Employee Benefit Guide

Golden Age Home Health, Inc.

August 1, 2025 - July 31, 2026

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This publication highlights recent plan design changes and is intended to fully comply with the requirement under the Employee Retirement Income Security Act ("ERISA") as a Summary of Material Modification and should be kept with your most recent Summary Plan Descriptions.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 21 where Notice of Creditable Coverage begins for more details.

About Your Benefits

At Golden Age Home Health, Inc., we are committed to providing a comprehensive and valuable benefits package to you and your family. Review this guide to learn about your options so you can make the most of your benefits. If you have any questions, feel free to reach out to Dakota Palomino at **405/692-1255** or dpalomino@goldenagehealth.com.

Eligibility and Enrollment

You are eligible to participate in Golden Age Home Health, Inc. benefits if you are a full-time employee. If you enroll for benefits, you may also cover your:

- Legal spouse
- Children up to age 26
- Unmarried children of any age who are mentally or physically disabled

Your benefits begin on the first of the month following 60 days. Please refer to the SPDs for each benefit to confirm whether you, your spouse and dependents are eligible.

Select Your Benefits Carefully

To get the most value from your benefits, carefully consider which options are right for you and your family. Because premiums for certain benefits are deducted on a pre-tax basis, IRS regulations may prohibit you from making enrollment changes until the end of the plan year, unless you experience a qualified election change.

Making Changes to Your Benefits

Each year, you have the opportunity to make changes to your benefits during Annual Enrollment. Any pre-tax benefit elections made during open enrollment must remain in effect until the following Annual Enrollment period, unless you experience a qualifying event which may allow for an election change. Examples of qualified life events include:

- Marriage, legal separation or divorce
- Birth or adoption of a child
- Change in a dependent's eligibility status
- Loss of eligibility for group health coverage, health insurance coverage, or Medicaid/CHIP
- Becoming eligible for a state premium assistance subsidy

If you believe you have a qualifying event please notify Human Resources immediately. You have **30** days from a qualified change in status to make changes. However, note that if you lose eligibility for Medicaid/CHIP, or become eligible for a state premium assistance subsidy, you have 60 days from that qualified change in status to make changes.

Keep in mind, the changes you make must be directly related to the event.

Medical Coverage

Terms to Know

- **Copay** - A set dollar amount you pay for a covered healthcare service, usually when you receive the service.
- **Deductible** - What you pay out of pocket for healthcare services before the plan begins to pay a portion.
- **Coinsurance** - Your share of the costs of covered healthcare services after you reach the deductible. You pay a percentage of the cost, and the medical plan pays the rest.
- **Out-of-pocket Maximum** - What you have to pay before the plan pays 100% of your covered costs.
- **Network** - The facilities and providers the medical plan has contracted with to provide healthcare services. In-network providers typically provide services at a lower negotiated rate. If you receive services from a provider that is **In-Network** it will cost you significantly less than going to a provider that is **Out-of-Network.**
- **Formulary Drug List:** A drug formulary is a list of generic and brand-name drugs that have been evaluated for safety and effectiveness, and that your insurance company considers “best choices”.
- **Generic Drugs**: FDA approved, and shown to be just as safe and effective as their more expensive brand-name counterparts.
- **Brand Name Drugs:** Carriers regularly review the latest prescription drugs on the market and maintains a list of brand name drugs that are clinically effective and not cost-restrictive.
- **Specialty Drugs:** Specialty drugs are typically used to treat chronic conditions like cancer or multiple sclerosis. These drugs tend to be more expensive and usually require special handling and monitoring. If you take a specialty medication, you could save money by using the carrier’s mail-order pharmacy. You can register for mail-order pharmacy by logging on to **www.bcbsok.com**

How the Plans Work

All plans use the Blue Cross and Blue Shield of Oklahoma network and cover 100% of the cost for preventive care services like annual physicals and routine immunizations. The way you pay for care is different with each plan.

