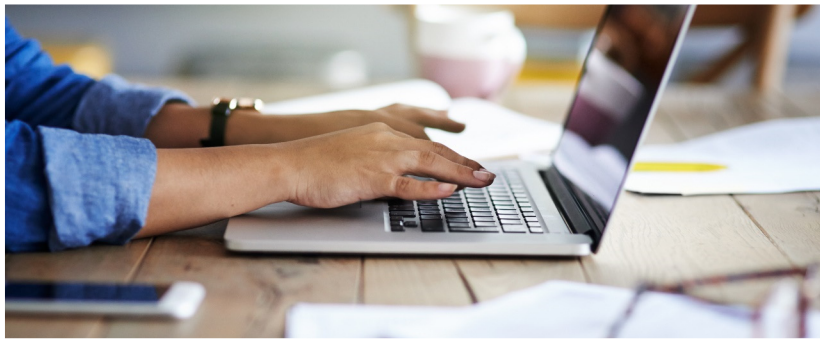
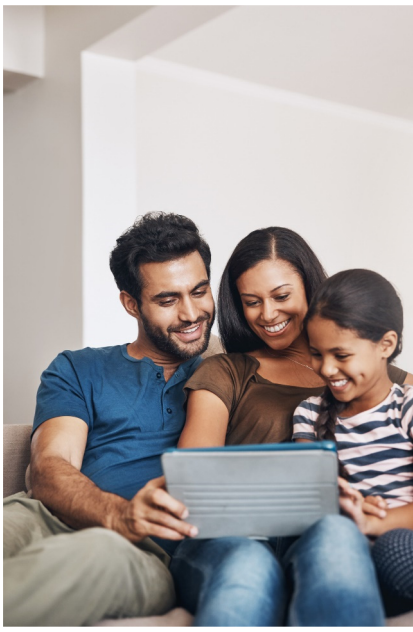
VIBRANTcare REHABILITATION





2025

EMPLOYEE BENEFITS GUIDE

For benefits effective January 1, 2025

Important Enrollment Information

VibrantCare Rehabilitation, Inc. strives to offer you and your dependents a competitive and comprehensive benefits package. We encourage you to take the time to review the benefits available to you, presented in this Guide, and choose the ones that best suit your needs.

Once you have made your elections, you will **not** be able to change them until the next Open Enrollment period, unless you experience a qualified change in status.

Reminders

- **ALL benefitted employees must submit their benefit elections through UKG at https://secure4.entertimeonline.com/ta/6156182.login**. There will be no automatic renewal of your current benefits.
- **Don't forget:** Before visiting a doctor, hospital or facility, make sure you check the participating status. Your dollar goes further when you use in-network providers!
- **Be sure to check that services you are having performed are covered by the Plan regardless if the provider is participating with PHCS or not.**

How do I enroll?

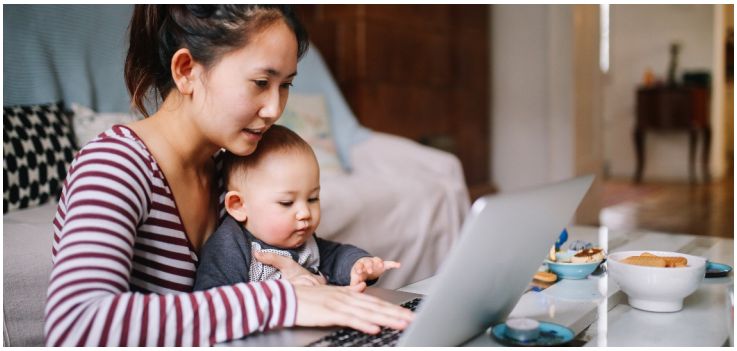
You must submit your benefit elections through UKG.

How often can I change plan elections?

Unless you have a qualified change in status, you cannot make changes to your elected benefits until the next open enrollment period.

Qualified changes in status include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse, commencement or termination of adoption proceedings, or change in your spouse's benefits or employment status.

You must notify Human Resources within 31 days of experiencing a qualified change in status and complete the appropriate forms.



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 page 19 for more details.

Eligibility Information

Who is eligible to elect benefits?

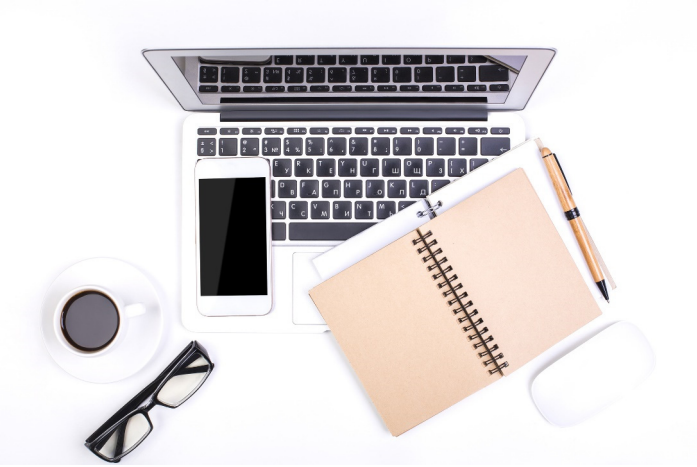
If you are a full-time employee working 40 hours or more per week or a regular part-time employee working 32-39 hours per week, you are eligible to enroll in the benefits described in this guide. Please remember that only eligible dependents can be enrolled.

When Does Coverage begin?

New Hires are eligible to participate in VibrantCare's Benefits on the 61st day from hire and with continuous employment if you are a regularly scheduled, and a full-time or regular part-time employee working at least 32 hours per week.

Reinstated or employees changing status to full time or regular part time are eligible to participate in VibrantCare's Benefits on the 61st day from re-hire or status change date and with continuous employment.

All benefit elections must be made within 31 days of your date of hire or change to full-time status.



Dependent Eligibility

Eligible dependents include a spouse or child.

- A spouse includes an opposite sex or same sex spouse who resides in the same household as the employee. A marriage certificate must be provided to enroll a spouse.
- A child includes a natural child, stepchild, adopted child or foster child of the health plan participant. The foster child(ren) must not be eligible for coverage provided by any governmental program or law and are under 26 years old. Dependent coverage for your child(ren) under your medical, dental, vision and prescription plan is up to age 26.

Dependent Status Verification / Eligibility Audit

VibrantCare reserves the right to request documentation to substantiate that your dependents are eligible to participate in the benefit plans. At any time, a Dependent Eligibility Audit could be conducted, where a sample of employees will be asked to provide verification of their dependent's status. If you choose to cover a dependent on the benefit plans at VibrantCare, please be prepared to provide the necessary documents to prove dependent status and eligibility, if needed. A marriage license is required to enroll your spouse in the benefit plans.

Please remember that if you are enrolling a dependent(s), you are only enrolling eligible dependent(s). Please be sure to include a Social Security Number for each dependent when enrolling through UKG.

