIL. BCBSIL provides you with affordable care options and gives you access to a range of discounts on glasses, frames, lenses, and laser vision correction. BCBSIL vision partners with EyeMed to provide you with an extensive network of optometrists, ophthalmologists and opticians in private practices and at optical retailers including Walmart, Bard Optical, All About Eyes, Target, LensCrafters, and more! For more details on your vision coverage and exclusive savings and promotions, visit **member.eyemedvisioncare.com/bcbsilhalo** or download the EyeMed Members Mobile App.

To locate an in-network provider, visit eyedoclocator. **eyemedvisioncare.com/bcbsilhalo/en**.



BCBSIL Vision Plan		
	In-Network	**Out-of-Network Reimbursement**
Frequency (Exams/Lens/Frames)	12/12/24	
Exam	$10 copay	Up to $45
Spectacle Lens		
• Single Vision	$25 copay	Up to $30
• Bifocal	$25 copay	Up to $50
• Trifocal	$25 copay	Up to $65
• Lenticular	$25 copay	Up to $100
Standard Progressive Lens	$25 copay	Up to $50
Allowance	$140 with 20% off for balances over $140	Up to $70
Elective Contact Lens—Fitting and Evaluation	$40 max copay	Up to $105
Elective Contact Lens	$140 allowance	

Visit **Glasses.com** to access a huge selection of frames and lenses with your benefits using 3-D virtual try-on technology!

Vision Plan Contributions

BCBSIL Vision—Bi-Weekly Contributions	
Single	$2.76
EE + 1	$4.35
EE + 2 or more	$7.80

For more details on your vision coverage and exclusive savings and promotions, visit member.eyemedvisioncare.com/bcbsilhalo or download the EyeMed Members Mobile App

03

Feeling Secure

HALO

Feeling Secure

Health Savings Account (HSA)

An HSA is an individually owned savings account that accompanies a qualified high deductible health. The funds may be used towards future eligible medical expenses or retirement. Your HSA funds may be rolled over from year to year. HSAs offer a triple tax advantage:

- Contributions are pre-tax or tax-deductible
- Earnings on the balance and investments are not taxed
- Funds withdrawn for qualified medical expenses are not taxed

The IRS has a limit on how much you can contribute to your HSA on an annual basis, these limits are outlined below. Employees age 55 and older may contribute an additional $1,000 annually in catch-up contributions. The maximum HSA contributions are:

- Single: $4,150
- Non-single: $8,300

You have the option to invest your HSA funds up to $2,000 annually. For more information, visit **www.healthequity.com**.





HALO contributes to your HSA, employees with single coverage receive $500/year and employees with all other coverage receive $1,000/year. The first contribution occurs in September, and the second in January. This is free money and the funds are yours to keep. To receive the contribution, you must be enrolled in the HSA benefit. You are not required to contribute any money to receive the election and can set a $0 amount.

*****You cannot contribute towards or receive HSA contributions if you are not enrolled in the High Deductible Health Plan.**

Feeling Secure



Flexible Spending Accounts (FSA)

A FSA allows you to contribute pre-tax funds from each paycheck to be used towards eligible healthcare and/or dependent care expenses. These are administered through WEX. You may also contribute to a commuter FSA, for eligible transit/parking expenses for your work commute.

IRS rules state you cannot contribute more than the following amounts:

- Healthcare FSA: $3,200 annually
- Limited Purpose FSA: $3,200 annually
- Dependent care FSA: $5,000 annually
- Commuter FSA: $315 monthly

Important: At the end of the year, remaining money up to $640 will be rolled over to the following year for you to continue using. If you have a balance above $640, that money will be forfeited, so choose your FSA election amount wisely.

Health Savings Account & Flexible Spending Account contribution limits are based on the calendar year.

Feeling Secure

Healthcare Flexible Spending Account

NOTE: You are not eligible to contribute to the medical FSA if you are enrolled in the medical HDHP with HSA plan.

