



2026 Benefits Guide



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This 2026 Benefit Summary highlights recent plan changes and is intended to fully comply with the requirements under the Employee Retirement 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

Adfinitas Health was founded in 2007 by Douglas Mitchell, MD, MBA and Hung Davis, MD, CMD, both board-certified internal medicine hospitalist physicians. Their strong backgrounds enable Adfinitas Health to strategically assign lead physicians, hospitalist physicians, and advanced practice providers to each client hospital and post-acute care center based on their experience, credentials, and match to the individual needs, goals, and culture of each facility. We have developed a reputation for compassionate care delivered effectively and efficiently.

Our first hospital partner was established in 2007 with Anne Arundel Medical Center, where we began providing consultative inpatient and co-management services for medical and surgical specialists. Since then, we have grown to provide care throughout Maryland, Pennsylvania, and Massachusetts. Adfinitas Health employs more than 500 providers and corporate staff.

At Adfinitas Health we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefit package that is easy to understand, easy to access and affordable for all our employees. We are pleased to present you with the Adfinitas Health Benefits Guide, which outlines your various options to assist you with understanding the available converge and selecting the benefits that best fit your needs. Benefits enrollment is important, so make sure that you don't miss your opportunity to enroll during your eligibility period.

You can also view overviews of our benefit plans by accessing our benefits portal at www.employeenavigator.com.

Sincerely,

Stephanie Stewart, CHRO



Eligibility

Eligible Employees:

You may enroll in the Adfinitas Health Employee Benefits Program if you are a full-time employee working at least 30 hours per week.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse, and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, step-children and children obtained through court-appointed legal guardianship.

When Coverage Begins:

Open enrollment benefit elections and changes are effective January 1, 2026. Newly hired employees and dependents will be effective in Adfinitas Health's benefits programs on the first day of the month or coinciding following the start of active employment. All elections are in effect for the entire plan year and can only be changed during Open Enrollment, unless you experience a family status event.

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact the Human Resources team to make these changes.



Changes in Benefit Elections

Open Enrollment:

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefits plan. All elections and changes take effect on the first day of the plan year. During Open Enrollment, you can:

- Add, change, or delete coverage
- Add, or drop dependents from coverage
- Enroll, or re-enroll in dependent or health care flexible spending accounts.
- To continue your FSA benefits, you must re-enroll each plan year.

If you do not make your 2026 benefit elections during open enrollment, you will automatically be defaulted to your prior year elections, with a few exceptions.

Medical Benefits

If you are currently enrolled for medical benefits and you do not make a medical plan election at open enrollment your benefits will be mapped as follows:

2025 Plan Name		2026 Plan Name
Choice HSA \$3,300	➡	Choice HSA \$3,400
Choice \$2,000	➡	Choice \$5,000
Choice Plus \$1,500	➡	Choice \$4,500

Flexible Spending Account

If you are currently enrolled in the FSA, if you do not make an election at open enrollment your contribution amount will be defaulted to zero (\$0).

Health Savings Account

If you are currently enrolled in the HSA, if you do not make an election at open enrollment your contribution amount will be defaulted to zero (\$0).



Medical

For 2026, Adfinitas Health will offer medical coverage through CareFirst. The plan comparison chart in the following pages is a brief outline of what is offered. Please refer to the summary plan description for complete plan details.

Updated Medical Plan Designs and Contributions

For 2026 there are several changes to the CareFirst medical plans. Please review the plan deductibles, coinsurance and out of pocket maximums with care to ensure you understand the benefits. Rates for the medical plans will increase in 2026 to reflect the change in claims costs over the last year.

Fertility Treatment Benefits

Adfinitas Health's 2026 plans through CareFirst meet the standards for Maryland's state mandate for fertility treatment. These benefits may be different than the fertility treatment benefits included in prior plan years.

	Choice HSA Plan	Choice Plan \$5,000 Ded	Choice Plan \$4,500 Ded
	In-Network Benefits	In-Network Benefits	In-Network Benefits
ANNUAL DEDUCTIBLE			
Individual	\$3,400	\$5,000	\$4,500
Family	\$6,800	\$10,000	\$9,000
Coinsurance	20% after Deductible	20% after Deductible	0% after Deductible
OUT-OF-POCKET MAXIMUM			
Individual	\$6,800	\$7,500	\$7,000
Family	\$13,600	\$15,000	\$14,000
PHYSICIAN OFFICE VISIT			
Primary Care	\$0 after deductible	\$20 copay	\$20 copay
Specialty Care	\$20 after deductible	\$40 copay	\$30 copay
PREVENTIVE CARE			
Adult Periodic Exams	No charge	No charge	No charge
Well-Child Care	No charge	No charge	No charge
DIAGNOSTIC SERVICES			
X-Ray and Lab Tests	20% after deductible	20% after deductible	No charge
Complex Radiology	20% after deductible	20% after deductible	\$30 copay
OUTPATIENT FACILITY BENEFITS			
Urgent Care Facility	20% after deductible	\$50 copay	\$50 copay
Emergency Room Facility Charges	20% after deductible	20% after deductible	\$250 copay per visit, after Deductible (waived if admitted)
Outpatient Facility and Surgical Charges	20% after deductible	20% after deductible	No charge. Deductible applies to Physician services
INPATIENT FACILITY BENEFITS			
Inpatient Facility Charges	20% after deductible	20% after deductible	\$300 Copay per occurrence after Deductible
OUT-OF-NETWORK BENEFITS*			
Deductible	\$6,800 / \$13,600	\$10,000 / \$20,000	\$9,000 / \$18,000
Coinsurance	40%	40%	20%
Out-of-Pocket Maximum	\$13,600 / \$27,200	\$15,000 / \$30,000	\$14,000 / \$28,000

*In addition to the out-of-network deductible and coinsurance, additional charges may apply if you choose to see an out-of-network provider.

Prescriptions

Prescription benefits for Adfinitas Health are included with the CareFirst medical plans. Mail Order and Specialty medications are provided through CVS Caremark.

CareFirst	Choice HSA Plan	Choice Plan \$5,000 Ded	Choice Plan \$4,500 Ded
	In-Network Benefits	In-Network Benefits	In-Network Benefits
RETAIL PHARMACY (30 DAY SUPPLY)			
Deductible	Combined with Medical Deductible	N/A	N/A
Generic (Tier 1)	\$15 copay after deductible	\$15 copay	\$15 copay
Preferred (Tier 2)	\$35 copay after deductible	\$35 copay	\$35 copay
Non-Preferred (Tier 3)	\$60 copay after deductible	\$60 copay	\$60 copay
Preferred Specialty Drugs (Tier 4)	50% to a \$100 maximum after deductible	50% to a \$100 maximum	50% to a \$100 maximum
Non-Preferred Specialty Drugs (Tier 5)	50% to a \$150 maximum after deductible	50% to a \$150 maximum	50% to a \$150 maximum
Preventive Drugs	\$0	\$0	\$0
MAIL ORDER PHARMACY (90 DAY SUPPLY)			
Generic (Tier 1)	\$30 copay after deductible	\$30 copay	\$30 copay
Preferred (Tier 2)	\$70 copay after deductible	\$70 copay	\$70 copay
Non-Preferred (Tier 3)	\$120 copay after deductible	\$120 copay	\$120 copay

Medical/Prescription Employee Contributions (Bi-Weekly 26 per yr)			
	Choice HSA Plan	Choice Plan \$5,000 Ded	Choice Plan \$4,500 Ded
Employee	\$56.25	\$140.87	\$193.32
Employee & Spouse	\$182.65	\$324.01	\$478.19
Employee & Child(ren)	\$122.43	\$235.19	\$350.89
Family	\$241.41	\$438.70	\$649.22

Home Delivery

Easy and Convenient

With this service you can:

- Purchase up to a three-month supply of your medicine at once.
- Enjoy convenient delivery to the address of your choice
- Enjoy free standard shipping of your orders
- Talk with a registered pharmacist, 24 hours a day, seven days a week
- Order refills anytime online or by phone

24/7/365 Service

Order online, by phone, or by mail



CareFirst Resources

Your **CareFirst** medical benefits provide you with access to people, resources, and tools to help you when you aren't feeling your best. You also have access to programs that may help you improve or maintain your health.



Manage Your Healthcare with My Account

As a CareFirst BlueCross BlueShield (CareFirst) member, your personalized benefit information is available 24/7. Register for My Account for secure online access to your coverage details, ID card and more. Plus, you'll also be able to quickly locate in-network providers and facilities nationwide.