Medical Benefits

LUMINARE HEALTH (FORMERLY KNOWN AS TRUSTMARK)

Below is a brief summary of the medical plans available to you. Please visit the BenePortal **www.vibrantcarebenefits.com** to review the full plan summaries. **There is no requirement to select a Primary Care Physician (PCP) to coordinate your care. However, you are encouraged to select a Primary Care Physician.**

To locate a list of current Preferred Providers for physicians, call **877.952.7427** or visit **www.multiplan.com/phcspracanc** and select the PHCS network then select Practitioner & Ancillary.

	Base Plan		Choice Plan	
Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Calendar Year Deductible	$500/$1,000	$2,000 / $4,000	$500/$1,000	$2,000 / $4,000
Out-of-Pocket Maximum	$4,500 / $9,000	$10,000 / $20,000	$3,500/$7,000	$10,000 / $20,000
Coinsurance	80%	60%	95%	50%
Preventive Care Services	Covered 100%	60% after deductible	Covered 100%	50% after deductible
PCP Office Visit	$25 copay	60% after deductible	$25 copay	50% after deductible
Specialist Office Visit	$40 copay	60% after deductible	$40 copay	50% after deductible
Outpatient Lab and X-Ray (Non-Preventative)	80% after deductible	60% after deductible	95% after deductible	50% after deductible
Emergency Room Care	80% after $250 Copay. *Copay waived if admitted.*		95% after $250 Copay. *Copay waived if admitted.*	
Urgent Care	$100 copay	60% after deductible	$100 copay	50% after deductible
Inpatient Hospital*	80% after deductible	60% after deductible	95% after deductible	50% after deductible
Outpatient Surgery*	80% after deductible	60% after deductible	95% after deductible	50% after deductible
Skilled Nursing Facility*	80% after deductible	60% after deductible	95% after deductible	50% after deductible
Home Health Care (100 visits per calendar year)	80% after deductible	60% after deductible	95% after deductible	50% after deductible
Inpatient Mental Health/Substance Abuse*	80% after deductible	60% after deductible	95% after deductible	50% after deductible
Outpatient Mental Health/Substance Abuse	$25 copay	60% after deductible	$25 copay	50% after deductible
Family Planning* Tubal Litigations, Vasectomies, Fertility Testing for Diagnosis Only	Varies based on the facility in which it is performed		Varies based on the facility in which it is performed	

* Service requires pre-certification

Know Your Network

LUMINARE HEALTH (FORMERLY KNOWN AS TRUSTMARK)

Luminare Health Network Overview

Luminare Health offers a unique, hybrid medical network to maximize provider access. This network arrangement separates claims & providers into their own categories:

Professional Claims

PHCS will be the PPO network for all professional claims. PHCS will be the PPO network for all professional claims. To look-up participating providers in the PHCS network, visit **www.multiplan.com/phcspracanc** and select the PHCS network, then select Practitioner & Ancillary. Or, call the Luminare Health Customer Service number located on your ID Card. Some examples of professional providers are:

- Primary Care Physician (PCP)
- Specialist
- Chiropractor
- OBGYN
- Urgent Care Facilities

Facility Claims

All facility claims will be processed through the Reference Based Pricing (RBP) program. This arrangement eliminates the network restrictions and allows all facility claims to be processed as in-network. Please see the attached FAQ for additional information. Some examples of facility providers are:

- Hospitals
- Surgery Centers
- Emergency Rooms

Reference Based Pricing (RBP) FAQs

What is RBP?

Your health plan uses reference-based pricing to pay providers a fair and reasonable amount for eligible healthcare claims based on the average cost paid by Medicare and an additional percentage determined by your employer. With this change, you'll no longer be limited by a PPO network. You are free to seek care from any provider of your choosing.

What will this cost me?

You are still responsible for copayments, coinsurance, and deductibles just as in your old plan.

What if I receive bills or collection notices for unpaid charges?

In the unlikely event this occurs, contact the Luminare Health Customer Service Department.

What if I'm uncertain if my provider visit will be charged as a "facility" claim?

When in doubt, we suggest visiting a provider that participates in the PHCS network. If your visit is coded as a "professional" claim, this will ensure your benefits are paid at the in-network level. To look-up participating providers in the PHCS network, visit **www.phcs.com** and select the Multiplan network, then select Practitioner & Ancillary or call the Luminare Health Customer Service number located on your ID Card.

Prescription Drug Plan

RXBENEFITS AND EXPRESS SCRIPTS

Below are the prescription drug benefits. If you elect to participate in either medical plan, you are automatically enrolled in the prescription drug plan through RxBenefits and Express Scripts.

Prescription Drug for Base & Choice Plans

General Services	Retail (Up to a 30-day supply)	Mail Order (Up to a 90-day supply)	Out-of-Network
Generic	10% coinsurance **Copay:** $5 minimum, $20 maximum	10% coinsurance **Copay:** $10 minimum, $40 maximum	Member pays 100% at the time of purchase then reimbursed 50% after the applicable copay.
Formulary	20% coinsurance **Copay:** $20 minimum, $40 maximum	20% coinsurance **Copay:** $40 minimum, $80 maximum	
Non-Formulary	35% coinsurance **Copay:** $45 minimum, $90 maximum	35% coinsurance **Copay:** $90 minimum, $180 maximum	
Specialty	20% coinsurance **Copay:** $150 maximum	20% coinsurance **Copay:** $150 maximum	
Out-of-Pocket Maximum Individual/Family	Combined with medical		

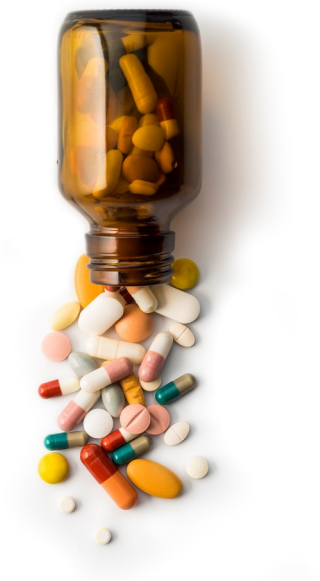
A formulary is an extensive list of FDA-approved prescription drugs that include products in every major therapeutic category. Under the "mandatory generic provision," if a generic drug is available and the patient requests a brand name formulary drug, the member must pay 100% of the difference between the Brand name price and the Generic price, plus the appropriate brand name copay. The only exception is if the physician writes "Dispense As Written" on the prescription, then you only pay the appropriate brand name copay.

Why use Mail Order?

Using the mail order program for your maintenance medications will save you money. You will receive a 90-day (3-month) supply for the equivalent of two (2) retail copays. In addition to the savings, your prescriptions will be delivered right to your home.

To begin using mail order, log in to your account on **www.express-scripts.com**, and for any medicine that displays the "Transfer to Home Delivery" option, click the button, then select the item, click "add to cart," and complete the checkout process.

To find participating pharmacies call RxBenefits at **800.334.8134**.



Vision Plan (Coverage Bundled with VibrantCare Medical Insurance)

LUMINARE HEALTH (FORMERLY KNOWN AS TRUSTMARK)

Below are the vision benefits. **Please note that vision is not a standalone option—you must elect a medical plan to receive vision coverage. If you participate in either medical plan, you will be automatically enrolled in the vision plan**.

