



2025 Employee Benefits Guide



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This 2024 Benefit Summary highlights recent plan changes and is intended to fully comply with the requirements under the Employee Retirement Income Security Act (ERISA) as a Summary Material Modification (SMM) and should be kept with your most recent Summary Plan Description (SPD). This document does not guarantee any benefits.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

WELCOME TO THE EMPLOYEE BENEFITS GUIDE

Omega Technical Services recognizes the importance of benefits within the overall compensation package provided to all of our eligible employees. Please review the following pages for a summary of our benefit offerings.

MEDICAL

Blue Cross Blue Shield of Tennessee
Policy # 171739
www.bcbst.com
1.800.565.9140

DENTAL

Sun Life
Policy # 972787
www.sunlife.com/account
1.800.247.6875

VISION

Sun Life
Policy # 972787
www.vsp.com
1.800.877.7195

SHORT-TERM DISABILITY

One America
Policy #00625687
1.800.533.5318 Ext. 3
www.oneamerica.com/employers/offerings/employee-benefit-solutions

GROUP LONG-TERM DISABILITY

One America
Policy #00625687
1.800.533.5318 Ext. 3
www.oneamerica.com/employers/offerings/employee-benefit-solutions

LIFE AND AD&D (EMPLOYER & EMPLOYEE PAID)

One America
Policy #00625687
1.800.533.5318 Ext. 3
www.oneamerica.com/employers/offerings/employee-benefit-solutions

HEALTH SAVINGS ACCOUNT

Health Equity
www.healthequity.com
1.866.346.5800

ACCIDENT, CRITICAL ILLNESS, AND HOSPITAL INDEMNITY

Principal
Policy #1024692
www.principal.com

TELADOC

Blue Cross Blue Shield of Tennessee
www.bcbst.com/teladoc
1.800.TELADOC (835.2362)
1.800.818.8581 – Nurseline

EMPLOYEE ASSISTANCE PROGRAM

ComPsych – One America
Web ID: ONEAMERICA3
1.855.387.9727
www.guidanceresources.com

401(K)

Fidelity
www.fidelity.com

OMEGA HUMAN RESOURCES DEPARTMENT

Email: hr@omegatechserv.com
Phone: 865.272.3371

BENEFIT ADVOCATE CENTER

Email: bac.omegatechserv@ajg.com
Phone: 833.213.2716



BENEFITS OVERVIEW

2025 Plan Year Runs
January 1, 2025 - December 31, 2025

2025 AT A GLANCE

This year we offer our medical plans through Blue Cross Blue Shield. To better provide for the needs of our employees and their families, Omega will offer two medical plans in 2025; PPO plan and an HSA plan.

Eligible Employees may enroll themselves in benefits as well as their eligible dependents. Employees may select any of the tiers below when adding dependent coverage. See key terms below for coverage selection:

Employee only: Employees may select this tier if they wish only to enroll themselves on the plan.

Employee + Spouse: Employees may select this tier if they wish to enroll themselves and their legal spouse on the plan.

Employee + Child(ren): Employees may select this tier if they wish to enroll themselves and one or more children on the plan.

Family: Employees may select this tier if they wish to enroll themselves, their legal spouse, and one or more children on the plan.

New employees who are benefits eligible **must enroll via Paycom within 10 days** of their date of hire.

Benefits are effective on date of hire and terminate the last day of employment.

Children up to age 26 may be covered on your insurance plan, regardless of dependent status. At the end of the month that the dependent turns 26, they will automatically be dropped from the insurance plan and offered COBRA coverage. A COBRA notice will be mailed from the Medical carrier.

KEY TERMS

Full-Time Employee: Defined as an employee working 30 or more hours per week. Full benefits include all benefits in accordance with Omega Technical Services policy.

Effective Date: All full time employees benefit effective date is immediate following date of hire and will terminate following the last day worked.

HOW TO MAKE CHANGES

You are only allowed to make mid-year changes if one of the following Qualified Events occur:

- | | |
|---|--|
| ■ Marriage | ■ Change in residence due to an employment transfer for you or your spouse |
| ■ Divorce | ■ Commencement or termination of adoption proceedings |
| ■ Legal separation | ■ Change in spouse's benefits or employment status. |
| ■ Birth or adoption of a child | ■ Your election changes must be submitted to HR within 30 days of the qualifying event. |
| ■ Change in child's dependent status | |
| ■ Death of spouse, child or other qualified dependent | |

WAIVING COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, providing that you request enrollment **within 30 days** after your other creditable group or government sponsored coverage ends.

COBRA

COBRA continuation is offered to covered employees, their spouses, their former spouses, and their dependent children when group health coverage would otherwise be lost due to certain specific events. COBRA continuation applies to Medical, Pharmacy, Dental, and Vision. Qualified individuals may be required to pay for the entire premium for coverage up to 102 percent of the cost of the plans selected and may continue for up to 18 months or 36 months (if applicable).

PAYCOM ENROLLMENT INSTRUCTIONS

How to Enroll

TO ENROLL IN BENEFITS, LOG INTO THE PAYCOM APP VIA YOUR MOBILE DEVICE OR THROUGH YOUR WEB BROWSER. THE STEPS TO ENROLL ARE THE SAME FOR BOTH DEVICES.

STEP 1

From the Notifications Center, tap the current year's Benefits Enrollment. Review the instructions and tap "Start Enrollment."



STEP 2

Review your information. Tap "Edit" to change anything or "Next" to continue.



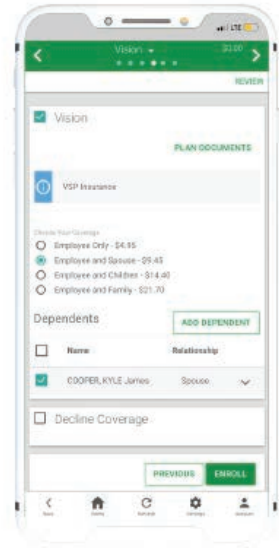
STEP 3

Complete the Pre-Enrollment Questions and tap "Save and Next." You can also edit existing dependent and beneficiary information on this screen, as well as add a dependent or beneficiary.



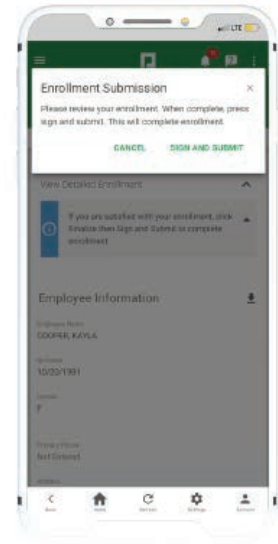
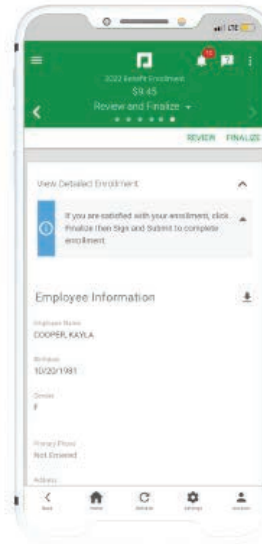
STEP 4

Choose to enroll in or decline a plan by checking the appropriate option. If necessary, choose which dependents to add. When finished, tap "Enroll." Continue for each benefit plan.

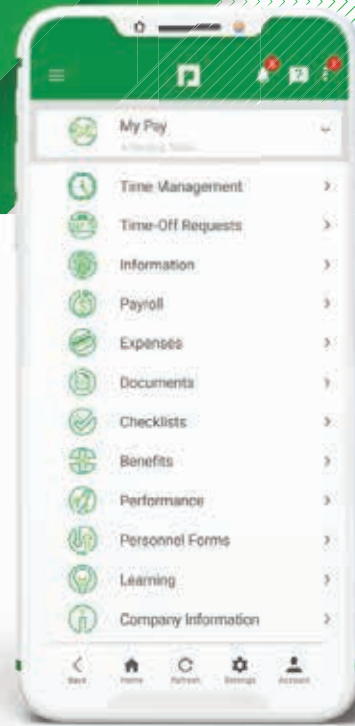


STEP 5

When finished, review your enrollment and tap "Finalize." Then, tap "Sign and Submit" in the pop-up window. To view your current benefits at anytime, navigate to *Benefits > Current Benefits*.