PPO: This Plan has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays until you reach your annual out-of-pocket maximum.

Telemedicine

Getting to the doctor when you’re sick is never easy. That’s why Blue Cross and Blue Shield of Oklahoma offers telemedicine for non-emergency care. You can connect with a U.S. board-certified medical professional by phone or video chat. For further details, visit www.bcbsok.com

Medical and Prescription Coverage

Administered by Blue Cross and Blue Shield of Oklahoma

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with a Medical plan through Golden Age Home Health, Inc.

	S730ADT Blue Advantage Silver PPO 104	G744ADT Blue Advantage Gold PPO 109	G746ADT Blue Advantage Gold PPO 112
	IN-NETWORK	IN-NETWORK	IN-NETWORK
Deductible (Individual/Family)	$4,350/$13,050	$1,600/$4,800	$2,100/$6,300
Coinsurance	40%	20%	20%
Out-of-Pocket Maximum (Individual/Family)	$9,200/$18,400	$7,250/$14,500	$6,250/$18,400
BASIC & PHYSICIAN CARE			
Preventive Care	$0	$0	$0
Primary Care Office Visit	$50	$40	$35
Specialist Office Visit	$75	$65	$60
Virtual Visits	$50	$40	$35
Independent Lab/X-Ray	DED + 40%	DED + 20%	DED + 20%
Independent Diag MRI / CT	DED + 40%	DED + 20%	DED + 20%
SICK AND QUICK CARE			
Urgent Care Facility	$50	$50	$50
Emergency Room	$600 plus DED + 40% (Copay waived if admitted)	$400 plus DED + 20% (Copay waived if admitted)	$500 plus DED + 20% (Copay waived if admitted)
HOSPITALIZATION			
Inpatient Hospital	$250 plus DED + 40%	$200 plus DED + 20%	$250 plus DED + 20%
Outpatient Surgery	$200 plus DED + 40%	$150 plus DED + 20%	$200 plus DED + 20%
PHARMACY			
Retail (up to 30 days)	Preferred participating: $10/$20/$50/$100; Participating: $20/$30/$70/$120	Preferred participating: $10/$20/$50/$100; Participating: $20/$30/$70/$120	Preferred participating: $5/$10/$50/$100; Participating: $15/$20/$70/$120
Mail Order (90 days)	$30/$60/$150/$300	$30/$60/$150/$300	$15/$30/$150/$300
Specialty Drugs	Preferred: $250; Non preferred: $350	Preferred: $250; Non preferred: $350	Preferred: $250; Non preferred: $350
OUT-OF-NETWORK CARE			
Your medical plan offers out-of-network care. However, please be aware that you will be responsible for charges in addition to the out- of-network deductible and coinsurance. Out-of-network providers will typically charge you the difference between the amounts they bill and what the Blue Cross and Blue Shield of Oklahoma pays (known as balance billing). These charges are in addition to, and do not count towards your out-of-network out-of-pocket maximum.			
Deductible (Individual/Family)	$8,700/$26,100	$3,200/$9,600	$4,200/$12,600
Coinsurance	50%	40%	40%
Out-of-Pocket Maximum (Individual/Family)	Unlimited	Unlimited	Unlimited

Finding In-Network Providers

You save the most money when you choose in-network doctors, facilities and pharmacies. Log on to www.bcbsok.com or call the number on your Member ID Card to find providers in the Blue Cross and Blue Shield of Oklahoma network.

Employee Medical Costs– Age Banded

Golden Age Home Health, Inc. contributes 60% for Employees and 0% for Dependents toward the cost of Medical coverage.

