2026

BENEFITS ENROLLMENT GUIDE

Xclusive Services

Internal Team Members

XCLUSIVE SERVICES

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If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 28-29 where Notice of Creditable Coverage begin for more details. For additional Medicare education, refer to the Contacts page for more resources.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice.

Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

TERMS TO KNOW

In-Network and Out-of-Network	The facilities, providers and suppliers your insurer or plan is contracted with to provide services. Using out-of-network providers may lead to higher costs and increased out-of-pocket expenses.
Qualified Life Event	A major life change that allows you to make changes to your health plan. Some major changes include marriage, divorce, the birth of a child, loss of a job, or dependent child turns 26. Qualifying life events MUST be completed within 30 days of the event.
Coinsurance	The percentage of costs of a covered health care service you pay after you've paid your deductible.
Deductible	An amount you must pay out of pocket for your healthcare before your insurance company begins to kick in for certain covered healthcare services.
Copays	A fixed amount you pay to see your doctor or specialist when you are rendered a service.
Insurance Premium	The amount you are deducted from your paycheck every pay period for your health and welfare benefits.
Prescription Tiers	The different cost levels you pay for a medication. Each tier is assigned a cost. This is how much you will pay when you fill a prescription, if applicable.
Out Of Pocket Maximum	The most you will pay for covered services in a plan year. After you spend this amount, your health plan pays 100% of the costs of covered benefits.
Preferred Provider	A provider who has a contract with your insurer or plan to provide services to you at a discount.

BENEFITS OVERVIEW

Xclusive Services is proud to offer a comprehensive benefits package to eligible, full-time Team Members who work 30 hours per week and have completed their eligibility requirement. The complete benefits package is briefly summarized in this booklet. You will receive plan booklets, which give you more detailed information about each of these programs.

Eligibility

You and your dependents are eligible for Xclusive Services benefits on the first of the month following the date of full-time employment start, so long as you are a full-time Team Member working 30 hours per week.

Eligible dependents are your legal spouse, children under age 26 and disabled dependents of any age.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days.

Enroll

New Team Members can enroll as early as the first day of active employment. Elected benefits are effective the 1st day of the month following your full time start date.

All elections and changes can be completed electronically, and more information can be found by contacting your Human Resources department

Qualifying Events

- Marriage, divorce, legal separation or annulment
- Loss of coverage
- Birth, adoption or placement for adoption of an eligible child
- Death of your spouse or child
- Change in residence that affects your eligibility for coverage (i.e. moving out of a medical plan’s network area)
- FMLA Leave, COBRA event, Court Judgment or Decree
- Becoming eligible for Medicare or Medicaid

You have 30 days from the date of a Qualified Status Change to submit a change request to Human Resources. Changes will be effective on the day of the event. If you do not make your changes during the 30-day status change period, your changes cannot be made until the next open enrollment period. Your benefit election changes must be consistent with your change in status event.

MEDICAL BENEFITS

curative

Administered by Curative

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Curative.

	PPO Plan		
	With Baseline Completion	Without Baseline Completion	Out-of-Network
Calendar Year Deductible	$0 / $0	$5,000 / $10,000	$10,000 / $20,000
Annual Out-of-Pocket Maximum (includes deductible)	$0 / $0	$7,500 / $15,000	$15,000 / $30,000
Coinsurance	0%	20%	50%
Doctor's Office			
Primary Care Office Visit	$0	$25 copay per visit	CYD/50%
Specialist	$0	$50 copay per visit	CYD/50%
Urgent Care	$0	CYD/20%	CYD5/0%
Preventative Services (routine exams, immuniza- tions, well baby care and mammograms)	Covered at 100%	Covered at 100%	CYD/50%
Prescription Drugs			
RX Out-of-Pocket Maximum	$7,500 / $15,000	N/A	N/A
Retail—Generic Drug	$0	$50 copay per prescription	CYD/40%
Retail—Preferred brand	$250 copay per prescription	$50 copay per prescription	CYD/40%
Retail—Non-formulary Drug	$50 copay per prescription	$100 copay per prescription	CYD/40%
Retail—Specialty drugs (Non-Preferred)	$250 copay per prescription	CYD/25%	CYD/40%
Mail Order Available (90-day supply)			
Hospital Services			
Emergency Room	$0	CYD/20%	CYD/20% $0 copay with Base completion
Inpatient	$0	CYD/20%	CYD5/0%
Outpatient Surgery	$0	CYD/20%	CYD/50%

MEDICAL BENEFITS

Administered by Curative

Curative is transforming healthcare with a groundbreaking approach that eliminates financial barriers and simplifies access to care. With $0 out-of-pocket costs, Aetna's Health First nationwide provider network, and comprehensive coverage, Curative ensures you get the care you need, when you need it—without the hassle.