You are eligible for an eye exam, once every 12 months and corrective lenses, frames or contact lenses every 12 months.

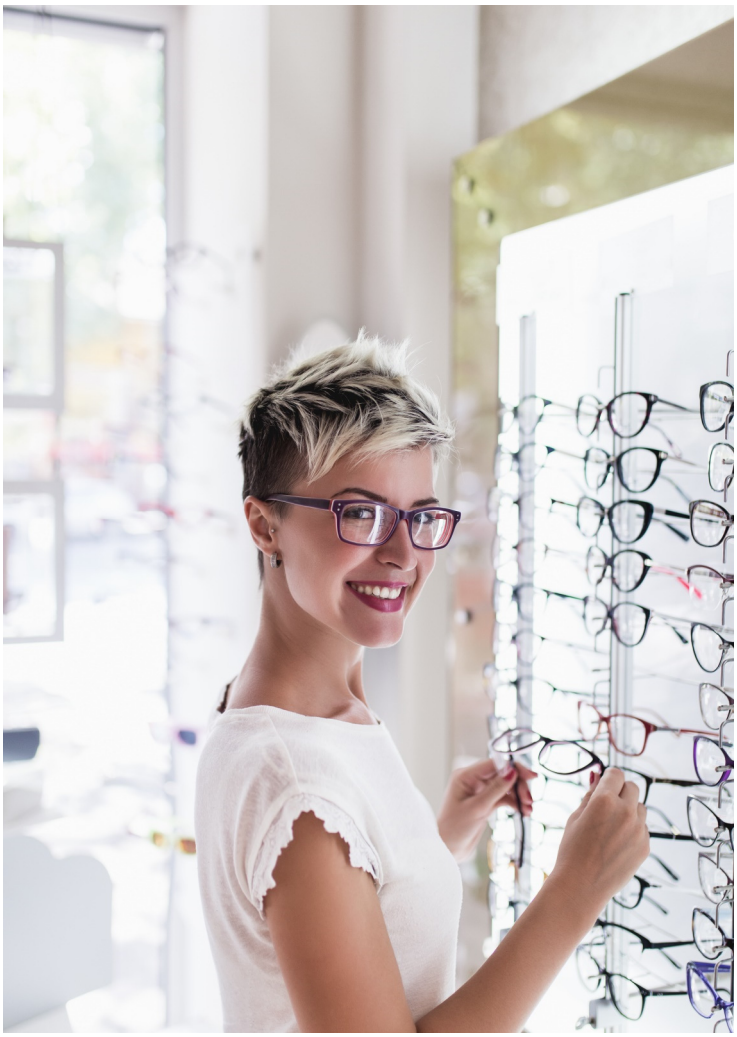
To locate a list of current Vision Providers, please visit **www.multiplan.com/phcspracanc** and select the PHCS network Or, call **888.909.7427**.

For the eye exam and refraction, if your vision provider is contracted within the PHCS network, they should submit the claim directly, and no payment should be required up front. If your provider is non-participating, payment for the exam and refraction may be required up front and you will need to submit the claim for reimbursement.

For the hardware benefit (glasses or contact lenses), all providers may require the member to pay upfront and you will need to submit itemized receipts to be reimbursed.

Vision Plan

Services	
Calendar Year Deductible	None
Percentage Payable: Eye Examinations, Eyeglass Lenses and Frames or Contact Lenses	100%
Benefit Maximums: Eye Examinations Eyeglass Lenses and Frames or Contact Lenses	 $60 $160
Benefit Period: Eye Examinations Eyeglass Lenses and Frames or Contact Lenses	 12 Consecutive Months 12 Consecutive Months



Dental Plan

AETNA

Below is a summary of the dental plan. You do have out-of-network benefits with the PPO Plan. However if you elect a provider that is not in-network, your provider can balance bill you. By using an out-of-network provider, this can be additional out of pocket cost to you.

Orthodontia is covered **only** for children (appliance must be placed prior to age 20).

Dental Plan

Services	DMO In-Network Only	PPO In-Network	PPO Out-of-Network
Deductible* Individual/Family	N/A	$50/$150	$50/$150
Calendar Year Maximum (per patient)	N/A	$1,000	$1,000
Preventive Services	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic Services Root Canal, Scaling, Oral Surgery	Plan pays 60%	Plan pays 80%	Plan pays 70%
Major Services Inlays, Onlays, Crowns, Dentures	Plan pays 60%	Plan pays 50%	Plan pays 50%
Orthodontia Benefits	$2,000 copay	Plan pays 50%	Plan pays 50%
Orthodontia Lifetime Maximum	N/A	$750	$750

* Deductible applies to Basic and Major Services only

Need help finding a provider?

To find an Aetna dental provider, please call **877.238.6200** or visit **www.aetna.com**.

Flexible Spending Accounts

LUMINARE HEALTH (FORMERLY KNOWN AS TRUSTMARK)

Healthcare & Dependent Care Flexible Spending Accounts (FSAs)

VibrantCare provides you with the opportunity to pay for out-of-pocket medical, dental, vision and dependent care expenses with pre-tax dollars through a Flexible Spending Account.

Your enrollment in the FSA Plan will become effective the first of the month following two months of continuous full-time employment. The FSA Plan is provided through and administered by Luminare Health and allows eligible employees to set aside a specific pretax dollar amount for unreimbursed medical, dental, vision, certain over-the-counter items that are accompanied by a prescription, and dependent care expenses.

If you have predictable out-of-pocket expenses, you should consider opening an FSA.

You can choose to participate in either or both FSAs as described on this page.

Unreimbursed Medical Account

You can contribute funds into an Unreimbursed Medical Account FSA to pay for out-of-pocket health care expenses that are not covered by your health, dental, or vision insurance plan for you and your dependents. Examples of these expenses include office visit co-pays, prescription drug co-pays, qualified over the counter medications that are accompanied by a prescription, and co-insurance for dental care. Expenses resulting from procedures that are not medically necessary are not eligible for reimbursement. Employees do not need to be participating in the health or dental plan offered through VibrantCare in order to take advantage of the FSA. The maximum amount that an eligible employee may elect to contribute under the Medical FSA for the 2025 Plan Year shall be $2,400.

Dependent Care FSA

You can contribute funds into a Dependent Care FSA to use for the reimbursement of expenses incurred through daycare for qualified dependents. Dependents include your children under the age of 13 and disabled dependents of any age that you claim on your federal income tax return. In order for a dependent to qualify under the Dependent Care FSA, they must live with you and rely on you for more than half of their financial support. On an annual basis, eligible employees may elect to contribute up to a maximum of $5,000 into a Dependent Care FSA.

Flexible Spending Accounts

LUMINARE HEALTH (FORMERLY KNOWN AS TRUSTMARK)

Elections Once A Year

You must make new contribution elections at the beginning of each plan year (January 1st). The amount you choose to deposit in your Medical Account FSA and/or Dependent Care FSA cannot be changed during the year unless you have a family status change.