Scan the QR code
or visit [carefirst.com/
myaccount](https://carefirst.com/myaccount) to register.



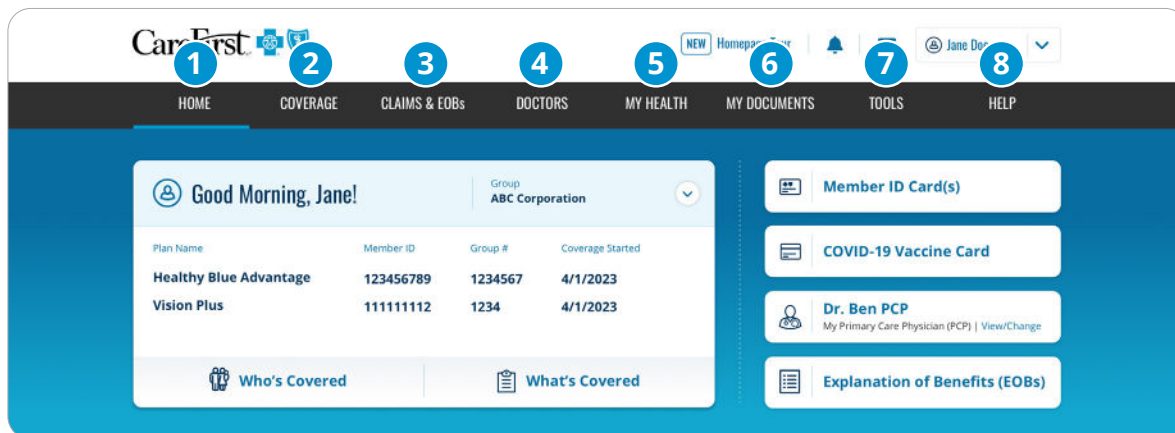
Get started

Members 12 years of age and older may register for My Account. Have your member ID or, the last four digits of your social security number. Signing up is easy and only takes a few minutes.

Complete a few more steps and you're ready to access your personalized member portal.

Already registered?

Explore the features My Account offers on the next page.



My Account at a glance

1 Home

- Quickly view plan information including effective date, copays, deductible, out-of-pocket status and recent claims activity
- Manage your personal profile details including password, username and email, or choose to receive materials electronically
- Send a secure message via the *Message Center*
- Check *Alerts* for important notifications

2 Coverage

- Access your plan information—plus, see who is covered
- Update your other health insurance information, if applicable
- View, order or print member ID cards
- Review the status of your health expense account (HSA or FSA)¹
- Order and refill prescriptions
- View prescription drug claims

3 Claims & EOBs

- Check your claims activity, status and history
- Review your Explanation of Benefits (EOBs)
- Track your remaining deductible and out-of-pocket total
- Submit out-of-network claims
- Review your year-end claims summary

4 Doctors

- Find in-network providers and facilities nationwide, including specialists, urgent care centers and labs
- Select or change your primary care provider (PCP)
- Locate nearby pharmacies

5 My Health

- Access health and wellness discounts through Blue365
- Learn about your wellness program options¹
- Track your Blue Rewards progress¹

6 My Documents

- Look up plan forms and documents²
- Download *Vitality*, your annual member resource guide

7 Tools

- Access the Treatment Cost Estimator to calculate costs for services and procedures³
- Use the Drug Pricing Tool to determine prescription costs

8 Help

- Find answers to many frequently asked questions
- Send a secure message
- Locate important phone numbers

¹ Only if offered by your plan.

² Only available when using a computer.

³ The doctors accessed via this website are independent providers making their own medical determinations and are not employed by CareFirst. CareFirst does not direct the action of participating providers or provide medical advice.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. and Group Hospitalization and Medical Services, Inc., which are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Finding a Specialist

A specialist is a health care practitioner who focuses on a particular type of medicine or type of patient. Some examples include cardiologists (heart), dermatologists (skin), oncologists (cancer), and obstetricians (pregnancy and childbirth).

Our Find a Doctor tool can help you find a specialist that suits both your medical and personal needs.

Before you start

Not a member? That's OK. You don't have to be a CareFirst member to search our networks. Just visit carefirst.com/findadoc and choose "I am a CareFirst guest" when prompted. You'll also need to select the plan you're interested in and your location before you start your search.

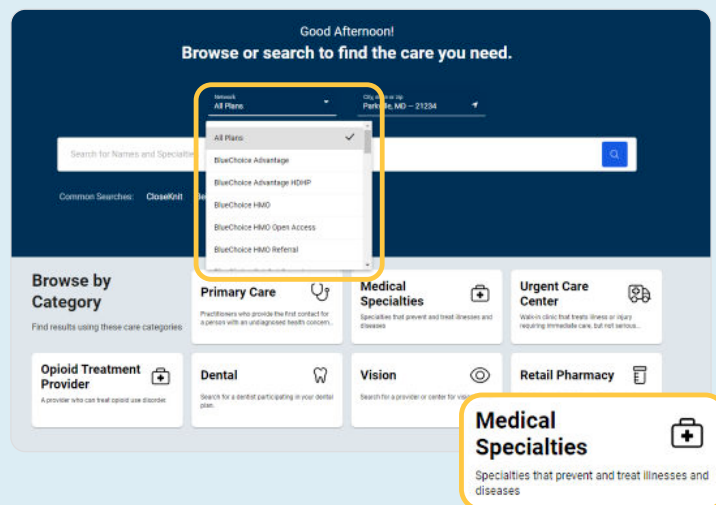
CareFirst members: For best results, you'll want to log in to your My Account page. To do this, visit member.carefirst.com and enter your username and password. Then follow these steps.

1. Click on *Doctors* in the main navigation bar.
2. Select *Find a Doctor* from the drop-down menu.
3. On the following page, click *Proceed*.

Step 1: Start your specialist search

First, be sure you have the right network selected from the *Network* menu.*

- For medical specialists, choose your medical plan.
- For vision specialists, choose your vision plan.
- For dental specialists, choose your dental plan.
- For pharmacies, choose your drug plan.



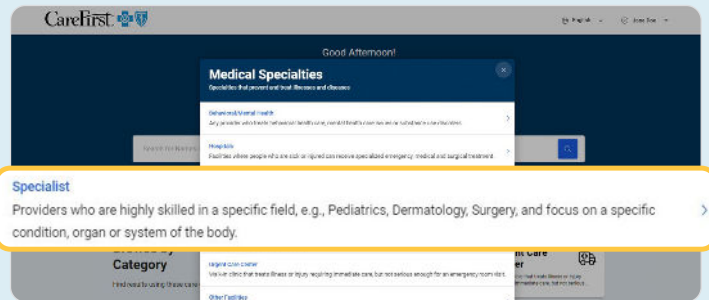
After you've chosen your network, you can narrow your search by selecting from the tiles shown in the *Browse by Category* area.

Or, if you already have the name of a specialist and would like to see if they're in our network, you can enter their name in the search bar.

* Some services may be covered under your medical plan.

Step 2: Focus your search

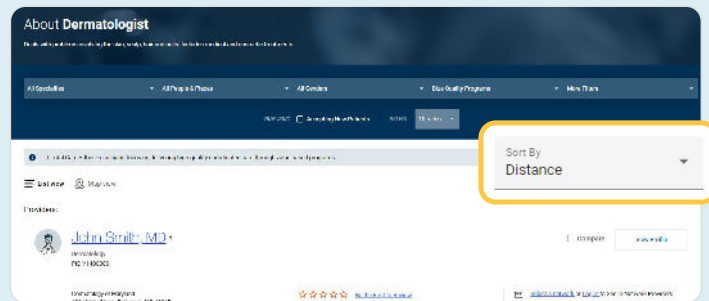
If you choose a tile, the Find a Doctor tool will offer a list of suggestions to help focus your search. You can choose from these suggestions or simply type the specialty you're looking for in the search bar.



Step 3: Review your results

However you choose to search, the tool will provide you with a list of specialists to review. In-network doctors will appear at the top of the list, with those closest to you shown first.