The healthcare FSA can be utilized for any of the following types of expenses incurred by you and your family:

- Copays
- Coinsurance
- Some services not covered by medical or dental insurance, vision care, and prescription copays

Dependent Care FSA

The dependent care FSA allows you to use pre-tax funds towards eligible expenses such as:

- Daycare
- Preschool
- Babysitting
- Summer day camp
- Dependent adult daycare

The dependent care FSA should be used on expenses incurred to work, seek work, or attend school. Dependent must be under age 13 or incapable of self-care.

The dependent care FSA includes a grace period and run-out period, here's how they work:

- **Grace period**—This allows you to continue to incur claims through March 15th following the close of the plan year
- **Run-out period**—Claims for the prior year and incurred during the grace period can be filed through March 31st

Commuter FSA

Commuter FSAs pre-tax funds can be used towards expenses related to commuting to and from work for mass transit, vanpooling, and work-related parking costs.

This includes:

- Transit passes, tokens
- Fare cards, vouchers
- Parking passes

Reminder: Unused funds over $640 at the end of the calendar year will not be refunded. There are no exceptions to this; it is an IRS regulation.

Debit Card

All FSA benefits are administered by WEX. You will receive a debit card to use for eligible medical, dental, vision, and dependent care expenses.

For more information, contact WEX (formerly Discovery Benefits)!
866-451-3399
www.wex.com

Want the App? Search for Benefits by WEX in the App Store or on Google Play.

Feeling Secure

Life and AD&D Benefits

Our Life and AD&D insurance plans provide financial protection in the event of the death of a covered person or upon certain other losses suffered as the result of an accident.

Life and Disability Reminders

- If you are enrolled in medical, the company will provide your Basic Life and AD&D coverage
- If you are not enrolled in medical, you may elect the Basic Life and AD&D
- Coverage can be moved to an individual policy at separation from HALO.

Your Coverage

- Basic Life and AD&D coverage is two times your annual salary up to a maximum of $250K.
- Employees earning over $200k have a maximum benefit of two times your annual salary up to a maximum benefit of $500k
- Coverage amount is reduced by 50% at age 70

Plan Design Features	HALO
Benefit	2x annual salary
Maximum Benefit	Lesser of 2x annual salary or $250,000
Maximum Benefit (Employees Over $200k)	Lesser of 2x annual salary or $500,000



Feeling Secure

Supplemental Life

You have the option to purchase additional Life coverage for yourself, your spouse and your dependent children. Premiums for employee and spouse/partner vary based on your age and will increase according to the age ranges below and your age on September 1st of every calendar year.

- Employee coverage is available in $10,000 increments up to the lesser of $400,000 or 5x salary
- Employee benefits reduce by 50% at age 70
- Spouse/partner coverage is available in $5,000 increments up to $50,000
    - Spouse/partner coverage cannot exceed 50% of employee coverage
    - Spouse/partner supplemental life coverage terminates at age 70
    - Spouse/partner rates are based upon employee age
- Child coverage of $10,000 is available for dependent children over 6 months - the age of 19. If your child(ren) are Full-Time Student status, coverage is eligible through the age of 26.
- The guaranteed issue amounts are $200,000 for employee and $30,000 for spouse/partner
- You can elect up to the Guaranteed Issue Amount, during your New Hire Enrollment.
- If you do not make an election as a New Hire, you will be eligible to elect up to 2 increments of coverage at Open Enrollment, which is not subject to Underwriting Approval.
- Any increases that exceed 2 increments of coverage increase, or that increase beyond the Guaranteed Issue Amount, will be subject to Underwriting Approval.
- If you make an election that requires submission of Evidence of Insurability, it is your responsibility to partner with the Benefits Team the application.
- Coverage can be moved to an individual policy at separation from HALO.

Supplemental Life Contributions—Employee and Spouse

Bi-Weekly Contributions (based on units of $1,000)	
Under Age 29	$0.037
Age 30-34	$0.051
Age 35-39	$0.055
Age 40-44	$0.069
Age 45-49	$0.106
Age 50-54	$0.175
Age 55-59	$0.309
Age 60-64	$0.485
Age 65-69	$0.637
Age 70+	$1.431

To calculate bi-weekly cost—($ amount of requested additional insurance/$1,000) × rate (table above) = bi-weekly cost.