Pre-Tax Contributions

Your contributions are automatically withheld – in equal amounts – from your paychecks throughout the year before taxes are applied (pre-tax). Your contributions are credited to an account(s) set up in your name through the FSA administrator, Luminare Health.

Claims Submission

You pay for eligible expenses as you normally would. Then you submit your receipts with your claim form for reimbursement. Please refer to your plan booklet to determine what expenses are eligible. Claims must total at least $25.00 before a reimbursement can be processed.

Reimbursements

You are reimbursed tax-free – so you never pay taxes on the money you set aside in Flexible Spending Accounts! Claims are processed and reimbursement checks are issued weekly. Direct deposit is also available.

Provider's Social Security Number (Dependent Care FSA) The IRS requires that you provide the name, address and social security number or other tax identification number of your dependent care provider. Form 2441 Child and Dependent Care Expenses must be filed with your Federal Income Tax Return.

Use It or Lose It

Any money remaining in your FSAs at the end of each plan year (December 31st) **will be forfeited** if you do not submit the claim for processing within 90 days following the end of the Plan Year. This means that for the 2025 Plan Year (1/1/25 – 12/31/25) you can submit eligible claims incurred during the plan year for reimbursement through the plan until 3/31/26.

Effect on Your Other Benefits

You do not pay FICA taxes on your FSA contributions. As a result, your future Social Security benefits may be lower. In addition, a federal tax credit is also available for your dependent care expenses. You may not, however, claim the same expense in both places. We recommend that you consult a tax advisor to determine the approach that works best for your situation.

What are Pre-Tax Dollars?

Pre-tax dollars are monies you authorize to be withheld from your paycheck before federal income; Social Security, Medicare and State (if applicable) taxes are deducted. At year-end, your W-2 statement for tax reporting will show as taxable income your regular gross salary minus your pre-tax contributions. This statement will reflect your reduced taxable income. By anticipating your family's medical and dependent care costs for the next year and contributing to an FSA, you can actually lower your taxable income.

Basic Life and AD&D Insurance

THE HARTFORD

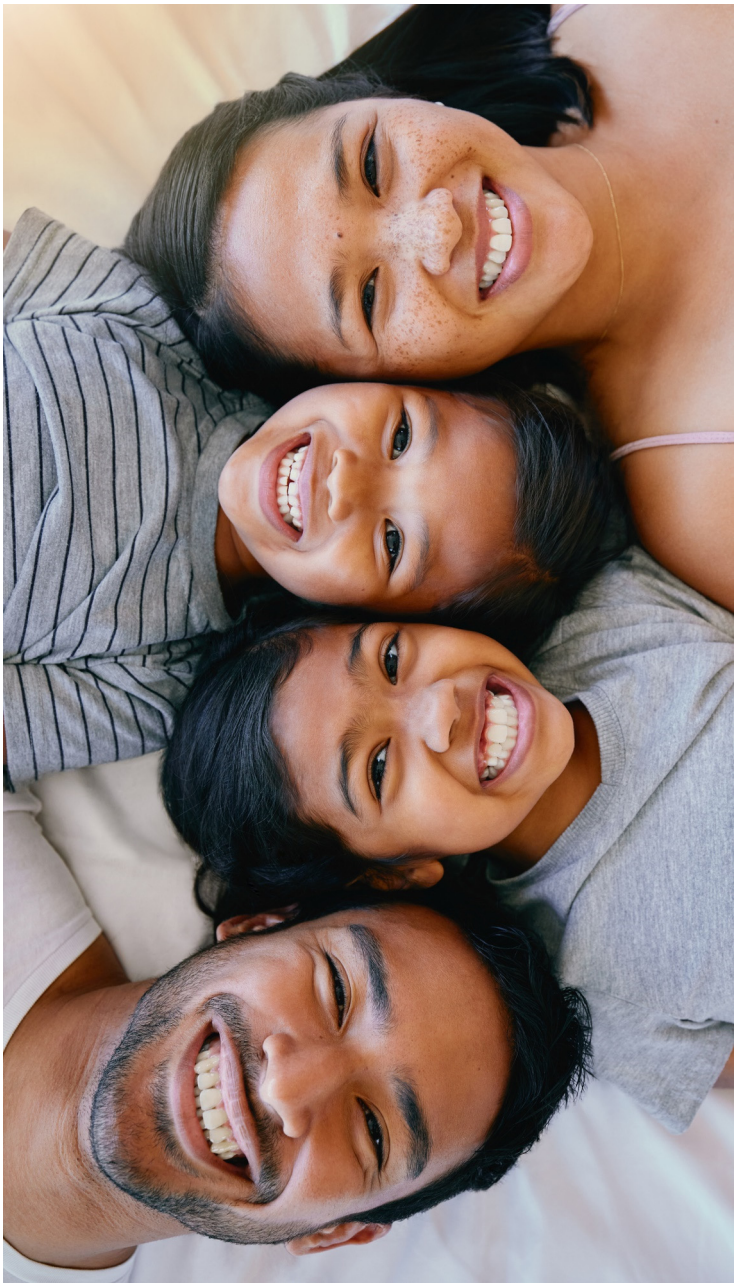
Basic Life and Accidental Death and Dismemberment Insurance (AD&D) in the amount of 1 times your base annual earnings to a maximum of $500,000 is available to all benefit-eligible employees through The Hartford and is 100% company paid.

Basic Life and AD&D Insurance	
Eligibility Waiting Period	61st day of continuous employment
Guaranteed Issue Amount	The guaranteed issue amount is the amount of insurance that you may elect without providing evidence of good health. Guarantee Issue amount is $200,000. Existing amounts of coverage will be grandfathered over.
Age Reductions	On the first of the month of your 70th birthday, your insurance coverage amount will reduce by 35% of the original amount. On the first of the month of your 75th birthday, your insurance coverage amount will reduce by 60% of the original amount. On the first of the month of your 80th birthday, your insurance coverage amount will reduce by 75% of the original amount.

The Hartford Life Essentials

You now have access to benefits and services that can help you make the most of every stage of your life. Your life insurance includes new features that help you live fully today and better prepare you for tomorrow.

Visit **www.thehartford.com/employee-benefits/value-added-services** for more details!



Even if you will not be making new elections or changes, it is strongly recommended that all employees log onto UKG to verify and update your beneficiary information during enrollment.

Supplemental Life and AD&D Insurance

THE HARTFORD

Supplemental Term Life/AD&D is a voluntary insurance program that allows you to add to the protection you already have through VibrantCare's Basic Life/AD&D Plan and to purchase Life/AD&D Insurance for your spouse and dependent children. You can purchase significant amounts of insurance at competitive group rates. You'll also enjoy the ease and reliability of having your premiums paid through post-tax payroll deduction.

When you enroll for Supplemental Life insurance, you are automatically enrolled for Supplemental AD&D insurance. The benefit amount for Supplemental AD&D insurance is equal to the benefit amount for Supplemental Life Coverage.

Your coverage will be effective on your eligibility date, provided you are actively-at-work on that day. If you are not in active employment because of an injury, sickness, temporary lay-off, or leave of absence on the date that insurance would otherwise be effective, your insurance will be delayed. Insurance will be delayed for a spouse or child if that dependent is totally disabled on the date that insurance would otherwise be effective. However, newborn children are insured from live birth.

