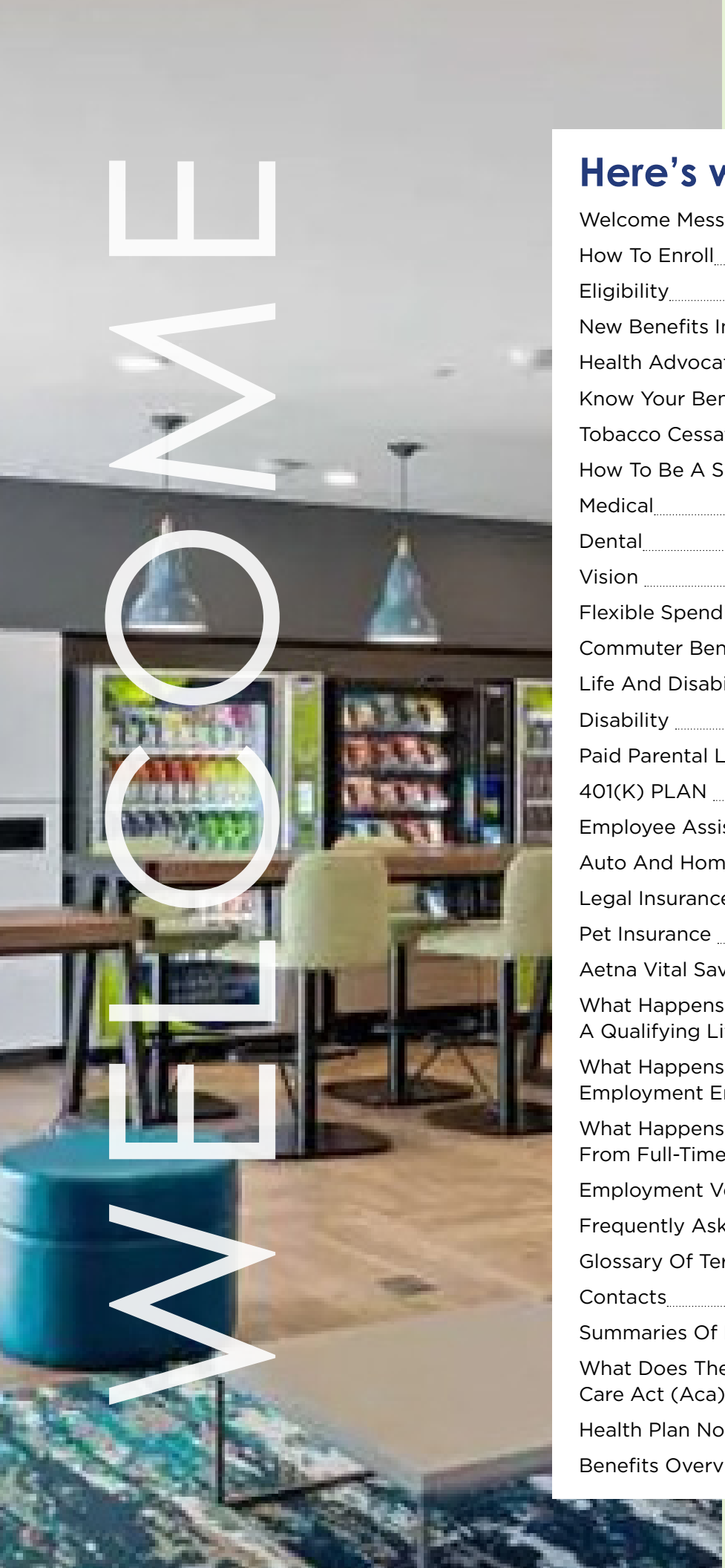
ASSOCIATE BENEFITS

Extended Stay America

2025

STAYwell

extended STAY AMERICA®



Here's where to find...

WELCOME MESSAGE

ESA Management is excited to have you on our team!

At ESA, we believe that our associates are what separates us from the competition. It is our associates who bring ESA's Purpose and Core Values to life every day when serving each other, our guests, and others such as the communities in which we operate. This is why we strive to put the interests of you and your family at the forefront of everything we do.

This benefits guide is intended to provide you with information regarding the benefits that are available at our company.

STAY ASSURED

ESA's health, welfare, and retirement benefit programs are an essential part of our associates' lives. Therefore, we are committed to offering competitively designed and affordably priced benefit programs by engaging with some of the highest quality healthcare and supplementary providers. Be sure to read about Health Advocate to understand the many ways they can assist you in understanding ESA's benefit offerings as you and your family members navigate through the complicated world of health care.

STAY WELL

Never underestimate the power of wellness. Each of us has the responsibility to prioritize our physical, social, mental, emotional, and financial health. At ESA, we offer many resources at our disposal to assist you in this regard. Please use this guide to learn how to access and take advantage of these resources to address any needs you or of your fellow associates may have, either now or in the future. Also, be sure to look out for our StayWell icons on communications sent by ESA throughout the year.

Thanks for taking the time to be informed. We urge you to explore which of ESA's many programs are beneficial for you and your family.

Warmest Regards,

Greg Juceam
President & CEO

Mike Moore
Chief Human Resources Officer

STAYwell STAYwell STAYwell

This guide describes the benefit plans and policies available to you as an associate(s) of the company. The details of these plans and policies are contained in the official plan and policy documents. This guide is only meant to cover the major points of each plan or policy. It doesn't contain all of the details that are included in the Summary Plan Description (SPD). If there is a conflict between this Guide and the official Plan Documents, the Plan Document governs.

HOW TO ENROLL

All associate(s) must go online to enroll or decline each benefit type. Detailed instructions on how to enroll on MyADP can be found in the MyADP Training Guide. To access the training guide go to the Forms and Plan Documents tile under Your Benefits on MyADP.

ACTION REQUIRED

You must enroll via MyADP by accessing the online portal at https://my.adp.com/. If you are newly eligible and do not enroll within 31 days, you will forfeit benefits.

ELIGIBILITY

Associate(s) are eligible to participate in our group benefit programs (see chart on next page).

- **You may enroll the following dependents:**
  - Your legally married spouse
  - Your spouse is only eligible for medical and dental coverage with ESA if they do not have access to other coverage through their employer.

Marriage license must be provided.

- **Dependent children under age 26**
  - Dependent children include natural children, stepchildren, legally adopted children, foster children or children placed with you for adoption, children under your care due to a court order and children for whom you have legal guardianship.
  - Unmarried children of any age if totally disabled and claimed as a dependent on your federal income tax. Documentation of handicapped status must be provided.

Birth Certificate or Adoption Paperwork or Guardianship Paperwork for each child must be provided.

Dependents NOT eligible to participate include:

- Grandchildren, nieces, nephews, or other children who do not meet specifications listed above
- Domestic partners
- Ex-spouses
- Parents, step-parents, grandparents, aunts, uncles, or other relatives that are not qualified legal dependents

Full-Time Benefit	When To Enroll	Eligibility Waiting Period
Medical/Prescription Health Savings Account Dental Vision Flexible Spending Accounts Supplemental Life Dependent Life Short-Term Disability Long-Term Disability Buy-Up Plan Pet Insurance Legal Insurance	Within 31 days of your date of hire or status change from part-time to full-time	1st of the month after completing 60 days of full-time employment
Basic Life and AD&D Long-Term Disability Basic Plan	You are automatically enrolled by the company	1st of the month after completing 60 days of full-time employment
Health Advocate Service	You are automatically enrolled by the company	No Waiting Period
Employee Assistance Program	You are automatically enrolled by the company	No Waiting Period
401k Plan	Anytime after Date of Hire	**Employee Contributions: No Waiting Period Employer Discretionary Match: 6 Months
Aetna Vital Savings*	Anytime after Date of Hire	No Waiting Period
Part-Time Benefit	**When To Enroll**	**Eligibility Waiting Period**
Vision	Within 31 days of your date of hire	1st of the month after completing 60 days of part-time employment
Employee Assistance Program	You are automatically enrolled by the company	No Waiting Period
Aetna Vital Savings	Anytime after Date of Hire	No Waiting Period
401k Plan	Anytime after Date of Hire	**Employee Contributions: No Waiting Period Employer Discretionary Match: 6 Months
Pet	Within 31 days of your date of hire or status change from part-time to full-time	1st of the month after completing 60 days of full-time employment
Legal		

*Full-time associates may not participate if enrolled in an Aetna medical plan

**Once eligible, match contributions are added to your account on a per pay check basis along with your personal contributions.

NEW BENEFITS IN 2025!

Healthee

We're excited to announce that we have partnered with Healthee so you can pick your plans with confidence and navigate your healthcare with ease! Here's what you can look forward to with Healthee:

Personalized recommendation system to help you

- pick the best plans for you and your family
- Simplified access to health benefits information, including costs

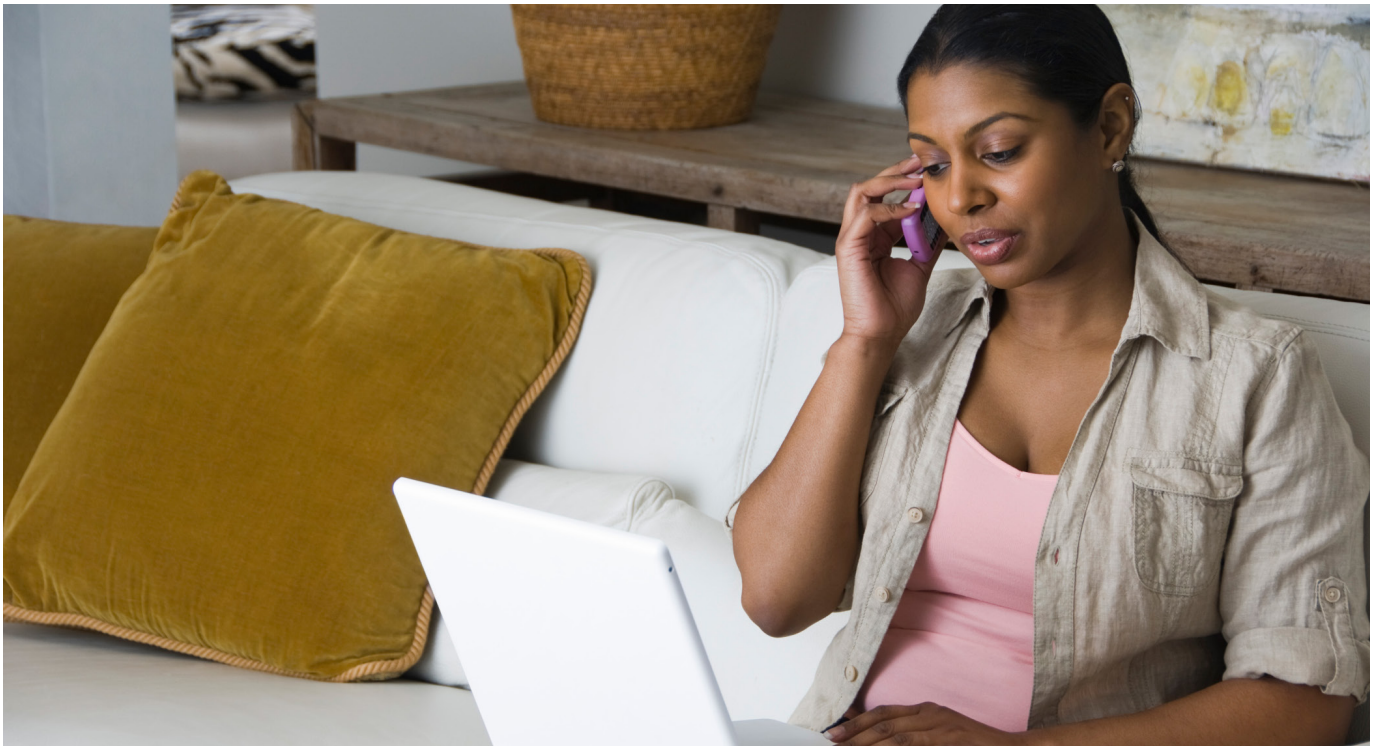
Tools to help you make the most of your health plan

- Virtual assistant and enhanced support to answer all your questions anytime
- Everything you need when it comes to finding a provider
- 24/7 telehealth at $0 cost, including mental health, for associates enrolled in an ESA medical plan

Health Advocate EAP

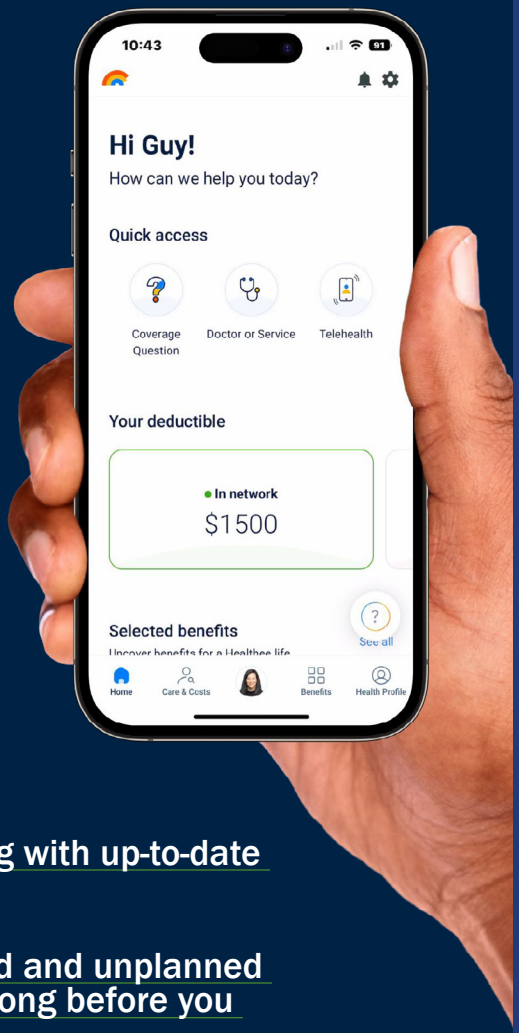
We are pleased to announce that Health Advocate will be our new Employee Assistance Program (EAP) provider starting in 2025. Health Advocate is dedicated to providing compassionate emotional support when you need it most. Their Care Managers and masters-level clinicians offer personalized coaching on a wide range of mental health and well-being issues. Whether you need help with stress, work/life balance, or personal challenges, they are here to tailor their support to your unique needs. With Health Advocate's mobile app or website, you can easily access:

- Personalized assessments and checklists
- Online counseling and coaching
- Instant navigation to digital therapy
- State-specific Legal Center
- Financial fitness resources
- Virtual access to counselors, coaches, and other experts
- Work/Life Support, including eldercare, childcare, relocation support, and more



Healthee

One unified platform for all your healthcare needs



Designed to make employee health benefits simpler and less costly, Healthee is available as both a web and mobile app. Associates enrolled in an ESA medical plan have access to Healthee. Associates not enrolled can use Healthee to access their digital ID Cards.