FREQUENTLY ASKED QUESTIONS ABOUT PAYCOM'S EMPLOYEE SELF-SERVICE®



Where do I access Employee Self-Service?

- » Access Employee Self-Service at paycom.com or through the Paycom app, available on the App Store® or Google Play®.
- » Employee Self-Service in the mobile app includes everything you'd find on the desktop version, so you can use it on the go!

Who do I contact if I forget my username?

- » Contact your company's HR department if you forget your username.
- » [Show Me How to Reset My Username](#)

Who do I contact if I forget my password?

- » Click the "forgot password" link on the Employee Self-Service login screen, and follow the prompts to retrieve your password. Or contact your company's HR department.
- » [Show Me How to Reset My Password](#)

Is that a zero in my username?

- » Your username will always start with the number zero (0). The additional letters and numbers will be a combination. A zero (0) is more narrow than an O in Paycom, so that's how you can tell the difference.

Who do I call for help?

- » Contact your manager or your company's HR department for help.

Where can I view my pay stubs?

- » Within Employee Self-Service, go to the "Payroll" tab and then select "View Pay Stubs." You'll find year-to-date totals and specific pay stubs from each previous payroll.

I recently made a change to my benefits/tax status. How will that affect my check?

- » Under the "Payroll" tab, "Test Sample Paycheck" will allow you to hypothetically make a change to hours worked, deductions, tax information and more to see what your take-home amount would be.
- » [Show Me How to Update My Tax Info](#)
- » [Show Me How to Update My Dependents and Beneficiaries](#)

How will I know if I have a task that needs to be completed?

- » In Employee Self-Service, a notification center appears on the right-hand side. This will alert and inform you of any specific tasks that have been assigned for you to complete.

How can I get training on the new system?

- » Paycom University is your go-to spot for easy, quick, on-demand training on every aspect of Employee Self-Service. To access these courses in Employee Self-Service, go to the "My Learning" tab and select "Paycom University."
- » Find a full library of Show Me How Guides by accessing the Help Menu within Employee Self-Service

How do I get started?

- » [Show Me How to Verify My Phone Number for Two-Factor Authentication](#)
- » [Show Me How to Change My Language Preference](#)
- » [Show Me How to Update My Emergency Contact Information](#)

Where can I approve my check?

- » Within Employee Self-Service, you will have a notification under "My Pay" at the top of your homepage.
- » It will compare your current check to the prior one.
- » Click the green "Approve Check" button if correct or click the blue "Ask Here" button if you have any questions or concerns.

How will I know if I have a payroll error to correct?

- » As with check approval, you will receive notifications under "My Pay" of issues to resolve. Whether these involve your time sheet, PTO, expenses or otherwise, our software will guide you through fixing them.

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MEDICAL INSURANCE



As a full-time employee of Omega Technical Services, you have the choice between two medical plans through Blue Cross Blue Shield of Tennessee (BCBST):

- Option 1: PPO plan
- Option 2: High Deductible Health Plan (QHDHP/HSA)

Regardless of the plan you select, your deductible will run from January 1–December 31.

- Both plans provide the option of using out-of-network providers, but to save money, use in-network providers where BCBST has negotiated significant discounts.
- By electing to go out-of-network, members will be responsible for the difference between the actual charge and BCBST UCR (Usual, Customary and Reasonable) charge, in addition to the out-of-network deductible and coinsurance.

HOW TO GET STARTED

Select your medical plan:

- OPTION 1: PPO
- OPTION 2: HDHP / HSA

TIP: Get the most out of your insurance by using in-network providers.

FREQUENTLY ASKED QUESTIONS

HOW MANY HOURS DO I NEED TO WORK TO BE ELIGIBLE FOR MEDICAL INSURANCE?

You must be a full-time employee working a minimum of 30 hours per week on a regular basis.

DOES THE DEDUCTIBLE RUN ON A CALENDAR YEAR OR POLICY YEAR BASIS?

A calendar year basis.

HOW LONG CAN I COVER MY DEPENDENT CHILDREN?

Dependent children are eligible until the end of the month in which they turn age 26.

I JUST GOT HIRED. WHEN WILL MY BENEFITS BECOME EFFECTIVE?

Your medical insurance will begin on the 1st day of employment for full-time employees.



BCBST
Policy # 171739
www.bcbst.com

MEDICAL PLAN OPTIONS

In-Network Benefits				
	Option 1: PPO		Option 2: HDHP / HSA	
Calendar Year Deductible Individual / Family	\$1,000 / \$2,000		\$3,300 / \$6,600	
Coinsurance (unless otherwise stated)	20%		20%	
Out-of-Pocket Maximum Individual / Family	\$4,000 / \$8,000		\$6,000 / \$12,000	
The out-of-pocket maximum includes deductibles and medical copayments				
Preventive Care	100%, no deductible		100%, no deductible	
Office Visits				
Primary Care	\$25 copay		20% after deductible	
Specialist	\$50 copay			
X-ray and Lab	20% after deductible		20% after deductible	
Inpatient / Outpatient Services	20% after deductible		20% after deductible	
Outpatient Surgery	20%, after deductible		20% after deductible	
Emergency Room/Services	20% after deductible		20% after deductible	
Prescription Drugs				
Tier 1	\$10 copay		20% after deductible	
Tier 2	\$10 copay			
Tier 3	\$35 copay			
Tier 4	\$50 copay			
	Monthly Premiums	Bi-Weekly Premiums	Monthly Premiums	Bi-Weekly Premiums
Employee Only	\$0.00	\$0.00	\$0.00	\$0.00
Employee + Spouse	\$822.74	\$379.73	\$607.16	\$280.23
Employee + Child(ren)	\$620.79	\$286.52	\$458.13	\$211.44
Employee + Family	\$1,522.07	\$702.49	\$1,123.26	\$518.43

(1) Family deductible is embedded; an individual covered in a family will not exceed the individual deductible

(2) Out-of-Pocket maximum includes all cost-sharing: deductible, coinsurance and copays

(3) All Out-of-Network services subject to deductible, coinsurance and balance billing

Premiums will be withheld from your paycheck on a pre-tax basis. Based upon your individual tax bracket, this could save you a considerable amount of money.

Your election can only be changed during the plan year if you experience a qualifying life status change (see page 4 for a listing of “Qualified Events”). You must notify Human Resources within 30 days of the event. Both plans are detailed in BCBST’s 2025 Certificate of Coverage (COC). This is a brief summary only. For exact terms and conditions, please refer to your certificate.

QUICK TIPS ON CARE OPTIONS

While we recommend that you seek routine medical care from your primary care physician whenever possible, there are alternatives available to you. Services may vary, so it's a good idea to visit the healthcare provider's website. Be sure to check that the facility is in-network by calling the toll-free number on the back of your medical ID card, or by visiting www.bcbst.com.

PRIMARY CARE

For routine, primary/ preventive care or non-urgent treatment, we recommend going to your doctor's office. Your doctor knows you and your health history and has access to your medical records. You may also pay the least amount out of pocket.

TELADOC (BLUE CROSS BLUE SHIELD OF TENNESSEE)

Teladoc Health lets you talk with a doctor 24/7 using your phone, online video chat or our mobile app*.

And you'll typically pay less than you would for a visit to the office or urgent care clinic.

Employees can get started in one of three ways:

- Log in at bcbst.com/teladoc.
- Call 1.800.TELADOC.
- Open the BCBSTN app and tap **Talk to a Doctor Now**.

URGENT CARE

Sometimes you need medical care fast, but a trip to the emergency room may not be necessary.

During office hours, you may be able to go to your doctor's office. Outside regular office hours—or if you can't be seen by your doctor immediately—you may consider going to an Urgent Care Center, where you can generally be treated for many minor medical problems faster than at an emergency room.

EMERGENCY ROOM

An emergency medical condition is any condition (including severe pain) which you believe that without immediate medical care may result in serious injury or is life threatening.

Emergency services are always considered in-network. If you receive treatment for an emergency in a non-network facility, you may be transferred to an in-network facility once your condition has been stabilized.