Evidence of Insurability (EOI) may be required for certain elections. (See "Your Coverage Options" below for details.) In the event that you are required to submit an EOI form, your newly elected coverage is not effective until The Hartford approves your election. You will be notified by The Hartford directly upon their approval or denial of your election.

Supplemental Life and AD&D Insurance	
Eligibility Waiting Period	61st day of continuous employment
Employee	1, 2, 3, 4, or 5 x Salary to a maximum of $500,000 **Please note: If you are electing 3, 4, or 5x salary for Life Insurance, EOI will be required.**
Spouse	Increments of $10,000 to a maximum of $100,000, not to exceed 50% the employees elected amount.
Child(ren)	Increments of $1,000 to a maximum of $10,000

Supplemental Life Monthly Premiums per $1,000 of Coverage

Age	Employee
< 20	$0.042
20-24	$0.074
25-29	$0.074
30-34	$0.074
35-39	$0.84
40-44	$0.126
45-49	$0.179
50-54	$0.295
55-59	$0.464
60-64	$0.717
65-69	$1.318
70-74	$2.678
75+	$5.409

Child(ren) Dependent Life is $0.12 per $1,000.

Supplemental AD&D Monthly Premiums

Per $1,000 of Coverage	
Employee	$0.022
Spouse	$0.025
Child	$0.0392

Disability Benefits

THE HARTFORD

Short-Term Disability (STD)

If you reside outside of the State of California, you have an opportunity to participate in a Short-Term Disability (STD) Plan. This STD Plan provides you with short-term income protection if you become disabled from a non-occupational accident, sickness or pregnancy.

Please note: If you are a resident of California, your benefits will be paid for by the state-mandated STD plan.

If you elect coverage during your initial eligibility period (defined as enrollment within 31 days of your initial eligibility date), coverage will become effective on your date of eligibility, provided you are actively-at-work on that day. Otherwise, coverage is effective on the first day that you meet the eligibility and "actively-at-work" requirements. Actively-at-work means you are performing the normal duties of your usual job on a full-time basis at the usual place of work.

For annual open enrollment periods:

If you do not elect short term disability during your initial eligibility period and wish to elect it during the annual enrollment period, you must complete an Evidence of Insurability (EOI) form. Your STD coverage is not effective until The Hartford approves your Evidence of Insurability form. You will receive notice from The Hartford upon the approval or denial of your request for coverage.

Short-Term Disability Insurance	
Eligibility Waiting Period	61st day of continuous employment.
Elimination Period (Benefits Begin)	To be eligible for benefits, you must be unable to work due to injury or illness. Benefits begin on the 30th calendar day of a qualifying injury and the 30th calendar day of qualifying illness.
Weekly Benefit/ Maximum Weekly Benefit	If you purchase Voluntary Short Term Disability, the plan provides you w/ income protection to replace a portion of your pre-disability weekly earnings. The STD Benefit is 60% of your Salary, up to a maximum of $500 per week.
Benefit Period	Benefits are payable for 26 weeks.

Pre-Existing Conditions

Benefits may be limited for disabilities arising from pre-existing conditions. These are disabilities beginning within the first 12 months of coverage and resulting from a sickness or injury that was diagnosed or treated during the 3 months prior to the coverage effective date.

Rehabilitation

Our ultimate goal is to help you return to gainful employment. Our consultants review each Disability claim and determine if The Hartford rehabilitation services would be appropriate and effective. After reviewing your claim, if we feel you would benefit from our services, we will contact you.

Disability Benefits

THE HARTFORD

Long-Term Disability (LTD)

Long-Term Disability Insurance (LTD) provides you with protection against the loss of your income due to a disability that prevents you from working and earning an income. This coverage is offered through The Hartford and is 100% company paid, meaning there is no cost to you.

Coverage will become effective on your date of eligibility, provided you are actively-at-work on that day. Otherwise, coverage is effective on the first day that you meet the eligibility and "actively-at-work" requirements. Actively-at-work means you are performing the normal duties of your usual job on a full-time basis at the usual place of work.

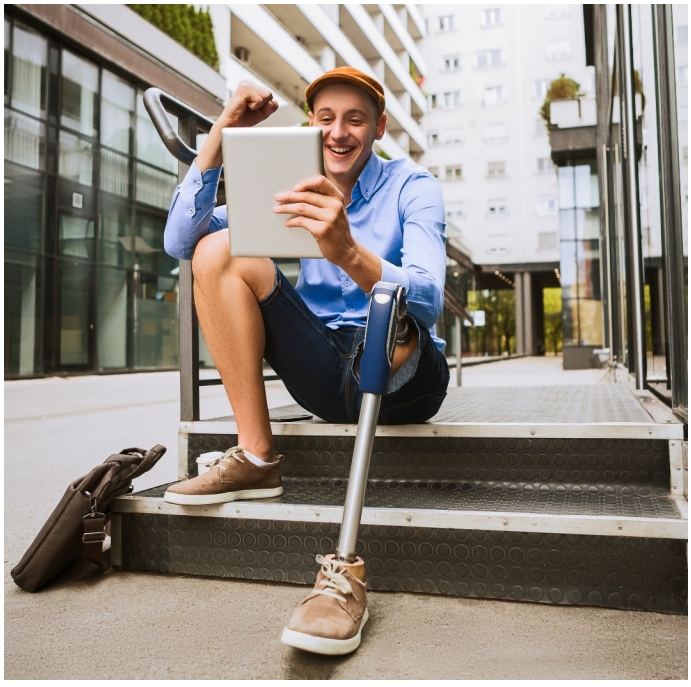
Long-Term Disability Insurance	
Eligibility Waiting Period	61st day of continuous employment
Elimination Period	To be eligible for benefits, you must be out of work for 180 continuous days due to an occupational or non-occupational injury or illness.
Monthly Benefit	The plan provides you with income protection to replace up to 60% of your pre-disability monthly earnings.
Minimum Monthly Benefit	The greater of 10% or $100
Maximum Monthly Benefit	$5,000 *(combined with other income benefits, as specified, in your Certificate of Insurance Booklet)*
Own Occupation Period	24 Month Own Occupation; Any Occupation thereafter
Earnings Test	80%/60%

LTD Benefit Duration

As long as you remain totally disabled, LTD benefit payments will continue according to the following schedule:

Age of Disability	Duration of Payments
Prior to age 62	To normal retirement age* or 42 months if greater
63	36
64	30
65	24
66	21
67	18
68	15
69+	12

* Normal retirement age means the Social Security normal retirement age as stated in the 1983 revision of the United States Social Security Act.



401(k) Profit-Sharing Plan

THE STANDARD

Eligibility

You are eligible to enroll in VibrantCare's 401(k) Profit Sharing Plan, as a full-time employee. If you are not full-time (e.g., part-time, per diem), you must meet the 1,000 hour eligibility requirement during the plan year in order to be eligible to participate. (Your vesting will be calculated using the 1,000-hour requirement.) You can join the plan on the first day of any month after you have met all of the eligibility requirements.