When you complete your baseline visit within the first 120 days, you'll unlock the full benefits of Curative's innovative health plan, including:

- **$0 Out-of-Pocket Costs:** Say goodbye to copays and deductibles—enjoy healthcare with just one competitive monthly premium.
- **Nationwide Network Access:** Gain access to a wide range of providers across the country, ensuring care wherever you are.
- **Comprehensive Coverage**: From routine check-ups to specialized treatments, Curative has you covered for all your healthcare needs.
- **Mental Health Support:** Access therapy and psychiatry services with $0 out-of-pocket costs, supporting your emotional and mental wellbeing.
- **Innovative Solutions:** Experience simplified, transparent healthcare designed to meet your needs and eliminate complexity.

So, what exactly is a Baseline Visit?

A Baseline Visit is your starting point to unlock Curative benefits.
It helps you maximize your health plan and keep **$0 costs for covered care and prescriptions**. Complete it within **120 days of your plan start**. After receiving your welcome email, register and schedule your visit in the Member Portal at **health.curative.com**.

Pharmacy Benefits:

Curative covers drugs based on clinical guidelines, safety, effectiveness, and cost efficiency. Covered medication are listed in the formulary, which is regularly updated.

Questions? Call 855-4-CURATIVE (855-428-7284) or scan the QR to learn more on the FAQ page!

EMPLOYEE CONTRIBUTIONS

MEDICAL

Medical Plan Rates – PPO Plan	
Weekly Rates (52)	
Employee Only	$30.45
Employee & Spouse	$118.25
Employee & Children	$94.60
Family	$141.90

curative

DENTAL BENEFITS

Dental Insurance

Administered by Reliance Matrix

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Reliance Matrix Life Insurance Company dental benefit plan. Reliance Matrix uses Ameritas Dental Network.

	Low Plan	High Plan
Services	**In-Network and Out-of-Network**	
Annual Deductible	$100 per person $300 family limit	$50 per person $150 family limit
Calendar Year Maximum	$750 per person	$1,000 per person
Preventive Dental Services (Routine Exam, Bitewing X-rays, Full Mouth/Panoramic X- rays, Periapical X-rays, Cleaning, Fluoride for Children 13 and under, Sealants)	100%	100%
Basic Dental Services (Space Maintainers, Fillings for Cavities, Restorative Composites, (anterior and posterior teeth), Simple Extractions, Anesthesia)	80% after deductible	80% after deductible
Major Dental Services (Onlays, Crowns, Crown Repair, Endodontics (nonsurgical), Endodontics (surgical), Periodontics (nonsurgical), Perio-dontics (surgical), Denture Repair, Prosthodontics (fixed bridge; removable complete/partial dentures), Complex Extractions)	50% after deductible	50% after deductible
Orthodontia (Coverage up to 18)	50% up to $750 Lifetime Maximum	50% up to $1,000 Lifetime Maximum
Out-of-Network Reimbursement	MAC	90th U&C

Ameritas

Scan here to Find a Dentist

EMPLOYEE CONTRIBUTIONS

Administered by Reliance Matrix

DENTAL

Dental – Low Plan	
Weekly Rates (52)	
Employee Only	$3.63
Employee & Spouse	$7.08
Employee & Children	$9.69
Family	$13.13

Dental – High Plan	
Weekly Rates (52)	
Employee Only	$5.89
Employee & Spouse	$11.57
Employee & Children	$16.34
Family	$22.02

VISION BENEFITS

Vision Insurance

Administered by Reliance Matrix (VSP Choice Network + Affiliates)