The Different Healthcare Options and What To Use Them For

\$ Teladoc (Non-Life-Threatening)	\$\$ Doctor's Office (Non-Life-Threatening)	\$\$\$ Urgent Care Center (Non-Life-Threatening)	\$\$\$\$ Emergency Room (Life-Threatening)
» Headaches » Fever and flu symptoms » Cough, cold, and sore throat » Skin irritations/rashes	» Headaches » Fever and flu symptoms » Cough, cold, and sore throat » Skin irritations/rashes » Earaches and infections » Minor cuts, bumps, sprains, and burns » Urinary tract infections » Back and joint pain	» Earaches and infections » Minor cuts, bumps, sprains, and burns » Fever and flu symptoms » Allergic reactions » Animal bites » Mild asthma » Headaches » Urinary tract infections » Back and joint pain	» Sudden numbness or weakness » Disorientation or difficulty speaking » Sudden dizziness or loss of coordination » Seizure or loss of consciousness » Shortness of breath or severe asthma attack » Head injury or major trauma » Blurry or lost vision » Severe cuts or burns » Overdoses » Uncontrolled bleeding » Coughing or vomiting blood » Heart attack or chest pain » Severe allergic reactions



Talk to Doctors When You Need Them



Use Teladoc™ Health to talk to a doctor by phone or video chat. It's available 24/7 for non-emergencies. And it typically cost less than you'd pay for an office visit or urgent care trip.

You can use Teladoc Health for:

- › General Medical: See a doctor for allergies, cold, fever, flu and more.
- › Mental Health: Talk to an expert for anxiety, depression and other issues.
- › Dermatology: Get treatment for skin conditions by uploading pictures.
- › Nutrition Counseling: Get a nutrition plan from dietitians.
- › Back & Joint Care: Work with a health coach to manage your pain.
- › Tobacco Cessation: Talk to a doctor about enrolling in this program.



How do I use Teladoc Health?

You'll need to register an account by answering a few quick questions. Make sure to have your Member ID card ready when you register. To get started:

- › Log in to the **BCBSTN**™ app and choose **Talk to a Doctor Now**, or
- › Visit **bcbst.com/Teladoc**, or
- › Call **1-800-TELADOC (1-800-835-2362)**.

HEALTH SAVINGS ACCOUNT (HSA)



Two ways you can put money into your HSA:

1. Regular payroll deductions on a pre-tax basis
2. Lump-sum contributions of any amount, anytime, up to the maximum limit.

CONTRIBUTE
UP TO
\$4,300
SINGLE, OR
\$8,550
FAMILY

UNDERSTANDING A HEALTH SAVINGS ACCOUNT (HSA)

WHAT IS AN HSA?

A savings account where you can either direct pre-tax payroll deductions or deposit money to be used to pay for current or future qualified medical expenses for you and/or your dependents. Once money goes into the account, it's yours to keep—the HSA is owned by you, just like a personal checking or savings account.

THE HSA CAN ALSO BE AN INVESTMENT OPPORTUNITY.

Depending upon your HSA account balance, your account can grow tax-free in an investment of your choice (like an interest-bearing savings account, a money market account, a wide variety of mutual funds—or all three). Of course, your funds are always available if you need them for qualified health care expenses.

YOUR FUNDS CAN CARRY OVER AND EVEN GROW OVER TIME.

The money always belongs to you, even if you cease employment with Omega Technical Services, and unused funds carry over from year to year. You never have to worry about losing your money. That means if you don't use a lot of health care services now, your HSA funds will be there if you need them in the future - even after retirement.

HSA FUNDS CAN BE USED FOR YOUR FAMILY.

You can use your HSA for your spouse and tax dependents for their eligible expenses - even if they're not covered by your medical plan.

WHAT ARE THE RULES?

- You must be covered under a Qualified High Deductible Health plan (QHDHP) in order to establish an HSA (Medical Opt 2).
- You cannot establish an HSA if you or your spouse also have a medical FSA, unless it is a Limited Purpose FSA.
- You cannot be enrolled in Medicare or Tricare due to age or disability.
- You cannot set up an HSA if you have insurance coverage under another plan, for example your spouse's employer, unless that secondary coverage is also a qualified high deductible health plan.
- You cannot be claimed as a dependent under someone else's tax return.

WHAT ELSE SHOULD I KNOW?

- **SAVE:** You can invest up to the IRS's annual contribution limit. Contributions are based on a calendar year. The contribution limits for 2025 are \$4,300 for Single and \$8,550 for Family coverage. If you're age 55 or older, you are allowed to make extra an extra \$1,000 contribution each year.
- **GROW:** The contributions grow tax-free and come out tax-free as long as you utilize the funds for approved services based on the IRS Publication 502, (medical, dental, vision expenses and over-the-counter medications with a physician's prescription).
- **OWN:** Your unused contributions roll over from year to year and can be taken with you if you leave your current job.
- **CHOOSE:** If you use the money for non-qualified expenses, then the money becomes taxable and subject to a 20% excise tax penalty (like in an IRA account).
- There is no penalty for distributions following death, disability (as defined in IRC 72), or attainment of Medicare eligibility age, but taxes would apply for non-qualified distributions.
- If your healthcare expenses are more than your HSA balance, you need to pay the remaining cost another way, such as a credit card or personal check. You can request reimbursement later, after you have accumulated more money in your account. But save your receipts in case you are ever audited!

YOU CAN USE HSA FUNDS FOR IRS-APPROVED ITEMS SUCH AS:

- Doctor's office visits
- Dental services
- Eye exams, eyeglasses, laser surgery, contact lenses and solution
- Hearing aids
- Orthodontia, dental cleanings, and fillings
- Prescription drugs and some over-the-counter medications (with a physician's prescription)
- Physical therapy, speech therapy, and chiropractic expenses

More information about approved items, plus additional details about the HSA, is available at [irs.gov](https://www.irs.gov).

Every time you use your HSA, save your receipt in case the IRS asks you to prove your claim was for a qualified expense. If you use HSA funds for a non-qualified expense, you will pay tax and a penalty on those funds.

The HSA is your personal account and contains your personal funds. It can be considered an asset by a creditor and garnished as applicable.

As an HSA account holder, you will be required to file a Form 8889 with the IRS each year. This form identifies any contributions, distributions, or earned interest associated with your account.

FREQUENTLY ASKED QUESTIONS:

WHAT WILL I PAY AT THE PHARMACY WITH THE HSA QUALIFIED PLAN OPTIONS?

You will pay the actual discounted cost of the drug until you satisfy your calendar year deductible in full.

WHAT WILL I PAY AT THE PHYSICIAN'S OFFICE WITH THE HSA QUALIFIED PLAN?

You'll provide your ID card at the time of the visit and the physician's office will submit the claim to Blue Cross Blue Shield. You will not owe anything at the time of the visit. Later you'll receive an Explanation of Benefits (EOB) from Blue Cross Blue Shield that shows the charges discounted based on their contract with the physician. When you receive a bill from the physician's office, you pay the portion of the discounted cost you are responsible for as shown on the EOB.

WHERE CAN I GET A COPY OF AN EOB?

You can access all of your EOB information, as well as obtain other important information, by logging on to the carriers website or download the app.



DENTAL INSURANCE



As a full-time employee at Omega Technical Services, your dental benefits are available immediately following your date of hire and terminated the last day worked.

As of January 1, 2025, Omega's dental provider will be Sun Life. If services are provided by an in-network provider, your provider agrees to a negotiated charge and you will not be responsible for balance billing. Additionally, the provider's office will file a claim for you so there is no paperwork for you to complete.

HOW TO FIND A DENTIST

To find a provider visit www.sunlife.com

You will not receive a paper ID Card but one can be printed from www.sunlife.com.

Dental services are divided into three coverages:

- Preventive procedures include exams, x-rays and preventive care and is paid entirely by the plan.
- Basic procedures include basic restorative treatment, endodontics, oral surgery, and periodontics.
- Major procedures include complex restorative surgeries and prosthodontics.

As a member of Sun Life, you have access to one of the nation's largest dental networks and when seeing a dentist in either Sun Life networks, you cannot be balance billed - giving you added savings.

You are also free to visit non-network dentists, but you may be balance billed for services that exceed the Sun Life in-network contracted rates.