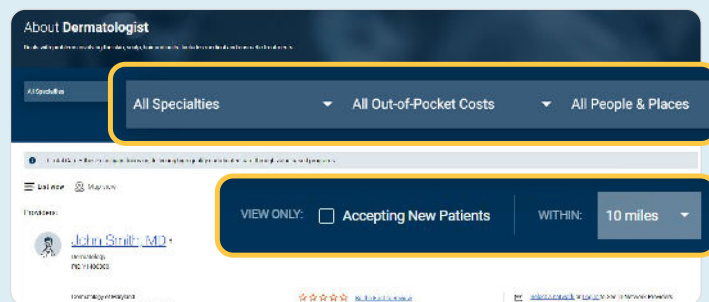
You can change how the results are sorted by clicking on the *Sort By* menu. You can also change the area you're searching by clicking *City, State or Zip*.



Step 4: Refine your results

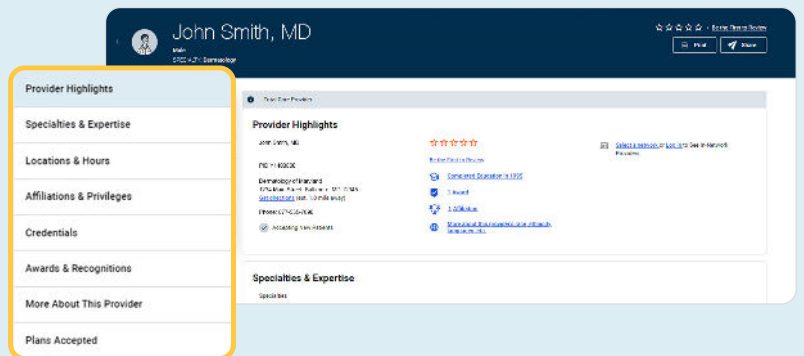
You can refine your search results in two places—the *Filter* bar and *View Only* bar.

When you make a selection from either of the two bars, the Find a Doctor tool will automatically refresh your search results.



Step 5: Learn more

Once you've found a specialist that fits your needs, click on their name to learn more about them. Provider profiles contain contact information, professional affiliations, whether they're accepting new patients and more.



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SUM7116-1N (7/24)

Know Before You Go

Your money, your health, your decision

Choosing the right setting for your care—from allergies to X-rays—is key to getting the best treatment with the lowest out-of-pocket costs. It's important to understand your options so you can make the best decision when you or your family members need care.*

Primary care provider (PCP)

The best place to get consistent, quality health care is your primary care provider (PCP). If you have a medical issue, having a doctor who knows your health history often makes it easier to get the care you need.

CloseKnit Virtual Care

Our virtual-first practice, CloseKnit, offers 24/7/365 virtual primary care, behavioral health, and urgent care services.

Primary care patients have access to a dedicated Care Team equipped to treat most medical concerns virtually, through CloseKnit's convenient mobile app. The team can direct to in-person or specialty care when needed and can help patients manage medications, chronic conditions, navigate billing and more.

Urgent care services, for conditions such as cold or flu, and behavioral health visits, are available to patients regardless of whether they've selected CloseKnit as their primary care provider.

24-Hour Nurse Advice Line

Registered nurses are available 24/7 to discuss your symptoms with you and recommend the most

appropriate care. Call 800-535-9700 anytime to speak with a nurse.

Convenience care centers (retail health clinics)

These are typically located inside a pharmacy or retail store (like CVS MinuteClinic or Walgreens Healthcare Clinic) and offer care for non-emergency situations like colds, pink eye, strep tests and vaccinations. These centers usually have evening and weekend hours.

Urgent care centers

Urgent care centers (such as Patient First or ExpressCare) provide treatment for injuries and illnesses that require prompt medical attention but are not life-threatening (sprains, minor cuts, flu, rashes, minor burns). These centers have doctors on staff and offer weekend/after-hours care.

Emergency room (ER)

Emergency rooms treat acute illnesses and trauma. Go to the ER right away if you or a family member have sudden symptoms that need emergency care, including (but not limited to): chest pain, trouble breathing or head trauma. Prior authorization is not needed for emergency room services.



Did you know that **where** you choose to get lab work, X-rays and surgical procedures can have a big impact on your wallet? Typically, services performed in a hospital cost more than non-hospital settings like LabCorp, Advanced Radiology or ambulatory surgery centers.

* The medical providers mentioned in this document are independent providers making their own medical determinations and are not employed by CareFirst BlueCross BlueShield. CareFirst does not direct the action of participating providers or provide medical advice.

When you need care

When your PCP isn't available, being familiar with your options will help you locate the most appropriate and cost-effective medical care. The chart below shows how costs* may vary for a sample health plan depending on where you choose to get care.

	Sample Cost	Needs or Symptoms	24/7	Rx
24-Hour Nurse Advice Line	No Cost	If you are unsure about your symptoms or where to go for care, call 800-535-9700, anytime day or night to speak to a registered nurse.		
CloseKnit Virtual Care (24/7/365 virtual care for members)	\$	■ Cough, cold and flu ■ Urgent care needs ■ Illness while traveling ■ Therapy	✓	✓
Convenience Care (e.g., CVS MinuteClinic or Walgreens Healthcare Clinic)	\$\$	■ Cough, cold and flu ■ Pink eye ■ Ear pain	✗	✓
Urgent Care (Non-life threatening illness or injury requiring immediate care, e.g., Patient First or ExpressCare)	\$\$\$	■ Sprains ■ Cut requiring stitches ■ Minor burns	✗	✓
Emergency Room (Life-threatening illness or injury)	\$\$\$\$	■ Chest pain ■ Difficulty breathing ■ Abdominal pain	✓	✓

To determine your specific benefits and associated costs:

- Log in to *My Account* at carefirst.com/myaccount;
- Check your Evidence of Coverage or benefit summary;
- Ask your benefit administrator; or
- Call Member Services at the telephone number on the back of your member ID card.

For more information and frequently asked questions, visit carefirst.com/needcare.

PLEASE READ: The information provided in this document regarding various care options is meant to be helpful when you are seeking care and is not intended as medical advice. Only a medical provider can offer medical advice. The choice of provider or place to seek medical treatment belongs entirely to you.

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SUM3424-1P (8/23)

What is CloseKnit?

Virtual-first care centered around you

We're a virtual-first practice that you can connect with 24/7/365. We offer primary care, urgent care, mental health support and other specialized care to help you live a healthier life. Instead of going to a doctor's office, your visit can be done online—anytime, anywhere.



Primary Care

- Well care, preventive and sick visits with a dedicated Care Team
- Health guides who can answer health, benefits and billing questions
- 24/7 chat with a real person when you need us
- Available for adults ages 18+



Urgent Care

- Help for non-emergency conditions such as cold/flu symptoms and minor injuries
- Same-day care, even if we are not your primary care provider
- Available for adults and children ages 2+



Mental Health

- 1-on-1 counseling with a licensed therapist
- Psychiatry services for medication management
- Available for adults and children ages 2+



And More ...

- Diet and nutrition support
- Breastfeeding support

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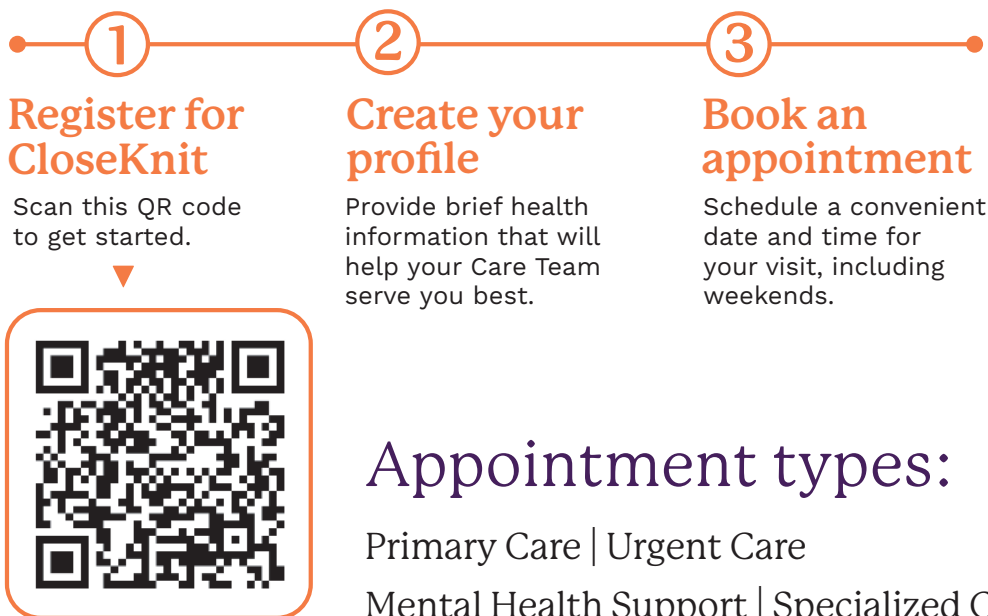
CloseKnit is a registered trademark owned by, and is the trade name of, Atlas Health, LLC. Atlas Health, LLC d/b/a CloseKnit provides telehealth services to CareFirst BlueCross BlueShield members.