Dependent Child Life Insurance Contribution

Bi-Weekly Contributions
$0.0508 per $1,000

Feeling Secure

Short Term Disability

Short term disability (STD) replaces your weekly income while you are out of work following a non-work-related accident or illness.

- Benefits go into effect on the 8th day of a qualified disability
- Maximum of 13 weeks with doctor certification
- If you are enrolled in the medical plan, short term disability will be provided by the company
- If you are not enrolled in the medical plan and wish to be covered you may purchase disability insurance.

New York Life	
STD	**Benefits**
Benefit Percentage	66.67%
Weekly Benefit Maximum	$1,500
Benefits Begin	8th day accident 8th day sickness
Benefits Duration	13 weeks

Long Term Disability

Long term disability (LTD) protects your income by providing you with a percentage of your income while you are disabled. Benefits begin after 90 days of a qualified disability until age 65.

New York Life	
LTD	**Benefits**
Benefit Percentage	60%
Monthly Benefit Maximum	$10,000
MaximumMonthly Benefit (Employees Over $200k)	$15,000
Benefits Waiting Period	90 days



Feeling Secure

Voluntary Critical Illness, Hospital Indemnity, and Group Accident

If you're concerned about the financial impact large medical expenses can have on you and your family or they are diagnosed with a serious illness or sustain a serious injury resulting in a hospital visit, consider enrolling in critical illness, group hospital indemnity, or group accident insurance coverage through Cigna.

Critical illness, group hospital indemnity, and group accident coverages allow you to transition a policy to individual when separating from HALO.

In addition to the standard coverage, each policy offers a $50 Wellness Incentive Benefit. This is payable when you get applicable preventive care. Voluntary Procedures are not covered under this policy.

Voluntary Critical Illness

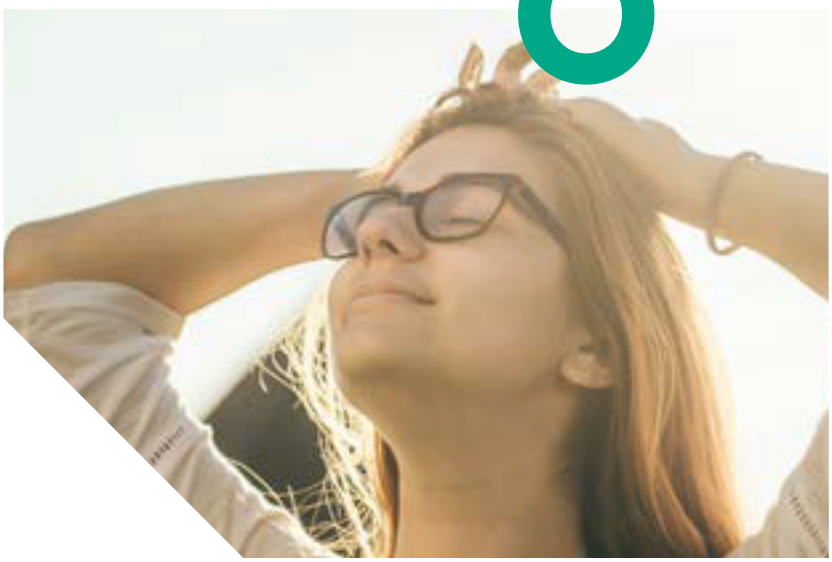
The critical illness group plan pays a lump-sum benefit if a covered person is diagnosed with a heart attack, stroke, cancer or many other conditions. It can help cover out-of-pocket medical expenses for treatments that aren't covered by your medical plan, such as deductibles and coinsurance.