If services are provided by a non-network provider, charges in excess of the 80th percentile of usual and customary charges will be your responsibility. Please be sure to consult either the online directory or call Sun Life Customer Service to confirm that your dentist is in the network.

Sun Life Dental	Option 1 – Basic		Option 2 – Buy-Up	
	In-Network			
Plan Year Annual Deductible Individual / Family	\$50 / \$150		\$50 / \$150	
Plan Year Annual Maximum Benefit Individual / Family	\$1,500* per covered person		\$2,000**	
Preventive Services	100% , deductible does not apply		100%, deductible does not apply	
Basic Services	90% after deductible		90% after deductible	
Major Services	60% after deductible		60% after deductible	
	Monthly Premium	Bi-Weekly Premiums	Monthly Premium	Bi-Weekly Premiums
Employee Only	\$0.00	\$0.00	\$2.29	\$1.06
Employee + Spouse	\$26.87	\$12.40	\$31.42	\$14.50
Employee + Child(ren)	\$37.05	\$17.10	\$43.54	\$20.10
Employee + Family	\$63.92	\$29.50	\$72.67	\$33.54

*Plan includes a \$500 Rollover amount with a total rollover limit of \$1,250. If the annual spend is less than \$700 on dental services in a year, they can rollover \$500 for the next year. This allows covered individuals to increase their annual maximum dollars for future treatments.

**Plan includes a \$600 Rollover amount with a total rollover limit of \$1,500. If the annual spend is less than \$800 on dental services in a year, they can rollover \$600 for the next year. This allows covered individuals to increase their annual maximum dollars for future treatments.



VISION INSURANCE



All full time employee at Omega Technical Services have the option to elected vision coverage upon enrollment. This coverage is effective immediately following your date of hire and terminates following the last day worked.

As of January 1, 2025, Omega’s vision provider will be Sun Life. Omega’s vision plan covers routine eye care, including eye exams and eyeglasses (lenses and frames) or contacts. When you choose an in-network provider for your eye exam and materials, you are responsible for the copay only. If you choose a provider that is not in network with Sun Life will reimburse you according to the plan’s non-network benefit schedule (listed below under “Out-of-Network Provider”).

Go to www.sunlife.com to find an in-network provider near you.

Sun Life Vision	In-Network	
Vision Exam Covered every 12 months Ophthalmologist (M.D.) Optometrist (O.D.)	Covered in full after \$10 copay	
Frames Covered every 24 months	Plan pays up to \$150 after \$25 copay	
Lenses Covered every 12 months Single Bifocal Trifocal Lenticular Progressive	Covered in full after \$25 copay	
Contact Lenses		
Standard Contact Lens Fitting Exam Fee*	\$40 copay	
Elective Contact Lenses	Plan pays up to \$150	
	Monthly Premium	Bi-Weekly Premiums
Employee Only	\$6.86	\$3.17
Employee + Spouse	\$13.72	\$6.33
Employee + Child(ren)	\$15.09	\$6.96
Employee + Family	\$21.91	\$10.11

*Standard contact lens fitting fee applied to an existing contact lens user who wears disposable, daily wear, or extended lenses only. The specialty contact lens fitting fee applies to new contact lens wearers and/or a member who wears toric, gas permeable, or multi-focal lenses. For the specialty fit, the member is responsible for any charges over \$50.

HOW TO FIND A PROVIDER

To find a provider in your area, visit www.sunlife.com.

- Click on “Find an eye care professional” at the top of the page
- Enter your location, coverage type, Superior National Network, and click search.



BENEFIT ADVOCATE CENTER (BAC)



Insurance | Risk Management | Consulting

Ask Your Advocate Team

Maximize your healthcare benefits with the help of a team of licensed healthcare advocates.

Gallagher is ready to help you get the most from your benefits program by providing support from an advocate at no cost to you. Get assistance with:

1 Enrollment support
Need help enrolling in your company's benefits during annual enrollment, a life event, or if you're newly hired?

2 Insurance cards
Are you missing your insurance cards, need replacement cards, or need to get in touch with an insurance carrier?

3 Benefits questions
Do you need help with specific benefits questions relating to how plans work, coverage questions, or in-network benefits?

4 Eligibility rules
Who can be covered under the plan and when?

5 Provider search
Do you need help finding an in-network or specialty provider?

6 Prescription/pharmacy issues
Is the pharmacy telling you that your medication is not covered or charging you the full price? Do you need help getting a pre-authorization for your medication?

7 Claim/complex issues
Are you unsure if your insurance will pay for a certain procedure? Do you have a complex situation and need assistance with an appeal, billing coding issue, or out-of-network claim?

8 Nurse advocacy
Do you need assistance with a medical diagnosis, treatment options, pre-authorization issue, specific benefits, or drug denial?

Hours of Operation

Monday – Friday
8 a.m. – 9 p.m. EST

Connect with us

Omega Technical Services

(833) 213-2716
bac.omegatechserv@ajg.com

Translation Services Available

AJG.com The Gallagher Way. Since 1927.

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LIFE INSURANCE AND AD&D



REVIEW YOUR LIFE INSURANCE POLICY

- Basic Life and AD&D
- Voluntary Life / AD&D

Omega Consultants provides 1x salary up to \$50,000 in Basic Life and Accidental Death & Dismemberment (AD&D) insurance for employees.

This coverage is offered through One America at no cost to you.

VOLUNTARY LIFE AND AD&D

VOLUNTARY LIFE AND AD&D AND DEPENDENT LIFE

You can purchase Life and AD&D Coverage at a group rate through Omega. One America guarantees issue coverage during your initial enrollment period— which means you can't be turned down for coverage based on medical history. Any election above the guaranteed amount will require approval by One America.

For your specific rates please visit Paycom. Your premium is based on your Age & Salary for STD / Life is based on Salary.

- **Voluntary Employee Life/AD&D:** minimum \$10,000 to a maximum \$300,000, in \$10,000 increments. Guarantee issue up to \$180,000 at initial eligibility.
- **Voluntary Spouse Life/AD&D:** minimum \$5,000 up to 100% of the employee amount, to \$100,000 maximum in \$5,000 increments. Guarantee issue up to \$25,000 at initial eligibility.
- **Optional Child(ren) Life:** \$10,000 coverage. Guarantee issue is \$10,000 (>14 days of age) and \$1,000 for dependents under 14 days of age.
- If you don't enroll in the Voluntary Life and AD&D plan during your initial enrollment period, you'll be required to complete an Evidence of Insurability form (EOI) and be approved by One America before you're able to get coverage in the future.
- You must be enrolled in Voluntary Life and/or AD&D coverage in order for your spouse, and/or eligible dependent children to enroll.

ADDITIONAL BENEFITS

ACCELERATED DEATH BENEFIT

If you're terminally ill, you may be able to receive a portion of your life benefit.

COVERAGE DURING DISABILITY

If you're disabled, you may be able to continue your coverage and not pay premium.

PORTABILITY

If you no longer qualify for coverage, you may be able to continue coverage for yourself and your covered dependents.

CONVERSION OF TERMINATED COVERAGE

If coverage terminates, you may be able to convert coverage to an individual policy.

If you do not enroll in Life insurance upon initial eligibility (within 30 days of your date of hire), you may be asked to complete an Evidence of Insurability form if you wish to enroll (or increase your coverage) at a later date.

*Please remember to update your Beneficiary in Paycom for Voluntary and Basic Life.

DISABILITY

- Short-Term Disability
- Group Long-Term Disability



SHORT-TERM DISABILITY

Voluntary Short-Term Disability (STD) insurance is offered through One America. The plan benefit is 60% of basic monthly earnings up to a maximum of \$1,500 per week. Benefits are paid after an elimination period of 7 calendar days for an accident or illness. Benefits can continue for up to 12 weeks.

Pregnancy is considered a disability under the policy. A traditional birth is covered up to 6 weeks. A Caesarean birth is covered up to 8 weeks.

Premiums are deducted before-tax. Employees who are approved for Short-Term Disability are not able to use leave time beyond the first 7 days (elimination period).