Am I eligible?

There are only two requirements for registration:

1. Adults 18+ can sign up (dependents ages 2-17 can be added to your account)
2. Must have a CareFirst BlueCross BlueShield health plan, including CareFirst Medicare Advantage and CareFirst Community Health Plan Maryland (some exclusions apply)

How do I get started?



Appointment types:

Primary Care | Urgent Care

Mental Health Support | Specialized Care

Welcome to CloseKnit! We're here for you 24/7/365

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Dental

Adfinitas Health will offer employee paid dental benefits through United Concordia. You have the freedom to select the dentist of your choice; however, when visiting a participating, in-network dentist you will have lower out-of-pocket costs, no balance billing, and claims will be submitted by your dentist on your behalf.

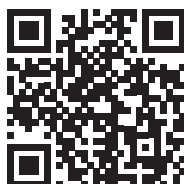
United Concordia	Concordia Preferred Plan	
	In-Network Benefits	Out-of-Network Benefits
ANNUAL DEDUCTIBLE		
Individual	\$50	\$50
Family	\$150	\$150
Waived for Preventive Care?	Yes	Yes
ANNUAL MAXIMUM		
Per Person	\$1,500 excludes Class 1 and Orthodontia	
SCHEDULE OF BENEFITS		
Preventive – Class I	100%	80%
Basic – Class II	80% after deductible	60% after deductible
Major – Class III and Class IV	50% after deductible	35% after deductible
ORTHODONTIA		
Benefit Percentage	50% – no deductible	50% – no deductible
Adults and Children to age 26	Covered	Covered
Lifetime Maximum	\$1,500 per person (combined network and non-network)	
Employee Contributions (Bi-Weekly 26 per yr)		
Employee	\$15.43	
Employee & Spouse	\$30.51	
Employee & Child	\$36.23	
Family	\$54.65	

GET THE MAX OUT OF YOUR DENTAL PLAN

Create a *MyDentalBenefits* account

It's the online hub where you can check your coverage details, see claims and payments, print extra ID cards and more.

Set up an account after your plan's effective date. When you're ready, simply visit UnitedConcordia.com/GetMDB. Make sure to have your member ID or social security number handy.



Visit in-network dentists

You'll save money by staying in network for your dental care. Just visit to locate an in-network dentist near home or work.



Download the United Concordia Dental app

The app lets you access your *MyDentalBenefits* info from your smartphone or tablet. You can log in with the same user ID and password.

Get our Chomper Chums® app for kids

No more nagging – children love brushing alongside their favorite Chomper Chum. A built-in timer ensures they brush, floss and rinse for a full two minutes.

Sign up for tips via email

Each month, we'll send pointers to help you understand your dental plan and keep your mouth healthy. Sign up for emails when you create your *MyDentalBenefits* account.

Go paperless

Sign up to get an email when you have a new Explanation of Benefits. View or print it from your *MyDentalBenefits* account.

Who can I call with questions about my dental plan?

Call Dental Customer Service toll free at 800.332.0366 or visit www.ucci.com.

Vision

Vision coverage is employee paid through **CareFirst BCBS**. Using an in-network provider gives you the best benefit, but the plan also includes an out-of-network allowance. If you go out-of-network for services you will be responsible for filing your claim with CareFirst BCBS.

CareFirst Group Number	CareFirst Vision	
	In-Network	Out-of-Network
COPAY		
Routine Exam – every 12 months	No Copay	Reimbursed up to \$45
VISION MATERIALS		
Frames – every 12 months	\$130 Retail Allowance, 20% off balance Davis Vision Frame Collection - No Copay for over 200 frames	Reimbursed up to \$60
Standard Lenses – every 12 months Single Vision Lined Bifocal Lined Trifocal Standard Lenticular	\$20 copay	Reimbursed up to \$52 Reimbursed up to \$82 Reimbursed up to \$101 Reimbursed up to \$181
Elective Contacts – every 12 months, covered in lieu of eyeglass lenses Non-Selection Medically necessary	\$130 allowance No Copay	Reimbursed up to \$112 Reimbursed up to \$285
Laser Vision Correction	Up to 25% off standard price	No discounts available
Vision Employee Contributions (Bi-Weekly 26 per yr)		
Employee	\$2.83	
Employee & Spouse	\$5.67	
Employee & Child(ren)	\$5.95	
Family	\$8.30	

Please refer to the summary plan description for complete plan details.



Vision

Did you know that eye exams allow eye care professionals to take a non-invasive look inside the body? An eye care professional can detect up to 20 chronic medical conditions during an eye exam, from diabetes and heart disease to hypertension and cognitive dysfunction, even before symptoms occur.

How the plan works

Our pluses

Davis Vision® administers BlueVision Plus. Our vision plans provide an affordable way for members to receive their annual eye exams. And if you need corrective lenses, we have you covered there too.

National network

More than 121,000 access points across the U.S. accept BlueVision Plus. This includes private practices, retailers, and online retailers such as Visionworks, Walmart, Costco and [Glasses.com](https://www.glasses.com).

How do I find a provider?

To find a provider, go to carefirst.com and use the Find a Provider feature or call Davis Vision for a list of network providers closest to you at [800.783.5602](tel:8007835602), available seven days a week. Service is available 8 a.m.–11 p.m., Monday through Friday; 9 a.m.–4 p.m., Saturday; and noon–4 p.m. on Sunday.

Be sure to ask your provider if they participate with the Davis Vision network before receiving care.

How do I receive care from a network provider?

Call your provider and schedule an appointment. Identify yourself as a CareFirst BlueVision Plus member and provide the doctor with your identification number, as well as your date of birth. Then go to your appointment and receive care. There are no claim forms to file.

What if I go out-of-network?

Staying in-network gives you the best benefit, but BlueVision Plus does offer some out-of-network coverage. However, you will be responsible for all payments upfront and need to file a claim with Davis Vision for reimbursement. You must also pay any balances over the allowed benefit to the non-participating provider. Find the claim form at carefirst.com: locate For Members, then click on Forms, Vision, Davis Vision.

Can I get contacts and eyeglasses in the same benefit period?

No. BlueVision Plus covers one pair of eyeglasses OR a supply of contact lenses per benefit period.

When do I get my ID card?

Member ID cards are mailed to your home after enrollment. You can also access your member ID card—along with other claims and benefit information—at My Account or on the CareFirst mobile app. Visit carefirst.com/myaccount to register.

BlueVision Core vs BlueVision Plus

Some CareFirst members have an embedded vision product called BlueVision Core (exam only with discounts) plan AND a BlueVision Plus plan. To ensure you are receiving your BlueVision Plus benefits look for the VU indicator on your member ID card.

Access to in-network online retail partners: [Glasses.com](https://www.glasses.com), Warby Parker and Befitting

Mail order replacement contact lenses: Davis Vision's mail order contact lens replacement service is powered by ABB Optical Group, the nation's #1 optical distributor and second largest contact lens provider. By accessing davisvisioncontacts.com, members can easily order replacement contact lenses at significant savings and have them shipped directly to their doorstep.

- **Hearing aid discounts** through YourHearing Network
- **Free LASIK consultation Under \$1,000/eye for conventional LASIK** (usually \$1,677/eye)
- **40%-50% off** the national average price
- **1,000 locations nationwide**

Flexible Spending Accounts

The Flexible Spending Account (FSA) plan with WEX allows you to set aside pre-tax dollars to cover qualified expenses you would normally pay out of your pocket with post-tax dollars. The plan is comprised of a health care spending account and a dependent care account. You pay no federal or state income taxes on the money you place in an FSA.

How an FSA works:

- Choose a specific amount of money to contribute each pay period, pre-tax, to one or both accounts during the year.
- The amount is automatically deducted from your pay at the same level each pay period.
- As you incur eligible expenses, you may use your flexible spending debit card to pay at the point of service OR submit the appropriate paperwork to be reimbursed by the plan.