You may choose group critical illness insurance as follows:

- Employee coverage can be elected in increments of $10,000 up to $30,000
- Spouse coverage can be elected in increments of $5,000 up to $15,000, election cannot exceed 50% of the employee coverage amount
- Child coverage can be elected in increments of $5,000 up to $15,000

Planning on growing your family?
The Hospital Indemnity benefit offers the following on a hospital delivery:

Admission: $1,000
Newborn Admission: $1,000
Hospital Stay: $200 daily benefit



Feeling Secure

Critical Illness Contributions

Age Band	$10,000	$20,000	$30,000
Employee (EE)—Bi-Weekly Contributions			
<25	$1.68	$3.35	$5.03
25 to 29	$1.91	$3.82	$5.73
30 to 34	$2.47	$4.94	$7.41
35 to 39	$3.38	$6.76	$10.14
40 to 44	$4.34	$8.69	$13.03
45 to 49	$6.08	$12.16	$18.24
50 to 54	$8.05	$16.11	$24.16
55 to 59	$10.83	$21.66	$32.48
60 to 64	$13.47	$26.94	$40.42
65 to 69	$16.80	$33.59	$50.39
70 to 74	$23.64	$47.29	$70.93
75 to 79	$34.50	$68.99	$103.49
80 to 84	$38.78	$77.56	$116.34
85+	$54.00	$108.01	$162.01

Age Band	$5,000	$10,000	$15,000
Spouse (SP)—Bi-Weekly Contributions			
<25	$0.75	$1.50	$2.25
25 to 29	$0.81	$1.62	$2.43
30 to 34	$1.03	$2.05	$3.08
35 to 39	$1.41	$2.81	$4.22
40 to 44	$1.77	$3.53	$5.30
45 to 49	$2.53	$5.07	$7.60
50 to 54	$3.80	$7.61	$11.41
55 to 59	$5.38	$10.75	$16.13
60 to 64	$6.85	$13.70	$20.55
65 to 69	$8.09	$16.18	$24.27
70 to 74	$11.02	$22.03	$33.05
75 to 79	$12.99	$25.98	$38.97
80 to 84	$17.70	$35.40	$53.10

Age Band	$5,000	$10,000	$15,000
Children (CH)			
	$1.26	$2.52	$3.79

Feeling Secure

Voluntary Hospital Indemnity

The hospital indemnity insurance program offered through Cigna is a supplemental insurance plan that offers a lump sum cash benefit to help cover out-of-pocket expenses due to hospitalization fees not covered by your insurance. Whether it is a covered hospital stay, intensive care stay or post-hospital skilled nursing facility care, you can use this payment to offset any related costs.

Hospital Indemnity Contributions

Bi-Weekly Contributions	
Single	$9.21
EE + Spouse	$18.37
EE + Child(ren)	$16.52
Family	$25.16

Voluntary Group Accident

The group accident insurance plan helps offset your out-of-pocket expenses in the event of an accident, such as copays, coinsurance, and other medical expenses. This plan covers accidents that occur off the job and includes a range of incidents from common injuries to more serious events.

Group Accident Contributions

Bi-Weekly Contributions	
Single	$5.58
EE + Spouse	$8.65
EE + Child(ren)	$10.97
Family	$14.04



Feeling Secure

401(k) Savings Plan



BOK Financial administers our 401(k) plan. This benefit allows you to save money for your retirement. Contributing is a convenient way to invest in your future by building a source of income for your retirement.

Eligibility

You must be 18 years of age and are eligible the first of the month following 30 days of employment to contribute to the 401(k).

Auto-Enrollment

An automatic deferral amount of 3% of your compensation will be withheld from each of your paychecks. The automatic deferral amount will be contributed as a pre-tax elective deferral to the plan.



Contributions

You can choose to contribute a percentage of your income (1%-100% in whole percentages only) or a specified dollar amount to the plan biweekly on either a pre-tax or an after-tax (Roth) basis. Contributions are deducted from each biweekly pay check. You are allowed to change, stop, or restart the amount of your contribution at the next reasonable pay period.