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

Service	In-Network	Out-of-Network
Eye Exam — once every 12 months	$10 copay	Up to $45
Lenses — once every 12 months		
Single Vision Lenses	$25 copay (Deductible applies to a complete pair of glasses or to frames, whichever is selected)	Up to $30
Lined Bifocal Lenses		Up to $50
Lined Trifocal Lenses		Up to $65
Lenticular Lenses		Up to $100
Frames — once every 12 months	$130 allowance (The Costco and Walmart allowance will be the wholesale equivalent)	Up to $70
Contact Lenses — once every 12 months		
Fit & Follow Up Exams	Member cost $60 allowance	No benefit
Medically Necessary	Covered in full	Up to $210
Elective	$130 allowance	Up to $105

No need for an ID card. To take advantage of your Reliance Matrix vision benefit, simply contact a VSP provider and let them know you have VSP coverage—they handle the paperwork for you.

There are four ways to find an in-network doctor:

- Visit www.vsp.com and select the VSP Choice Network + Affiliates Network
- Scan the QR code in this page
- Call VSP at 800.877.7195
- Download our mobile app, benefit tools and search for a doctor near you

EMPLOYEE CONTRIBUTIONS

Vision Rates

Administered by Reliance Matrix (VSP Choice Network + Affiliates)

VISION

Vision Plan	
Weekly Rates (52)	
Employee Only	$2.20
Employee & Spouse	$4.27
Employee & Children	$3.74
Family	$5.82

LIFE INSURANCE

Administered by Reliance Matrix

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Xclusive Services. The company provides basic life insurance of $50,000 at no cost to you as a Full-Time Team Member of Xclusive Services.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Xclusive Services provides AD&D coverage of $50,000 at no cost to you. This coverage is in addition to your company-paid life insurance described above as a Full-Time Team Member of Xclusive Services.

Voluntary Life Insurance

Insured by Reliance Matrix

You may also purchase life insurance for your dependents if you purchase coverage for yourself.

Annual Enrollment— Current Team Members enrolled with Voluntary Life can purchase one increment of $10,000, not to exceed the Guarantee Issue (GI) amount.

Any elected amount over the GI amount or over the allowed one-increment increase will require the completion of an Evidence of Insurability (EOI) form and will be subject to medical underwriting approval. A current Team Member enrolling in Life Insurance for the first time will need to complete an EOI form for any elected amount. Payroll deductions will not be applied until the additional amount is approved by the carrier.

Employee—$10,000 to $100,000—in increments of $10,000.
Benefit reduces to 65% at age 65, 40% at age 70, 20% at age 75 and terminates at retirement.
Spouse—$5,000 to $50,000—in increments of $5,000, Not to exceed 100% of employee amount.
Children— All Child amounts are guaranteed issue.

Employee

Age	Weekly Rates (per $1,000 of coverage)
18-24	$0.024
25-29	$0.033
30-34	$0.042
35-39	$0.042
40-44	$0.059
45-49	$0.094
50-54	$0.163
55-59	$0.293
60-64	$0.432
65-69	$0.726
70+	$1.082

Spouse

Age	Weekly Rates (per $1,000 of coverage)
18-24	$0.024
25-29	$0.033
30-34	$0.042
35-39	$0.042
40-44	$0.059
45-49	$0.094
50-54	$0.163
55-59	$0.293
60-64	$0.432
65-69	$0.726
70+	$1.082

Child

Weekly Rates (per $1,000 of coverage)
$0.053

LIFE INSURANCE

Administered by Reliance Matrix

Voluntary Accidental Death & Dismemberment Insurance

Insured by Reliance Matrix

This insurance can be added on Voluntary AD&D insurance and provides coverage in the event of accidental death or serious injury resulting in dismemberment. Unlike traditional Life Insurance, AD&D specifically covers accidents rather than natural causes of death. It typically pays out a lump sum benefit to the policyholder or their beneficiaries in the event of a covered accident.

Employee—$10,000 to $100,000—in increments of $10,000, Not to exceed 5 times annual salary.
Spouse— $5,000 to $50,000—in increments of $5,000, Not to exceed 50% of the employee's covered amount.
Children— $1,000, $5,000, or $10,000, not to exceed employee amount.