Important rules to keep in mind:

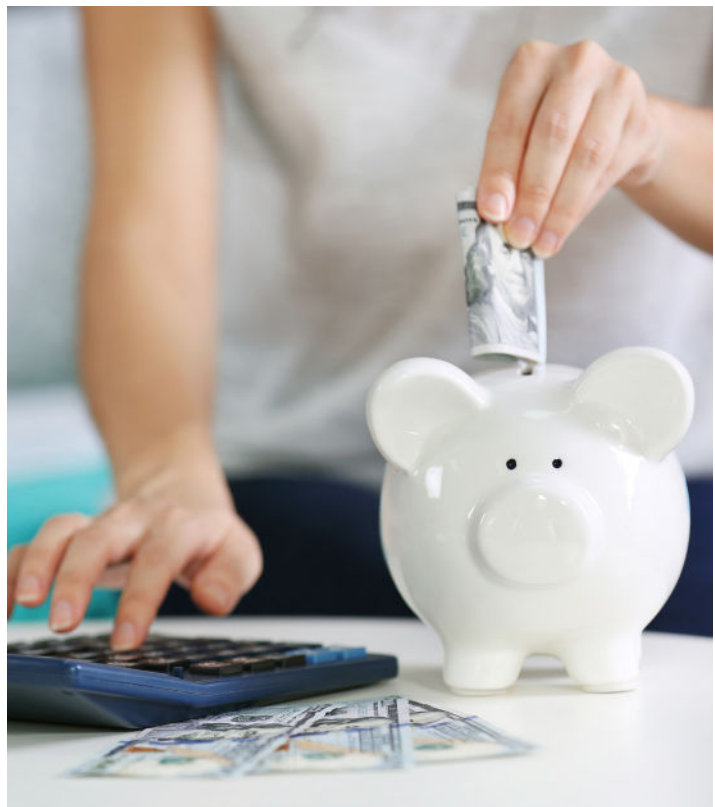
- The IRS has a strict “use it or lose it” rule. If you do not use the full amount in your FSA, you will lose any remaining funds.
- Once you enroll in the FSA, you cannot change your contribution amount during the year unless you experience a qualifying life event.
- You cannot transfer funds from one FSA to another.

Examples of FSA Eligible Expenses

- Acupuncture
- Bandages
- Chiropractors
- Contact lenses
- Copays
- Deductibles
- Lab work
- Prescriptions
- Dental Services
- Orthodontia
- And more!

Visit benefitslogin.wexhealth.com for more information.

REMINDER: Your FSA elections are annual and do not carry over into the new plan year. You must make a new election each year.



Flexible Spending Accounts

Health Care FSA through WEX

(Not compatible with an HSA or Qualified High Deductible Health Plan) Health Care FSAs help you stretch your budget for health care expenses for you and your dependents by allowing you to pay for these expenses using tax-free dollars. In **2026 you may set aside up to \$3,400** in pre-tax dollars, which is deducted out of your pay throughout the year. Funds can be used to pay for qualified expenses for you, your spouse, and your dependent children, even if they are not enrolled in the group medical plan.

The Health Care FSA has a grace period of 2 ½ months (until March 15, 2027) for you to incur claims for the 2026 plan year. You will have until May 30, 2027, to submit claims for reimbursement for the 2026 plan year, including claims incurred during the grace period. Any funds remaining in your Health Care FSA as of May 30, 2027, will be forfeited.

Dependent Care FSA

(Compatible with an HSA and Qualified High Deductible Health Plan)

The Dependent Care FSA allows you to pay for eligible dependent care expenses with tax free dollars. You may set aside up to **\$7,500 in 2026** in pre-tax dollars, or \$3,750 if you are married and file taxes separately from your spouse.

Contributing to a Dependent Care FSA allows you to pay dependent care expenses so that you and your spouse can work, look for work, or attend school full-time. Eligible expenses include day care, before / after school care, summer day camp and elder care. When submitting a claim, you can only be reimbursed up to the amount you have contributed to date, less any previous reimbursements.

REMINDER: If you enroll in the Health Care FSA you are not eligible to contribute to a Health Savings Account (HSA). You can still enroll in the Dependent Care FSA.

WEX Benefits Visa Card

New participants or anyone requesting a new card will receive a WEX Benefits Visa card for easy access to your funds. Participants with an active Discovery debit card may continue to use their current card. Present your debit card at the time of service when purchasing eligible over-the-counter items, prescription drugs, office visit copays, etc. Payment is made directly from your account. Remember to keep your receipts; WEX may reach out to you and ask for substantiation.



Mobile App

The WEX mobile app provides you with quick easy access to your online account. After logging in the first time, you can set up fingerprint access right from your phone.



Health Savings Accounts

If you enroll in the Choice HSA Plan you are eligible to open a Health Savings Account (HSA). An HSA can help you save money by allowing you to pay for eligible health care expenses with tax-free dollars. You can use the funds to pay for qualified expenses such as medical and prescription drug expenses, as well as dental and vision expenses, for you, your spouse, and all dependents you claim on your tax return even if they are not enrolled in the group health plan. Funds withdrawn from your HSA are tax-free when used to pay for qualified health care expenses. For detailed information about HSA eligible expenses please refer to IRS Publication 502 or contact a tax professional.

Note: If you elect the Choice HSA Plan and open a Health Savings Account you are prohibited from contributing to a Health Care Flexible Spending Account (FSA).

How the HSA Works with your Medical Plan

An HSA combines traditional medical coverage with a tax-free savings account. You can contribute tax-free dollars into your HSA to pay for services covered under the plan (tax-free), including expenses you must pay to meet your annual deductible. You decide how much and when to use the funds in your account – you can use the funds to pay for your health care expenses or save the funds for future health care costs. Whatever funds you do not use during the plan year roll over to the next year and can earn interest.

The IRS establishes a limit that you can contribute into your HSA each year. The limits are based on whether you are enrolled for individual medical coverage or if you have dependents on your plan. For 2026, the HSA contribution limits are:

- **Individual** – \$4,400
- **Family** - \$8,750
- Those age 55 and older can make an additional “catch up” contribution of \$1,000 each year

There are certain circumstances when someone is not eligible to contribute to an HSA. **You are not eligible to open an HSA or contribute to an HSA if:**

- You are not enrolled in a Qualified High Deductible Health Plan (QHDHP).
- You are covered by another non-QHDHP health plan, such as a spouse’s or domestic partner’s PPO plan.
- You are enrolled in Medicare.
- You are in the TRICARE or TRICARE for Life military benefits program.
- You received Veterans Administration (VA) benefits within the past three months.
- You are claimed as a dependent on another person’s tax return.
- You are covered by a full medical flexible spending account (FSA). This includes your spouse’s or domestic partner’s FSA

Remember to submit your authorization to deduct your HSA contribution from your paycheck to HR@adfinitashealth.com. The form can be found in the Cason Group Portal or Employee Portal at www.adfinitashealth.com. (Username: AdfinitasWork PW: Teamwork2023)

Opening and Funding your Optum Bank HSA

It takes only minutes to enroll in the HSA from Optum Bank. Go to: <https://enrollhsa.optumbank.com/enrollment#/?group=901607>. Be sure to have your Social Security Number, a valid e-mail address and your UHC Medical ID card with your group and employer ID numbers handy.

The online enrollment process takes about 10 minutes to complete. Once you start the enrollment process, you must complete it before logging off, or none of your information will be saved.

You will hear from Optum Bank via mail within 10 business days of applying. You may be required to provide proof of identification. Once approved you will receive a welcome kit and your Optum Bank HSA card(s).

Life and AD&D

Administered by Lincoln

Adfinitas Health provides Basic Life and Accidental Death & Dismemberment (AD&D) benefits to eligible employees at no cost. Life insurance helps protect your family from the financial risk and sudden loss of income in the event of your death. The AD&D benefit will be paid in the event of a loss of life, sight, hearing, speech, or limb by accident while covered under the plan.

Basic Life and AD&D

Adfinitas Health provides you with basic life insurance in the amount of \$100,000 at no cost to you. If you die as the result of an accident your beneficiary will receive an additional \$100,000. Evidence of Insurability / proof of good health is not required.

Lincoln Group Life / AD&D	
EMPLOYEES WORKING 30+ HOURS PER WEEK	
Benefit Maximum	\$100,000
Guaranteed Issue	\$100,000
Benefit Age Reduction	Benefit reduces to \$65,000 at age 70 and to \$50,000 at age 75.



Important Note about Evidence of Insurability

Unless you are a new hire enrolling for the first time, evidence of insurability is required to add coverage to an existing amount. If you do not elect voluntary life insurance when you are first eligible, any amounts you elect will be subject to evidence of insurability.