Pre-existing limitations apply to injuries or sickness (including pregnancy) and all related conditions and complications, in the 3 months prior to your effective date under this policy. After 12 months of consecutive coverage, you may qualify for benefits related to a pre-existing condition.

For your specific rates please visit Paycom. Your premium is based on your Age & Salary for STD / Life is based on Salary.

GROUP LONG-TERM DISABILITY

Because some disabilities continue for a significant amount of time, Long-Term Disability (LTD) coverage can help provide partial income replacement when you're unable to work during a serious disability or extended illness. **Your LTD benefit equals 60% of your pre-disability earnings (up to a monthly amount of \$6,000)**, and is covered at not cost to you, but 100% paid by One America.

LTD benefits start after you have been disabled for 90 days and can continue until you return to work, retire (up to age 65 or Social Security normal retirement age depending on the date of disability), or death.

If you do not enroll in disability insurance coverage upon initial eligibility (within 30 days of your date of hire), you may be asked to complete an Evidence of Insurability form if you wish to enroll at a later date.



VOLUNTARY CRITICAL ILLNESS



CRITICAL ILLNESS

Principal's Critical Illness insurance helps you to maintain financial security during the lengthy, expensive recovery period of a serious medical event such as cancer, heart attack, or stroke. It provides a lump sum benefit to help with the out-of-pocket medical and/or non-medical expenses of critical illness and/or cancer. You can choose policy amounts in \$5,000 increments up to \$50,000. This plan is portable; you can take it with you even if you leave employment. Coverage is available for you, your spouse, and eligible dependents. Premiums are payroll deducted for your convenience. It includes recurrent benefit which extends coverage to a second covered diagnosis, enabling insured employees to receive benefits up to 200% of the plan's value. Specified diseases include ALS (Lou Gehrig's Disease), Anthrax, Cholera, Encephalitis, Meningitis, Rocky Mountain Spotted and Typhoid Fevers, Tuberculosis, Primary Sclerosing.

Coverage	Percent of Policy Amount
Cancer Diagnosis	100%
Heart Attack/Stroke	100%
Major Organ Transplant	100%
Bone Marrow Transplant	100%
End-Stage Renal Failure	100%
Burns (3rd degree, over at least 50% of body)	100%
Specified Diseases*	100%
Prostate Cancer and/or Carcinoma In Situ	30%
Coronary Artery Bypass Surgery	30%
Alzheimer's Disease	30%
Angioplasty/Stent	10%
Skin Cancer Diagnosis	10%
Cancer Vaccine	\$75 lifetime, one-time payment
Cancer Treatment & Care	\$50/month, up to 12 months

Please note: Critical Illness rates are based on your age and the amount of the benefit elected. Your personalized rates are available on Paycom.



VOLUNTARY ACCIDENT RECOVERY



ACCIDENT RECOVERY

This plan provides lump sum benefits for covered accidents, such as benefits for:

- Fractures
- Concussions
- Emergency treatment
- Hospital confinement
- Accidental death and dismemberment

These benefits can help with the out of pocket medical and non-medical expense associated with an accident.

Coverage is provided 24 hours a day - no matter where the accident occurs.

Coverage is guaranteed; no health questions or underwriting required. The plan is portable; you can take it with you even if you leave employment.

Coverage is available for you, your spouse, and eligible dependents and premiums are payroll deducted.

Benefits are provided for hospitalization, surgery, and follow-up with a physician.

To promote healthier routines, insureds can receive an annual payment of \$60, \$75 or \$105 (based on the plan you select) for having covered health screenings and tests.

Coverage Type	Bi Weekly Rates
Employee	\$6.76
Employee + Spouse	\$10.28
Employee + Child(ren)	\$12.21
Family	\$18.53



IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) or call 800.318.2596 (TTY: 855.889.4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

VOLUNTARY HOSPITAL INDEMNITY

This plan provides a reassuring layer of financial protection for you and your family by paying you cash to cover the unexpected expenses in the event of hospitalization. Benefits are paid directly to you, with no coordination of benefits with the medical plan. The plan provides coverage for hospitalization, intensive care, sickness, and wellness. It is portable; you can take it with you even if you leave employment.

Coverage is available for you, your spouse, and eligible dependents.



Hospital Procedure/Service	
First-Day Hospital Confinement	\$1,000
Daily Hospital Confinement (per day, up to 30 days)	\$100
Intensive Care Confinement (per day, up to 10 days)	\$100
Extended Hospitalization (per day)	\$100
Covered Conditions	
Newborn Care	Complications only; Payable under Hospital or ICU Confinement
Complications of Pregnancy	Included
Normal Pregnancy	Included
Normal Pregnancy Waiting Period	10 Months
Mental/Nervous	Included
Substance Abuse	Included
Sickness & Accidents	24-hour Coverage
Pre-Existing Condition Limitation	12-Dec
Wellness Benefit	
Annual Benefit Amount	\$50

Coverage Type	Bi Weekly Rates
Employee	\$9.63
Employee + Spouse	\$21.23
Employee + Child(ren)	\$14.72
Family	\$27.27



EMPLOYEE ASSISTANCE PROGRAM (EAP)



Call Your ComPsych® GuidanceResources® program anytime for confidential assistance.

Call: **855.387.9727**

Go online: **guidanceresources.com**

TDD: 800.697.0353

Your company Web ID: **ONEAMERICA3**

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. Your GuidanceResources program provides support, resources and information for personal and work-life issues. The program is company-sponsored, confidential and provided at no charge to you and your dependents. This flyer explains how GuidanceResources can help you and your family deal with everyday challenges.

Confidential Counseling

3 Session Plan

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultants™—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling (up to 3 sessions per issue per year) and other resources for:

- › Stress, anxiety and depression
- › Relationship/marital conflicts
- › Problems with children
- › Job pressures
- › Grief and loss
- › Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- › Getting out of debt
- › Credit card or loan problems
- › Tax questions
- › Retirement planning
- › Estate planning
- › Saving for college

Legal Support and Resources

Expert info when you need it.

Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- › Divorce and family law
- › Debt and bankruptcy
- › Landlord/tenant issues
- › Real estate transactions
- › Civil and criminal actions
- › Contracts

Work-Life Solutions

Delegate your "to-do" list.

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- › Child and elder care
- › Moving and relocation
- › Making major purchases
- › College planning
- › Pet care
- › Home repair

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GuidanceResources® Online

Knowledge at your fingertips.

GuidanceResources Online is your one stop for expert information on the issues that matter most to you...relationships, work, school, children, wellness, legal, financial, free time and more.

- › Timely articles, HelpSheets™, tutorials, streaming videos and self-assessments
- › "Ask the Expert" personal responses to your questions
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EstateGuidance® lets you quickly and easily write a will on your computer. Just go to www.guidanceresources.com and click on the EstateGuidance link. Follow the prompts to create and download your will at no cost. Online support and instructions for executing and filing your will are included. You can:

- › Name an executor to manage your estate
- › Choose a guardian for your children
- › Specify your wishes for your property
- › Provide funeral and burial instructions



Your ComPsych® GuidanceResources® Program

CALL ANYTIME

Call: **855.387.9727**

TDD: 800.697.0353

Online: **guidanceresources.com**

Your company Web ID: **ONEAMERICA3**

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EDUCATION ASSISTANCE PROGRAM

Omega Technical Services is committed to providing employees with the opportunity to enhance and develop their knowledge and skills to meet the individual's career development goals as well as develop our workforce capabilities. We recognizes that obtaining and continuing education can be a key component to support this objective.

Please see below for highlights of the Education Assistance Program.

OVERVIEW

The Educational Assistance benefit is designed to assist regular full-time employees with payment of undergraduate, graduate, or certification costs to an accredited college, university, or certifying organizations.

ELIGIBILITY

Full-time, regular employees who have completed six-months of employment are eligible under this policy. Field employees working under a customer contract must have at least one year remaining under contract, including options, following the completion of the educational course or certification program.

UNDERGRADUATE DEGREE/GRADUATE DEGREE/CERTIFICATION PROGRAM

If approved, Omega Technical Services will provide up to \$5,000 annually (Subject to change) for continuing education or certifications through an accredited program that either offers growth in an area related to his or her current position or that may lead to promotional opportunities. This education may include college credit courses, continuing education unit courses, seminars and certification tests that are job-related.. Please note these funds are subject to IRS tax rules and is recorded in the year that it is paid to the employee.