Company Match

The company may offer an annual match of 50% on the first $1,000 of your contributions (maximum match of $500 annually). The match is made in January for the previous year's contributions. You must work at least 1,000 hours and be employed on the last day of the calendar year to be eligible for the match.

Feeling Secure

Automatic Enrollment

The eligible automatic contribution arrangement (EACA) provisions apply to the Plan. This type of automatic enrollment allows the plan administrator to enroll employees in the Plan.

What happens when I become eligible for the Plan?

If you are eligible to make elective deferrals and meet the requirements below and you do not make a deferral election by your entry date, the plan administrator will begin deducting automatic deferrals from each of your paychecks and will submit those amounts to the Plan (automatic deferrals) on your behalf.

An automatic deferral amount of 3% of your compensation will be withheld from each of your paychecks. The automatic deferral amount will be contributed as a pre-tax elective deferral to the Plan.

If you do not wish to have automatic deferrals withheld from each of your paychecks or if you want to change the amount withheld, you must make a deferral election. If automatic deferrals have already started, you may make a deferral election to change the amount being withheld or to stop the deferrals entirely.

If automatic deferrals are withheld from my paycheck can I take that money out of the Plan right away?

Yes, you may request that your automatic deferrals and any earnings on those deferrals be distributed to you as long as you make the request in writing within 90 days of when the automatic deferrals were first withheld from your paycheck. Any matching contributions associated with the automatic deferrals that you take from the Plan by the deadline will be forfeited. After that deadline has passed you will only be able to take the automatic deferrals out of the Plan when elective deferrals can be distributed.

Do the Plan's automatic enrollment features apply to me if I have already made a deferral election?

No, if you have already made a deferral election that amount will continue to be withheld from each of your paychecks until you make a new election.

Feeling Secure

Elective Deferrals

Your elective deferrals are amounts that you chose to (or are assumed to have chosen to) have withheld from your paycheck and contributed to the Plan in your name. Please see the section of your SPD titled "Eligibility for Participation" to determine if you are eligible to make elective deferrals and "Contributions to the Plan" for the type of compensation you may defer into the Plan.

How do I make or change my deferral election?

You may make or change your deferral election by going to the following web site or calling the voice response unit at the following number: **www.startright.bokf.com** or calling **800.876.9557**.

Once I make a deferral election, how often can I change, stop, or re-start the election?

You may change or re-start your deferral election as of the next reasonable pay period. You may stop your deferrals at any time.

StartRight RetireRight

Download the Start Right Retire Right Mobile App to stay connected to your retirement plan account. The mobile app allows you to do everything that you can do from your online account.



Feeling Secure

Elective Deferrals

If I make a deferral election is the amount withheld from my paychecks taxed?

You will have the option to decide if the amount you elect to defer into the Plan is taxed or not. If you chose to have your elective deferrals go into the Plan as pre-tax elective deferrals, you will not be taxed until you take the money out of the Plan. If you chose to have your elective deferrals go into the Plan as Roth elective deferrals, you will be taxed on that money when it is taken out of your paycheck, but it will not be taxed again when you take it out of the Plan. The earnings on those Roth elective deferrals may be taken out tax-free if certain conditions are met. Please see the SPD for more information on Roth elective deferrals.

Are there any limits to how much I can defer into the Plan?

Your elective deferrals are subject to the following limits:

- Your total amount of deferrals cannot be more than $22.500
- If you are age 50 or over, you may defer an additional amount, called a "catchup contribution," of up to $7,500

  These amounts are subject to change, annually, and are based on contributions made January 1 to December 31 of a given year.

The plan administrator may establish additional rules you will need to follow when making your deferral election. Your deferral election is only effective for compensation you have not received yet. The plan administrator may also reduce or totally suspend your election if they determine that your election may cause the Plan to fail to satisfy any of the requirements of the Internal Revenue Code.

How will my account balances be invested if I do not make an investment election?