Voluntary Life and AD&D

Employees have the option to purchase additional life insurance from Lincoln. Coverage is available for family members. Rates are based on employee age and the amount of coverage elected.

Lincoln Voluntary Life / AD&D	
EMPLOYEES WORKING 30+ HOURS PER WEEK	
Employees	Increments of \$10,000 up to \$500,000. Evidence of Insurability will be required if you elect an amount over \$200,000 when initially eligible.
Spouses	Increments of \$5,000 up to 100% of the employee election, or \$250,000, whichever is less. Evidence of Insurability will be required if you elect an amount over \$50,000 when initially eligible.
Children	Day 1 to 14 Days: \$10,000; 14 days but less than 6 months: \$10,000; 6 months but less than 26 years (or 26 years if unmarried, & a full-time student): \$10,000 Evidence of insurability is not required.

VOLUNTARY LIFE and AD&D		
Age as of January 1, 2026	Monthly Rate Per \$1,000 of Total Coverage	
	Employee and Spouse	Children
Under 30	\$0.025	\$0.20
30-34	\$0.030	
35-39	\$0.039	
40-44	\$0.065	
45-49	\$0.105	
50-54	\$0.168	
55-59	\$0.268	
60-64	\$0.292	
65-69	\$0.419	
70-74	\$0.722	
75+	\$2.060	
VOLUNTARY AD&D		
Employee: \$0.035, Spouse: \$0.025, Child: \$0.200		
Spouse rate is based on age of employee		

After-Tax Contributions

Contributions for voluntary life and AD&D are made after taxes. Please note that the rates shown are monthly. If you are a smoker you will pay more for coverage.

Voluntary Offerings

You have the option to purchase additional voluntary benefits from Lincoln to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, and out-of-pocket costs not covered by your medical insurance.

Accident Insurance

In the event of an off-the-job accident, accident insurance will pay you a cash benefit regardless of what is paid by your medical insurance. Benefits are paid directly to you, and you are free to use the money received to cover whatever expenses you see fit. Below are some examples of covered injuries and expenses:

- Broken bones
- Burns
- Eye injuries
- Lacerations
- Emergency Room visit
- Ground or air ambulance
- Concussion
- Dislocations

Tier	Accident Plan Monthly Rate
Employee	\$11.57
Employee & Spouse	\$19.34
Employee & Child(ren)	\$20.33
Family	\$28.10

Want to learn more about Accident insurance? Visit www.lincolfinancial.com

Critical Illness Insurance

The Critical Illness plan from Lincoln can help with the treatment costs of a covered critical illness such as a heart attack, invasive cancer, severe burns, End Stage Renal Disease, or stroke. More importantly, it can help you focus on recuperation instead of the distraction of out-of-pocket costs. Benefits are paid directly to you, or the person of your choice. Coverage is available to employees, spouses, and dependent children. Choose benefit amounts of: \$10,000, \$15,000 or \$20,000. The plan pays a percentage of your elected benefit amount for each covered condition. Preexisting condition limits apply. You can choose a benefit amount for your spouse and dependent children in the amount of: \$5,000, \$7,500, \$10,000 up to 50% of employee benefit amount.

Critical Illness Monthly Rate – Employee / Spouse / Child											
Benefit Amount	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
\$5,000.00	\$0.62	\$0.87	\$1.23	\$1.89	\$2.91	\$4.80	\$7.57	\$9.15	\$16.05	\$17.07	\$29.45
\$10,000.00	\$1.24	\$1.73	\$2.45	\$3.78	\$5.82	\$9.60	\$15.14	\$18.30	\$32.10	\$34.14	\$58.89
\$15,000.00	\$1.86	\$2.60	\$3.68	\$5.67	\$8.73	\$14.40	\$22.71	\$27.45	\$48.15	\$51.21	\$88.34
\$20,000.00	\$2.48	\$3.46	\$4.90	\$7.56	\$11.64	\$19.20	\$30.28	\$36.60	\$64.20	\$68.28	\$117.78
Child(ren) Monthly Rate per \$1,000 of coverage	\$0.224										

Hospital Indemnity Insurance

Hospital Indemnity insurance helps protect you from the financial costs of unexpected health events that result in hospitalization or other treatment. You can choose coverage for yourself and your family members (more information about dependent eligibility is included in the plan documents). No medical questions asked!

Disability Insurance

To protect your income in case you are unable to work due to a non-work related illness or injury, Adfinitas Health provides disability benefits at no cost to you through **Lincoln**. Full-time employees are eligible for Short-Term Disability (STD) and Long-Term Disability (LTD) benefits after six months of employment. Part-time employees and PRN employees are not eligible for this benefit.

Short-Term Disability (STD) Insurance

If you have been unable to work due to a non-work related injury or illness the STD benefit pays you a percentage of your weekly earnings for up to 13 weeks after a 14 day elimination period for sickness and for accidental injury. The schedule of benefits amounts is below:

- Six months to two years of service: 60% of salary up to a maximum benefit of \$1,500 per week.
- Two to three years of service: 60% of salary up to a maximum benefit of \$2,000 per week.
- Three or more years of service: 60% of salary up to a maximum benefit of \$2,500 per week.

Long-Term Disability (LTD) Insurance

The LTD plan provides income protection in the event of an extended illness or injury. The plan pays 60% of your monthly earnings up to a maximum monthly benefit amount of \$12,500 for employees earning over \$100,000 a year. For employees at all other income levels the LTD plan pays 60% of monthly income up to a maximum monthly benefit of \$5,000. Benefits begin after 90 days of disability. Benefits may be reduced by income you receive from other sources such as workers' compensation, Social Security or other disability coverage. Benefits continue as long as you meeting the insurance company's definition of disability until you reach the Social Security Normal Retirement Age (SSNRA).

Pre-existing condition limitations apply. LTD payments are not payable for a disability caused by a pre-existing condition, which is a injury or illness for which you have consulted a doctor or received treatment during the three months prior to the effective date of your coverage. A condition will no longer be considered a pre-existing condition after you have been enrolled in the LTD plan for at least 12 consecutive months. If, after the effective date for LTD coverage, you received no treatment for the disability for 6 consecutive months, then no pre-existing review is necessary.

Please note: employees do not accrue paid time off or time in service with Adfinitas Health during periods of extended absence, short- or long-term disability.

If you need assistance with a disability claim please contact Lincoln at www.lincolnfinancial.com or 800.423.2765



Employee Assistance Program

You don't have to face your challenges alone!

Our Employee Assistance Program (EAP) through **Lincoln** offers you and your family members confidential and professional counseling at no cost to you. The program is completely confidential. Only your EAP professional will know you called. Staff members are highly trained, master's level professionals, and are available 24 hours a day, 7 days a week to assist with a variety of personal and professional issues including stress, depression, drug and alcohol addiction and abuse, parenting, financial issues, relationship issues mental health, grief, and work/life balance. You have access to 5 face to face sessions of assessment, consulting and referral per presenting issue, per individual per year. Don't delay if you need help.

The resources you need to meet life's challenges

EmployeeConnectSM offers professional, confidential services to help you and your loved ones improve your quality of life.

In-Person Guidance	Unlimited 24/7 assistance	Online Resources
Some matters are best resolved by meeting with a professional in person. With <i>EmployeeConnectSM</i>, you and your family get: ■ In-person help for short-term issues (up to five sessions with a counselor per person, per issue, per year) ■ In-person consultations with network lawyers, including one free 30-minute in-person consultation per legal issue, and 25% off subsequent meetings	You and your family can access the following services anytime — online, on the mobile app or with a toll-free call: ■ Information and referrals on family matters, such as child and elder care, pet care, vacation planning, moving, car buying, college planning and more ■ Legal information and referrals for family law, estate planning, consumer and civil law ■ Financial guidance on household budgeting and short- and long-term planning	<i>EmployeeConnectSM</i> offers a wide range of information and resources you can research and access on your own. Expert advice and support tools are just a click away when you visit GuidanceResources.com or download the <i>GuidanceNowSM</i> mobile app. You'll find: ■ Articles and tutorials ■ Videos ■ Interactive tools, including financial calculators, budgeting worksheets and more

Take advantage of *EmployeeConnectSM*

For more information about the program, visit [GuidanceResources.com](#), download the *GuidanceNowSM* mobile app or call 888.628.4824.