Employee

Age	Weekly Rates (per $1,000 of coverage)
18-24	$0.024
25-29	$0.033
30-34	$0.042
35-39	$0.042
40-44	$0.059
45-49	$0.094
50-54	$0.163
55-59	$0.293
60-64	$0.432
65-69	$0.726
70+	$1.082

Spouse

Age	Weekly Rates (per $1,000 of coverage)
18-24	$0.024
25-29	$0.033
30-34	$0.042
35-39	$0.042
40-44	$0.059
45-49	$0.094
50-54	$0.163
55-59	$0.293
60-64	$0.432
65-69	$0.726
70+	$1.082

Child

Weekly Rates (per $1,000 of coverage)
$0.053

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SHORT TERM DISABILITY (STD)

Administered by Reliance Matrix

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Disability insurance provides protection for your most valuable asset....your ability to earn an income. For details and enrollment options, visit: https://www.reliancematrix.com.

Short-Term Disability (STD) insurance provides income if you become disabled due to an injury or illness that is not work related.

Benefit Amount: 60% of weekly base earnings to a weekly max of $1,000

Elimination Period: Benefits begin the day following the 14th consecutive calendar day of disability for Accident/Injury and Sickness.

Benefit Duration: 13 weeks

Pre-existing condition: 3 month look back / 12 month exclusion.

Important! You will not be eligible for STD benefits if you are receiving workers' comp benefits.

SHORT TERM DISABILITY

Age	Weekly Rates (per $100 of coverage)
18-24	$0.167
25-29	$0.191
30-34	$0.198
35-39	$0.174
40-44	$0.147
45-49	$0.158
50-54	$0.167
55-59	$0.195
60-64	$0.205
65-69	$0.225
70+	$0.276

Do I need to answer any health questions to enroll?

If you contribute to the cost of your insurance, you may need to complete health questions if you don't elect coverage when it's first available to you and you want to elect later, or if you want to increase coverage. To answer health questions, please fill out our Evidence of Insurability (EOI) Application. Health questions must be approved by Reliance Matrix before coverage takes effect. Please see your Certificate for details.

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LONG TERM DISABILITY (LTD)

Administered by Reliance Matrix

Long Term Disability (LTD) insurance provides income if you become disabled due to an injury or illness that is not work related.

Benefit Amount: 60% of monthly base earnings to a monthly max of $5,000

Elimination Period: Benefits begin the day following the 90th consecutive calendar day of disability

Benefit Duration: Longer of Social Security Normal Retirement Age or duration schedule below*

Pre-existing condition: 3 month look back / 12 month exclusion.

*Longer of Social Security Normal Retirement Age or duration schedule below	
Age on Date of Disability	Benefit Duration (years)
61 or less	To age 65
62	3½
63	3
64	2½
65	2
66	1¾
67	1 ½
68	1¼
69 or more	1

LONG TERM DISABILITY

Age	Weekly Rates (per $100 of coverage)
18-24	$0.012
25-29	$0.020
30-34	$0.035
35-39	$0.057
40-44	$0.092
45-49	$0.128
50-54	$0.180
55-59	$0.198
60-64	$0.180
65-69	$0.121
70+	$0.088

Do I need to answer any health questions to enroll?

If you contribute to the cost of your insurance, you may need to complete health questions if you don't elect coverage when it's first available to you and you want to elect later, or if you want to increase coverage. To answer health questions, please fill out our Evidence of Insurability (EOI) Application. Health questions must be approved by Reliance Matrix before coverage takes effect. Please see your Certificate for details.

VOLUNTARY BENEFITS

Administered by Reliance Matrix

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Accident

The Accident plan provides cash payments directly to you to help cover out-of-pocket costs, such as deductibles or coinsurance. The full schedule of benefits payable for accidental injuries include initial/follow-up treatment, ambulance trips, medical imaging, surgeries, concussion, dislocations and fractures, hospital stays, AD&D, and health screening benefits. It is important to note this benefit is for off the job accidents only. Some benefits are payable once per covered accident, while others are once per plan year.