Employer Matching

VibrantCare matches your 401k contributions!
VibrantCare matches 50% of your deferrals up to 6% of pay on a per-pay period basis. In other words, if you contribute at least 6% of pay, VibrantCare will contribute 3% of pay to your retirement account.

Roth 401(k)

Roth 401(k) contributions are a type of salary deferral administered like a conventional 401(k) plan with one major difference, they are made post -tax. That means you pay taxes now and receive tax-free distributions (similar to a Roth IRA). In order to receive tax-free distributions, you must be at least 59 ½ and you must have your funds in the account for at least 5 years.As a general rule, Roth 401(k) contributions are a good fit if you're in a lower tax bracket today than you expect to be when you retire. This may be especially true for younger workers.

Similar to a Roth IRA, Roth 401(k) contributions can be distributed to beneficiaries tax free. As a result, Roth 401(k) contributions can be an exceptional estate-planning tool.If making post-tax retirement plan contributions now for tax-free distributions later sounds appealing, Roth 401(k) contributions may be right for you.

Enrollment

In order to begin saving, you may call Customer Service Representative at **800.858.5420** between 5:00 a.m. and 5:00 p.m. Pacific Time or go online **https://login.standard.com**. The enrollment form you will complete will depend on whether you want Mainspring Managed or Mainspring Select (please refer to your Enrollment Booklet). You must also complete a Designation of Beneficiary Form and send to Human Resources for your employee file. Please note that if you are married and you wish to designate a beneficiary other than your spouse, you must obtain spousal consent.

Employee Pre-Tax 401(k) Contributions

You may contribute a percentage of your compensation on a pre-tax basis (provided it does not exceed the maximum amount allowed by the IRS - $23,500). This means the money goes into the Plan prior to you paying income taxes. You defer paying income taxes on your savings dollars until you receive them as a distribution from the Plan.

Employee Roth 401(k) Contributions

You may also contribute a percentage of your compensation on an after-tax basis. This means the money comes out of your paycheck after you have already paid taxes on it. The advantage of contributing on a Roth basis is that if you withdraw your account after you have reached age 59 ½ and you have had your account for at least 5 years, your withdrawal from the Roth account will be tax-free. This means that you will not pay taxes on your contributions or their earnings.

401(k) Profit-Sharing Plan

THE STANDARD

PLEASE NOTE: You can elect to contribute on a pre-tax basis (traditional 401(k contributions), on an after-tax basis (Roth), or any combination of the two. However, you may not contribute more than the maximum limit allowed by the IRS ($23,500).

Catch-up Contributions

In addition, if you are age 50 or will reach age 50 by the end of the year, you will be able to make an additional pre-tax contribution (catch-up contribution), over and above the amount allowed by the other applicable limits.

Rollover Contributions

If you have funds in another employer's qualified retirement plan or a rollover IRA, you may be allowed to transfer or rollover those funds into this Plan. You will be able to direct the investment of your rollover contributions into any of the investment options that are available under the Plan. In addition if you currently have an IRA, those funds may be transferred or rolled over into this Plan.

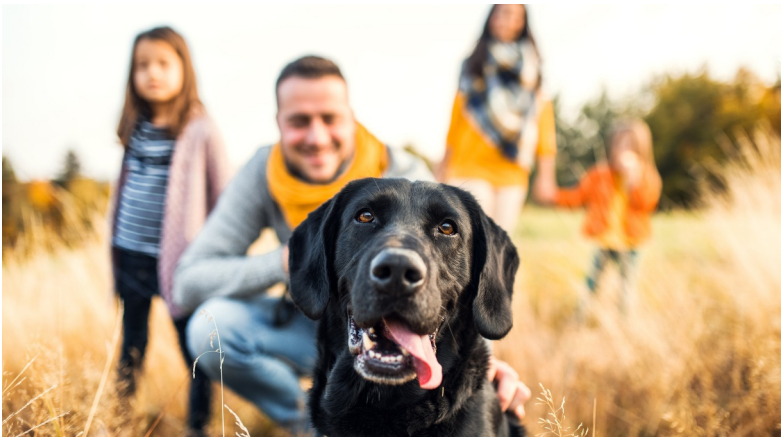
Vesting

Vesting means that you are entitled to all or part of your account without the requirement of continuing your employment. You are always 100% vested in your contributions and their earnings. Vesting is calculated from your date of hire.

Even if you will not be making new elections or changes, it is strongly recommended that all employees verify and/or update beneficiary information during enrollment.

Voluntary Benefits

PET BENEFIT SOLUTIONS & COUNTRYWIDE BY IDIQ



Pet Benefits

VibrantCare is pleased to offer two products from Pet Benefit Solutions.

Pet Assure Discount Plan

Pet Assure is a veterinary discount plan that provides an instant 25% discount on in-house medical services at any participating veterinarian. All pets are eligible - no exclusions on type, breed, age or health condition of your pets. Pet Assure also includes a 24/7 Lost Pet Recovery Service from ThePetTag. You can enroll in this benefit for $4.15 per pay period.

To locate a participating veterinarian, visit **petbenefits.com/search**. You can search for a vet by address or zip code.

PetPlus Prescription Discount Plan

The PetPlus Prescription Savings Plan provides you with wholesale prices on brand name prescriptions and products. You can enroll any dog or cat, no exclusions. Shipping is always free, and most prescriptions are available for same-day pickup at over 60,000 Caremark pharmacies like CVS, Walmart or Target. Save with PetPlus.

ID Theft Protection

Countrywide by IDIQ offers Secure Pro and Secure Plus plans for credit monitoring and ID Theft Protection. You can also elect coverage for your spouse, domestic partner and dependents over age 18.

Secure Plus Plan

With the Secure Plus Plan, you are able to view your credit report and score from all three bureau's annually, get $1,000,000 in ID Theft Insurance, and 24/7 daily credit monitoring. The cost is $4.15 per person per pay period for the Secure Plus plan.

Secure Pro Plan

With the Secure Pro Plan, you are able to view your credit report and score from TransUnion quarterly, get $1,000,000 in ID Theft Insurance, and 24/7 daily credit monitoring. The cost is $5.52 per person per pay period for the Secure Pro plan.

Pre-Paid Legal Services

Countrywide by IDIQ offers Pre-Paid Legal Services that are voluntary benefits offered to full and part-time eligible employees and are designed to provide specific legal services, when the need arises, on an affordable basis. The cost is $6.90 per pay period. The plan covers you, your spouse and dependents up to the age of 26.