Age Band	S730ADT Blue Advantage Silver PPO 104	G744ADT Blue Advantage Gold PPO 109	G746ADT Blue Advantage Gold PPO 112	Age Band	S730ADT Blue Advantage Silver PPO 104	G744ADT Blue Advantage Gold PPO 109	G746ADT Blue Advantage Gold PPO 112
<15	$260.05	$297.58	$298.27	40	$434.44	$497.13	$498.29
15	$283.17	$324.03	$324.79	41	$442.60	$506.46	$507.65
16	$292.01	$334.14	$334.92	42	$450.42	$515.41	$516.62
17	$300.85	$344.26	$345.06	43	$461.30	$527.86	$529.09
18	$310.37	$355.15	$355.98	44	$474.90	$543.42	$544.69
19	$319.88	$366.04	$366.90	45	$490.87	$561.70	$563.02
20	$329.74	$377.32	$378.20	46	$509.91	$583.49	$584.85
21	$339.94	$388.99	$389.90	47	$531.33	$607.99	$609.41
22	$339.94	$388.99	$389.90	48	$555.80	$636.00	$637.49
23	$339.94	$388.99	$389.90	49	$579.94	$663.62	$665.17
24	$339.94	$388.99	$389.90	50	$607.13	$694.74	$696.36
25	$341.30	$390.55	$391.46	51	$633.99	$725.47	$727.16
26	$348.10	$398.33	$399.26	52	$663.56	$759.31	$761.08
27	$356.26	$407.66	$408.62	53	$693.48	$793.54	$795.40
28	$369.51	$422.83	$423.82	54	$725.77	$830.49	$832.44
29	$380.39	$435.28	$436.30	55	$758.07	$867.45	$869.48
30	$385.83	$441.50	$442.54	56	$793.08	$907.51	$909.64
31	$393.99	$450.84	$451.89	57	$828.43	$947.97	$950.19
32	$402.15	$460.18	$461.25	58	$866.17	$991.15	$993.47
33	$407.25	$466.01	$467.10	59	$884.86	$1,012.54	$1,014.91
34	$412.69	$472.23	$473.34	60	$922.60	$1,055.72	$1,058.19
35	$415.41	$475.35	$476.46	61	$955.23	$1,093.06	$1,095.62
36	$418.13	$478.46	$479.58	62	$976.65	$1,117.57	$1,120.18
37	$420.85	$481.57	$482.70	63	$1,003.50	$1,148.30	$1,150.98
38	$423.57	$484.68	$485.82	64+	$1,019.82	$1,166.97	$1,169.70
39	$429.00	$490.91	$492.05				

Dental Coverage

Administered by Delta Dental of Oklahoma

Good oral care enhances overall physical health and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Dental benefit plan.

	Select PPO		Select PPO + Premier	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Annual Deductible (Individual/Family)	$50	$50	$50	$50
Annual Maximum (Per Person)	$1,500	$1,500	$1,500	$1,500
Preventive Care (Routine Cleaning and X-rays)	0%	0%	0%	0%
Basic Services (Fillings, Basic Root Canals)	20% after deductible	20% after deductible	20% after deductible	20% after deductible
Major Services (Extractions, Crowns)	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Orthodontia (Children up to age 26)	50%	50%	50%	50%
Orthodontia Lifetime Maximum (Per Person)	$1,500	$1,500	$1,500	$1,500

**The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider. A non-network provider may balance bill you for the difference.*

Employee Dental Costs

Coverage Tier	Select PPO (Bi-Weekly Payroll Deduction)	Select PPO + Premier (Bi-Weekly Payroll Deduction)
Employee Only	$15.69	$25.38
Employee + Spouse	$32.31	$49.38
Employee + Child(ren)	$39.69	$65.08
Employee + Family	$53.54	$96.46

Finding In-Network Dentists

You typically pay less for services when you use a dentist in the Delta Dental of Oklahoma network. You can find an in-network dentist by visiting **www.deltadentalok.org** or calling **1-800-522-0188**.

Vision Coverage

Administered by MetLife Inc

Golden Age Home Health, Inc.'s Vision plan covers routine eye exams and helps you pay for glasses or contact lenses. Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages.

	Vision Plan	
	In-Network	**Out of Network**
Eye Exam (Once every 12 months)	Covered in full after $10 copay	$45 allowance
LENSES (Once every 12 months)		
Single Vision	Covered in full after $25 copay	$30 allowance
Bifocal	Covered in full after $25 copay	$50 allowance
Trifocal	Covered in full after $25 copay	$65 allowance
Lenticular	Covered in full after $25 copay	$100 allowance
Progressive	Your cost will be limited to a copay that MetLife has negotiated for you	$50 allowance
Scratch Resistant		
Anti-Reflective Coating		
FRAMES (Once every 12 months)		
Frames	$25 copay; Up to $130 allowance (20% off remaining balance); Costco, Walmart and Sam's Club: $70 allowance	Up to $70 allowance
CONTACT LENSES (Once every 12 months)		
Fitting	Up to $60 copay	
Elective	Up to $130 allowance	Up to $105 allowance
Medically Necessary	Covered in full after $25 copay	$210 allowance
Lasik	Averaging 15% off the regular price or 5% off a promotional offer	

Employee Vision Costs

Coverage Tier	Vision Plan (Bi-Weekly Payroll Deduction)
Employee Only	$ 4.01
Employee + Spouse	$ 8.03
Employee + Child(ren)	$ 6.80
Employee + Family	$11.21

Finding In-Network Eye Doctors

You can find an in-network eye doctor in the MetLife Inc network by visiting **www.metlife.com** or calling **1-800-638-5433**.

Basic Life and Accidental Death & Dismemberment Insurance

Administered by MetLife Inc

Golden Age Home Health, Inc. provides Basic Life and Accidental Death and Dismemberment (AD&D) insurance at no cost to eligible employees. All benefit eligible employees are automatically enrolled in this coverage.

	How it Works	Basic Life and AD&D (Company-paid benefit)
Basic Life	Your beneficiaries receive this benefit if you pass away	$75,000 Guarantee Issue Amount: $75,000
Basic AD&D	You (or your beneficiaries) receive this benefit if you pass away or are seriously injured in an accident	$75,000

The benefit will reduce by 35% upon reaching age 65, and to 50% of the original amount at age 70.

Keep Your Beneficiaries Up to Date

- Make sure to keep this information updated so your benefit is paid according to your wishes.
- This may be done by completing a Beneficiary Designation form with your employer and the carrier.

Voluntary Life and Accidental Death & Dismemberment Insurance

Administered by MetLife Inc

As an added benefit, you have the opportunity to purchase financial support through the Voluntary Life and Accidental Death and Dismemberment Plan. You **MUST** elect coverage on **YOURSELF** in order to elect coverage for a spouse and/or child(ren).

	How it Works	Voluntary Life and AD&D (Employee-paid benefit)
Life	Your beneficiaries receive this benefit if you pass away	**You:** Increments of $10,000 up to the lesser of 5 times your basic annual earnings or $500,000 **Your spouse:** Increments of $5,000 up to $100,000, not exceed 50% of the employee's supplemental life benefit **Your child(ren):** Flat Amount: $1,000, $2,000, $4,000, $5,000, or $10,000 up to $10,000
AD&D	You (or your beneficiaries) receive this benefit if you pass away or are seriously injured in an accident	**You:** Increments of $10,000 up to the lesser of 5 times your basic annual earnings or $500,000 **Your spouse:** Increments of $5,000 up to $100,000, not exceed 50% of the employee's supplemental life benefit **Your child(ren):** Flat Amount: $1,000, $2,000, $4,000, $5,000, or $10,000 up to $10,000

The benefit will reduce by 35% upon reaching age 65, and to 50% at age 70.

Keep Your Beneficiaries Up to Date

- Make sure to keep this information updated so your benefit is paid according to your wishes.
- This may be done by completing a Beneficiary Designation form with your employer and the carrier.

IMPORTANT: An evidence of insurability (EOI) form must be submitted and approved by Carrier if:

- You are electing an amount over the Guarantee Issue (GI). The Guarantee Issue amounts are $50,000 for an employee and $25,000 for a spouse.
- Coverage is available up to the Guarantee Issue Limit without answering medical questions if you enrolled when you were initially eligible. If you didn't sign up when you were initially eligible you may have to answer medical questions to obtain this coverage.
- Please Note: If you are required to complete a medical questionnaire, you will be notified by HR.

Coverage will not be available until MetLife Inc provides approval.

Voluntary Life and AD&D Rates

Rates are subject to Age; please, see below for the expected rate.

Rates (Per $1,000 / Mo)			
Age:	**Employee**	**Spouse**	**Child**
0-29	$0.055	$0.055	
30-34	$0.071	$0.071	
35-39	$0.102	$0.102	
40-44	$0.120	$0.120	
45-49	$0.180	$0.180	
50-54	$0.276	$0.276	
55-59	$0.516	$0.516	
60-64	$0.728	$0.728	
65-69	$1.052	$1.052	
70-99	$1.690	$1.690	
AD&D	$0.016	$0.016	$0.016

Contact Information

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

Benefit	Vendor	Policy Number	Phone	Website or Email
Medical	Blue Cross and Blue Shield of Oklahoma	Y01920	1-800-942-5837	www.bcbsok.com
Dental	Delta Dental of Oklahoma	0008696	1-800-522-0188	www.deltadentalok.org
Vision	MetLife Inc	05938264	1-800-638-5433	www.metlife.com
Life and AD&D	MetLife Inc	05938264	1-800-638-5433	www.metlife.com
Voluntary Life and AD&D	MetLife Inc	05938264	1-800-638-5433	www.metlife.com

Name	Title	Phone	Email
Dakota Palomino	HR Director / Office Manager	405/692-1255	dpalomino@goldenagehealth.com
Pete Towne	Gallagher Benefit Services, Inc.	405/471-5041	pete_towne@ajg.com
Glenda Acker	Gallagher Benefit Services, Inc.	405/471-5022	glenda_acker@ajg.com

Legal Notices & 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 your group Medical Coverage.

If you would like more information on WHCRA benefits, please call your Plan Administrator at 800-942-5837
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NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

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

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of March 17, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since March 17, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Golden Age Home Health, Inc. is committed to the privacy of your health information. The administrators of the Golden Age Home Health, Inc. 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 Dakota Palomino at 405/692-1255 or dpalomino@goldenagehealth.com.

HIPAA Special Enrollment Rights

Golden Age Home Health, Inc. Health Plan Notice of Your HIPAA Special Enrollment Rights

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

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 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 31 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 Dakota Palomino, HR Director / Office Manager at 405/692-1255 or dpalomino@goldenagehealth.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 Golden Age Home Health, Inc.

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 Golden Age Home Health, Inc. 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. **Golden Age Home Health, Inc. has determined that the prescription drug coverage offered by the medical plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join a Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Golden Age Home Health, Inc. coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Golden Age Home Health, Inc. 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 Golden Age Home Health, Inc. 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 Golden Age Home Health, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date:	**08/01/2025**
Name of Entity/Sender:	**Golden Age Home Health, Inc.**
Contact—Position/Office:	**Dakota Palomino**
Office Address:	**934 SW 107th St** **Oklahoma City, OK 73170-5244**
Phone Number:	**405/692-1255**

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: Dakota Palomino. Contact your Plan Administrator for additional procedures or required documentation.

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 period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

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

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

Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

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

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

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

Golden Age Home Health, Inc. Health Plan
Dakota Palomino
934 SW 107th St
Oklahoma City, OK 73170-5244
405/692-1255

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Summary does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

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

The intent of this analysis is to provide you with general information regarding the provisions of current federal laws and regulation that may be applicable to your specific circumstances. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who would presumably know your specific circumstances and who specializes in this practice area should address questions regarding specific issues.

Golden Age Home Health, Inc.,
August 1, 2025 - July 31, 2026

This benefit guide prepared by

Gallagher

Insurance | Risk Management | Consulting