[GuidanceResources.com](#) login credentials:

Username: **LFGSupport** Password: **LFGSupport1**

EmployeeConnectSM

EMPLOYEE ASSISTANCE PROGRAM SERVICES

Confidential help 24 hours a day, seven days a week for employees and their family members. Get help with:

- Family
 - Addictions
 - Legal
 - Relationships
- Parenting
 - Emotional Support
 - Financial
 - Stress

ID Theft

Adfinitas Health partners with Legal Shield to provide employees the option to purchase identity theft protection. With LegalShield's Identity Theft Protection Service you will receive a credit report, detailed evaluation, daily monitoring, identity restoration and fraud alert notifications. Legal Shield provides 5 areas of identity theft protection: driver's license, Social Security, medical, character and criminal and financial.

For more information call 800.654.7757 or visit www.legalshield.com

Tier	ID Theft Rates	
	Monthly Rate	Weekly Rate
Employee	\$8.45	\$1.95
Family	\$15.95	\$3.68



401(k) Retirement Savings

Adfinitas Health provides employees with a retirement plan to help employees save for the future. Employees can contribute up to the IRS pre-tax limit. In order to be eligible to participate you must be 21 years of age. An eligible employee who has satisfied the eligibility requirements will become a participant in the plan as of their date of hire. Employees may enroll or make changes in any payroll period. The plan allows Adfinitas Health to make a discretionary matching contribution each year. Adfinitas Health will match 50% or the first 4% of base salary contributed to the plan up to the maximum of 2%. The company match will be 100% vested after four years of service. Please refer to the Adfinitas Health 401(k) Retirement Plan Summary Plan Description for more details about this benefit plan.

To make change to your existing investments (trade or move money), call Alerus customer service at [1.800.795.2697](tel:1.800.795.2697) or visit Alerus online at www.alerusrb.com. You will receive your user ID in the mail. If you do not have your user ID you can enter your Social Security Number or contact our call center at [1.800.433.1685](tel:1.800.433.1685). If you did not receive your PIN in the mail you can click on “Forgot PIN” and you will be asked for your personal information and will be able to register for your user ID and password.

Travel Assistance

Lincoln has partnered with On Call International to provide comprehensive *TravelConnect* services. *TravelConnect* is provided to you at no additional cost. This program assists you, expatriates and your dependents when you’re more than 100 miles from home. There is no enrollment process – insured employees are automatically covered.

You can use your *TravelConnect* services by calling the phone number on your ID card, available via MyOnCallPortal.com.

You will be connected with an assistance coordinator who’ll provide expert help.

1. For medical emergencies, the coordinator will work with On Call International’s medical team that includes nurse case managers, physician advisors, staff physicians, a full-time medical director, and chief medical officer who oversees all cases.
2. For travel arrangements and emergencies such as evacuations, the assistance coordinator will work with On Call International’s in-house transportation team and travel agency to address caller needs.

Key Services of TravelConnect

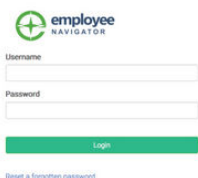
- Replacement of lost or stolen travel documents
- Emergency medical evacuations
- Evacuations for natural disasters and political emergencies
- Transportation of remains
- Return of children and pets to their home following a medical emergency



To access Travel Assistance call **603.328.1955** from anywhere in the world or toll free from the U.S. or Canada
866.525.1955

How To Enroll

ENROLL IN YOUR BENEFITS: ONE STEP AT A TIME



employee
NAVIGATOR

Username
Password

Login

[Reset a forgotten password](#)

Step 1: Log In

Go to www.employeeenavigator.com and click **Login**

- **Returning users:** Log in with the username and password you selected. Click **Reset a forgotten password**.
- **First time users:** Click on your Registration Link in the email sent to you by your admin or **Register as a new user**. Create an account, and create your own username and password.
- You may be required to enter personal identifying data and your company identifier, which will be provided to you by your HR admin.

Verify Your Account

First, let's find your company record

First Name

Last Name

Company Identifier
(provided by HR)



Participation Required

You can't say we didn't tell you, the following items are a **MUST HAVE** for HR. We require that you complete them. You can't say we didn't tell you, but if you don't, we'll have to go away! You'll be hearing from your HR and HR team items are completed.

1. Onboarding
2. Benefits Enrollment
3. HR tasks

Let's Begin!

You've got 2 items to complete.

1. Enroll in your benefits
2. Complete HR tasks.

Start Enrollments

Step 2: Welcome!

After you login click **Let's Begin** to complete your required tasks.

Step 3: Onboarding (For first time users, if applicable)

Complete any assigned onboarding tasks before enrolling in your benefits. Once you've completed your tasks click **Start Enrollment** to begin your enrollments.

TIP: If you hit "Dismiss, complete later" you'll be taken to your Home Page. You'll still be able to start enrollments again by clicking "Start Enrollments"



Onboarding Complete!

Great job! Now you can begin electing your benefits. There are 34 days left in Open Enrollment for you to complete this.

- Onboarding
1. Benefit Enrollment
 2. HR tasks

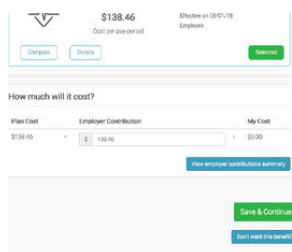
Start Enrollment

Dismiss, complete later

Step 4: Start Enrollments

After clicking **Start Enrollment**, you'll need to complete some personal & dependent information before moving to your benefit elections.

TIP: Have dependent details handy. To enroll a dependent in coverage you will need their date of birth and Social Security number.



\$138.46
Cost per pay period
Effective on 05/01/18
Employees

Compare Select

How much will it cost?

Plan Cost	Employer Contribution	My Cost
\$138.46	\$138.46	\$138.46

View employee contributions summary

Save & Continue

Don't want this benefit?

Step 5: Benefit Elections

To enroll dependents in a benefit, click the checkbox next to the dependent's name under **Who am I enrolling?**

Below your dependents you can view your available plans and the cost per pay. To elect a benefit, click **Select Plan** underneath the plan cost.

Click **Save & Continue** at the bottom of each screen to save your elections.

If you do not want a benefit, click **Don't want this benefit?** at the bottom of the screen and select a reason from the drop-down menu.

Who am I enrolling?

- Myself
- ☐ Elizabeth Reynolds (Spouse)
- ☐ Gwen Reynolds (Child)

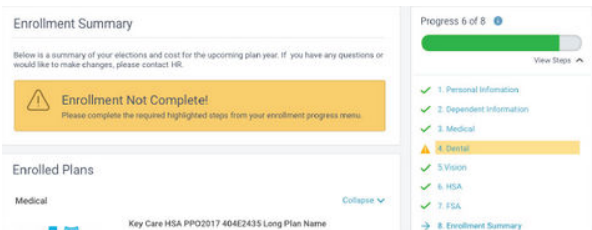
Step 6: Forms

If you have elected benefits that require a beneficiary designation, Primary Care Physician, or completion of an Evidence of Insurability form, you will be prompted to add in those details.

Step 7: Review & Confirm Elections

Review the benefits you selected on the enrollment summary page to make sure they are correct then click **Sign & Agree** to complete your enrollment. You can either print a summary of your elections for your records or login at any point during the year to view your summary online.

*TIP: If you miss a step you'll see **Enrollment Not Complete** in the progress bar with the incomplete steps highlighted. Click on any incomplete steps to complete them.*



Enrollment Summary

Below is a summary of your elections and cost for the upcoming plan year. If you have any questions or would like to make changes, please contact HR.

Enrollment Not Complete!
Please complete the required highlighted steps from your enrollment progress menu.