Countrywide's plans provide an array of valuable legal services including:

- Unlimited telephone consultations and advice
- Preparation of simple wills
- Advice on small claims court
- Review of contracts and documents
- Living will and medical powers of attorney
- Legal letters and phone calls
- Discounted rates

Additional Resources

Carrier Contacts

Plan	Carrier	Phone Number	Website
Medical	Luminare Health	1-877-498-8937	www.luminarehealth.com
Prescription Drug	RxBenefits with Express Scripts	1-800-334-8134	www.express-scripts.com
Dental	Aetna	1-877-238-6200	www.aetna.com
Vision	Luminare Health	1-877-498-8937	www.luminarehealth.com
Flexible Spending Accounts	Luminare Health	1-877-267-3359	www.luminarehealth.com
Basic Life and AD&D	The Hartford	1-800-523-2233	www.thehartford.com
Supplemental Life and AD&D	The Hartford	1-800-523-2233	www.thehartford.com
Disability Benefits	The Hartford	1-800-523-2233	www.thehartford.com
401k Benefits	The Standard	1-800-858-5420	https://login.standard.com
Pet Benefits	Pet Benefit Solutions	1-800-891-2565	www.petbenefits.com
Pre-Paid Legal Services	Countrywide by IDIQ	1-800-550-5297	www.countrywideppls.com www.identityiq.com

Benefits Member Advocacy Center

Available Monday-Friday, 8:30am – 5:00pm (EST)

The Benefits Member Advocacy Center, provided by our benefits consultant, Conner Strong & Buckelew, allows you to speak to a specially trained Member Advocate who can assist with benefit claims issues, coverage questions, and enrollment inquiries.

To Contact the Benefits Member Advocacy Center:

Call Member Advocacy at **800.563.9929**
or submit a request online anytime at
www.connerstrong.com/memberadvocacy.

Legal Notices

HIPAA/CHIP Special Enrollment Notice

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 Company 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 (CHIP).

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. If you request a change due to a special enrollment event within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

Eligibility for 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 (CHIP) 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 obtain more information, please contact Human Resources.

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 the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and 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 benefits. If you have any questions, please speak with Human Resources.

Important Notice from Express Scripts About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Express Scripts 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. Express Scripts has determined that the prescription drug coverage offered by the VibrantCare Prescription Drug 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 6th.

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 Express Scripts coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Express Scripts coverage, be aware that you and your dependents will 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 Express Scripts 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 Express Scripts 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).

Legal Notices

Date:	September 25, 2024
Name of Entity/Sender:	VibrantCare Rehabilitation
Contact--Position/Office:	14090 SW Freeway
Address:	Suite 101
	Sugar Land, TX 77478
Phone Number:	916.782.1212

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).

Notice of Privacy Practices for the VibrantCare Rehabilitation, Inc. – Group Health Plan

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Legal Duties

This Notice describes VibrantCare Rehabilitation, Inc. Group Health Plan's (the "Plan's") practices for protecting the privacy of your protected health information. "Protected health information" is individually identifiable health information created or received by or on behalf of the Plan, that relates to your physical or mental health or condition, the provision of health care to you, or payment for your health care.

This Notice describes the Plan's privacy practices, which include how the Plan may use, disclose, collect, handle, and protect Plan members' protected health information. The Plan is required by applicable federal and state laws to maintain the privacy of your protected health information. The Plan also is required by the HIPAA Privacy Ruse (45 C.F.R. parts 160 and 164, as amended) to give you this Notice about our privacy practices, our legal duties, and your rights concerning your protected health information. The Plan is required to follow the privacy practices described in the Notice as long as it is in effect. This Notice becomes effective 01/01/14 and will remain in effect unless we replace it.

The Plan is administered by Luminare Health on behalf of the Plan. You will receive a similar Notice of Privacy Practices from Luminare Health . When "Luminare Health " is mentioned below, we mean "Luminare Health " on behalf of the Plan.

We will monitor our practices for protecting the privacy of our members' protected health information. Due to changing circumstances, it may become necessary to revise our privacy practices and the terms of this Notice. We reserve the right to make the changes in our privacy practices and the new terms of our Notice will become effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. We will send you (the subscriber to the Plan) a new Notice within 60 days of making material changes to this Notice.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us as directed at the end of this Notice.

In order to administer our health benefit programs, the Plan will collect, use and disclose identifiable health information for certain activities, including payment and health care operations. The following categories describe many of the different ways that the Plan, or the Third Party Administrator for the Plan (Luminare Health) may use and disclose protected health information. For each category we explain what it means and, when appropriate, give some examples. Not every use or disclosure in a category will be listed. However, all the ways the Plan (and Luminare Health) may use and disclose your protected health information will fall within one of the categories.

I. Uses and Disclosures of Protected Health Information

A. For Payment and Health Care Operations

The following is a description of how, in order for the Plan to administer our health benefit programs, we (or Luminare Health) may use and/or disclose protected health information about you for payment and health care operations:

Payment

We may use and disclose your protected health information for all activities that are included within the definition of "payment" as set out in 45 C.F.R. – 164.501. For example, the Plan or Luminare Health may use and disclose your protected health information for payment activities, including but not limited to: paying claims from doctors, hospitals, pharmacies and others for services delivered to you that are covered by your health plan, determining your eligibility for benefits, coordinating benefits, examining medical necessity, obtaining premiums, and/or issuing explanations of benefits to the person who subscribes to the health plan in which you participate.

Health Care Operations

The Plan or Luminare Health may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as set out in 34 C.F.R. 164-501. For example, the Plan or Luminare Health may use and disclose your protected health information to rate our risk and determine the reserves for your health plan, to conduct quality assessment and improvement activities, to engage in care coordination or case management, and/or to manage the Plan and the like.

To Other Entities

The Plan or Luminare Health also may use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by the HIPAA Privacy Rule) who assist us in administering our programs and delivering health services to Plan members.

Business Associates

In connection with payment and health care operations activities, the Plan and Luminare Health may contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (including but not limited to member service support, utilization management, subrogation, support, or pharmacy benefit management). To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after the Plan or Luminare Health requires the business associates to agree in writing to contract terms designed to appropriately safeguard your information.

Other Covered Entities

In addition, we may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with their health care operations. For example, the Plan or Luminare Health may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

II. Other Possible Uses and Disclosures of Protected health Information

In addition to uses and disclosures for payment and health care operations, the Plan or Luminare Health may use and/or disclose your protected health information for the following purposes.

To Plan Sponsors

The Plan (or Luminare Health) may disclose your protected health information to the Plan sponsor of your group health plan to permit the Plan sponsor to perform plan administration functions. For example, the Plan sponsor may contact the Plan or Luminare Health regarding a member's questions, concern, or issue regarding claim, benefits, service, coverage, etc. The Plan or Luminare Health also may disclose summary health information (this type of information is defined in the HIPAA Privacy Ruse) about the enrollees in the Plan to the Plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.

Required by Law

The Plan (or Luminare Health) may use or disclose your protected health information to the extent that federal or state law requires the use or disclosure. For example, the Plan (or Luminare Health) must disclose your protected health information to the U. S. Department of Health and Human Services upon request for purposes of determining whether the Plan is in compliance with federal privacy laws.

Public Health Activities

The Plan (or Luminare Health) may use or disclose your protected health information for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for the purpose of preventing or controlling disease, injury or disability.

Health Oversight Activities

The Plan (or Luminare Health) may disclose your protected

Legal Notices

health information to a health oversight agency for activities authorized by law, including but not limited to: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

Abuse or Neglect
The Plan (or Luminare Health) may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

Legal Proceedings
The Plan (or Luminare Health) may disclose your protected health information: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (3) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Ruse. For example, the Plan may disclose your protected health information in response to a subpoena for such information.