- **Easily track all of your healthcare** spending with up-to-date deductible widgets
- **Estimate your cost of care** for both planned and unplanned events like dental cleanings and ER visits, long before you ever step foot in a waiting room
- **Access your medical, dental, and vision ID cards** at any time, right on your phone
- **Find top-rated doctors** in your area who accept your insurance plans
- **Book appointments online** without ever needing to make a call
- **Access a live benefits concierge team** who can tackle all of your technical and care questions

1. Register to Healthee with your work email
2. Start benefit ang getting Healtheeier!

Healthee

HEALTH ADVOCATE

Just as you may have a tax expert to help you prepare your taxes each year or a financial advisor to help you budget and save for retirement; you may ask yourself, where you can find an expert to help work through the many complexities of health care.

ESA provides this third party resource through Health Advocate, at no cost to you.

Who is Health Advocate? Health Advocate is a specialty advocacy service staffed by benefits experts and registered nurses, supported by clinical professionals. This service will be your own personal healthcare assistant to help you and your family with benefit-related questions or challenges.

Why take advantage of Health Advocate's services? They are independent and not affiliated with any of the ESA health plan vendors. They are a confidential service, and are here to help you and your family members navigate the complicated world of healthcare and health insurance.

What type of assistance is provided? Can't figure out your doctor's bill? Looking for help with a diagnosis? Need to find a primary care doctor or specialist? Need help coordinating appointments? Health Advocate is here to help you do the leg-work. Some of the services they can assist with include:

- Explain the ESA benefits programs and options available to you
- Find the right doctors, hospitals and other providers
- Resolve billing and insurance claims issues
- Schedule appointments and transfer medical records
- Coordinate care and schedule follow-up visits
- Transfer medical records
- Explain complex medical conditions and the latest treatments
- Secure second opinions
- Clarify benefits and get approvals for covered services
- Find options for non-covered services
- Estimate costs for medical procedures and negotiate payments
- Get assistance with elder care for your family members including guidance with Medicare

Who can call Health Advocate?

- Benefit eligible full-time associate(s)
- Their spouses
- Their dependent children
- Their parents
- Their parents-in-law

Health Advocate can assist you with being a good consumer.

Call (866) 695-8622, thru 12/31/24
(866) 799-2728, effective 1/1/25
Email: answers@HealthAdvocate.com

Or visit their website at:
www.HealthAdvocate.com/member

KNOW YOUR BENEFIT RESOURCES!

ESA provides both Healthee and Health Advocate to help you make the best benefits decisions for you and your family. The chart below outlines the differences between these two valuable resources:

Healthee

- Review Benefits Gallery
- Explore Personalized Coverage Options
- Book Appointments Online
- Cost Transparency (physicians and services)
- Review Provider Quality Ratings
- Plan Comparison Tool

Health Advocate

- Answer questions and resolve claims (EOBs)
- Review Treatment Options
- Medical Decision Support
- Review and negotiate medical bills
- Coordinate care and clinical services with physicians
- Help prepare for doctor visits, review results, and plan future care

TOBACCO CESSATION

HealthAdvocate℠

We can help you quit Tobacco

No matter what type of tobacco product you use, the Health Advocate Tobacco Cessation Program can help you take control of your habit for good at no cost to you. Through the program, you have access to telephonic support from a Coach, who will help you develop a personalized quit plan that is right for you.

You and your Coach will have weekly conversations to:

- Discuss your tobacco history
- Develop a quit plan
- Explore ways to tackle your triggers
- Find workable solutions to curb cravings
- Adopt new healthy behaviors

Program Features:

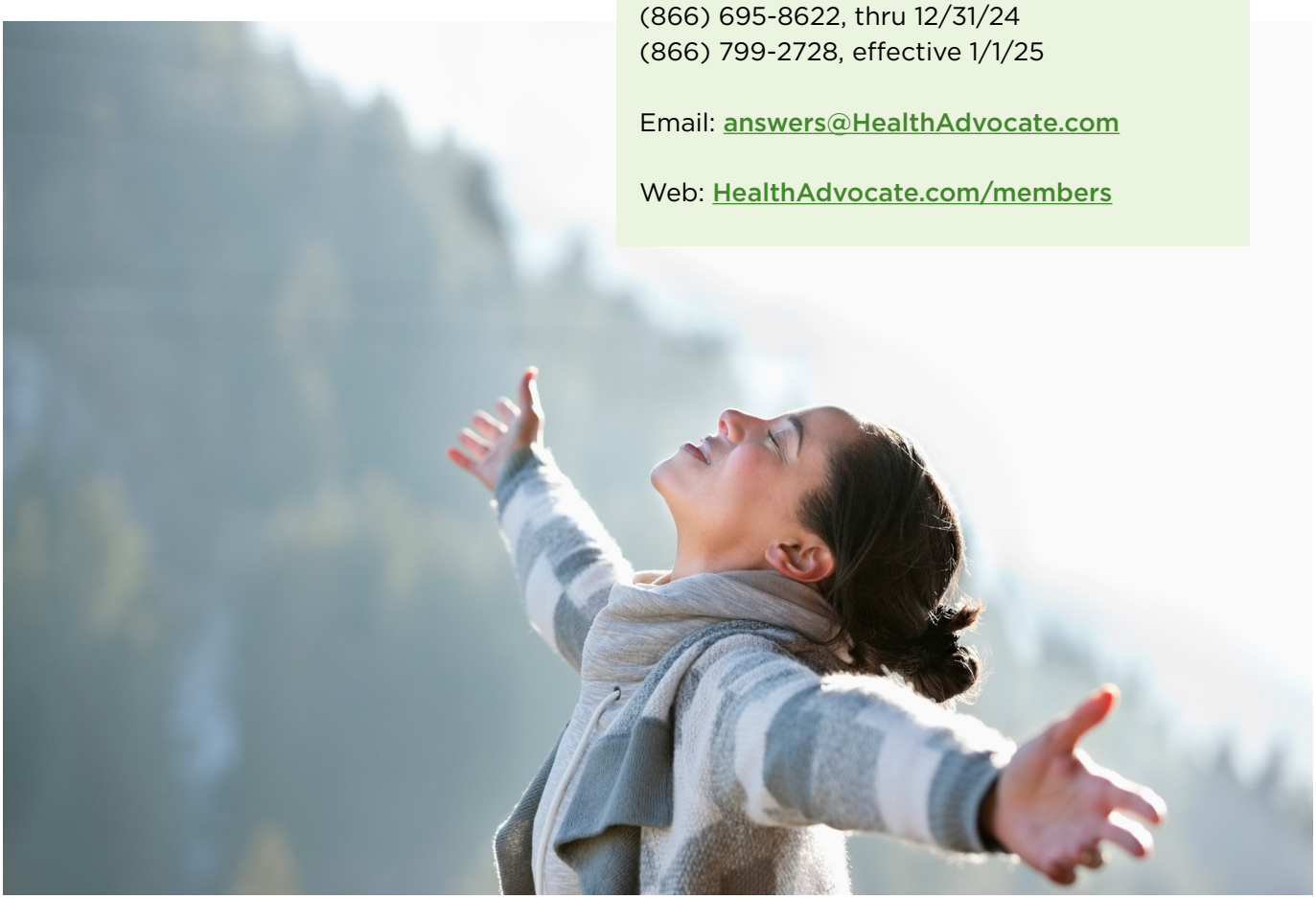
- Three month program which included two months of tobacco cessation interactions followed by an additional month of maintenance support
- Unlimited coaching and personal support available by telephone or email

Enroll today!

(866) 695-8622, thru 12/31/24
(866) 799-2728, effective 1/1/25

Email: answers@HealthAdvocate.com

Web: HealthAdvocate.com/members



HOW TO BE A SMART CONSUMER

We all share in the cost of our health plans. The better we use the plans, the better they operate.

Think about the following:

- How much time do you spend researching:
  - New computers
  - New car
  - Mobile phone
  - New gadgets for you or your family members

- How much time do you spend:
  - ✓ Searching for quality healthcare practitioners
  - ✓ Focusing on your own health and wellbeing
  - ✓ Preparing for a healthcare visit by taking notes and asking questions about your health condition
  - ✓ Researching and/or asking questions about the health plan:
    - What services are covered by the plan?
    - Are my providers in or out of network?

Throughout this guide there are tools, resources, helpful hints and programs to assist you with making your healthcare decisions.

MEDICAL

Member services: 800-443-0157

Website: www.aetna.com

You medical benefits are provided by AETNA and provides coverage for both in-network and out-of-network providers. You will always have stronger benefits when visiting in-network providers.

	Aetna Choice Plus II (CPII) Low Deductible (with HRA)		Aetna Choice Plus II (CPII) High Deductible (with HRA)		Aetna Choice POS II HSA Medical Plan (No HRA)	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
Calendar Year Deductible						
Associate	$1,150	$3,000	$1,600	$3,200	$2,000	$4,000
Associate + 1	$2,300	$6,000	$3,200	$6,400	$5,000	$10,000
Associate + Family	$3,450	$9,000	$4,800	$9,600	$5,000	$10,000
ESA's HRA Contribution						
Associate	$300		$300		N/A	
Associate + 1	$700		$700		N/A	
Associate + Family	$1,100		$1,100		N/A	
Calendar Year Out-of-Pocket Maximum						
Associate	$2,750	$6,000	$3,500	$7,000	$4,500	$9,000
Associate + 1	$5,500	$12,000	$7,000	$14,000	$9,000	$18,000
Associate + Family	$8,250	$18,000	$10,500	$21,000	$13,300	$26,600
BENEFITS						
All percentages below are the percentages you pay						
Lifetime Maximum	Unlimited per individual					
Coinsurance	20%*	50%*	20%*	50%*	20%*	50%*
Physician Services						
Office Visit	20%*	50%*	20%*	50%*	20%*	50%*
Physician Services	20%*	50%*	20%*	50%*	20%*	50%*
Surgery	20%*	50%*	20%*	50%*	20%*	50%*
Preventive Care						
Preventive**	No Charge	50%*	No Charge	50%*	No Charge	50%*
Diagnostic	20%*	50%*	20%*	50%*	20%*	50%*
Inpatient Hospital	20%*	50%*	20%*	50%*	20%*	50%*
Outpatient	20%*	50%*	20%*	50%*	20%*	50%*
Lab and X-ray						
Office, outpatient and inpatient	20%*	50%*	20%*	50%*	20%*	50%*
Emergency room & urgent care facilities	20%*		20%*		20%*	
Emergency Room	$200 copay + 20%*		$200 copay + 20%*		20%*	
Urgent Care Center	20%*		20%*		20%*	
Walk-In Clinic	$25 copay		$25 copay		20%*	
Mental Health & Substance Abuse	20%*	50%*	20%*	50%*	20%*	50%*
Teladoc	$40 Copay		$40 Copay		$40 Copay	

* After deductible is met.

** Includes immunization, mammogram, Pap smear, and maternity screening.

† Maintenance medications, including oral contraceptives, must be filled through home delivery or at CVS after three (3) retail fills unless you contact Aetna Concierge to opt-out.

MEDICAL

	Aetna Choice Plus II (CPII) Low Deductible (with HRA)		Aetna Choice Plus II (CPII) High Deductible (with HRA)		Aetna Choice POS II HSA Medical Plan (No HRA)	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network	In-Network	Out-Of-Network
PRESCRIPTION DRUGS—RETAIL (31-DAY SUPPLY)						
Generic	$9 copay	Not Covered	$9 copay	Not Covered	20%	Not Covered
Preferred brand	20%		20%		20%	
Non-preferred brand	20%		20%		20%	
PRESCRIPTION DRUGS—HOME DELIVERY OR CVS PICK-UP (90-DAY SUPPLY)†						
Generic	$27 copay	Not Covered	$27 copay	Not Covered	20%	Not Covered
Preferred brand	20%		20%		20%	
Non-preferred brand	20%		20%		20%	

Bi-Weekly Medical Plan Contributions

	Aetna CPII Low Deductible		Aetna CPII High Deductible		Aetna Choice POS II HSA Medical Plan	
	Tobacco	Non-tobacco	Tobacco	Non-tobacco	Tobacco	Non-tobacco
Associate Only	$160.07	$76.99	$119.87	$36.79	$120.56	$37.48
Associate + Spouse	$467.06	$300.91	$349.50	$183.35	$351.74	$185.58
Associate + Child(ren)	$383.61	$217.45	$295.51	$129.35	$297.33	$131.18
Associate + Family	$589.90	$423.74	$424.86	$258.71	$427.91	$261.75

For a complete list of covered services go to the Forms and Plan Documents tile under Your Benefits on MyADP.

Weekly Medical Plan Contributions

	Aetna CPII Low Deductible		Aetna CPII High Deductible		Aetna Choice POS II HSA Medical Plan	
	Tobacco	Non-tobacco	Tobacco	Non-tobacco	Tobacco	Non-tobacco
Associate Only	$80.03	$38.49	$59.93	$18.39	$60.28	$18.74
Associate + Spouse	$233.53	$150.45	$174.75	$91.68	$175.87	$92.79
Associate + Child(ren)	$191.80	$108.73	$147.75	$64.68	$148.67	$65.59
Associate + Family	$294.95	$211.87	$212.43	$129.35	$213.95	$130.88

For a complete list of covered services go to the Forms and Plan Documents tile under Your Benefits on MyADP.

In-Network Advantage

You have the freedom to use the provider of your choice. However, when you use an in-network provider, the percentage you pay out-of-pocket will be based on a negotiated fee, which is usually lower than the actual charges. If you use a provider who is outside of the network, you may be responsible for paying the difference between the reasonable and customary (R&C) charges and what the provider charges. R&C charges are set by the insurance carrier; R&C is the amount that is generally considered reasonable based on what most providers charge for a particular service in a geographic area.

Preventive Care - Paid 100% by the Plan

Preventive care services are those that are generally linked to routine wellness exams and screenings. Non-preventive services are those that are considered treatment or diagnosis for an illness, injury, or other medical condition. There are limits on how often you can receive preventive care. You should ask your health care provider whether your visit is considered preventive or non-preventive care. Examples of preventive care include:

- Heart health screening
- Mammogram (breast cancer screening)
- Gynecological visit (cervical cancer screening)
- COVID-19 vaccines
- Flu and pneumonia vaccines
- Colon cancer screening
- Routine colonoscopy
- Tetanus Shots
- Shingles vaccine
- Diabetes screening
- Prostate-Specific Antigen (PSA) Test

There are several benefits that are in place as a result of the Affordable Care Act (health care reform). These benefits are covered at 100% and may include:

- Contraceptive (birth control) counseling and FDA-approved birth control methods that need a prescription
- Breast-feeding support, supplies and counseling for females
- HPV (female) testing
- Screenings during pregnancy

MEDICAL

aetna℠

Copayments and Coinsurance

A copayment (copay) is the fixed dollar amount you pay for certain services. In some cases, you may be responsible for coinsurance after a copay is made.