The above is intended to highlight the policy. Please see the full Omega Technical Services Educational Assistance Policy for additional requirements and details and reach out to HR with any questions or concerns.



401(K)



Secure your financial future and maximize your savings potential through participating in Omega's 401(k) program!
The program offers:

- A generous dollar-for-dollar match up to 6% of your contributions
- An immediate vesting schedule
- Multiple investment options

By participating in our 401(k) program, you can double your contributions and watch your savings grow exponentially. With Omega's immediate vesting schedule, you have full ownership of your matched contributions from day one. This means that all the money contributed by Omega is yours to keep, regardless of how long you stay with the company. It's a valuable benefit that rewards your dedication and commitment to our team.

Employees are eligible to participate in the plan:

- Once they are actively employed at full-time status for 90 days
- Once they have completed a Fidelity enrollment packet prior to the enrollment window.

Contact Information – NetBenefits – 1.800.835.5097 / netbenefits.com



GALLAGHER MARKETPLACE



Benefits With Gallagher Marketplace

Giving you year-round access to additional benefits that could save you money.

Gallagher Marketplace is your gateway for discovering and accessing unique benefits that best fit your lifestyle. Our program offers significant savings on things you are already buying—like home and auto, pre-paid legal services, identity theft protection, pet insurance, renters insurance, boat or RV insurance, employee discount perks as well as extended vehicle warranties. Gallagher Marketplace also offers access to individual medical coverage as well as Medicare supplemental programs.

With a centralized hub, you can explore an array of benefit options, available not only to Gallagher clients but also to their friends and families.

Discover what benefits your organization offers through Gallagher Marketplace.

The Value

- Whether full-time, part-time or contract workers, all employees and their families are eligible
- Benefit access and potential savings through bundling with the ability to choose from multiple carriers
- Potential costs savings compared to shopping on your own
- Licensed insurance advisors to help find the policy that meets your needs

The Convenience

- Enroll any time of the year, not just during open enrollment
- Simple sign-up with payment options
- Easily compare rates from multiple carriers
- Schedule a callback from licensed insurance advisors for a time that's most convenient
- All programs are portable so you can keep the coverage no matter where life takes you

How It Works

- 1 Visit [Gallagher Marketplace](#) to see your available benefits.
- 2 Select a product to view more details.
- 3 Click on the partner link to learn more, get a free no obligation quote or apply for coverage.

Scan the QR code to learn more



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Insurance is subject to availability and individual eligibility.

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GLOSSARY OF MEDICAL TERMS

Coinsurance—The plan's share of the cost of covered services which is calculated as a percentage of the allowed amount. This percentage is applied after the deductible has been met. You pay any remaining percentage of the cost until the out-of-pocket maximum is met. Coinsurance percentages will be different between in-network and non-network services.

Copays—A fixed amount you pay for a covered health care service. Copays can apply to office visits, urgent care or emergency room services. Copays will not satisfy any part of the deductible. Copays should not apply to any preventive services.

Deductible—The amount of money you pay before services are covered. Services subject to the deductible will not be covered until it has been fully met. It does not apply to any preventive services, as required under the Affordable Care Act.

Emergency Room—Services you receive from a hospital for any serious condition requiring immediate care.

Lifetime Benefit Maximum—All plans are required to have an unlimited lifetime maximum.

Medically Necessary—Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, which meet accepted standards of medicine.

Network Provider—A provider who has a contract with your health insurer or plan to provide services at set fees. These contracted fees are usually lower than the provider's normal fees for services.

Out-of-pocket Maximum—The most you will pay during a set period of time before your health insurance begins to pay 100% of the allowed amount. The deductible, coinsurance and copays are included in the out-of-pocket maximum.

Preauthorization—A process by your health insurer or plan to determine if any service, treatment plan, prescription drug or durable medical equipment is medically necessary. This is sometimes called prior authorization, prior approval or precertification.

Prescription Drugs—Each plan offers its own unique prescription drug program. Specific copays apply to each tier and a medical plan can have one to five separate tiers. The retail pharmacy benefit offers a 30-day supply. Mail order prescriptions provide up to a 90-day supply. Sometimes the deductible must be satisfied before copays are applied.

Preventive Services—All services coded as Preventive must be covered 100% without a deductible, coinsurance or copayments.

UCR (Usual, Customary and Reasonable)—The amount paid for medical services in a geographic area based on what providers in the area usually charge for the same or similar service.

Urgent Care—Care for an illness, injury or condition serious enough that a reasonable person would seek immediate care, but not so severe to require emergency room care.



LEGAL NOTICES

NOTICE OF RIGHT TO ELECT COBRA CONTINUATION COVERAGE

WHAT IS COBRA CONTINUATION COVERAGE?

On April 7, 1986, a federal law was enacted (Public Law 99-272, Title X) requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end. This notice is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. You, your spouse and dependent children, if any, should all take the time to read the entire notice carefully.

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

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

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

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

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

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

- 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.”

*If a covered child of the employee is enrolled in the plan pursuant to a qualified medical child support order (QMCSO) during the employee’s period of employment, he or she is entitled to the same rights under COBRA as if he or she were the employee’s dependent.

HOW IS COBRA COVERAGE PROVIDED?

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

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee’s hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation

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

Your Election Rights: When the Plan Administrator or designated Plan Service Provider is notified that one of these events has happened, they will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage (because of one of the events described above) to inform the Plan Administrator or the designated Plan Service Provider that you want continuation coverage. If you do not choose continuation coverage in a timely manner, your group health insurance coverage will end.

Coverage Rights: If you choose continuation coverage, the Plan is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. Each covered person 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.

Maximum Period of Coverage: The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment (for reasons other than gross misconduct) or reduction in hours. In that case, the required continuation coverage period is 18 months. These 18 months may be extended for affected individuals to 36 months from termination of employment if other events (such as a death, divorce, legal separation, or Medicare entitlement) occur during that 18-month period. In no event will continuation coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage.

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

Disability: The 18 months may be extended to 29 months if a qualified beneficiary is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of COBRA coverage. This 11-month extension is available to all individuals who are qualified beneficiaries due to a termination or reduction in hours of employment.

To benefit from this extension, a qualified beneficiary must notify the Plan Administrator or designated Plan Service Provider of the disability determination on or before 60 days from the COBRA start date, and before the end of the original 18-month period. If you do not notify the Plan Administrator or the designated Plan Service Provider within the required period of time, you may lose your right to the extension.

The affected individual must also notify the Plan Administrator or designated Plan Service Provider within 30 days of any final disability determination that the individual is no longer disabled. Coverage will end on the first of the month, following at least 30 days after the date of the Social Security final disability determination letter.

California State Residence: Under California law, you may be eligible for a State mandated extension of benefits after your federally mandated COBRA period expires. California State laws allow an extension of COBRA benefits to a total of 36 months from the date of your qualifying event to Qualified Beneficiaries who begin COBRA coverage on or after January 1, 2003. You will be notified of this extension at the conclusion of your original COBRA coverage.

Flexible Spending Account or Medical Reimbursement Account: If you are participating in the company's Flexible Spending Account or Medical Reimbursement Account at the time of your termination or reduction of hours, you may also have the right to continue participation under COBRA based on the following parameters:

- You will be allowed to continue coverage for the remainder of the current plan year if you have a balance remaining in your account at the time of your termination or reduction in hours;
- You will not be able to receive reimbursements in excess of your original election amount in the account; and You make monthly payments in the same amount as your regular payroll deductions while you were an active employee.

You Must Give Notice of Some Qualifying Events: Under the law, the employee or a family member has the obligation to inform the Plan Administrator or the designated Plan Service Provider, at the address on this form, of a divorce, legal separation, or a child losing dependent status within 60 days of the date of the event. The employer has the responsibility to notify the Plan Administrator or designated Plan Service Provider of the employee's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage. If you fail to notify the Plan Administrator or the designated Plan Service Provider within 60 days, you may lose your right to continuation coverage.

Adding Dependents to COBRA Coverage: A child who is born to or adopted by the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator or designated Plan Service Provider of the birth or adoption.