Law Enforcement
Under certain conditions, the Plan (or Luminare Health) also may disclose your protected health information to law enforcement officials. For example, some of the reasons for such a disclosure may include but are not limited to: (1) it is required by law or some other legal process; or (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

Coroners, medical examiners, Funeral Directors, and Organ Donation
The Plan (or Luminare Health) may disclose protected health information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Research
The Plan (or Luminare Health) may disclose your protected health information to researchers when we receive an authorization from you, or when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to protect the privacy of the information; and (2) approved the research (if applicable).

To Prevent a Serious Threat to Health or Safety
Consistent with applicable federal and state laws, the Plan (or Luminare Health) may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Military Activity and national Security, Protective Services
Under certain conditions, the Plan (or Luminare Health) may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of a foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.

Inmates
If you are an inmate of a correctional institution, the Plan (or Luminare Health) may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation
The Plan (Luminare Health) may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Others Involved in Your Health Care
Unless you object, the Plan (or Luminare Health) may disclose your protected health information to a friend or family member that you have identified as being involved in your health care. We also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then we may, under unusual or emergency circumstances, using our professional judgment, determine whether the disclosure is in your best interest.

III. Required Disclosures of Your Protected Health Information
The Plan is required by law to make the following disclosures:

Disclosure to the Secretary of the U. S. Department of Health and Human Services
The Plan is required to disclose your protected health information to the Secretary of the U. S. Department of health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Disclosures to You
The Plan is required to disclose to you most of your protected health information that is in a "designated record set" (defined below) when you request access to this information. We also are required to provide, upon your request, an accounting of certain disclosures of your protected health information that are for reasons other than payment and health care operations.

IV. Other Uses and Disclosures of Your Protected Health Information
Uses and disclosures of your protected health information that do not fit into the categories described above will be made only with your written authorization. If you provide us (or Luminare Health) with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

V. Your Individual Rights
The following is a description of your rights with respect to your protected health information:

Right to Access
You have the right to look at or get copies of your protected health information in a designated record set. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

You may request that we or (Luminare Health) provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your protected health information.

To inspect and/or copy your protected health information, you may obtain a form to request access by contacting Luminare Health (see the information on your identification card) or by contacting the Plan by using the contact information listed at the end of this Notice. The Plan (or Luminare Health) may charge you a reasonable, cost-based fee for responding to your request. If you request an alternative format, we will charge a cost-based fee for providing your protected health information in that format. If you prefer, we (or Luminare Health) will prepare a summary or an explanation of your protected health information for a fee. Contact us (or Luminare Health) using the information listed at the end of this Notice for a full explanation of our fees.

The Plan (or Luminare Health) may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. A licensed health care professional will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, the denial will not be reviewable.

If this event occurs, the Plan (or Luminare Health) will inform you in our denial that the decision is not reviewable.

Right to an Accounting
You have a right to an accounting report of certain disclosures of your protected health information that are for reasons other than treatment, payment or health care operations. Please keep in mind that most disclosures of protected health information will be for purposes of payment or health care operations, and therefore would not be

Legal Notices

included in an accounting report.

To the extent that there are disclosures to account for, the accounting report will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

You may request an accounting report by contacting Luminare Health at the Customer Service phone number on the back of your identification card. Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. If you have any questions regarding an accounting of disclosures made by the Plan, please contact the Privacy Officer as described at the end of this Notice.

The first account report you request within a 12-monthh period will be free. If you request an accounting report more than once in a 12-month period, the Plan (or Luminare Health) may charge you a reasonable, cost-based fee for responding to these additional request.

Right to Request a Restriction
You have the right to request a restriction on the protected health information the Plan (or Luminare Health) uses or discloses about you for treatment, payment or health care operations. The Plan is not required to agree to these additional restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memoralized in writing.
You may request a restriction by contacting Luminare Health at the Customer Service phone number on the back of your identification card, or by contacting the privacy Officer as instructed at the end of this Notice. In your request explain: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

Right to Request Confidential Communications
If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that the Plan (or Luminare Health) communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work e-mail.

You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the alternative location you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuing explanations of benefits to the subscriber of the health plan in which you participate.

Right to Request Amendment
If you believe that your protected health information is incorrect or incomplete, you have the right to request that the Plan (or Luminare Health) amend your protected health information. Your request must be in writing, and must explain why the information should be amended.

We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to a Paper Copy of this Notice
You are entitled to receive this Notice in written form other than in this manual. Please contact us using the information listed at the end of this Notice to obtain this Notice in written form.

Questions and Complaints
If you want more information about the Plan's privacy policies or practices or have questions or concerns, please contact us using the information listed below.

You may send a written complaint to the Plan (using the contact information listed below) concerning the Plan's policies and procedures related to the HIPAA Privacy Rule the Plan's compliance with such policies and procedures, or the Plan's compliance with the HIPAA Privacy Rule.

You also may submit a complaint, in writing or electronically, to the U. S. Department of Health and Human Services. Upon request, we will provide you with the address to file a complaint with the U. S. Department of Health and Human Services.

We support your rights described above. The Plan will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

Contact Office: VibrantCare Rehabilitation
14090 SW Freeway
Suite 101
Sugar Land, TX 77478
ATTN: Group Health Plan Privacy Officer
(916-782-1212)

VibrantCare's Initial Notice About Special Enrollment Rights

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

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

To request special enrollment or obtain more information, contact:
VibrantCare Rehabilitation
14090 SW Freeway
Suite 101
Sugar Land, TX 77478
916-782-1212

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS ** CONTINUATION COVERAGE RIGHTS UNDER COBRA**

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

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

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

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [choose and enter appropriate information: must pay or aren't required to pay] for COBRA continuation coverage.

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

Legal Notices

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

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

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

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

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

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event. You must provide this notice to: VibrantCare Rehabilitation, Inc. Human Resources.

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

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

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

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

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

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

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

Plan contact information
VibrantCare Rehabilitation
14090 SW Freeway
Suite 101
Sugar Land, TX 77478
916-782-1212

Insurance Marketplace Notice

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1] Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution, as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact the insurance carrier's customer service number located on your ID card. 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. To get information about the Marketplace coverage, you can call the government's 24/7 Help-Line at 1-800-318-2596 or go to https://www.healthcare.gov/marketplace/individual/.

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.

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

3. Employer Name VibrantCare	4. Employer Identification Number 20-5975221	
5. Employer Address 14090 SW Freeway, Suite 101	6. Employer phone number 916-782-1212	
7. City Sugar Land	8. State TX	9. Zip Code 77478
10. Who can we contact about employee health coverage at this employer? Heather Tenconi	11. Phone Number 916-789-8134	12. Email Address htenconi@vibrantcare.com

VibrantCare Rehabilitation reserves the right to modify, amend, suspend or terminate any plan, in whole or in part, at any time. The information in this Enrollment Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies, or errors are always possible. In case of discrepancy between the Guide and the actual plan documents the actual plan documents will prevail.