Enrolled Plans

Medical

Key Care HSA PPO2017 404E2435 Long Plan Name

Progress 6 of 8

1. Personal Information
2. Dependent Information
3. Medical
4. Dental
5. Vision
6. HSA
7. FSA
8. Enrollment Summary

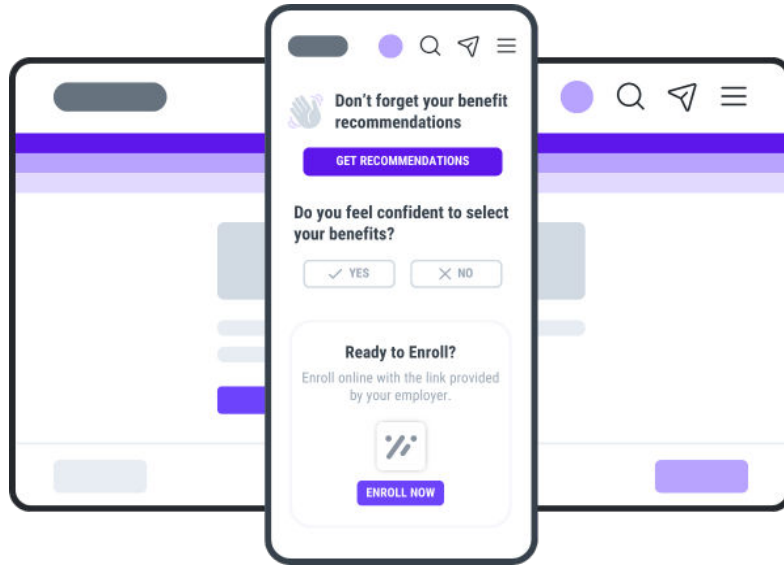
Step 8: HR Tasks (if applicable)

To complete any required HR tasks, click **Start Tasks**. If your HR department has not assigned any tasks, you're finished!

You can login to review your benefits 24/7!

Get to Know Brite

Your Digital Benefits Guide



Choosing benefits doesn't have to be complicated. Brite breaks it down, helping you compare plans, find network doctors –all in one easy-to-use guide.

Explore Your Benefit Options

Your guide has everything you need to make smart, informed choices this plan year:

1. **Your employer will send a link to your digital guide soon.**
2. **Click the link or scan the QR code to access your benefits guide on any device.**

See all benefits available to you

Access education resources

Enroll in your benefits portal



https://britehr.app/Adfinitas_2026



Gallagher Marketplace



Save Money with Gallagher Marketplace

Clients saved \$400+ on auto insurance in 2024.*

Get a free, no-obligation quote and save on your home and auto insurance with over 40 carriers nationwide.

Looking for more savings? Our program offers significant savings on things you are already buying — like pre-paid legal services, identity theft protection, pet insurance, renters insurance and boat or RV insurance, as well as extended vehicle warranties and an employee discount program — all in one centralized hub.

Discover what benefits your organization offers through Gallagher Marketplace.

The value	The convenience
• Whether full-time, part-time or contract workers, all employees and their families are eligible. • Compare real, no-obligation quotes from multiple carriers on one site. • Potential cost savings compared to shopping on your own. • Call and talk to licensed insurance advisors to help understand and find the policy that meets your needs.	• Enroll any time of the year, not just during open enrollment. • Monthly, quarterly and annual payment option available. • 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.
- 4 Enter your employer name when prompted.



Scan the QR code to learn more.

AJG.com The Gallagher Way. Since 1927.

*Insurance is subject to availability and individual eligibility. Savings based on 2024 Insuramatch customer survey.

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Important Contacts

Carrier Contacts

	Carrier	Phone Numbers	Website
Medical and Prescription	CareFirst	800.544.8703	www.carefirst.com
Dental	United Concordia (UCCI)	800.332.0366	www.ucci.com
Vision	CareFirst	800.544.8703	www.carefirst.com
Life / AD&D and Disability	Lincoln Financial	800.423.2765 Monday - Thursday, 8 a.m. to 8 p.m. Friday, 8 a.m. to 6 p.m. Eastern	clientservices@lfg.com for benefit questions claims@lfg.com for claims inquiries or questions on existing claims LifeClaims@lfg.com to submit life insurance claims Disability Claims@LFG.com to submit disability claims
Accident / Critical Illness / Hospital Indemnity	Lincoln Financial	800.423.2765	lincolnfinancial.com for real-time benefit information
401(k)	Alerus	800.433.1685	admin@alerusmail.com
ID Theft	Legal Shield	800.654.7757	www.legalshield.com
Flexible Spending Account	Wex Inc.	833.225.5939	www.wexinc.com
Health Savings Account	Optum	866.234.8913	www.optumbank.com
Employee Assistance Program	Lincoln Financial	888.628.4824	GuidanceResources.com Log in credentials: Username: LFG Support Password: LFGSupport1
Adfinitas Health Human Resources	Stephanie Stewart, CHRO	240.904.2369	ss Stewart@adfinitashealth.com



Annual Enrollment Notices and Disclosures

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. For further details, please refer to the Plan's Summary Plan Description.

If you would like more information on WHCRA benefits, please call your Plan Administrator at [240.904.2369](tel:240.904.2369).

Newborns' and Mothers' Health Protection Act

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

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

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

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

If you or your dependents are **not** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial [877.KIDS.NOW](tel: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](tel:866.444.EBSA) (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your state for more information on eligibility.

ALABAMA – Medicaid

<http://myalhipp.com>
855.692.5447

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>

ARKANSAS – Medicaid

<http://myarhipp.com>
855.MyARHIPP (855.692.7447)

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

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://hcpf.colorado.gov/child-health-plan-plus>
Customer Service: 800.359.1991 | State Relay 711
Health Insurance Buy-In Program (HIBI)
<https://www.mycobibi.com/>
HIBI Customer Service: 855.692.6442

FLORIDA – Medicaid

www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html
877.357.3268

GEORGIA – Medicaid

GA HIPP: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>
678.564.1162, Press 1
GA CHIPRA: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>
678.564.1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
<https://www.in.gov/medicaid/> | 800.457.4584
Family and Social Services Administration
<http://www.in.gov/fssa/dfr/> | 800.403.0864

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

KANSAS – Medicaid

<https://www.kancare.ks.gov/>
800.792.4884 | HIPP Phone: 800.967.4660

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>

LOUISIANA – Medicaid

www.medicaid.la.gov or www.ldh.la.gov/lahipp
888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)

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

MASSACHUSETTS – Medicaid and CHIP

<https://www.mass.gov/masshealth/pa>
800.862.4840 | TTY: 711 | Email: masspremassistance@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 HIPPA 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-medicare-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.MyWVHIP (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, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
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

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

Paperwork Reduction Act Statement

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

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

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

Adfinitas Health, LLC is committed to the privacy of your health information. The administrators of the Adfinitas Health, LLC Health Plan (the “Plan”) use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan’s policies protecting your privacy rights and your rights under the law are described in the Plan’s Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Stephanie Stewart at sstewart@adfinitashealth.com. The notice also is available online at thecasongroup.com.

HIPAA Special Enrollment Rights

Adfinitas Health, LLC Health Plan Notice of Your HIPAA Special Enrollment Rights

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

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

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

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

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

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

To request special enrollment or to obtain more information about the plan’s special enrollment provisions, contact Stephanie Stewart at sstewart@adfinitashealth.com.

Important Warning

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

Notice of Creditable Coverage

Important Notice from Adfinitas Health, LLC About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Adfinitas Health, LLC 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. Adfinitas Health, LLC has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

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 Adfinitas Health, LLC coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Adfinitas Health, LLC coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Adfinitas Health, LLC 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 Adfinitas Health, LLC 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, 2026
Name of Entity/Sender: Adfinitas Management, LLC
Contact: Stephanie Stewart
Address: 7250 Parkway Drive
Suite 120
Hanover, Maryland 21076-1343
Phone Number: 240.904.2369

COBRA General Notice

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

****Continuation Coverage Rights Under COBRA****

Introduction

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

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

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

What is COBRA continuation coverage?

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

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

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

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

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

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Adfinitas Human Resources Department, 7250 Parkway Dr. Suite 500, Hanover, MD 21076-1343 or ssewart@adfinitashealth.com.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Adfinitas Management, Human Resources Department

Address: 7250 Parkway Dr., Suite 120
Hanover, MD 27076-1343

Phone Number: 240.940.2369

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

Marketplace-eligible individuals who live in states served by [HealthCare.gov](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, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](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, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Stephanie Stewart.

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 Adfinitas Health, LLC		4. Employer Identification Number (EIN) 42-2540636	
5. Employer address 250 Parkway Dr., Suite 120		6. Employer phone number 240.940.2369	
7. City Hanover	8. State MD	9. ZIP code 27076-1343	
10. Who can we contact about employee health coverage at this job? Stephanie Stewart			
11. Phone number (if different from above)		12. Email address sstewart@adfinitas.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: Regular full-time employees working 30 or more hours per week, as defined by the employer
- ☐ Some employees. Eligible employees are:

■ With respect to dependents:

- ☒ We do offer coverage. Eligible dependents are: Legal Spouse and dependent children up to age 26, as defined by the employer.
- ☐ 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



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