Expiration of COBRA Coverage: The law also provides that continuation coverage may be cut short for any of the following five reasons:

- The company no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time;
- The qualified beneficiary becomes covered after the date he or she elects COBRA coverage under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
- The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA coverage;
- The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Limits to Pre-Existing Conditions: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. These rules are generally effective for plan years beginning after June 30, 1997. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follow:

If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Insurance Premiums: Under the law, you may have to pay all or part of the premium for your continuation coverage. You may also be required to pay a 2% administration fee above the cost of the premiums. If you are disabled, you may be required to pay 150% of the premium during the 11-month extension period.

Grace Period: There is a grace period of 30 days for payment of the regularly scheduled premium.

Conversion Coverage: At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries may be allowed to enroll in an individual conversion health plan provided a conversion health plan is available to active employees. Please read your health plan benefits booklet or Summary Plan Description regarding any option for conversion coverage after the expiration of COBRA coverage. If there is an option for conversion to an individual policy, follow the instructions provided to apply for the coverage, as it would be separate coverage, and would not simply be an extension of COBRA coverage.

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 ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of 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.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) NOTICE

Federal law requires that group health plans allow certain employees and dependents special enrollment rights when they previously declined coverage and when they have new dependents. This law, the Health Insurance Portability and Accountability Act (HIPAA) also addresses the circumstances under which treatment for medical condition may be excluded from health plan coverage.

The information in this notice is intended to inform you, in a summary fashion, of your rights and obligations under these laws. You, your spouse and any dependents should all take the time to read the entire notice carefully.

Special Enrollments: If you decline enrollment for yourself or your dependents (including your spouse) because of having other health insurance coverage at the time of your eligibility to participate, you may enroll yourself or your dependents at a future point, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days of such an event.

Please note that the company group health plan may have a pre-existing condition exclusion period. If you are a late applicant, the pre-existing condition limitation period may be up to 18 months. Check your benefit booklet or Summary Plan Description for details.

The Plan will not treat pregnancy as a pre-existing condition. Additionally, the Plan will not impose any pre-existing condition exclusion or limitation with regard to a child who, as of the last day of the 30-day period beginning with the date of birth, adoption, or placement for adoption, is covered under the Plan or has other creditable coverage.

Pre-Existing Conditions Limitations: Under HIPAA, the circumstances under which treatment for medical conditions may be excluded from health plan coverage are limited. Under the law, the length of an existing condition or exclusion must be reduced by your prior health plan coverage. A "pre-existing condition" is defined as an illness, injury or condition which was diagnosed or for which medical advice, care or treatment was recommended or received within the six-month period prior to your enrollment date in the plan, or if the plan has a waiting period, prior to the first day of the waiting period.

Certificate of Creditable Coverage: You are entitled to a certificate from your employer, or former employer, that shows evidence of your prior health coverage. HIPAA requires an employer (who may designate a Plan Service Provider) to provide a certificate of creditable coverage to:

- An individual who is entitled to elect COBRA continuation coverage;
- An individual who loses coverage under a group health plan and who is not entitled to elect COBRA continuation coverage; and
- An individual who has elected COBRA continuation coverage and such coverage ends for any reason.

Plans must also provide a certificate of creditable coverage upon request by a plan participant any time within 24 months of a loss of coverage.

Applying for Reduction of a Pre-Existing Condition Limitation: The pre-existing condition limitation period will be reduced by creditable coverage you have had under other qualifying health plans, provided you have not experienced a period of more than 63 continuous days during which you were not covered by a health plan, excluding any waiting period for plan coverage.

Qualifying group health plans include: 1) a group health plan; 2) individual health insurance; 3) Medicare; 4) Medicaid; 5) a military-sponsored health care program; 6) a medical care program of the Indian Health Service or of a tribal organization; 7) state health benefits risk pool; 8) a Federal employee health benefit program; 9) a public health plan; or 10) any health plan under section 5(e) of the Peace Corps Act.

Following your submission of a certificate of creditable coverage from your prior group health plan(s), the plan administrator (or the designated Plan Service Provider) will notify you of your pre-existing condition limitation period under the health plan. If you feel that the Plan Administrator erred in determining your period of creditable coverage under another group health plan in arriving at your pre-existing condition limitation period under this plan, you may appeal the determination by making a written request for review to the Plan Administrator within thirty (30) days of notice of your applicable pre-existing condition limitation period under the health plan. Please include with your appeal any evidence you feel should be considered by the Plan Administrator. The Plan Administrator will respond to your request for review within thirty (30) days of receipt of the appeal.

Obtaining Additional Information: If you need assistance in determining your rights under ERISA or HIPAA, you may contact your Plan Administrator or the U.S. Department of Labor by writing to the Chicago Regional office at 200 W. Adams Street, Suite 1600, Chicago, IL 60606, or by calling the Department at **312.353.0900**.

If you have any questions about this notice or the law, please contact your Plan Administrator at the number or location provided in your benefits booklet or Summary Plan Description.

Also, if you have changed marital status, or if you, your spouse or any other qualified dependents have changed addresses, please notify your local Human Resources Representative.

IMPORTANT NOTICE FROM OMEGA TECHNICAL SERVICES ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

This notice only applies if you or your dependents are currently enrolled in our group health insurance plan and are eligible or enrolled in Medicare. You may disregard this notice if this does not pertain to you.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Omega Technical Services 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. Omega Technical Services has determined that the prescription drug coverage offered by the Blue Cross Blue Shield Life & Health 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 Omega Technical Services coverage may be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. If you do decide to join a Medicare drug plan and drop the Omega Technical Services medical plan, be aware that you and your dependents may not be able to get this coverage back.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Omega Technical 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 Omega Technical 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 800.MEDICARE (800.633.4227). TTY users should call 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 800.772.1213 (TTY 800.325.0778).

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

Date:	January 1, 2025
Name of Entity / Sender:	Omega Technical Services
Contact:	Cindy Light, Human Resources
Address	118 Mitchell Rd Oak Ridge, TN 37830
Phone Number:	865.272.3371

SPECIAL ENROLLMENT NOTICE

During the open enrollment period, eligible employees are given the opportunity to enroll themselves and dependents into our group health plans.

If you elect to decline coverage because you are covered under an individual health plan or a group health plan through your parent's or spouse's employer, you may be able to enroll yourself and your dependents in this plan if you and/or your dependents lose eligibility for that other coverage. You must request enrollment within 30 days after the other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll any new dependent within 30 days of the event. To request special enrollment or obtain more information, contact Human Resources.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had, or are going to have, a mastectomy, you may be entitled to certain benefits under 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.
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your Plan Administrator at [865.272.3371](tel:865.272.3371).

NEWBORNS ACT DISCLOSURE—FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length 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 18 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF PRIVACY PRACTICES

Omega Technical Services is subject to the HIPAA privacy rules. In compliance with these rules, it maintains a Notice of Privacy Practices. You have the right to request a copy of the Notice of Privacy Practices by contacting Human Resources.

IMPORTANT INFORMATION REGARDING 1095 FORMS

As an employer with 50 or more full-time employees, we are required to provide 1095-C forms to each employee who was employed as a full-time employee for at least one month during the calendar year, without regard to whether they were covered by our group health plan. These employees should expect to receive their Form 1095-C in early March 2025. We are also required to send a copy of your 1095-C form to the IRS.

The information reported on Form 1095-C is used in determining whether an employer owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used by you and the IRS to determine eligibility for the premium tax credit.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY (HIPAA) NOTICE

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

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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

YOU RIGHTS

You have the right to:

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

YOUR CHOICES

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

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

OTHER USES AND DISCLOSURES

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

YOUR RIGHTS

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

GET A COPY OF HEALTH AND CLAIMS RECORDS.

You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

ASK US TO CORRECT HEALTH AND CLAIMS RECORDS

You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

REQUEST CONFIDENTIAL COMMUNICATIONS

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

We will consider all reasonable requests and must say "yes" if you tell us you would be in danger if we do not.

ASK US TO LIMIT WHAT WE USE OR SHARE

You can ask us not to use or share certain health information for treatment, payment, or our operations.

We are not required to agree to your request.