Reimbursable Benefits	Urgent Care, ER Visit, ICU, Ambulance Transport, X Rays, Casts, Physical Therapy
Common Accident Causes	Organized Sports, Vehicular Accidents, Everyday Hazards
Reimbursement Ranges	$75 - $4,000+ for various common injuries

Critical Illness

Critical illness insurance provides a lump-sum payment for an insured person diagnosed with any of the following critical illnesses while insurance is in effect for the insured person, after any applicable waiting period and subject to any pre-existing condition limitation: Cancer, Heart Attack, Stroke, Organ Transplant, Kidney Failure, and more.

Covered Illnesses	Invasive Cancer, Heart Attack, Stroke, Kidney Failure
Benefit	$10,000, $20,000, or $30,000
Dependents Covered	Employee, with options for Spouse and Child amounts

Hospital Indemnity

Hospital indemnity coverage eases the financial impact of a Team Member's hospitalization by providing a lump sum payment to help cover the costs associated with a hospital stay. Hospital indemnity coverage can be used to supplement medical insurance to help handle additional out-of-pocket costs that add up after a hospital stay. This can include copayments, coinsurance, deductibles, and incidental hospital expenses or other expenses such as transportation and lodging needs.

Hospital Admission Benefit	$1,000 per admission
ICU Admission Benefit	$2,000 per admission
Hospital Confinement Benefit	$200 per day
ICU Confinement Benefit	$400 per day

EMPLOYEE CONTRIBUTIONS

ACCIDENT COVERAGE PLAN

Coverage	Weekly Rates
Employee	$2.41
Employee + Spouse	$3.73
Employee + Child(ren)	$4.59
Employee + Family	$6.02

CRITICAL ILLNESS PLAN

Age	Weekly Rates (per $1,000 of coverage)
0-29	$0.08
30-34	$0.12
35-39	$0.15
40-44	$0.21
45-49	$0.33
50-54	$0.47
55-59	$0.66
60-64	$0.97
65-69	$1.46
70-74	$2.38
75-79	$3.97
80-84	$5.46
85+	$8.83

HOSPITAL INDEMNITY PLAN

Coverage	Weekly rates
Employee	$4.11
Employee + Spouse	$7.91
Employee + Child(ren)	$5.93
Employee + Family	$9.62

LEGAL SERVICES

Administered by LegalEASE

What is LegalEASE?
LegalEASE is a legal benefit plan that gives affordable and convenient access to legal services. It offers members a structured way to handle personal legal matters without the stress of finding and paying for an attorney on their own.

What you get with a LegalEASE benefits plan:
- An attorney with expertise specific to your personal legal matter
- Access to a national network of attorneys with exceptional experience that are matched to meet your needs
- In and out-of-network coverage
- Concierge help navigating common individual or family legal issues

As a member, you have access to a national network of over 21,500 attorneys who are matched to your specific legal needs. Being a LegalEASE benefits member also saves you time and costly legal fees. But most importantly, it gives you confidence and provides coverage* for:
- Home and consumer (Buying, selling, foreclosure and tenant disputes)
- Financial (Debt collection, collections, contracts)
- Auto and traffic (Traffic matters and license suspensions)
- Family (Adoption, name change)
- Estate planning and wills (Will, living will, health care power of attorney)

To learn more about your legal benefits plan, visit https://www.legaleaseplan.com/lped or call 1(800) 248-9000.

LegalEase	
Weekly Rates (52)	
Individual Plan	$4.96

IDENTITY THEFT PROTECTION

Administered by IDShield

IDShield helps you protect your identity and reputation, offering full-service restoration and dedicated professionals to assist in the event of identity theft

With IDShield you will receive:

- $5 Million Identity Fraud Protection Plan
- Online Privacy and Reputation Management
- Device Protection
- Financial Account Monitoring
- Identity, Credit and Social Media Monitoring
- Credit Score Tracker
- Real-Time Alerts

In the event of identity theft, a dedicated licensed private investigator will restore your identity back to its pre-theft status – guaranteed.

This benefit can cover you and members of your household. For more information visit www.shieldbenefits.com/xclusive

Individual Plan	Family Plan
The participant only	The participant
	The participant's spouse
	Parents/in-laws/stepparents
	Dependent children under age 18
	Adult children over age 26 who live in the primary participant's household, as well as dependents over age 26 who are mentally and/or physically incapacitated
	Dependent children 18-26 are also covered for consultation and restoration

IDSheild	
Weekly Rates (52)	
Individual Plan	$1.87
Family Plan	$3.52

PET INSURANCE

Administered by Nationwide

Nationwide® Pet Insurance
Protect your pets with My Pet Protection Choice℠ – available only through workplace benefit programs. Nationwide offers two ready-made employee plans plus the ability to customize coverage for individual pets and their specific care needs.