The Plan's default investments are intended to meet the requirements to be a Qualified Default Investment Alternative (QDIA). If you do not make an investment election your account balances will be placed in investments selected by the plan administrator. See the attached Qualified Default Investment Alternative information which provides information on the default fund you will be invested in if you fail to make an investment election.

HALO Employees have access to a Free Licensed Financial Advisor. Learn more by contacting **Benefits@halo.com**.

Feeling Secure

Work/Life Balance

Life can certainly have its share of challenges; don't let it get you down! Halo has partnered with New York Life to provide Employee Assistance to employees and their families. Below you will see the variety of services offered to help improve your overall wellbeing.

Life Assistance Program

You and your family members have access to various counseling services including legal, financial, and work-life balance assistance. Counseling calls are answered by a Master's or PhD-level counselor who will collect general information and discuss your needs. The program provides a maximum of three sessions per issue, per year.

Well-being Coaching

To help achieve health and wellness goals, you have access to five telephonic sessions per year with a certified coach. The certified coach can help with goals including stress and time management.

Contact information:

You may access services 24/7 via phone at **800.344.9752** or online at **guidanceresources.com (web ID: NYLGBS)**.

Achieve Work/Life Balance

For help handling life's challenges go online to guidanceresources.com for articles and tools on topics including wellness, legal regulations, family, care giving, pet care, career and education, money, home and auto.

Legal Consultation and Referrals*

Receive a free 30-minute consultation with a network attorney. And up to a 25% discount on select fees.

Financial Consultations

Receive a free 30-minute consultation and 25% discount on tax planning and preparation.



04

HALO Benefits Contact Information

HALO

HALO Benefits Contact Information

Medical

Blue Cross Blue Shield of Illinois
800.676.BLUE (2583)
bcbsil.com
HDHP Group #PM0023
PPO Group #PM0025

Pharmacy Benefits

CVS
844.256.4046
www.caremark.com

Virtual Primary Care

TeleDoc
800.835.2362
teladoc.com/bcbsil

MDLIVE Virtual Visits

888.676.4204
MDLIVE.com/bcbsil

Health Savings Account (HSA)

Health Equity
886.346.5800
www.healthequity.com

Flexible Spending Account (FSA)

Wex (formerly Discovery Benefits)
866.451.3399
www.wex.com

Dental

Delta Dental of Illinois
800.323.1743
www.deltadentalil.com
Group #20210

Vision

Blue Cross Blue Shield of Illinois
855.362.5539
member.eyemedvisioncare.com/bcbsilhalo
Group #281298

Life and Disability

New York Life (formerly Cigna)
800.362.4462
newyorklife.com/group-benefit-solutions
Group #s:
Basic Life: FLX966896
Basic AD&D: OK968384
STD:LK751865
LTD: LK964719

Life Assistance Program

New York Life
800.344.9752
guidanceresources.com
Web ID: NYLGBS

401(k)

BOK Financial
800.876.9557
startright.bokf.com

Voluntary Coverages

Cigna
800.351.9214
my.cigna.com
Accident: Group #AI961176P
Critical Illness: Group #CI96113P
Hospital Indemnity: Group #HC960527P

MyHealthyHALO Wellness Program

888.282.0822
http://www.myhealthyhalo.com

Cancer Navigation

Cancer Experts Now
855.946.5735
cancerexpertnow.com/access/

General Benefits Questions

Benefits@halo.com


HALO

Important Employee Notices

Federal regulations require that plan sponsors, such as HALO, provide various notices to their employees. In keeping with these requirements, we are providing the copies of the following Notices.

- General Notice of COBRA Continuation Rights
- HIPAA Special Enrollment Notice
- HIPAA Privacy Notice
- Medicare Part D Notice
- Medicaid and the Children's Health Insurance Program (CHIP) Notice
- Women's Health and Cancer Rights Notice
- Newborns' and Mothers' Health Protection Act of 1996
- Genetic Information Non-discrimination Act of 2008
- Uniform Service Employment & Reemployment Rights Act (USERRA)
- New Health Insurance Marketplace Coverage Options and Your Health Coverage
- Notice Regarding Wellness Program
- The Mental Health Parity and Addiction Equity Act of 2008

If you have any questions regarding any of these Notices, please contact the Human Resources Department at:

Contact--Position/Office:	Matt Barbian – Benefits Administrator/Sterling
Address:	1500 Halo Way, Sterling, IL 61081
Email Address:	**Benefits@halo.com**
Phone Number:	815.625.0980

General Notice of COBRA Continuation Rights

This Notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. Please read it carefully.