GET A LIST OF THOSE WITH WHOM WE'VE SHARED INFORMATION

You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you ask us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

GET A COPY OF THIS PRIVACY NOTICE

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

Choose someone to act for you.

If you have given someone medical power of attorney or if someone is your legal spouse, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

FILE A COMPLAINT IF YOU FEEL YOUR RIGHTS ARE VIOLATED

You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1.877.696.6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

We will not retaliate against you for filing a complaint.

YOUR CHOICES

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

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care.
- Share information in a disaster relief situation.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

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

- Marketing purposes
- Sale of your information

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive.

We can use your health information and share it with professionals who are treating you.

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

PAY FOR YOUR HEALTH SERVICES

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

ADMINISTER YOUR PLAN

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

RUN OUR ORGANIZATION

We can use and disclose your information to run our organization and contact you when necessary.

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

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

HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

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

HELP WITH PUBLIC HEALTH AND SAFETY ISSUES

We can share health information about you for certain situations such as:

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

DO RESEARCH

We can use or share your information for health research.

COMPLY WITH THE LAW

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

RESPOND TO ORGAN AND TISSUE DONATION REQUESTS AND WORK WITH A MEDICAL EXAMINER OR FUNERAL DIRECTOR

We can share health information about you with organ procurement organizations.

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

ADDRESS WORKERS' COMPENSATION, LAW ENFORCEMENT, AND OTHER GOVERNMENT REQUESTS

We can use or share health information about you:

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

RESPOND TO LAWSUITS AND LEGAL ACTIONS

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

We are required by law to maintain the privacy and security of your protected health information.

We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

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

CHANGES TO THE TERMS OF THIS NOTICE

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

OTHER INSTRUCTIONS FOR NOTICE

Effective Date of this Notice: January 1, 2025

Health Plan's Privacy Official:

Cindy Light 118 Mitchell Rd

Oak Ridge, TN 37830

P: 865.273.5780

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are **not** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **877.KIDS.NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **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, 2024. Contact your state for more information on eligibility.

ALABAMA – Medicaid http://myalhipp.com 855.692.5447	INDIANA – Medicaid Health Insurance Premium Payment Program Family and Social Services Administration http://www.in.gov/fssa/dfr/ 800.403.0864 All other Medicaid https://www.in.gov/medicaid/ 800.457.4584
ALASKA – Medicaid The AK Health Insurance Premium Payment Program http://myakhipp.com/ 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	IOWA – Medicaid and CHIP (Hawki) Medicaid: https://hhs.iowa.gov/programs/welcome-iowa-medicaid 800.338.8366 Hawki: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki 800.257.8563 HIPP: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp 888.346.9562
ARKANSAS – Medicaid http://myarhipp.com 855.MyARHIPP (855.692.7447)	KANSAS – Medicaid https://www.kancare.ks.gov/ 800.792.4884 HIPP Phone: 800.967.4660
CALIFORNIA – Medicaid Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 Fax: 916.440.5676 Email: hipp@dhcs.ca.gov	KENTUCKY – Medicaid Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 KIHIPPPROGRAM@ky.gov KCHIP: https://kynect.ky.gov 877.524.4718 Medicaid: https://chfs.ky.gov/agencies/dms
COLORADO – Medicaid and CHIP Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.mycohibi.com/ HIBI Customer Service: 855.692.6442	LOUISIANA – Medicaid www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
FLORIDA – Medicaid www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html 877.357.3268	MAINE – Medicaid Enrollment: https://www.mymaineconnection.gov/benefits/s/?language=en_US 800.442.6003 TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 TTY: Maine relay 711
GEORGIA – Medicaid GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra 678.564.1162, Press 2	

MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/masshealth/pa 800.862.4840 TTY: 711 Email: masspreassistance@accenture.com
MINNESOTA – Medicaid
https://mn.gov/dhs/health-care-coverage/ 800.657.3672
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084 Email: HSHIPPProgram@mt.gov
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 Lincoln: 402.473.7000 Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program 603.271.5218 Toll free number for the HIPP program: 800.852.3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 800.356.1561 CHIP: http://www.njfamilycare.org/index.html 800.701.0710 (TTY: 711) Premium Assistance: 609.631.2392
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://dma.ncdhhs.gov 919.855.4100
NORTH DAKOTA – Medicaid
https://www.hhs.nd.gov/healthcare 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid and CHIP
http://healthcare.oregon.gov/Pages/index.aspx 800.699.9075

PENNSYLVANIA – Medicaid and CHIP
https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html 800.692.7462 CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx CHIP Phone: 800.986.KIDS (5437)
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program 800.440.0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) https://medicaid.utah.gov/upp/ Email: upp@utah.gov 888.222.2542 Adult Expansion: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: https://medicaid.utah.gov/buyout-program/ CHIP: https://chip.utah.gov/
VERMONT – Medicaid
https://dvha.vermont.gov/members/medicaid/hipp-program 800.250.8427
VIRGINIA – Medicaid and CHIP
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 and Chip: 800.432.5924
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid and CHIP
https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid: 304.558.1700 CHIP Toll-free: 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since July 31, 2024, or for more information on special enrollment rights, contact either:

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

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
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 ebssa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

USERRA UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) was signed on October 13, 1994. The Act applies to persons who perform duty, voluntarily or involuntarily, in the “uniformed services,” which include the Army, Navy, Marine Corps, Air Force, Coast Guard, and Public Health Service commissioned corps, as well as the reserve components of each of these services.

Federal training or service in the Army National Guard and Air National Guard also gives rise to rights under USERRA. In addition, under the Public Health Security and Bioterrorism Response Act of 2002, certain disaster response work (and authorized training for such work) is considered “service in the uniformed services” as well.

Uniformed service includes active duty, active duty for training, inactive duty training (such as drills), initial active duty training, and funeral honors duty performed by National Guard and reserve members, as well as the period for which a person is absent from a position of employment for the purpose of an examination to determine fitness to perform any such duty. USERRA covers nearly all employees, including part-time and probationary employees. USERRA applies to virtually all U.S. employers, regardless of size.

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) are authorized to investigate and resolve complaints of USERRA violations.

- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1.866.4.USA.DOL** or visit its website at www.dol.gov/vets.
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, depending on the employer, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.
- The rights listed here may vary depending on the circumstances. The USERRA notice can be viewed on the internet at https://www.dol.gov/vets/programs/userra/USERRA_Private.pdf
- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don’t elect to continue coverage during your military service, you have the right to be reinstated in your employer’s health plan when you are reemployed, generally without any waiting periods or exclusions (e.g. pre-existing condition exclusions) except for service-connected illnesses or injuries.
- Under the terms of USERRA, if the military leave is 31 or fewer days, the employer may not charge a higher premium than would be charged to active employees with similar coverage. If the leave exceeds 31 days, the employer may charge up to 102 percent of the applicable premium.

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 EMPLOYER 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, 2024, through July 31, 2025. 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, 2024. 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, 2024. 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](https://www.healthcare.gov) and either - submit a new application or update an existing application on [HealthCare.gov](https://www.healthcare.gov) between March 31, 2024 and July 31, 2025, 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, 2024, and July 31, 2025, 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](https://www.healthcare.gov) or call the Marketplace Call Center at 800.318.2596. TTY users can call 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, 2024 and July 10, 2024, you can request this special enrollment in the employment-based health plan through September 8, 2024. 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 Omega's Human Resources 865.272.3371.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.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 Omega Technical Services		4. Employer Identification Number (EIN) 57-1017150	
5. Employer address 118 Mitchell Rd		6. Employer phone number 865.272.3371	
7. City Oak Ridge	8. State TN		9. ZIP code 37830
10. Who can we contact about employee health coverage at this job? Cindy Light			
11. Phone number (if different from above)		12. Email address HR@omegatechserv.com	

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

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

☐ All employees. Eligible employees are:

☒ **Some employees. Eligible employees are: Full-Time employees, working a minimum of 30 hours per week on a regular basis and retirees**

■ With respect to dependents:

☒ **We do offer coverage. Eligible dependents are: legal spouse, child(ren) up to age 26, and any dependent children who are totally disabled.**

☐ We do not offer coverage.

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

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

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

This benefits guide prepared by



Gallagher

Insurance | Risk Management | Consulting