Pet Protection When It Matters Most
Plans cover:
- Accidents and injuries
- Common and serious illnesses
- Chronic conditions
- Hereditary issues
- Testing, diagnostics, and procedures
- Holistic and alternative care
- Emergency care and specialists
- No networks, no pre-approval

Coverage Options
- Accident Coverage – Support for unexpected injuries
  Illness Coverage – Support when pets get sick
  Wellness Coverage – Support for proactive care

Easy to Use
1. Visit any vet, anywhere
2. Submit claims from any device
3. Get reimbursed for eligible expenses once the deductible is met

Learn more today by going to **www.PetsNationwide.com.**

Feature	Accident & Illness	Accident, Illness & Wellness	Customizable
Deductible	$250	250	$100–$500
Reimbursement	80%	80%	50%, 70%, or 80%
Accident Coverage	Yes	Yes	Yes
Illness Coverage	Yes	Yes	Optional
Wellness Coverage	No	$450	$450 or $800

Enroll today!

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Administered by AllOne Health

An Employee Assistance Program (EAP) offers confidential support and resources to help employees navigate personal and professional challenges, including mental health, financial concerns, and work-life balance. This program is designed to enhance overall wellbeing by providing access to counseling services, expert advice, and practical tools tailored to individual needs.

Full-Time employees of Xclusive Services have access to the AllOne Health EAP at no cost for all full-time employee.

Program Access and Technology

- 24/7/365 Access by Text, Email, Mobile App, Online, and Always Live Answer Phone
- HIPAA-compliant Video Chat Sessions
- Member Portal and App
- EAP Landing Page

Clinical Assessment and Mental Health Sessions

- Telephonic Sessions for Assessment, Referral, and Short-Term Problem Resolution
- Face-to-Face Sessions for Assessment, Referral and Short-Term Problem Resolution
- Global Provider Network of 55,000+ Licensed Clinicians
- 24/7 Access to Clinicians for Urgent Mental Health Issues

Legal and Financial Consultation

- Telephonic Legal Consultation for Unlimited Number of Issues per Year. Includes One 30-minute In-Office of Telephonic Consultation with Local Attorney and 25% Discount for Continued Services
- Telephonic Financial Consultation for Unlimited Number of Issues per Year
- Identity Theft Prevention/Recovery. Includes 30-Minute Consultation
- AllOne Health's Member Portal Has Interactive Legal Document Preparation Including Will Prep and Other Common Legal Documents

Work-Life Referrals and Resources

- Unlimited Child, Elder, and Pet Care Referrals
- Unlimited Personal Services and Community-Based Resources Referrals
- Online Access to Library of Work-Life Topics and Resources

Contact AllOne Health: Call 855-RSL-HELP (855-775-4357) or Visit allonehealth.com/reliance-matrix. Code: RSLI859

GreatWorkPerks

EMPLOYEE DISCOUNTS

Administered by Great Work Perks

Discover a world of exclusive savings and perks designed to help you enjoy more—at work, at home, and everywhere in between.

Amazing discount access to places like:
•Theme Parks: Disneyland, Universal Studios, LEGOLAND, Six Flags, SeaWorld, and more
•Movie Tickets: AMC, Regal, Cinemark, and others
•Hotels & Travel: Hilton, Marriott, Hyatt, Disney Cruise Line, CityPASS, and more
•Car Rentals: Avis, Budget, Alamo, National
•Shopping & Dining: KFC, Subway, IHOP, Firestone, Claire's, Chuck E. Cheese, and hundreds more
•Gym Memberships: Access 12,000+ gyms nationwide, including LA Fitness, Crunch, YMCA, and more—just $28/month
•Exclusive Local Discounts: Over 500,000 offers nationwide, tailored by zip code
•Refundable Tickets: Only Great Work Perks offers refundable ticket options

•**FREE to you as an Xclusive Service employee.**
•No long-term commitments
•Ability to extend gym and fitness program benefits to your spouse
•Receive FREE one-on-one, goal-oriented well-being coaching in areas such as fitness, nutrition, stress management, and sleep

More information to come!