Introduction

You are receiving this Notice because you have recently become covered (or may soon become covered) under a group health plan (the "Plan"). This Notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 this coverage.
If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events happens:

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

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happen:

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 any of the following qualifying events happen:

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 (under Part A, Part B or both;
The parents become divorced or legally separated; or,
The child is no longer eligible for coverage under the Plan as a "dependent child".

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualified event has occurred. When the qualifying event is the end of employment or reduction of hours, disability, death of an employee or the employee's becoming entitled to Medicare benefits, the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events, such as divorce or legal separation or the dependent child losing eligibility under the Plan, you must notify the Plan Administrator within 60 days of the qualifying event occurring. You must provide this notice, along with any requested documentation to:

Contact--Position/Office:	Matt Barbian – Benefits Administrator/Sterling
Address:	1500 Halo Way, Sterling, IL 61081
Email Address:	**Benefits@halo.com**
Phone Number:	(815)625-0980

General Notice of COBRA Continuation Rights Continued

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualifying 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.

When the qualifying event is the death of the employee, the employee becoming entitled to Medicare benefits, divorce or legal separation, or a dependent child losing eligibility under the Plan, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction in the employee's hours of employment and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his or her employment terminates, COBRA continuation coverage for his spouse and dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event. Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and any family members covered under the Plan may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last until the end of the 18-month period of coverage. You must provide this notice of disability, along with any requested documentation to HALO

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

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, provided notice of the second qualifying event is

properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits, becomes divorced or legally separated or if the dependent child is no longer eligible as a dependent child under the Plan, but only if this second event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Questions

Questions concerning your Plan or your COBRA coverage continuation rights should be addressed to the Plan contact. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and any other laws or regulations affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at **www.dol.gov/ebsa.**

Keep the Plan Informed of Any Address Changes

In order to protect your rights and the rights of your family, you should keep the Plan Administrator informed of any changes in the addresses of covered family members. You should also keep a copy for your records of any notices you send to the Plan Administrator.

Health Insurance Portability and Accountability Act of 1996 - Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to maintain the privacy of your health information and to provide you with a notice of the plan's legal duties and privacy practices with respect to your health information. The notice describes how the plan may use or disclose your health information, under what circumstances it may share your health information without your authorization (generally to carry out treatment, payment, or health care operations), and your rights with respect to your health information.
As required by HIPAA, HALO maintains the confidentiality of your health information and has policies and procedures in place to help protect it from improper use and disclosure.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage

If you are declining 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 you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
Example: You waived coverage because you were covered under a plan offered by your spouse's employer. Your spouse terminates his/her employment. If you notify HALO within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under our health plan.

Marriage, Birth, or Adoption

If you have a new dependent as a result of a 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, or placement for adoption.
Example: When you were hired by us, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in

this group health plan. However, you must apply within 31 days from the date of your marriage.

Medicare Part D Notice of Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with HALO 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. HALO has determined that the prescription drug coverage offered by the HALO Health and Welfare Plan 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 HALO coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

If you do decide to join a Medicare drug plan and drop your current HALO coverage, be aware that you and your dependents will not be able to get this coverage back (except during certain open enrollment periods).

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

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every

month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. Note that you will receive 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 HALO 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).

Contact--Position/Office:	Matt Barbian – Benefits Administrator/Sterling
Address:	1500 Halo Way, Sterling, IL 61081
Email Address:	**Benefits@halo.com**
Phone Number:	(815)625-0980

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 January 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)	Website: Health Insurance Premium Payment (HIPP) Program 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
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: 1-800-766-9012
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	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: (617) 886-8102

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
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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ 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 http://www.oregonhealthcare.gov/index-es.html 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: http://gethipptexas.com/ 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://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING - Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 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

Paperwork Reduction Act Statement

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

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

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under this Act. 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.

Newborns' and Mothers' Health Protection Act of 1996

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above. A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery. In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

Genetic Information Non-Discrimination Act of 2008 (GINA)

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family members of the individual, except as specifically allowed by this law. To comply with this law, HALO will generally never require a benefits participant to provide any genetic information when responding to any request for medical information in connection with enrollment in any HALO benefits plan or accessing any of your HALO plan benefits. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic test, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. For more information about GINA, visit www.dol.gov/ebsa/faqs/faq-GINA.html

Uniformed Services Employment & Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) was enacted in 1994 following U.S. military action in the Persian Gulf. USERRA prohibits discrimination against individuals on the basis of membership in the uniformed services with regard to any aspect of employment. Since its enactment, USERRA has been modified and expanded by additional federal laws, such as the Veterans Benefits Improvement Act of 2008.

Maintenance of Benefits During Leave

A person who is reemployed upon returning from completion of uniformed service is entitled to the rights and benefits that he or she would have attained if he or she had remained continuously employed.

Health Benefits

An employer must allow individuals absent due to uniformed services to elect to continue health insurance coverage for themselves and their dependents. Health insurance coverage must be continued until the earlier of:

- 24 months beginning on the date when the absence began; or
- The day after the date the employee fails to apply for return to work following completion of their service.

Individuals who are absent from work for less than 31 days may not be required to pay more for coverage than the employee share charged to employees that are actively at work. Employers may charge all other individuals no more than 102 percent of the full premium under the plan.

If benefits are cancelled because the employee did not elect to continue coverage or failed to pay premiums, the employer must restore to the employee benefits equivalent to those the employee would have had if leave had not been taken, including family or dependent coverage. The employee cannot be required to serve a new pre-existing condition waiting period, wait for open enrollment or pass a medical examination to obtain reinstatement of coverage.

Exchange Notice

Beginning in 2014, there is 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.

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.

The 2025 open enrollment period for health insurance coverage through the Marketplace begins on Nov. 1, 2024 and will end on Dec. 15, 2024. Individuals must have enrolled or changed plans prior to Dec. 15, 2024, for coverage starting as early as Jan. 1, 2025. After Dec. 15, 2024, you can get coverage through the Marketplace for 2025 if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

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 8.39% of your household income for the year(9.12% for 2023), 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. (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.)

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 or contact your HR department.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

The Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans to apply the same treatment limits on mental health or substance-related disorder benefits as they do for medical and surgical benefits. The MHPAEA also extends this parity requirement to inpatient and outpatient services, whether in-network or out-of-network, and to emergency care services and prescription drugs. MHPAEA revised the definition of "mental health benefits" to include substance use disorder benefits. The MHPAEA also requires group health plans to apply the same beneficiary financial requirements to mental health or substance use disorder benefits as they apply for medical and surgical benefits, including limits on deductibles, co-payments and out-of-pocket expenses. Plan administrators are also required to make the criteria for "medical necessity" determinations with respect to mental health and substance use disorder benefits available to plan participants, beneficiaries or providers upon request.

NOTICE REGARDING WELLNESS PROGRAM

HALO wellness program is a voluntary wellness program. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary personal health assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which will include a blood test which can provide information on conditions like hyperlipidemia, diabetes, and others. You are not required to complete the health assessment or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program may receive an incentive from HALO. Although you are not required to complete the health assessment or participate in the biometric screening, only employees who do so will receive an incentive. Additional incentives may also be available throughout the year.

If you are unable to participate in any of the health-related activities required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting HALO Human Resources.

The information from your health assessment and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as condition management programs. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and HALO may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to HALO, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) health coaches or others directly involved in the wellness program in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.
If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact HALO Human Resources.