Coinsurance is the percentage of covered expenses shared by the associate and the plan. For example, if the plan pays 80% of an in-network covered charge, you pay 20%. In some cases, coinsurance is paid after you meet the deductible.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum limits the amount of coinsurance you will pay for eligible healthcare expenses for each plan year. Once you reach that maximum, ESA begins to pay 100% of eligible expenses.

Annual Deductible and Health Reimbursement Account (HRA)

Your annual deductible is the amount of money you must first pay out-of-pocket before your plan begins paying for services covered by coinsurance. If you are enrolled in the Low Deductible or High Deductible plan, ESA contributes funds into a Health Reimbursement Account (HRA) to help you satisfy your annual deductible during the year.

HRA funds are prorated based on the number of months remaining in the plan year from your coverage effective date. Associates with mid-year election changes due to a qualifying event will keep the same proportion of fund that was given on their effective date.

Another great benefit about the HRA is that **ESA allows associates to roll over these funds each year just like a savings account!** The additional funds can be helpful if your medical spend fluctuates each year.

In-Network Only			
	Total Deductible	HRA Funds Provided by ESA	Associate Portion
Associate Only	$1,150	$300	$850
Associate + Spouse	$2,300	$700	$1,600
Associate + Family	$3,450	$1,100	$2,350
Associate Only	$1,600	$300	$1,300
Associate + Spouse	$3,200	$700	$2,500
Associate + Family	$4,800	$1,100	$3,700
*Once the Associate Portion of the deductible is paid, you will only pay 20% of the cost of services up to the Out-of-Pocket Maximum			

If you leave ESA, unused, HRA balances are returned to ESA.

After you meet your deductible, the plan pays for 80% of eligible expenses (coinsurance) until you meet your out-of-pocket maximum. If you receive services from an out-of-network provider, you must meet a higher deductible and a higher percentage of coinsurance.

MEDICAL

Low Deductible and High Deductible Health Plan Options with HRA

In Network Example:

Associate Only - High Deductible Plan option with In-Network Deductible of $1,600 - ESA Funded HRA Amount it $300

Deductible Expense = $1,300 ($1,600 Deductible - $300 HRA)

Claim Example #1

- Aetna receives a claim for $200.00
- Aetna applies discount on the claim for the negotiated price - $80.00
- Allowed expense is $120.00 owed to the physician

HRA pays $120.00 first ($180 left in HRA)

$0.00 – you owe nothing

Claim Example #2

- Aetna receives a claim for $500.00
- Aetna applies discount on the claim for the negotiated price - $240.00
- Allowed expense is $260.00 owed to physician

HRA pays $180.00 ($0 left in HRA)

$80 - you owe on claim

Claim Example #3

- Aetna receives a claim for $500.00
- Aetna applies discount of $300.00
- Allowed expense is $200.00 owed to the physician

You no longer have HRA money available – you owe $200.00 on this claim

Claims continue to be processed throughout the plan year based on:

- Your remaining Deductible responsibility
- In-network Cost Sharing - 80% plan paid & 20% coinsurance

IMPORTANT NOTE: Eligible unused HRA funds rollover year after year

MEDICAL

HEALTH SAVINGS ACCOUNT (HSA)

ESA offers a qualified High Deductible Health Plan (HDHP) called the HSA Medical Plan. Under the HSA Medical Plan, all medical and prescription services (with the exception of preventive services, which are covered at 100% in-network) apply to the annual deductible. Once you meet the annual deductible, the plan pays 80% in-network toward most health care expenses until you meet the annual out-of-pocket maximum.

Additionally, when you participate in the HSA Medical Plan you can open a health savings account (HSA) to help you pay for eligible out-of-pocket health care expenses. Monies that you contribute from your paycheck are contributed on a pre-tax basis. The account is fully funded by you, the associate – there is no ESA funding. The annual amount you elect to be deposited into your HSA will be calculated based on the number of months remaining in the year, and deposited each pay period.

Note: Our health savings account administrator is Fidelity. When you elect to contribute to the HSA, be sure to OPEN your account on the Fidelity website at www.netbenefits.com; otherwise your money will have no place to go.

IRS Guidelines

When you enroll in the HSA Medical Plan and contribute to a health savings account, you can save money:

- The IRS sets annual limits on how much you can contribute on a pre-tax basis. For 2025, the maximum health savings account contributions are:
  - $4,300 for Self-Only enrollees
  - $8,550 for Family enrollees
  - $1,000 “catch-up” contribution for those age 55+

In addition, under IRS Guidelines you must meet the following qualifications to enroll in an HSA:

- Must be covered by a qualified high deductible health plan (HDHP). Which means you must be enrolled in the ESA HSA Medical Plan.
- Not covered under other health insurance that is not a High Deductible Health Plan (HDHP). This means you CANNOT:
  - Be enrolled in your spouse’s medical or pharmacy plan
  - Be covered through Medicare Part A or Part B
  - Be enrolled in a general-purpose Healthcare Flexible Spending Account (FSA) plan (either ESA’s or your spouse’s)
  - Be covered under TRICARE or Medicare
  - Be claimed as a dependent on another person’s tax return

Triple tax advantage:

- Contributions are not taxed
- Interest and investment earnings are tax-free
- Payments for qualified expenses are tax-free

We hope this information has helped you better understand the HSA Medical Plan and health savings account (HSA), and how they work together. If you have questions or need further clarification or assistance, use ESA's Health Advocacy service. at (866) 695-8622 or email answers@HealthAdvocate.com.

MEDICAL

To Find A Network Doctor Or Hospital

- Call Aetna Member Services at (800) 443-0157
- Log-on to www.aetna.com

Find Care and Pricing

The Find Care and Pricing section in your Aetna Member Website account, which you can find at www.aetna.com, will provide you with an estimate of medical costs at your selected provider before you schedule a visit.

Aetna Health App

The Aetna Health app makes it easier for you and your family to manage your benefits by providing on-the-go convenience.

Visit your member website at www.aetna.com to create an account and login. Once you have set up your account you can:

- Search for facilities, procedures or medications
- Find in-network providers
- Estimate and compare costs
- Access your medical ID card
- Track spending and progress toward deductibles
- View and pay your claims

Your 24-Hour Nurse - Just A Call Away

- Your medical coverage includes access to a registered nurse to call with questions or get help anytime, anywhere. With just a call, you'll have resources to manage an illness or injury, get help recognizing urgent and emergency symptoms, and locate doctors and hospitals in your area. Your nurse may even be able to make an appointment for you and assist you in coordinating your medical records for your visit.
- Call (800) 556-1555 to talk to a nurse today.

Health Decision Support

Aetna's Health Decision Support is a program in your Aetna Member Website account which you can log into at www.aetna.com. The program can help you:

- Gain a better understanding of conditions, related treatments, procedures and surgery options
- Understand complex medical terms
- Make better choices about your health care

You can complete a program in about 20 minutes or less, but if you don't finish a program you can come back at a later time and pick up where you left off.

Find A Pharmacy and View Pharmacy Benefits

Aetna provides valuable tools and resources to help you manage your prescriptions.

Here is how to get started:

- Step 1: Access the Aetna website at www.aetna.com
- Step 2: Log into your Aetna Member Website account
- Step 3: Click "Pharmacy"

Here you will find helpful tools and resources pertaining to your prescription drug plan.

- View your pharmacy benefits
- Find a pharmacy
- Estimate drugs costs
- View your pharmacy claims
- Get started with Mail Service
- Find drug information and side effects

Mail Order Maintenance with Opt-Out Provision

Maintenance medications or drugs that are used regularly to regulate conditions such as blood pressure and cholesterol are required to be filled using mail order or a retail CVS pharmacy (for a 90-day supply) unless you contact Aetna to opt-out.

Your plan allows for three fills of maintenance drugs at a retail pharmacy. You must then make a decision whether to use the mail order pharmacy or a CVS Pharmacy for 90-day refills.

If you decide to receive a 90-day prescription from your doctor, you have two options:

Option 1 - Prescriptions through Aetna Rx Home Delivery

- Step 1: Complete a Medication Order Form available online at www.aetna.com (within your Aetna Member Website account) or by calling member services - 1-888-RX AETNA.
- Step 2: Send Order Form to Aetna Rx Home Delivery along with your prescription and payment via regular mail or have your doctor fax the prescription and an Order Form.

Option 2 - Prescriptions through CVS Pharmacy

- Step 1: Go to a CVS Pharmacy retail location and fill your 90-day prescription.
- Step 2: Order refills via online at www.aetna.com (within your Aetna Member Website account) or by calling the CVS Pharmacy location.

If you decide to Opt-Out of the Mail Order Maintenance program, you must contact Aetna Concierge at 1-800-443-0157. You can even call right from the pharmacy. Once you Opt-Out of the program, the Opt-Out will be in place for the rest of the calendar year for all of your maintenance medications. In order to Opt-Out for the next year, you will need to contact Aetna Concierge again.

MEDICAL

Helpful Hints

Differences Between Emergency Room, Walk-In Clinic, and Urgent Care

Visit Walk-In Clinics

It's second nature for many of us to hit the emergency room (ER) when suddenly sick or injured. But if you've come down with a minor illness, like strep throat or an ear infection, the ER may not be your best option. The walk-in retail clinic may be a better option. Many are open seven days per week. Plus, your cost under ESA's plans is much lower.

CVS MinuteClinic

Non-emergency service	Average ER Cost1	Average Walk-In Cost1
Strep throat	$750 - $1,000	$59
Ear infection	$750 - $1,000	$59
Flu vaccination	$750 - $1,000	$59
Sinus infection	$750 - $1,000	$59
Your Costs Under ESA's Low and High Deductible Plans	$200 copay + 20% coinsurance	$25 copay
Your Costs Under ESA's HSA Medical Plan	20% coinsurance after deductible	20% coinsurance after deductible

Urgent Care Providers

If you have an urgent, but non-life-threatening, medical issue like an ankle sprain or the flu; an urgent care provider could be a good option for care.

You don't need an appointment, most clinics are open seven days per week and you typically wait an hour or less (you could wait 4 or more hours at an ER).

See the Savings - Urgent Care

Non-emergency service	Average ER Cost1	Average Urgent Care Cost1
Sprains	$750 - $1,000	$125 - $175
Influenza	$750 - $1,000	$125 - $175
Minor lacerations	$750 - $1,000	$125 - $175
Headaches–migraine and tension	$750 - $1,000	$125 - $175
Your Costs Under ESA's Low and High Deductible Plans	$200 copay + 20% coinsurance	20% coinsurance
Your Costs Under ESA's HSA Medical Plan	20% coinsurance after deductible	20% coinsurance after deductible

Did you know?

As an Aetna member, you can access all covered MinuteClinic® Services at little or no cost to you.

MinuteClinic is a walk-in clinic inside select CVS Pharmacy® and Target stores and is the largest provider of retail health care in the United States, making it easy to access care in your neighborhood.

MinuteClinic health care providers are qualified to help treat minor injuries and minor illnesses, such as non-severe cuts, blisters and wounds, skin conditions, bronchitis, flu-like symptoms, and strep throat. Other services include various physicals such as DOT physicals, woman's wellness, health screenings and numerous immunizations.

At MinuteClinic, you can get quick care even without an appointment at clinic locations that are open seven days a week, including evenings and weekends.

1. Average retail and ER pricing. Based on Aetna average claim costs. For illustrative purposes only.

MEDICAL

TELADOC

Access to a doctor anytime, anywhere

Teladoc provides 24/7 access to U.S. board-certified doctors and pediatricians through the convenience of phone or video for a $40 fee on the low and high deductible plan and coinsurance after the deductible on the HSA plan. This service will be available to associates and their covered dependents covered under one of ESA's medical plan options. Mental Health visits are now available through Teladoc.

Frequently asked questions:

What is Teladoc?

Teladoc provides 24/7 access to U.S. board certified doctors by phone or video for many non-emergency illnesses, including flu, allergies, sinus infections, mental health visits and more.

Who are the Teladoc doctors?

Teladoc doctors are licensed internists, family doctors, pediatricians and mental health professionals. They average 20 years of experience and are licensed to practice in your state.

Does Teladoc replace my doctor?

No. Teladoc doesn't replace your primary care doctor. Teladoc should be used for non-emergency illnesses when it is not convenient to get to the doctor or it is outside of regular office hours.

How do I set up my Teladoc account?

Visit the website **Teladoc.com/Aetna** and click "Member Login".

How do I request a visit?

Log in to your account online or via the app and click "Request a Consult." You can also request a visit by calling (855) 835-2362.

Is there a time limit when talking with a doctor?

There is no time limit for visits.

Am I charged more for talking longer?

There is no extra charge for longer doctor visits.

Can Teladoc doctors write a prescription?

Yes, Teladoc doctors can prescribe medication when medically necessary*. Visit **teladoc.com/prescription-policy** for details.

How do I pay for the visit?

You can pay with your HSA (health savings account) card, FSA (flexible spending account) card, credit card, debit card, or by using PayPal.

If the Teladoc doctor recommends that I see my primary care doctor or a specialist, do I still have to pay the Teladoc consult fee?

Yes. Just like any doctor appointment, you must pay for the consulting doctor's time.

Can my primary care doctor get a record of my Teladoc visit?

With your consent, we'll send an electronic copy of your Teladoc visit to your primary care doctor.

*TELADOC does not guarantee that a prescription will be written. TELADOC operates subject to state regulation and may not be available in certain states.Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services.

What Mental Health services does Teladoc Health Provide?

Teladoc Health licensed therapists and psychiatrists are here for you no matter what you are facing, whether it's big or small. They can help you improve your mood with things like:

- Learning to stay calm in stressful moments
- Managing and understanding depression
- How to handle relationship and family problems
- Controlling anxiety caused by work or personal issues
- Working through past trauma
- Overcoming burnout which could be causing mental or physical exhaustion and irritation

Understanding your Explanation of Benefits (EOB)

Please be sure to review your Explanation of Benefits (EOB) after each health care visit. It is important to understand your health care costs and how the ESA health plan works.

You can view, print or download your EOB and other documents at anytime by visiting your Aetna Member Website account which you can log into at www.aetna.com. Review each section carefully.

Personal information

- Your name and address
- Member ID as shown on your ID card
- Group # identifies your plan

Track your spending, savings and deductibles

- The first box is a summary of what you owe and the payments already made for the claims listed on your EOB.
- The second box shows the amount you save by using an in-network provider.
- The third box shows the amount you have remaining to meet your yearly in-network family or individual deductible.

aetna

Aetna Life Insurance Company
P.O. BOX 981106
EL PASO, TX 79998-1106

Statement date: May 14, 2012

Member: AMY S WELL
Member ID: W12345678
Group #: 0567054-10-001 A 71(1)T0
Group name: TEST INC

QUESTIONS? Contact us at aetna.com
1-800-331-1166
Or write to the address shown above.

AMY S WELL
111 AETNA STREET
HARTFORD CT 06156

THIS IS NOT A BILL
Keep this for your records

Explanation of benefits:

Track your health care costs

$25.24	$107.53	$0.00 (In-network)
Amount you owe or already paid	Amount you saved	Amount you have left to meet deductible
Amount billed $237.06	Going to a doctor or hospital in our network saves you money.	Annual deductible $1,000.00
Plan payments and discounts - $211.82	That's because we have arranged discounted rates with these providers.	Deductible used - $1,000.00
You owe $25.24	Our online provider directory can help you find a doctor or other health care professional. Just go to www.aetna.com.	Deductible remaining $0.00
$211.82 $25.24		$1,000.00
$0 $237.06		$0 $1,000.00

A guide to key terms

Term	This means	Your totals
Amount billed:	The amount your doctor or health care provider billed for services.	$237.06
Member rate:	The agreed upon amount your doctor or health care provider in our network accepts as their fee.	$107.53
Amount you saved:	The difference between the amount billed and the in-network arranged pricing.	$107.53
Pending or not payable:	A claim that needs more review by us or an amount we did not pay. You may or may not have to pay this. Read "Your Claim Remarks" to learn more.	$0.00
Deductible:	The amount you pay before your health plan will pay benefits.	$0.00
Coinsurance:	When you pay part of the bill and we pay part of the bill. This is your out-of-pocket amount.	$5.24
Copay:	A fixed dollar amount you pay when you visit a doctor or other health care provider.	$20.00

A message from Aetna
Introducing your new Explanation of Benefits. It has a simpler look and feel, designed with you in mind.

Be sure to match your Explanation of Benefits (EOB) to your doctor bill to ensure accuracy. Remember: What's on your EOB is all you should be paying. Your total out-of-pocket for the year should never exceed the out of pocket maximum of the coverage tier you selected. If you have questions about your EOB, contact Health Advocate at 866-695-8622.

MEDICAL

Aetna Concierge Services

ESA wants to do more than offer you great health care benefits. ESA wants to provide assistance to help you understand your benefits and give you the tools to make more informed decisions about your healthcare.

Knowing your options and cost estimates in advance can help you make decisions and better manage your health care expenses.

Aetna's Concierge Service can assist you with:

- Learning about your coverage – What is covered
- Selecting a doctor/hospital and determining if the doctor or hospital is in or out-of-network
- Questions about your diagnosis
- Planning for upcoming treatment

Simply call the number on your Aetna ID card or log into your Aetna Member Website account at www.aetna.com.

Aetna's Concierge team is available Monday through Friday from 8 a.m. to 6 p.m. ET.

Simple Steps Wellness Programs

Aetna offers six online wellness programs to help you reach your wellness goals:

- Step 1: From www.aetna.com, Log into Aetna Member Website account
- Step 2: Click "Stay Healthy"
- Step 3: Click "Complete a Health Assessment"
- Step 4: A personalized plan will be created just for you
- Step 5: Participate in the following for online coaching sessions
  - Balance – Manage your weight
  - Relax – Deal with stress
  - Nourish – Eat Healthier
  - Overcoming Insomnia – Sleep better
  - Breathe – Quit Smoking
  - Overcoming Depression – Be Happier

Aetna - One Flex Program

Get personalized care and support when you need it most

Quality health care is more than just going to the doctor once or twice a year. Sometimes you require personal, ongoing support to manage a health event or chronic condition. It would be great to have someone you can count on for guidance and answers.

That's where Aetna - One Flex comes in - and it's already part of your benefits plan, so you pay nothing extra.

Aetna - One Flex offers you:

- Ongoing, one-on-one phone calls with a nurse who serves as a trusted resource for you and your family
- Digital support that provides a variety of resources to help you better manage your health
- Customized health action plans based on your needs and preferences

To start using the digital support of Aetna - One Flex, log on to your secure Aetna Member Website account at **www.aetna.com.** First-time users will need to register. Then go to Stay Healthy.

Enhanced Maternity Program

You deserve plenty of support during this time. And you've got it. Aetna Maternity Program is a program to support you during your pregnancy, and even after your baby is born. You can take full advantage of this optional program. Some include:

- Helpful facts on prenatal care, labor and delivery, and more
- A personal nurse, if you have health conditions that may affect your pregnancy
- A stop-smoking program that can help you quit, if you smoke
- Get information for Dad or partner

How it works - This program is already included with your Aetna health benefits and insurance plan. All you have to do is sign up and complete a short survey so we can get to know about you and your pregnancy.

Sign up for Aetna Maternity Program today. You have two options:

- Choice# 1: Call us at 1-800-CRADLE-1 (1-800-272-3531), weekdays from 8 a.m. to 7 p.m. ET.
- Choice# 2: Log in to your secure Aetna Member Website account at **www.aetna.com**. Look under "Other Programs" and choose "Maternity program".

MEDICAL

Hello Heart

Have high blood pressure? Track you heart health for free with Hello Heart

Get started in a few simple steps:

Hello Heart is offered at no cost to Associates enrolled in the Aetna medical plan. Visit https://join.helloheart.com/ and enter Extended Stay America to sign up for Hello Heart today!

- No more guessing! Your free Hello Heart monitor pairs with your phone and automatically sends blood pressure readings to the app, so you can easily track trends over time.
- Get instant health readings, with clear explanations so you know what they mean. Want to share your health data and reports with your doctor? No problem!
- Hello Heart is all about YOU. Personalized insights, heart health tips, and easy-to-understand graphs so you can see how your daily choices may be impacting your heart health.
- Does that extra five minutes of walking really make a difference? It might! With Hello Heart, you can see how activity, weight, and medications may impact your readings.
- Enjoy your own privacy. The Hello Heart app is designed with technical and organizational controls to keep your data safe. You can share your info if you want, or not. Either way, you can use the app to access your health data whenever you need it!

If you have any questions regarding Hello Heart email support@helloheart.com or contact us at (800) 767-3471.

DENTAL

MetLife

Although you can choose any dental provider, when you use an in-network dentist, you will generally pay less. If you choose an out-of-network provider, you may be billed the difference between what Metlife pays, and what your out-of-network provider charges for the services. To locate an in-network provider, please visit **metlife.com**.

Plan includes out-of-network benefits, see plan summary for additional details.

Dental Plan Summary[1]	
Individual Deductible	$50 per calendar year
Family Deductible	$150 per calendar year
Plan Maximum	$1,500 per calendar year
Preventive Services	
Cleanings (Once every 6 months)	Covered at 100%
Oral Exams (One exam every 6 months)	Covered at 100%
X-Rays (Full mouth: one per 3 calendar years; and Bitewing: one set per calendar year)	Covered at 100%
Sealants	Covered at 100%
Basic Services	
Fillings	Covered at 80% after deductible
Periodontics	Covered at 80% after deductible
Endodontics	Covered at 80% after deductible
Oral Surgery	Covered at 80% after deductible
Simple Extractions	Covered at 80% after deductible
Major Services	
Bridges and Dentures	Covered at 50% after deductible
Crowns/Inlays/Onlays	Covered at 50% after deductible
Periodontal Surgery	Covered at 50% after deductible
Orthodontia Services	
Orthodontia (to age 19)	Covered at 50%
Orthodontia Benefit Maximum	$1,500 lifetime

1. Summary only; limitations and exclusions apply

For a complete list of covered services go to the Forms and Plan Documents tile under Your Benefits on MyADP.

Bi-Weekly Dental Plan Contributions

Dental Biweekly Deductions	Rates
Associate Only	$11.84
Associate + Spouse	$23.16
Associate + Child(ren)	$26.53
Associate + Family	$31.89

Weekly Dental Plan Contributions

Dental Weekly Deductions	Rates
Associate Only	$5.92
Associate + Spouse	$11.58
Associate + Child(ren)	$13.26
Associate + Family	$15.94

DENTAL TOOLS & RESOURCES

You Can Benefit from MyBenefits

MetLife Benefits Information Right from Your Desktop

By visiting MyBenefits, Metlife's website for associate(s) benefits administration, at **www.metlife.com/mybenefits**, you can get important information and helpful tools - right from your desktop. You can take advantage of a number of self-service capabilities, as well as a wealth of easy to access information, including planning tools and oral health awareness material. MyBenefits helps make managing your benefits simpler and easier.

Learn more about your benefits - so you can get more out of them!

Personalized Homepage for all Your MetLife Benefits

- **To find an in-network Dentist**, visit our website at **www.metlife.com** and select PDP plus as your network.
- **Access forms and documents** that you may need are located in the forms library for you to download.
- **Read special message boxes** on the homepage that make you immediately aware of timely benefits information.
- **Track claims online** and elect to receive e-mail notifications called eAlerts, which will provide information regarding status changes to your claims for certain benefits.

The MetLife Mobile App

MetLife's Dental mobile application[1] is available

Viewing your dental plan just got easier. Simplify your life with the MetLife Dental Mobile App. You can:

- Locate an in-network preferred dental provider
- View your claims
- View an electronic ID card. Please note: ID cards are not required to obtain dental services. Electronic cards may not be available for some plans

It's easy. Search "MetLife" at iTunes® App Store or Google Play® to download the app. Then use your MyBenefits log in information to access these features[2].

It's available 24 hour a day, seven days a week.

If you prefer, you can use our Find a Dentist tool on our mobile site. Here you can search out MetLife Dental PPO directory from your phone. Just visit **metlife.com** on your mobile device.

Keep an eye out for additional functionality from MetLife. We are committed to making it easier for you to work with us.

1. The features of the Dental Mobile App are not available for all MetLife Dental Plans.

2. Before using the MetLife Dental Mobile App, you must register at www.metlife.com/benefits from a computer. Registration cannot be done from your mobile device.

VISION

Our vision care benefits include coverage for eye exams, lenses and frames, contact lenses, and discounts for laser surgery. You have the choice to choose from two vision options. The vision plan is built around the EyeMed providers, who have higher benefits at a lower cost to you. When you need services, consider using an in-network provider for the most bang for your buck! When you use an out-of-network provider, you will be reimbursed for services according to the grid below. To locate an in-network provider, visit **www.eyemed.com**.

IN-NETWORK BENEFITS	Essential Vision Benefits	Enhanced Vision Benefits
Exam with dilation, once every calendar year	$10 copay	$0 copay
Standard Plastic Lenses Materials Copay		
Single Vision	$10 copay	$10 copay
Bifocal	$10 copay	$10 copay
Trifocal	$10 copay	$10 copay
Contact lenses or eyeglass lenses are allowed once each calendar year		
IN-NETWORK BENEFITS	Frames	Frames
Any frame available at a provider location	$150 Allowance + 20% off remaining balance	$200 Allowance + 20% off remaining balance
Frames are allowed once calendar year		
Lens Options - In-Network		
UV Coating	$15 copay	$0 copay
Tint (Solid & Gradient)	$15 copay	$0 copay
Standard Scratch-Resistance	$40 copay	$0 copay
Standard Polycarbonate	Covered	$0 copay
Standard Progressive	$10 copay	$0 copay
Standard Anti-Reflective Coating	$45 copay	$0 copay
Other Add-Ons and Services	20% off	20% off
IN-NETWORK BENEFITS	Contact Lenses **In Lieu of Lenses**	Contact Lenses **In Lieu of Lenses**
Standard Lens Fit & follow-Up	$40 copay	$0 copay
Conventional	$140 Allowance + 15% off remaining balance	$170 Allowance + 15% off remaining balance
Disposables	$140 Allowance	$170 Allowance
Medically Necessary	Covered In Full	Covered in Full
Contact lenses or eyeglass lenses are allowed once each calendar year		
Additional Discounts Available - In-Network		
Lasik or PRK vision correction	US Laser Network vision correction	US Laser Network vision correction

Out-of-Network benefits are also available.

Biweekly Vision Plan Contributions

	Essential	Enhanced
Associate Only	$2.86	$8.40
Associate + Spouse	$5.43	$15.96
Associate + Child(ren)	$5.71	$16.80
Associate + Family	$8.57	$25.19

For a complete list of covered services go to the Forms and Plan Documents tile under Your Benefits on MyADP.

Weekly Vision Plan Contributions

	Essential	Enhanced
Associate Only	$1.43	$4.20
Associate + Spouse	$2.71	$7.98
Associate + Child(ren)	$2.86	$8.40
Associate + Family	$4.28	$12.60

FLEXIBLE SPENDING ACCOUNT (FSA)

A Flexible Spending Account (FSA) is an account that allows you to contribute pre-tax dollars (reducing your taxable income) through your paycheck to use for eligible expenses. **Healthcare FSA is not available to associates enrolled in the HSA Medical Plan.**

If you anticipate having medical or dependent care expenses in the upcoming year, making pre-tax contributions through payroll deductions to an FSA can save you up to 35%, depending on your tax rate.

You will have 90 days after the calendar year to submit claims for reimbursement.

NOTE: You cannot change your election amount after you make your initial election during open enrollment or as a newly eligible associate, unless you have a qualified life event.

Healthcare FSA

You have the option to deduct an annual amount up to the IRS limit of $3,300 from your paycheck to help pay for eligible medical expenses. Some examples:

- Deductibles
- Coinsurance
- Prescriptions
- Copays
- Dental expenses (including orthodontia)
- Glasses & Contacts
- Chiropractic care
- Lasik eye surgery
- Over-the-counter (OTC) medications

Cosmetic services are **not** eligible for reimbursement

You may not enroll in the Healthcare FSA if you enroll in the ESA HSA Medical plan.

Healthcare FSA Plan Rules

Budget your contribution carefully. Contributions are made based on the calendar year. After the plan ends on December 31, you are eligible to roll over up to $660 of unused Health Care FSA expenses to the next calendar year.

Dependent Care FSA

If you work and have children or elder/disabled adults that you care for, you may find value in a Dependent Care FSA. Contribute up to $5,000 annually to be reimbursed for eligible dependent care expenses incurred while you are at work, including:

- Summer day camp
- Daycare
- Elder care
- Preschool
- Salary and payroll taxes for in home caregiver

If you are married and file income taxes separately, you may only contribute $2,500 annually. The combined contribution for a married couple filing cannot exceed $5,000 annually, if filing jointly.

Dependent Care FSA Plan Rules

Budget your contribution carefully. Contributions are made based on the calendar year. Any unused Dependent Care FSA amounts will be forfeited.

FSA Example	Participating in FSA	NOT Participating in FSA
(1) Your Annual Salary Before Taxes	$35,000	$35,000
(2) Less: Your Health Care FSA Election Your Dependent Care FSA Election	- $3,200 - $5,000	$0 $0
(3) Your Taxable Income	$26,800	$35,000
(4) Your Estimated Taxes (25% Federal & FICA) (5) Less: Health Care Expenses You Pay Out of Pocket Dependent Care Expenses You Pay Out of Pocket	- $6,700 $0 – paid by FSA $0 – paid by FSA	- $8,750 - $2,750 - $5,000
(6) Your Net Take-Home Salary	$20,100	$18,500
Your estimated savings under the FSA	$1,600	

COMMUTER BENEFITS

Who is eligible to participate?

All full-time and part-time associates.

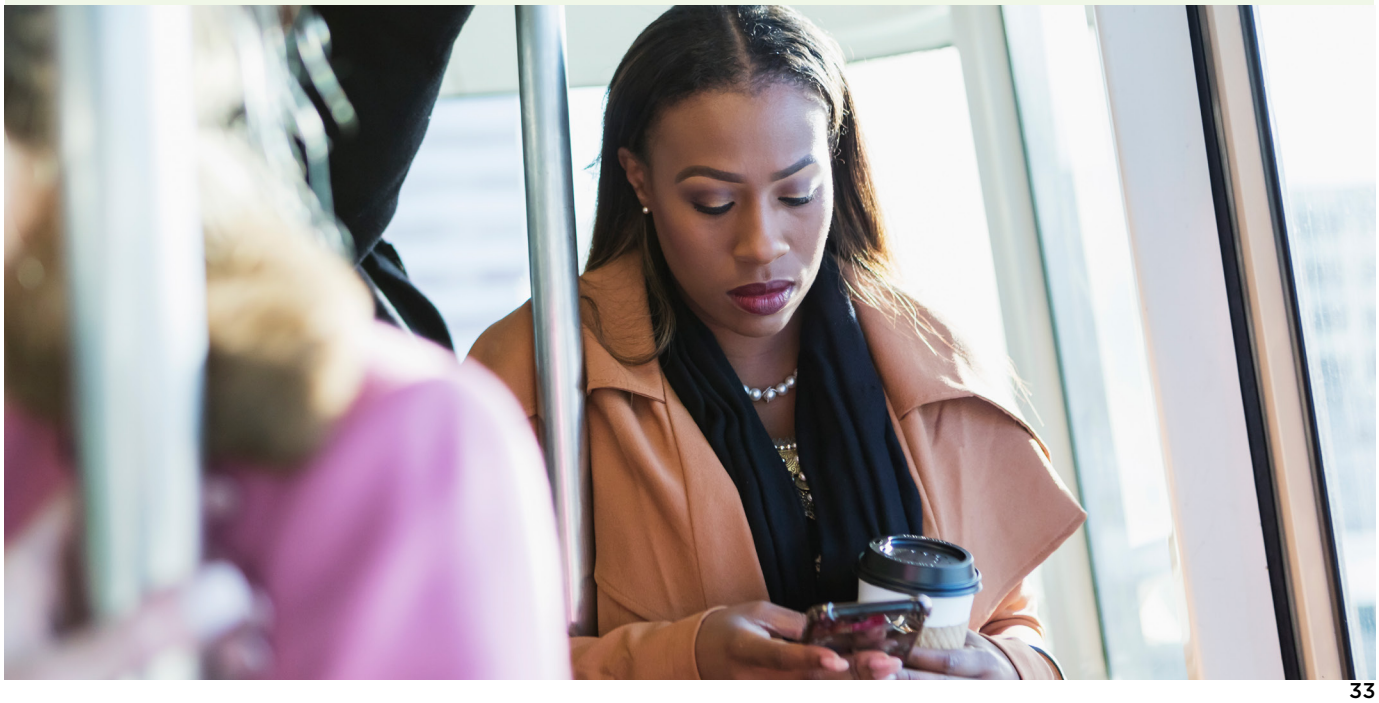
How does it work?

A commuter account allows you to set aside pre-tax dollars for mass transit and parking expenses associated with your daily commute to work.

There are two types of commuter accounts: mass transit and parking. You have the option to enroll in one or both accounts. You choose a monthly election amount, up to $325 for mass transit expenses and up to $315 for parking expenses. The money is placed in your account via payroll deduction and then used to pay for eligible commuting expenses.

Important!

- Your election for Transit and/or Parking will be deducted one time monthly.
- You must have funds in your commuter account before you can spend them.
- You may not be able to change your election amount or terminate your participation in the plan so enroll wisely.
- If your employment terminates before the end of the plan year, your account will be terminated. You may continue to file claims for eligible expenses that you incurred while you were actively participating in the plan.
- Any unused funds that remain in your account at the end of the year will carry over into the next plan year, if you continue to participate in the plan.



LIFE AND DISABILITY INSURANCE

Member services: 1-877-275-5462

Website: mylincolnportal.com

Life Insurance

We provide Basic Life and AD&D insurance at no cost to you! ESA pays for Basic Life and AD&D insurance benefits of one times your salary (rounded to the next higher $1,000) up to $300,000 for Full-time Associates. At the age of 70, benefits will be reduced by 50%.

If you would like additional coverage, Voluntary Life and AD&D insurance is available to you, your spouse and your dependent children. You must enroll in coverage for yourself in order to cover your spouse or children. If you don't enroll in Voluntary Life when it's first available to you, or elect an amount over the Guaranteed Issue, you may be required to complete an Evidence of Insurability (EOI) form.

Supplemental Life Insurance

In addition to the basic and AD&D life insurance coverage provided by ESA, we offer supplemental life insurance programs. Through Lincoln Financial Group, you can buy additional term life insurance at low rates for yourself and your dependents.

The supplemental life program provides an opportunity to purchase Associate coverage for 1, 2, 3, or 4 times your salary, up to a maximum of $1,000,000 (combined basic and supplemental). If you enroll when you are first eligible, you are guaranteed up to $400,000 (combined basic and supplemental life), with no Evidence of Insurability (proof of good health). Evidence of Insurability (EOI) will need to be completed if you purchase an amount in excess of $400,000, or if you elect coverage outside of your initial enrollment period. Please review the instructions for submitting EOI in this Benefits Guide if you are electing coverage in excess of $400,000. Please contact the Total Rewards Team if you have any questions.

Dependent Life Insurance

Spouses

You may also purchase term life coverage through Lincoln Financial Group for your spouse in an amount of $10,000, $25,000 or $50,000. If you elect coverage for your spouse when first eligible, your spouse can receive coverage with no Evidence of Insurability. Evidence of Insurability will need to be completed if you elect coverage for your spouse after your initial enrollment period.

Child

You may cover your dependent child(ren) up to age 26 with a term life policy through Lincoln Financial Group of either $5,000 or $10,000. No Evidence of Insurability is required.

Beneficiary Selection

Selecting your Beneficiary is important. You will need to designate a beneficiary for your life benefit(s) through the MyADP web portal. Make sure you have your beneficiary's Social Security number so you can complete this process. Even if you do not elect to enroll in ESA benefits, you must designate a beneficiary for your Basic life insurance benefit.

Supplemental Life

Age Bands	Biweekly Rates per $1,000 of Coverage	Weekly Rates per $1,000 of Coverage
<-24	$0.023	$0.012
25-29	$0.028	$0.014
30-34	$0.037	$0.018
35-39	$0.042	$0.021
40-44	$0.046	$0.023
45-49	$0.071	$0.035
50-54	$0.108	$0.054
55-59	$0.198	$0.099
60-64	$0.309	$0.155
65-69	$0.586	$0.293
70+	$1.615	$0.808

Spouse Life

Options	Biweekly Rate	Weekly Rate
$10,000	$0.942	$0.471
$25,000	$2.349	$1.175
$50,000	$4.689	$2.345

Child Life

Options	Biweekly Rate	Weekly Rate
$5,000	$0.489	$0.245
$10,000	$0.978	$0.489

Please note that your beneficiaries for Supplemental Life, will be the same as your Basic Life beneficiary.

As part of your annual review, be sure to review your beneficiaries on file and update as needed.

DISABILITY

These plans give you income protection in the event you are ill or injured in a non-work related injury, and can't come to work. If you don't enroll in Disability coverage when it's first available, you may be required to complete an application.

Short-Term Disability

Full-time associates may purchase short-term disability insurance within 31 days of your date of hire. Short-term disability provides disability coverage of 60% of your weekly earnings up to a maximum of $2,500 per week for 12 weeks. Benefits are payable on the 8th day of a disability or illness. It is important to note that the short-term disability plan includes a limitation for "pre-existing conditions." This means that you will not be eligible for disability payments for a condition that existed in the 3 months prior to your effective date of coverage, until you have been covered for 12 months (this applies to illnesses and to pregnancy).

If you do not purchase short-term disability when you are first eligible, you will need to provide Evidence of Insurability.

Short Term Disability			
Biweekly Rate Per $10 of Weekly Benefit	**$0.254**	**Weekly Rate Per $10 of Weekly Benefit**	**$0.127**
Biweekly Payroll Deduction Example		**Weekly Payroll Deduction Example**	
Salary Examples	Per Pay	Salary Examples	Per Pay
$30,000	**$8.79**	**$30,000**	**$4.39**
$50,000	**$14.65**	**$50,000**	**$7.33**
$70,000	**$20.52**	**$70,000**	**$10.26**

Long-Term Disability - At No Cost To You

ESA provides all Full-time associates with Basic Long-Term Disability coverage at no cost to you. This is a company-paid benefit that replaces 50% of your monthly salary, up to $5,000 per month, should you experience a qualifying disability. The benefit is payable after 90 consecutive days of total disability.

Long-Term Disability - Buy-Up

You may also purchase additional Buy-Up Long-Term Disability benefit. The buy-up program allows you to receive a benefit of 60% of your salary up to $15,000 per month. If you purchase this additional coverage, any buy-up benefits you receive are not subject to taxes (because you pay for the premium cost). Similar to the short-term disability, the long-term disability plans include a pre-existing condition limitation.

Long Term Disability			
Biweekly Rate Per $100 of Monthly Salary	**$0.236**	**Weekly Rate Per $100 of Monthly Salary**	**$0.118**
Biweekly Payroll Deduction Example		**Weekly Payroll Deduction Example**	
Salary Examples	Per Pay	Salary Examples	Per Pay
$30,000	**$5.90**	**$30,000**	**$2.15**
$50,000	**$9.85**	**$50,000**	**$4.93**
$70,000	**$13.78**	**$70,000**	**$6.89**

Evidence of Insurability (EOI) is a health questionnaire that helps Lincoln Financial Group determine whether you and other dependent applicants qualify for new life and/or disability coverage or an increase in coverage. Questionnaires are completed and submitted on the Lincoln Financial Group website as outlined below.

Instructions for Online Submission

1. Visit www.lincolnfinancial.com.
2. In the "New Users" box, click "Register." Complete a one-time user registration. Use ESA's Company Code ExtendedStay and create a username and password. Click "Register," and you'll return to the previous page, where you'll log in.
3. Once you've logged in, select "Complete Evidence of Insurability/Statement of Health."
4. Enter your Coverage Information.
5. Enter your Applicant Information. You may pre-fill your information by entering your Associate(s) ID and clicking "Pre-Fill Your Information."
6. Enter your medical information. You must answer every question. If you answer "Yes" to a question, please provide details including dates, the name of and reason for any medication you take, and your prescribing physician's name and contact information.

Lincoln Financial Group will review your EOI to determine if you are approved for the coverage. Once approved, your election and payroll deduction will be updated in MyADP for the next applicable paycheck.

PAID PARENTAL LEAVE POLICY

ESA offers 6 weeks of Parental Leave paid at 100% of your base rate of pay. Leave may be taken intermittently, in at least weekly increments, beginning within the first 4 months of the birth, adoption, or foster care placement of a child and end within 7 months. Any state paid leave offsets the benefit. The purpose of the Policy is to give new parents additional flexibility and time to bond with their new child and adjust to their new family situation after the birth of a new child, or after adoption or foster placement of a child who is 17 years old or younger. This Policy is intended to create a flexible and family-friendly work environment and cultivate an atmosphere where associates can thrive while attending to essential family obligations.

Coordination with STD

- For birthing parents enrolled in the ESA's STD program, Paid Parental Leave will begin once your STD coverage ends.
- For birthing parents not enrolled in STD, Paid Parental Leave will begin when your disability period (as certified by your health care provider) ends. During the disability period, the associate will be eligible for paid time off through unused vacation, or unused personal days, with management approval. If an associate's health care provider indicates the associate is not disabled after the child's birth, Paid Parental Leave may begin immediately after the child's birth.

Requesting Paid Parental Leave

1. If the need for Parental Leave is foreseeable, you should notify your manager and include estimated timing and duration of leave 60 calendar days in advance.
2. If the need for Parental Leave is not foreseeable, you must notify your manager as soon as possible.
3. After notifying your manager, you are required to contact Lincoln Financial Group at 1-888-555-5555 to request FMLA, STD and/or Parental Leave.
4. Lincoln Financial Group will complete the claim intake, collect needed data to determine if the claim is payable and notify ESA of the approved length of time for parental leave pay. Any state paid leave offsets the parental leave benefit.

Should you have any questions, please reach out to your HR Business Partner or **e-mail benefits@esa.com**

401(K) PLAN

All Full-time and Part-time associates are eligible to participate in the ESA 401(k) plan.

A 401(k) is an employer-sponsored retirement savings plan that allows you to make pre-tax contributions to a retirement account. You can save up to the IRS annual maximums.

- You'll save and invest a percentage of your paycheck before taxes are taken out.
- Studies show that people who save money automatically via payroll deduction, rather than manually after being paid, are able to save more.
- With a 401(k), you control how your money is invested.
- Financial experts recommend saving 10% of your income toward your retirement.

Eligibility	Immediate upon date of hire
Match Eligibility	Six month waiting period
Match Calculation	50% of the first 6% deferral, ESA maximum match is 3% of your salary Once eligible, match contributions are added to your account on a bi-weekly basis along with your personal contributions.
Vesting	You are always 100% vested in your contributions ESA match is vested as follows from your date of hire: After 1 year of service – 33.3% After 2 years of service – 66.6% After 3 years of service – 100%

How To Enroll

You will receive an enrollment guide from Fidelity to your home address. Go online with Fidelity at **www.NetBenefits.com** or call 800-835-5097 to learn more and to enroll.

Fidelity Investments

Fidelity is the leading provider of investment management, retirement planning, portfolio guidance, brokerage and benefit outsourcing.

Fidelity offers:

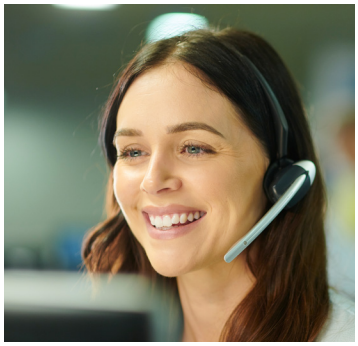
- Ease of administration
- Great website tools
- Educational resources

Roth 401k

Associates can elect Roth 401(k) contributions in addition to a pre-tax 401(k) election. The contribution limit for 2025 is $23,000, and if you will be at least age 50 by the end of the year, you are eligible to make an additional $7,500 catch up contribution. Starting January 1, 2025, individuals ages 60 through 63 years old will be able to make catch-up contributions up to $10,000 annually or 150% of the regular catch-up amount.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

HealthAdvocate℠



Getting Help is Easy! Here's What to Expect

Whether you need support to cope with a stressful issue or resources to make your work/life run more smoothly, Health Advocate's compassionate experts are standing to get you the help you need when you need it most.

Here's what to expect when you reach out:

When You Need Counseling Support

An EAP Professional will begin a brief intake process:

- Confirm your contact information
- Review the confidentiality guidelines and your EAP+Work/Life benefits

Assess for safety concerns, such as your risk of harm to yourself or others, domestic violence, abuse, drug or alcohol issues

Gather information about your reason for requesting counseling such as:

- Stress, anxiety, depression
- Family, relationship, and parenting issues
- Financial and job pressures
- Grief, loss and anger
- Substance abuse

Determine what type of counseling may work best for you (individual, family or couples)* and what counseling options are available

Connect you to the right professional to begin counseling sessions*

When You Need Work/Life Resources:

An EAP Work/Life specialist will gather information about your need for childcare, summer camps, after-school care, eldercare, special needs, legal or financial resources, relocation support and more

Find local resources that meet your needs and check for availability Connect you to a legal or financial specialist for a telephone consultation, if needed

Helping you no matter what

We're here for you for any issue, start to finish, every time to make your life happier, healthier, and easier. Our whole-person support extends to caring for the whole family. This means you, your spouse, dependent children, parents and parentsin- law can all use the Health Advocate services.

In a crisis, help is available 24/7.

(866) 695-8622, thru 12/31/24
(866) 799-2728, effective 1/1/25

HealthAdvocate.com/members
answers@HealthAdvocate.com

Call • Email • Message • Live Chat

To access your EAP benefit, you need Employee name, Date of Birth, and Zip Code.

AUTO AND HOME INSURANCE

Group Auto and Home Insurance

Farmers is a discount program that offers access to auto and residential insurance coverage via convenient payroll deductions. As a full-time associate, you can receive special group discounts on Auto and Home insurance through MetLife. Home and Auto insurance policies renew at different times during the year, therefore you can enroll at any time.

Farmers offers a broad line of insurance policies, including:

- Auto
- Boat
- Flood
- Motorcycle
- Personal Excess Liability
- Recreational Vehicle
- Renters
- Home/Condo
- Landlord's Rental Dwelling
- Mobile Home

A policy from Farmers offers many unique features, including:

- Payroll and group discounts
- Replacement cost coverage for total losses
- Replacement costs for special parts
- Deductible savings benefit
- Identity Theft resolution services
- Replacement cost coverage on home
- 24-hour claim reporting

To obtain a quote, call 800-438-6381 or visit www.myautohome.farmers.com

LEGAL INSURANCE

MetLife

Powerful legal protection on your side

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you can trust. With MetLife Legal Plans, you have access to the expert guidance and tools you need to navigate a broad range of personal legal needs. Whether you're buying or selling a home, starting a family, or caring for aging parents, the benefit provides protection at every step.

Reduce the out-of-pocket cost of legal services with MetLife Legal Plans.

How it works

Our service is tailored to your needs. With network attorneys available in person, by phone or by email and online tools to do-it-yourself — we make it easy to get legal help. And, you will always have a choice in which attorney to use. You can choose one from our network of prequalified attorneys, or use an attorney outside of our network and be reimbursed some of the cost.[1]

Best of all, you have unlimited access to our attorneys for all legal matters covered under the plan. For a monthly fee of $15.25 conveniently paid through payroll deduction, an expert is on your side as long as you need them.

Estate planning at your fingertips

Our website provides you with the ability to create wills, living wills and powers of attorney online in as little as 15 minutes. Answer a few questions about yourself, your family and your assets to create these documents instantly. In states where available, you also have access to sign and notarize your documents online through our video notary feature.[2]

How to use the plan:

1. **Find an attorney**

Create an account at members.legalplans.com to see your coverages and select an attorney for your legal matter. Or, give us a call at 800-821-6400 for assistance.

Legal Plan Contributions	Rates
Biweekly Deduction	$7.04
Weekly Deduction	$3.52

2. **Make an appointment**

Call the attorney you select and schedule a time to talk or meet.

3. **That's it!**

There are no copays, deductibles or claim forms when you use a network attorney for a covered matter.

Questions? Call the MetLife Legal Plans Client Service Center at **800-821-6400** Monday—Friday, **8:00 a.m. to 8:00 p.m., ET.**

PET INSURANCE

MetLife

No matter what unpredictable antics your furry family member gets into, your family isn't complete without them. With MetLife Pet Insurance, you can feel confident that their health and your wallet are protected if you're faced with an unexpected trip to the vet.

Why MetLife Pet Insurance?

- Flexible coverage with up to 90% reimbursement and freedom to visit any U.S. licensed vet
- Optional Preventive Care coverage
- 24/7 access to Telehealth Concierge Services—because accidents and illnesses don't always wait for your vet to be open
- Only provider to offer family plans, covering multiple cats and dogs on one policy
- Discounts up to 30% and additional offers on pet care, where available
- MetLife Pet mobile app to submit and track claims, manage your pet's health and wellness and find nearby pet services
- Coverage of previously covered pre-existing conditions when switching providers

To get a quote or enroll:

Visit www.metlife.com/getpetquote

Call **1-800-GET-MET8**

Essential Needs

- Accidents and illness
- Diabetes
- Ear infections
- Pancreatitis
- Cancer
- Hip dysplasia
- Cruciate ligament
- And more...

Sophisticated Care

- Laser therapy
- Holistic care
- Acupuncture
- Hydrotherapy
- IVDD
- And more...

Policy Features where available

- Telehealth
- Mortality benefits
- Discounts and rewards
- Deductible savings
- And more...

Optional Preventive Care Coverage

- Flea and tick
- Spay and neuter
- Heartworm
- Behavioral training
- Teeth cleaning
- And more...

AETNA VITAL SAVINGS

All Part-Time associates have immediate eligibility for this program. Vital Savings by Aetna is a discount program that allows you to save money on prescription drugs, dental care, vision care and more. There are no claim forms or referrals.

How to Enroll and Program Costs

To enroll:

- Visit the website at **www.vitalsavings.com/ESH**, or
- Call 1-877-698-4825

Use the code "ESH" to receive the special pricing for ESA part-time associates.

There is a fee for this program that you pay directly to Aetna - there is no payroll deduction available.

- Individual Program: $76 per year
- Family Program: $100 per year

Prescription Savings

Get discounts at the counter. Typically, savings can range from 10 to 40 percent on generic and brand-name drugs. Leading chains that participate include CVS and Rite Aid.

Dental Savings

The Vital Savings Dental discount card gives you access to savings on dental care services — without having insurance. Just present your card at any of the 156,000 participating dental offices for:

- **Big services:** You save on cleanings, crowns and checkups … even braces and whitening.
- **Big savings:** Your discount is immediate – saving you 15 to 50 percent per visit in most cases.

Vision Savings

Get eye exams, eyeglasses, contacts, LASIK surgery and more for less.

Big perks: You also get extras, like savings on gym memberships, vitamins and more.

Remember: The Vital Savings program is not insurance. The range of discounts provided under the program will vary depending on the type of provider and type of service received. The program does not make payments directly to the participating providers of medical and dental services. Some areas have limited services.

Full-time associates are eligible as long as you are not enrolled in any other ESA programs with Aetna.

WHAT HAPPENS IF YOU HAVE A QUALIFYING LIFE EVENT?

Making Changes During the Year

If you have a qualifying life event, you have 31 days* from the date of the event to make changes to your benefit elections. You must access MyADP in order to update your elections for your qualified life event. Any benefit change must meet IRS-approved guidelines and be consistent with the type of event you experience. You will be required to provide supporting documentation for your event. The Total Rewards Benefits Team will review your request and determine whether the change you are requesting is allowed per IRS Guidelines.

Qualifying Life Events Include But Are Not Limited To:

- Adding a dependent through birth, adoption, or marriage
- Your spouse terminating or obtaining new employment (when it affects eligibility for coverage)
- You or your spouse switching employment status from full-time to part-time or vice versa (when it affects eligibility for coverage)
- The loss of a dependent through divorce, death, or if your child reaches the maximum age limit for coverage
- Change in eligibility for Medicaid or Children's Health Insurance Program (CHIP) subsidy

*If you, your spouse or dependent child lose coverage under Medicaid or a state Children's Health Insurance Program (CHIP) or become eligible for state-provided premium assistance, you have 60 days from the date of the event to enroll.

WHAT HAPPENS IF YOUR EMPLOYMENT ENDS?

If your employment ends, your benefit coverage will terminate according to the following schedule:

Benefit Plan	Coverage End Date
• **Medical** • **Dental** • **Vision**	If your last day worked is the 1st-15th of the month: Coverage ends on the 15th of the month If your last day worked is the 16th of the month or later: Coverage ends on the last day of the month
• **Life/ AD&D Insurance** • **Short Term Disability** • **Long Term Disability** • **Health Care FSA** • **Dependent Care FSA**	Your last day worked
• **Health Savings Account**	You Maintain your Health Savings Account

Health and Welfare Plans

If you are enrolled in the medical, dental, vision or health care FSA plan on the day before your employment ends, you – and any of your covered dependents - may have the opportunity to continue coverage on your own through COBRA. Please note that unless you continue medical coverage under COBRA, any HRA balance will be forfeited.

- If you are eligible to continue any of your plan coverages, you will receive a COBRA packet from **Flores & Associates**. The packet will be mailed to your home address that is on record in MyADP.
- Generally you will receive your packet within 14 days of your last day worked.
- Instructions on electing and paying for COBRA coverage will be in your packet.

Life Insurance Benefits

Life insurance benefits (Basic Life and associate paid supplemental, spouse and child life) terminate the last day of your active employment or status change. Conversion of life insurance benefits is available from Lincoln Financial Group. If interested in converting your life insurance, the completed paperwork and your first premium must be paid to Lincoln Financial Group within thirty-one (31) days of your termination date.

If you wish to continue your life insurance benefits, reach out to the ESA Benefits Team at benefits@esa.com for a conversion package. Upon your request the benefits team will be able to mail/email the conversion package for your completion. Once you complete the form you will need to forward the completed form and your payment to Lincoln Financial Group before the 31 from termination date deadline.

401(k) Plan

If you were a participant in the ESA 401(k) plan, you can call Fidelity and they will explain your distribution options. In order to ensure that your termination of employment has been processed, plan to call Fidelity at least 30 days after your last day worked. Call 800-835-5097 or visit the Fidelity website at www.netbenefits.com.

Important: Before you separate from the company be sure to confirm that your current home address is correct in MyADP. If it is not, please update in MyADP or ask your manager to assist you.

WHAT HAPPENS IF YOUR STATUS CHANGES FROM FULL-TIME TO PART-TIME?

If your employment status changes from full-time to part-time, your benefit coverage will terminate according to the following schedule:

• **Medical** • **Dental**	If your status change occurs between the 1st-15th of the month: Coverage ends on the 15th of the month If your status change occurs the 16th of the month or later: Coverage ends on the last day of the month
• **Vision**	Coverage Continues
• **Life/ AD&D Insurance** • **Short Term Disability** • **Long Term Disability** • **Health Care FSA** • **Dependent Care FSA**	Date of status change
• **Health Savings Account**	You Maintain your Health Savings Account

Health and Welfare Plans

If you are enrolled in the medical, dental or health care FSA plan on the day before your status changes from full-time to part-time, you – and any of your covered dependents - may have the opportunity to continue coverage on your own through COBRA. Please note that unless you continue medical coverage under COBRA, any HRA balance will be forfeited.

- If you are eligible to continue any of your plan coverages, you will receive a COBRA packet from **Flores & Associates**. The packet will be mailed to your home address that is on record in ADP Vantage.
- Generally you will receive your packet within 14 days of your status change.
- Instructions on electing and paying for COBRA coverage will be in your packet.

Life Insurance Benefits

Life insurance benefits (Basic Life and associate paid supplemental, spouse and child life) terminate the last day of your active employment or status change. Conversion of life insurance benefits is available from Lincoln Financial Group. If interested in converting your life insurance, the completed paperwork and your first premium must be paid to Lincoln Financial Group within thirty-one (31) days of your termination date.

If you wish to continue your life insurance benefits, reach out to the ESA Benefits Team at benefits@esa.com for a conversion package. Upon your request the benefits team will be able to mail/email the conversion package for your completion. Once you complete the form you will need to forward the completed form and your payment to Lincoln Financial Group before the 31 from termination date deadline.

401(k) Plan

If you were a participant in the ESA 401(k) plan, you can continue participating. To enroll or make changes, call 800-835-5097 or visit the Fidelity website at www.netbenefits.com.

Important: Be sure to confirm that your current home address is correct in ADP Vantage. If it is not, please update in ADP Vantage or ask your manager to assist you.

EMPLOYMENT VERIFICATION

Are you applying for credit, leasing or renting, financing a purchase, or applying for government services?

We have partnered with The Work Number® service, which is a simple, secure and private way to get your employment and/or income information to the companies that need it. It's available 24/7, so that you can get the decisions you need when you need them.

From now on if the banker, the property manager, the car dealer or caseworker asks you how much money you make or to prove where you work, just send them to:

- www.theworknumber.com
- 800-367-5690 M-F 8:00 am to 8:00 pm (ET)
- member@equifax.com
- ESA Employer Code 4556338

Simple as that. Visit https://employees.theworknumber.com to learn more.

FREQUENTLY ASKED QUESTIONS (FAQS)

1. I can't sign in to MyADP, what should I do?

- Make sure you are registered. If you are not registered, click "Register" and follow the prompts.
- If you forgot your User ID or Password, click "I Forgot User ID or Password" and follow the prompts on the screen.
- If you still cannot sign in, contact your HRIS Admin or see your manager for assistance.

2. Where can I find instructions on how to enroll?

Detailed instructions on how to enroll on MyADP can be found in the MyADP Training Guide. To access the training guide go to the Forms and Plan Documents tile under Your Benefits on MyADP.

3. If I do not want to enroll in ESA's benefit plans, do I have to do anything?

No, if you are newly eligible to enroll and do not take action to elect benefits, you will only have ESA's company-paid benefits: Basic Life/AD&D, Long Term Disability (LTD), Health Advocate Program and Employee Assistance Program (EAP).

4. Can I change my elections and if so, how long do I have to change them?

After your initial enrollment, you can only change your elections during the annual Open Enrollment period or if you experience an IRS qualified life event. If you experience a qualified life event, you must go into MyADP and select Life Event within 31 days of the event in order to make any changes.

5. Do I have to enroll in all of the benefits?

No, you can enroll in each plan individually. ESA provides Basic Life/AD&D, Long Term Disability (LTD), as well as a Health Advocate Program and an Employee Assistance Program (EAP) at no cost to you.

6. If my child is over the age of 18, can I cover them as a dependent?

Yes, for the Medical, Dental and Vision Plans:

- You can cover your dependent children until they reach age 26.
- You may also cover your unmarried dependent children age 26 or older who are mentally or physically unable to care for themselves.

Yes, for the Child Life Plan:

- Your dependent children can be covered up to age 26.

Documentation will be required.

7. How do I submit my dependent's supporting documentation?

You may email your supporting documentation to benefits@esa.com or fax to 980-335-3379. Please indicate your Name and the supporting documentation type in the Subject line.

8. I take care of my parents and my sibling's children - can I cover them under ESA's Plan?

Parents are not eligible dependents under ESA's benefit plans and cannot be enrolled for coverage.

In order to be eligible for coverage, a dependent child must generally be under age 26. If the child is not your biological child, then they must be in one of the following categories to be eligible for coverage:

- Stepchild
- Legally adopted
- Foster child or child placed with you for adoption
- A child under your care due to a court order
- A child for whom you have legal guardianship

Documentation will be required.

9. When do I need to complete Evidence of Insurability (EOI) if newly eligible for Supplemental Life Insurance?

If newly eligible, an EOI is required when your combined basic and supplemental life amount is in excess of $400,000.

10. When do I need to complete Evidence of Insurability (EOI) if beyond my initial enrollment?

Beyond your initial enrollment period, you may only enroll or make changes during open enrollment or if you have a qualified life event.

- If electing Supplemental Life (Associate(s), Spouse and Child), Short Term Disability (STD) and/or Buy-Up Long Term Disability (LTD):

1. During Open Enrollment; or
2. Due to a qualified life event

Lincoln Financial Group will review your EOI to determine if you are approved for the coverage. If you are approved, your election and payroll deduction will be updated in MyADP for the next applicable paycheck.

11. I called customer service (Aetna, EyeMed, MetLife, Lincoln Financial Group) and am confused by the response. What should I do?

You can contact Health Advocate for assistance at (866) 695-8622 or **answers@HealthAdvocate.com**. You may also contact the Total Rewards Benefits Team at **benefits@esa.com** for assistance.

12. When will I receive my insurance ID cards?

- You can expect to receive any new ID cards at your home address within 15 days of your enrollment (or by January 1st if you enroll during Open Enrollment).
- Make sure your current home address is accurate in MyADP to ensure that you receive your cards timely.
- For Vision and Dental you will not receive an insurance card.
    - Simply provide your date of birth and social security number to your provider and they will be able to access your coverage.

GLOSSARY

GLOSSARY OF TERMS

COPAYMENT: A copayment (copay) is the fixed dollar amount you pay for certain in-network services on a PPO-type plan. In some cases, you may be responsible for coinsurance after a copay is made.

COINSURANCE: Your share of the costs of a healthcare service, usually figured as a percentage of the amount charged for services. You start paying coinsurance after you've met the deductible. Your plan pays a certain percentage of the total bill, and you pay the remaining percentage.

DEDUCTIBLE: A deductible is the amount of money you must meet before your plan begins paying for services covered by coinsurance. Some services, such as office visits that require copays, do not apply to the deductible. For example, if your plan's deductible is $1,000, you'll pay 100 percent of eligible healthcare expenses until you have met the $1,000 deductible.
After that, you share the cost with your plan by paying coinsurance.

FORMULARY: A list of prescription drugs covered by the plan. Also called a drug list.

IN-NETWORK: A group of doctors, clinics, hospitals, and other healthcare providers that have an agreement with your medical plan provider. You pay a negotiated rate for services when you use in-network providers.

OUT-OF-NETWORK: Care received from a doctor, hospital, or other provider not part of the plan agreement. You'll pay more when you use out-of-network providers since they don't have a negotiated rate with your plan provider. You may also be billed the difference between what the out-of-network provider charges for services and what the plan provider pays.

OUT-OF-POCKET MAXIMUM: This is the most you must pay for covered services in a plan year. After you spend this amount on deductibles and coinsurance, your health plan pays 100 percent of the costs of covered benefits. However, you must pay for certain out-of-network charges above reasonable and customary amounts.

HIGH DEDUCTIBLE HEALTH PLAN (HDHP): This type of medical plan requires that members reach a deductible prior to having services covered by coinsurance. All expenses paid by a member count toward the deductible and out-of-pocket maximum.

51

CONTACTS

Medical/Pharmacy Benefits

Aetna

Member services: 800-443-0157
Website: www.aetna.com

Advocacy Services / Tobacco Cessation

Health Advocate

Member services:
(866) 695-8622, thru 12/31/24
(866) 799-2728, effective 1/1/25
Website www.healthadvocate.com

Dental

MetLife

Member services: 800-638-5433
Website: www.metlife.com

Vision

Eyemed

Member services: 866-723-0513
Website: www.eyemed.com

Health Savings Account (HSA) / 401(k) Accounts

Fidelity

Member services: 800-835-5097
Website: www.netbenefits.com

Flexible Spending Account (FSA) / Commuter Benefit

Flores & Associates

Member services: 800-532-3327
Website: www.flores247.com

Telehealth

TELADOC

Member services:
855-TELADOC (835-2362)
Website: www.Teladoc.com/Aetna

Life & Disability

Lincoln Financial Group

Life

Member services: 888-787-2129
Website: www.mylincolnportal.com

Disability

Member services: 888-408-7300
Website: www.mylincolnportal.com

Employee Assistance Program (EAP)

Health Advocate

Member services:
(866) 695-8622, thru 12/31/24
(866) 799-2728, effective 1/1/25
Website: www.healthadvocate.com/esa

Group Home & Auto

MetLife

Member Services: 800-638-5433
Website: metlife.com

Vital Savings

Aetna

Member services: 877-698-4825
Website: www.vitalsavings.com/ESH

Pet Insurance

MetLife

Member Services: 855-270-7387
Email: pet_info@metlife.com

Legal Insurance

MetLife

Member Services: 800-638-5433
Website: metlife.com

For Other Benefits Questions
benefits@esa.com

MyADP Questions
HRIS@esa.com

SUMMARIES OF BENEFITS AND COVERAGE (SBC)

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2025-12/31/2025

aetna™ ESA MANAGEMENT, LLC. : Aetna HealthFund® Aetna Choice® POS II - ESA Low Deductible

Coverage for: All Tiers | Plan Type: POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-443-0157. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-443-0157 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: EE Only (EO) $1,150; EE+ 1 Dependent (EE+1) $2,300; EE+ Family (EE+F) $3,450. Out-of-Network: EO $3,000; EE+ 1 $6,000; EE+F $9,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. A Health Reimbursement Arrangement (HRA) is available that works with your medical plan, as described in your employer's Summary Plan Description.
Are there services covered before you meet your deductible?	Yes. In-network prescription drugs & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: EO $2,750; EE+1 Individual (IND) $5,250/ Family (FAM) $5,500; EE+F: IND $6,850/FAM $8,250. Out-of-Network: EO $6,000; EE+1 IND $12,000/FAM $12,000; EE+FAM: IND $18,000/FAM $18,000.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-443-0157 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/standard	Generic drugs	Copay/prescription, deductible doesn't apply: $9 (retail), $27 (mail order)	Not covered	Covers 31 day supply (retail), 32-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics. Maintenance drugs- after three 31 day retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.
	Preferred brand drugs	Copay/prescription, deductible doesn't apply: 20% (retail & mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: 20% (retail & mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	All prescriptions must be filled through the Aetna Specialty Performance Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance after $200 copay/visit	20% coinsurance after $200 copay/visit	Out-of-network emergency use paid the same as in-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% coinsurance	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	120 visits/calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	20% coinsurance	50% coinsurance	60 visits/calendar year for Physical, Occupational, Speech Therapy & Chiropractic care combined. Limited to treatment of Habilitation services.
	Habilitation services	20% coinsurance	50% coinsurance	None
	Skilled nursing care	20% coinsurance	50% coinsurance	60 days/calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If your child needs	Children's eye exam	Not covered	Not covered	Not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care - 60 visits/calendar year combined with rehabilitation services.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-443-0157.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-443-0157. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,150
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,150
Copayments	$0
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,750**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,150
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,150
Copayments	$0
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,150
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,150
Copayments	$0
Coinsurance	$150
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,300**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-443-0157.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2025-12/31/2025

aetna™ ESA MANAGEMENT, LLC. : Aetna HealthFund® Aetna Choice® POS II - ESA High Deductible

Coverage for: All Tiers | Plan Type: POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-443-0157. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-443-0157 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: EE Only (EO) $1,600; EE+ 1 Dependent (EE+1) $3,200; EE+ Family (EE+F) $4,800. Out-of-Network: EO $3,200; EE+ 1 $6,400; EE+F $9,600. Health Fund: $300 / $700 / $1,100	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. A Health Reimbursement Arrangement (HRA) is available that works with your medical plan, as described in your employer's Summary Plan Description.
Are there services covered before you meet your deductible?	Yes. In-network prescription drugs & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: EO $3,500; EE+1 Individual (IND) $5,250/ Family (FAM) $7,000; EE+F: IND $6,850/FAM $10,500. Out-of-Network: EO $7,000; EE+1 IND $14,000/FAM $14,000; EE+FAM: IND $21,000/FAM $21,000.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-443-0157 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/standard	Generic drugs	Copay/prescription, deductible doesn't apply: $9 (retail), $27 (mail order)	Not covered	Covers 31 day supply (retail), 32-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics. Maintenance drugs- after three 31 day retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.
	Preferred brand drugs	Copay/prescription, deductible doesn't apply: 20% (retail & mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription, deductible doesn't apply: 20% (retail & mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	All prescriptions must be filled through the Aetna Specialty Performance Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance after $200 copay/visit	20% coinsurance after $200 copay/visit	Out-of-network emergency use paid the same as in-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% coinsurance	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	120 visits/calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	20% coinsurance	50% coinsurance	60 visits/calendar year for Physical, Occupational, Speech Therapy & Chiropractic care combined. Limited to treatment of Habilitation services.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	60 days/calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If your child needs	Children's eye exam	Not covered	Not covered	Not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
dental or eye care	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care - 60 visits/calendar year combined with rehabilitation services.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-443-0157.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-443-0157. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,500**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$1,160
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,760**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,600
Copayments	$0
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,660**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-443-0157.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2025-12/31/2025

aetna™ ESA MANAGEMENT, LLC. : Aetna Choice® POS II - ESA HDHP HSA

Coverage for: All Tiers | Plan Type: POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.HealthReformPlanSBC.com or by calling 1-800-443-0157. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-443-0157 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: EE Only (EO) $2,000; EE+ 1 Dependent (EE+1): $5,000; EE+ Family (EE+F) $5,000. Out-of-Network: EO $4,000; EE+1: $10,000; EE+F $10,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: EO $4,500; EE+1 Individual (IND) $4,500/ Family (FAM) $9,000; EE+F: IND $4,500/FAM $13,300. Out-of-Network: EO $9,000; EE+1 IND $9,000/FAM $18,000; EE+FAM: IND $9,000/FAM $26,600.	The out–of–pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out–of–pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-443-0157 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care /screening /immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/standard	Generic drugs	Copay/prescription: 20% (retail & mail order)	Not covered	Covers 31 day supply (retail), 32-90 day supply (mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Your cost will be higher for choosing Brand over Generics. Maintenance drugs- after three 31 day retail fills, members are required to fill a 90-day supply at CVS Caremark® Mail Service Pharmacy or CVS Pharmacy.
	Preferred brand drugs	Copay/prescription: 20% (retail & mail order)	Not covered	
	Non-preferred brand drugs	Copay/prescription: 20% (retail & mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	All prescriptions must be filled through the Aetna Specialty Performance Pharmacy Network. Precertification required for coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network emergency use paid the same as in-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
attention	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except 50% coinsurance if pre-authorized.
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office & other outpatient services: 20% coinsurance	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	120 visits/calendar year. Pre-authorization required for out-of-network care.
	Rehabilitation services	20% coinsurance	50% coinsurance	60 visits/calendar year for Physical, Occupational, Speech Therapy & Chiropractic care combined. Limited to treatment of Habilitation services.
	Habilitation services	20% coinsurance	50% coinsurance	60 visits/calendar year for Physical, Occupational, Speech Therapy & Chiropractic care combined. Limited to treatment of Habilitation services.
	Skilled nursing care	20% coinsurance	50% coinsurance	60 days/calendar year. Pre-authorization required for out-of-network care.
	Durable medical equipment	20% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	20% coinsurance	50% coinsurance	Pre-authorization required for out-of-network care.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult & Child)
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care - 60 visits/calendar year combined with rehabilitation services.
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- For more information on your rights to continue coverage, contact the plan at 1-800-443-0157.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about

the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-443-0157. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol/gov/ebsa/healthreform
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact information is at: http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? **Yes.**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,160**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,020**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-443-0157.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 866-393-0002.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, disability, gender identity or sexual orientation.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: P.O. Box 24030, Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

TTY: 711

Language Assistance:

For language assistance in your language call 1-800-443-0157 at no cost.

Albanian -	Për asistencë në gjuhën shqipe telefononi falas në 1-800-443-0157.
Amharic -	ለቋንቋ እገዛ በ አማርኛ በ 1-800-443-0157 በነጻ ይደውሉ
Arabic -	1-800-443-0157 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني
Armenian -	Լեզվի ցուցաբերած աջակցության (հայերեն) զանգի 1-800-443-0157 առանց զնով:
Bahasa Indonesia -	Untuk bantuan dalam bahasa Indonesia, silakan hubungi 1-800-443-0157 tanpa dikenakan biaya.
Bantu-Kirundi -	Niba urondera uwugufasha mu Kirundi, twakure kuri iyi nomero 1-800-443-0157 ku busa
Bengali-Bangala -	বাংলায় ভাষা সহায়তার জন্য বিনামুল্যে 1-800-443-0157-তে কল করুন।
Bisayan-Visayan -	Alang sa pag-abag sa pinulongan sa (Binisayang Sinugboanon) tawag sa 1-800-443-0157 nga walay bayad.
Burmese -	ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 1-800-443-0157 ကို ခေါ်ဆိုပါ။
Catalan -	Per rebre assistència en (català), truqui al número gratuït 1-800-443-0157.
Chamorro -	Para ayuda gi fino' (Chamoru), ågang 1-800-443-0157 sin gåstu.
Cherokee -	ᎾᏍᎩᎾ ᏕᏣᏂᎯᏍᏗ ᏗᏂᏍᏕᎵᏍᎩ ᎾᎿᎢ (ᏣᎳᎩ) ᏫᏓᎳᏫᏍ 1-800-443-0157 ᎤᎾᎢ Ꮭ ᎠᏓᏍᏗ ᏧᎬᏩᎶᏗ ᏂᎨᏒᎾ.
Chinese -	欲取得繁體中文語言協助，請撥打1-800-443-0157，無需付費。
Choctaw -	(Chahta) anumpa ya apela a chi I paya hinla 1-800-443-0157.
Cushite -	Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 1-800-443-0157 irratti bilisaan bilbilaa.
Dutch -	Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 1-800-443-0157.
French -	Pour une assistance linguistique en français appeler le 1-800-443-0157 sans frais.
French Creole -	Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 1-800-443-0157 gratis.
German -	Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 1-800-443-0157 an.
Greek -	Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 1-800-443-0157 χωρίς χρέωση.
Gujarati -	ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 1-800-443-0157 પર કૉલ કરો.
Hawaiian -	No ke kōkua ma ka ʻōlelo Hawaiʻi, e kahea aku i ka helu kelepona 1-800-443-0157. Kāki ʻole ʻia kēia kōkua nei.

Hindi -	हिन्दी में भाषा सहायता के लिए, 1-800-443-0157 पर मुफ़्त कॉल करें।
Hmong -	Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 1-800-443-0157.
Ibo -	Maka enyemaka asụsụ na Igbo kpọọ 1-800-443-0157 na akwụghị ụgwọ ọ bụla
Ilocano -	Para iti tulong ti pagsasao iti pagsasao tawagan ti 1-800-443-0157 nga awan ti bayadanyo.
Italian -	Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 1-800-443-0157.
Japanese -	日本語で援助をご希望の方は、1-800-443-0157 まで無料でお電話ください。
Karen -	လၢတက်မၤစၢၤတက်ကတိၤကျိာ်အကိၢ် ကျိာ် ၁-800-443-0157 လၢတအိာ်ဒီးတက်လၢဘျုာ်လၢာ်စုၤဘာ်
Korean -	한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 1-800-443-0157 번으로 전화해 주십시오.
Kru-Bassa -	Bɛ́m̀ké gbo-kpá-kpá dyé pídyi ɖé Bǎsɔ́ɔ̀-wuɖuǔn wɛ̌ɛ, ɖá 1-800-443-0157
Kurdish -	بۆ یارمەتی بە زمانی کوردی بە خۆڕایی پەیوەندی بکەن. 1-800-443-0157 برای راهنمایی به زبان فارسی با شماره
Laotian -	ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ1-800-443-0157 ໂດຍບໍ່ເສຍຄ່າໂທ.
Marathi -	कोणत्याही शुल्काशिवाय भाषा सेवा प्राप्त करण्यासाठी, 1-800-443-0157 वर फोन करा.
Marshallese -	Ñan bōk jipañ ilo Kajin Majol, kallok 1-800-443-0157 ilo ejjelok wōnān.
Micronesian-Pohnpeyan -	Ohng palien sawas en soun kawewe ni omw lokaia Ponape koahl 1-800-443-0157 ni sohte isais.
Mon-Khmer, Cambodian -	សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 1-800-443-0157 ដោយឥតគិតថ្លៃ។
Navajo -	T'áá shi shizaad k'ehjí bee shíká a'doowol nínízingo Diné k'ehjí koji' t'áá jíík'e hólne' 1-800-443-0157
Nepali -	(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 1-800-443-0157 मा फोन गर्नुहोस् ।
Nilotic-Dinka -	Tën kuɔɔny ë thok ë Thuɔŋjäŋ cɔl 1-800-443-0157 kecïn aɣöc.
Norwegian -	For språkassistanse på norsk, ring 1-800-443-0157 kostnadsfritt.
Panjabi -	ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 1-800-443-0157 'ਤੇ ਮੁਫ਼ਤ ਕਾਲ ਕਰੋ।
Pennsylvania Dutch -	Fer Helfe in Deitsch, ruf: 1-800-443-0157 aa. Es Aaruf koschtet nix.
Persian -	برای راهنمایی به زبان فارسی با شماره 1-800-443-0157 بدون هیچ هزینه ای تماس بگیرید. انگلیسی
Polish -	Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 1-800-443-0157.
Portuguese -	Para obter assistência linguística em português ligue para o 1-800-443-0157 gratuitamente.
Romanian -	Pentru asistenţă lingvistică în românește telefonaţi la numărul gratuit 1-800-443-0157

Russian -	Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 1-800-443-0157.
Samoan -	Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 1-800-443-0157 e aunoa ma se totogi.
Serbo-Croatian -	Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 1-800-443-0157.
Spanish -	Para obtener asistencia lingüística en español, llame sin cargo al 1-800-443-0157.
Sudanic-Fulfude -	Fii yo on heɓu balal e ko yowitii e haala Pular noddee e oo numero ɗoo 1-800-443-0157. Njodi woo fawaaki on.
Swahili -	Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 1-800-443-0157 bila malipo.
Syriac -	[illegible] 1-800-443-0157 [illegible].
Tagalog -	Para sa tulong sa wika na nasa Tagalog, tawagan ang 1-800-443-0157 nang walang bayad.
Telugu -	భాషతో సాయం కోరకు ఎలాంటి ఖర్చు లేకుండా 1-800-443-0157 కు కాల్ చేయండి. (తెలుగు)
Thai -	สำหรับความช่วยเหลือทางด้านภาษาเป็น ภาษาไทย โทร 1-800-443-0157 ฟรีไม่มีค่าใช้จ่าย
Tongan -	Kapau ‘oku fiema'u hā tokoni ‘i he lea faka-Tonga telefoni 1-800-443-0157 ‘o ‘ikai hā ōtōngi.
Trukese -	Ren áninnisin chiakú ren (Kapasen Chuuk) kopwe kékkééri 1-800-443-0157 nge esapw kamé ngonuk.
Turkish -	(Dil) çağrısı dil yardım için. Hiçbir ücret ödemeden 1-800-443-0157.
Ukrainian -	Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 1-800-443-0157.
Urdu -	بلاقیمت زبان سے متعلق خدمات حاصل کرنے کے لیے ، 1-800-443-0157 . پر بات کریں-
Vietnamese -	Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 1-800-443-0157.
Yiddish -	פאר שפראך הילף אין אידיש רופט 1-800-443-0157 פריי פון אפצאל.
Yoruba -	Fún ìrànlọwọ nípa èdè (Yorùbá) pe 1-800-443-0157 lái san owó kankan rárá.

ACA NOTICE OF MARKETPLACE COVERAGE

WHAT DOES THE AFFORDABLE CARE ACT (ACA) MEAN TO YOU?:

If you meet the following eligibility requirements, you will be offered medical benefits: A part-time associate, have been with the organization for a 12 month period of time and worked an average of 30 hours per week within 12 months. Please look for a separate benefit package should you become eligible.

The remainder of this cover page and the next few pages outline Health Care Reform Marketplace information.

As mandated by the Health Care Reform, the enclosed Notice of Health Insurance Marketplace is included in this guide. An online Marketplace, or "Exchange", is a website where health insurance companies come together to give you a place to shop for health insurance. That way you have one place to compare options for private health insurance side by side. The options you are given are determined by your particular state and/or federal health care exchanges.

More changes required by the law went into effect on January 1, 2014. You may hear more and more about Health Care Reform—particularly about the state and federal Marketplaces that are open. Not only will the public media be reporting on this topic, you may also see ads for the Marketplace on television, online and in your mailbox. These ads (mostly from health insurance companies) will focus on encouraging you to consider electing health care coverage through the Marketplace.

If you have questions regarding the Marketplace

- Visit www.HealthCare.gov or call 800-318-2596

If you have questions as to your eligibility through Medicaid or the Children's Health Insurance Program (CHIP):

- Visit HealthCare.gov or call (800) 318-2596 to find out more about your state Medicaid program and options that may be available to you.
- Visit InsureKidsNow.gov or call (877) 543-7669 to learn more about the CHIP program.

Special note to all Full Time Benefit eligible associates: Extended Stay America's sponsored medical plans comply with all Health Care Reform requirements. As long as you are eligible and/or enrolled in Extended Stay America's medical plan, your coverage will meet the mandated affordability and coverage requirements. Since Extended Stay America's medical plans meet Health Care Reform requirements, it is unlikely you will receive any kind of financial help from the government to pay for any coverage you may purchase from a public marketplace. The Marketplace is not related to Extended Stay America's benefit plan or Open Enrollment.

We encourage each associate to research your options and choose the optimum coverage for your individual circumstances.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact ESA Benefits Department.

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

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

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 ESA Management LLC		4. Employer Identification Number (EIN) 90-1015925
5. Employer address 13024 Ballantyne Corporate Place Suite 1000		6. Employer phone number 980-345-1600
7. City Charlotte	8. State NC	9. ZIP code 28277
10. Who can we contact about employee health coverage at this job? Total Rewards Team		
11. Phone number (if different from above) 980-345-1948	12. Email address benefits@esa.com	

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

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

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

Full-time associates regularly scheduled to work at least 37 hours per week and Part-time associates who meet the requirements set forth by the ACA.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouses who do not have access to coverage through their own employers, children up to age 26 regardless of marital or student status AND unmarried children of any age who are incapable of supporting themselves due to a mental or physical disability occurring prior to age of 26.

☐ 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 will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $36.79
b. How often? ☐ Weekly ☒ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

LEGAL NOTICES

ESA MANAGEMENT, LLC
HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE: this packet of notices related to our healthcare plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notices from ESA Management, LLC. About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice From ESA Management, 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 ESA Management LLC. and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. ESA Management, LLC has determined that the prescription drug coverage offered by the ESA Management, LLC Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to wait to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty*.

Special Enrollment Period Exceptions to the Late Enrollment Penalty

There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage

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. See the ESA Management, LLC Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D

Generally speaking, if you decide to join a Medicare drug plan while covered under the ESA Management, LLC Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the ESA Management, LLC Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your ESA Management, LLC prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage

Contact the person listed below for further information, or call 980-345-1600. **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 ESA Management, LLC changes. You also may request a copy.

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 whether or not you are required to pay a higher premium (a penalty).

Date: January 1, 2025
Name of Entity/Sender: ESA Management LLC, Benefits Dept.
Address: 13024 Ballantyne Corporate Place , Charlotte, NC 28277
Phone Number: (980) 345-1600

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

ESA MANAGEMENT, LLC
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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

This Notice is provided to you on behalf of:

ESA Management, LLC. Associate(s) Welfare Benefit Plan

* This notice pertains only to healthcare coverage provided under the plan

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by ESA Management, LLC that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it pays for all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
  - **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.

Other Uses and Disclosures of Your PHI Not Requiring Authorization. The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:

- **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as ESA Management, LLC) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.

- **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
- **Required by Law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For Public Health Activities:** : The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For Health Oversight Activities:** : The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

- **Uses and Disclosures Requiring Authorization:** : For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, or breach notification process, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this Notice, is:

Melanie Goodwin
Director, Benefits
980-345-1851

Effective Date

The effective date of this notice is: January 1, 2025

.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

ESA MANAGEMENT, LLC EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an associate(s), termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact:
ESA Benefits Department
benefits@esa.com
(980) 345-1600

*** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.**

GENERAL COBRA NOTICE

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;
- 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 in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

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. If you believe you are eligible for this extension, contact the Plan Administrator.

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 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.

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

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

ESA Benefits Department
benefits@esa.com
980-345-1600

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

ESA Management, LLC Associate(s) Benefit Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

ESA Management, LLC. Associate(s) Benefit Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Low Deductible	In-Network	Out-of-Network
Individual Deductible	$1,150	$3,000
Family Deductible	$3,450	$9,000
Coinsurance	20%	50%
High Deductible	In-Network	Out-of-Network
Individual Deductible	$1,600	$3,200
Family Deductible	$4,800	$9,600
Coinsurance	20%	50%
HSA	In-Network	Out-of-Network
Individual Deductible	$2,000	$4,000
Family Deductible	$5,000	$10,000
Coinsurance	20%	50%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

ESA Benefits Department
benefits@esa.com
980-345-1600

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact ESA Benefits Department, **benefits@esa.com**, 980-345-1600.

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

ESA Management, LLC Wellness Program is a voluntary wellness program available to . The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in the guide.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting ESA Benefits Department, benefits@esa.com, 980-345-1600

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and ESA Management, LLC may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact ESA Benefits Department, **benefits@esa.com**, 980-345-1600.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

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

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

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

To see if any other states have added a premium assistance program since July 31, 2022, 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
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OMB Control Number 1210-0137 (expires 1/31/2026)

Employer Name:	**EXTENDED STAY AMERICA**
Employer State of Situs:	**NORTH CAROLINA**
Name of Issuer:	**EXTENDED STAY AMERICA**
Plan Marketing Name:	**ESA MANAGEMENT, LLC EMPLOYEE WELFARE BENEFIT PLAN**
Plan Year:	**2024-2025**

Ten (10) Essential Health Benefit (EHB) Categories:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (like surgery and overnight stays)
- Laboratory services
- Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)
- Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)
- Pregnancy, maternity, and newborn care (both before and after birth)
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)

2020-2022 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)				Employer Plan Covered Benefit?
Item	**EHB Benefit**	**EHB Category**	**Benchmark Page # Reference**	
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	YES
2	Allergy Injections and Testing	Ambulatory	Pg. 11	YES
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	YES
4	Durable Medical Equipment	Ambulatory	Pg. 13	YES
5	Hospice	Ambulatory	Pg. 28	YES
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	YES
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	YES
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	YES
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	NO
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	YES
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	YES
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	NO
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	YES
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	YES
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	YES

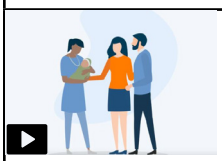
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	YES
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	YES
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	YES
19	Skilled Nursing Facility	Hospitalization	Pg. 21	YES
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	YES
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	YES
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	YES
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	YES
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	YES
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	YES
26	Tele-Psychiatry	MH/SUD	Pg. 11	NO
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	YES
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	NO
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	NO
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	YES
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	YES
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	YES
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	YES
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	NO
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	YES
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	YES
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	YES
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	YES
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	YES
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	YES
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	YES
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	YES

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

BENEFITS OVERVIEW VIDEOS

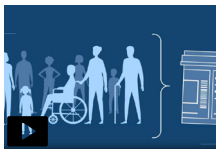
<Intro text for Benefits Over Videos will go here.>

Qualifying Life Event



Prescription Drugs: Benefits Overview

Prescription Drugs: Tips to Manage Costs

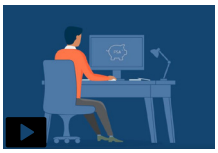


Health Savings Account (HSA)

How to Optimize Your HSA

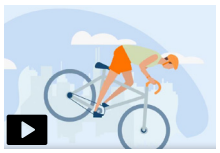
Flexible Spending Account (FSA)

How to Optimize Your FSA



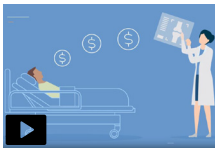
Dependent Care FSA

Accident Insurance

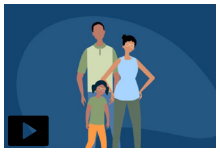


Critical Illness Insurance

Hospital Indemnity Coverage



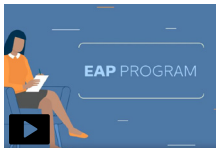
Vision Insurance



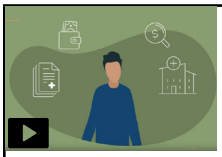
Life and AD&D Insurance

Disability Insurance

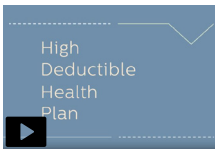
Employee Assistance Program



Benefits Key Terms Explained



Medical Plans: HDHP



The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.

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