CONTACT INFORMATION

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Phone	Website/Email
Curative PPO	Curative	855.428.7284	https://health.curative.com/
Dental	Reliance Matrix	800.351.7500	https://dentalnetworkpartners.ameritas.com/
Low Plan	Reliance Matrix	800.351.7500	https://secure.rsli.com/userservices/
High Plan	Reliance Matrix	800.351.7500	https://secure.rsli.com/userservices/
Vision	Reliance Matrix	800.351.7500	www.vsp.com
Basic Life AD&D	Reliance Matrix	800.351.7500	https://secure.rsli.com/userservices/
Voluntary Life and AD&D	Reliance Matrix	800.351.7500	https://secure.rsli.com/userservices/
Short Term Disability	Reliance Matrix	800.351.7500	https://secure.rsli.com/userservices/
Voluntary Benefits	Reliance Matrix	800.351.7500	https://secure.rsli.com/userservices/
Identity Theft	IDShield	888.494.8519	www.shieldbenefits.com/xclusive
Employee Assistance Program	AllOne Health	855.775.4357	allonehealth.com/reliance-matrix Code: RSLI859
Legal Benefits	LegalEASE	866.458.7149	https://www.legaleaseplan.com/lped
Pet Insurance	Nationwide	877.738.7874	https://partnersolutions.nationwide.com/pet/xclusivestaffing

Administrator	Phone	Email
Xclusive Services Human Resources	303.430.1700 x200	benefits@xclusiveservices.com

LEGAL NOTICES

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: PPO Plan

With Baseline completion (Individual: 0% coinsurance and $0 deductible; Family: 0% coinsurance and $0 deductible)

Without Baseline completion (Individual: 20% coinsurance and $5,000 deductible; Family: 20% coinsurance and $10,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 303-430-1700 x200 or benefits@xclusiveservices.com

Newborns' and Mothers' Health Protection Act

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

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, 2025. 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	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://kynect.ky.gov 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: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Xclusive Services is committed to the privacy of your health information. The administrators of the Xclusive Services Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Xclusive Services Human Resources at 303-430-1700 x200 or benefits@xclusiveservices.com

HIPAA Special Enrollment Rights

Xclusive Services Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Xclusive Services Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Xclusive Services Human Resources at 303-430-1700 x200 or benefits@xclusiveservices.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

Notice of Creditable Coverage

Important Notice from Xclusive Services

About Your Prescription Drug Coverage and Medicare

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. **Xclusive Services has determined that the prescription drug coverage offered by the medical 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 Xclusive Services coverage may be affected. If you do decide to join a Medicare drug plan and drop your current Xclusive Services coverage, be aware that you and your dependents may or 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 Xclusive Services 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 Xclusive Services 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 re- quired to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	**January 01, 2026**
Name of Entity/Sender:	**Xclusive Services Human Resources**
Office Address:	**8774 Yates Dr Ste 210** **Westminster, Colorado 80031-6906 United States**
Phone Number:	**(303) 430-1700 Ext. 200**

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single employer group health plans)

**** 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 a employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualify- ing 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 a employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

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

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

When is COBRA continuation coverage available?

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee 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: Xclusive Services Human Resources at benefits@xclusiveservices.com.

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 Team Members may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA contin- uation 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 con- tinuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and

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

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[1] 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

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start

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/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

Xclusive Services Human Resources
8774 Yates Dr Ste 210
Westminster, Colorado 80031-6906
United States
(303) 430-1700 Ext. 200

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution - as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based 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. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Xclusive Services Human Resources at benefits@xclusiveservices.com

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name Xclusive Services		4. Employer Identification Number (EIN)
5. Employer address 8774 Yates Dr Ste 210		6. Employer phone number (303) 430-1700 Ext. 200
7. City Westminster	8. State Colorado	9. ZIP code 80031-6906
10. Who can we contact about employee health coverage at this job? Xclusive Services Human Resources Department		
11. Phone number (if different from above)	12. Email address benefits@xclusiveservices.com	

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting