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2027 Employee Benefits Guide

Hawaii Employees

What's New for 2027?

Annual Enrollment is November 2 through November 13, 2026. This is the one time per year to make changes to your benefit plan elections unless you have a qualifying family status change. The elections made during this Annual Enrollment period will apply for the January 1 to December 31, 2027 plan year.

Below outlines key features of note on the benefit plans and changes to the benefits offerings for the 2027 plan year. Details on each plan can be found on their respective pages within this guide.

- The HMSA and Kaiser plans will still be offered.
- The PPO and HMO offered through HMSA have some changes to copays or Rx out-of-pocket maximums.
- The Kaiser HMO plan coinsurance has been adjusted for the 2027 plan year.
- To comply with Hawaii regulations, if you elect employee only medical coverage, your contributions will be a percentage of your monthly salary capped at a set limit.
- There are premium contribution changes for the medical plans. The new premium amounts for the 2027 plan year are referenced on page 10 of this guide.
- New for 2027! All employees will have access to Inflection. Inflection is an educational platform that provides additional resources to employees and their families. We recognize many times people may be facing challenges with Fertility, Menopause, Divorce, ElderCare, End of Life, or just general moments that need support. Inflection is a robust online platform that has been built by experts in those fields to help you navigate through these periods of life. Additional information can be found on page 27.

Please review this guide in its entirety to ensure you have a full understanding of your benefits options and make all enrollment changes between November 2 and November 13, 2026.

If you fail to take action during Annual Enrollment, you will be defaulted to your 2026 elections with the exception of a Flexible Spending Account (FSA) and a Dependent Care Flexible Spending Account (DCFSA). Contributions to pre-tax spending accounts must be re-elected each year.

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We all work together to make AT Collective a success, and our teamwork extends to your benefits. Your health and well-being are important to us, so we provide benefit options to make your and your family's lives better. Together, let's invest in you. Read over this guide for details on your 2027 benefits from A to Z. If you have questions, your Benefits Service Center and Employee Benefits Department are here to help.

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See **page 30** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to Automobile Club of Southern California. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Eligibility & Enrollment

We offer a variety of benefits to support you and your family's needs and that allows you to choose options that cover what's most important to you.

You may select any combination of medical, dental and/or vision plan coverage. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of AT Collective, must elect coverage for yourself in order to elect any dependent coverage.

Eligibility

A regular employee is any person who is scheduled to work at least twenty (20) hours per week. You are eligible to participate in the medical, dental, vision, spending accounts, life and disability plans, along with additional benefits.



When Does Coverage Begin?

For Annual Enrollment: Your elections are effective on January 1.

For New Hires: Your elections are effective the first of the month following thirty (30) days of continuous service of at least twenty (20) hours per week. Medical coverage is effective four weeks after your start date.

You won't be able to change your benefits until the next annual enrollment period unless you experience a Qualifying Life Event.

Eligible Dependents

Dependents eligible for coverage in the plans include:

- Your current legal spouse, not divorced or legally separated.
- Your Registered Domestic Partner.*
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children and children for whom legal guardianship has been awarded to you or your spouse/registered Domestic Partner).
- Dependent children 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility is required upon enrollment.

*Note: A domestic partner is not considered a spouse under federal law but would be charged the spouse or family tier. As a result, if you elect to have your partner covered under your plan, you will pay income tax and Social Security payroll tax on the portion of the insurance premium that ACE contributes to your partner's policy. Domestic partners are treated as post-tax deductions.

Thoughts & Tips:

You cannot change your benefit selections during the plan year unless you have a Qualifying Life Event, such as marriage and/or the birth or adoption of a child.

Dependent Verification

If you plan to enroll dependents in a benefit plan, you are required to provide proof of relationship before coverage for those dependents can take effect.

Please review the chart below and on the next page to confirm that your dependents meet the eligibility criteria and that you have the required documents to verify their eligibility. Once you have gathered the necessary documents, follow the steps below to submit your documentation.

How to Submit Your Documentation:

Upload: Log on to www.myclubbenefits.com and follow the directions under "Upload your Dependent Documentation"

Fax: 877-965-9555

Mail: Auto Club Benefits Verification Center
P.O. Box 299109
Lewisville, TX 75029-9109

DEPENDENT TYPE	ELIGIBILITY RULES	DOCUMENTS REQUIRED FOR VERIFICATION
SPOUSE (2 DOCUMENTS REQUIRED)	Your spouse is the person to which you're legally married. Legal spouses include common-law spouses in states that recognize common law marriages, including Texas.	Unless married this year, more than one document is required when adding your spouse to coverage. Provide the following as proof of your current relationship: -Government-issued marriage license/certificate AND -Current or previous tax year's joint 1040 federal tax return if filing jointly (first page only), or -Employee's and spouse's current or previous year's 1040 federal tax return if filing married but separately (first page only) or -Current or previous year copy of tax confirmation notice(s) if filed online, must show both names and filing status as married (Tax returns must indicate tax year, employee name, spouse name and filing status) OR Please provide one of the following in addition to the documents listed above (must include your name and your spouse's name and be dated within the past 6 months): -Documentation of current joint ownership of residence, or -Documentation of joint tenants on current lease of residence
COMMON-LAW SPOUSE (2 DOCUMENTS REQUIRED)	Your spouse is the person to which you're legally married. Legal spouses include common-law spouses in states that recognize common law marriages, including Texas.	One of the following as proof of your current relationship: -Current or previous tax year's joint 1040 federal tax return if filing jointly (first page only), or -Employee's and spouse's current or previous year's 1040 federal tax return if filing married but separately (first page only) or -Current or previous year copy of tax confirmation notice(s) if filed online, must show both names and filing status as married (Tax returns must indicate tax year, employee name, spouse name and filing status) AND One of the following as proof of marriage (documents of current joint ownership or tenants must include your name and your spouse's name and be dated within the past 6 months): -Documents demonstrating fulfillment of state requirements for common-law marriage, or -Documentation of current joint ownership of residence, or -Documentation of joint tenants on current lease of residence
REGISTERED DOMESTIC PARTNER (2 DOCUMENTS REQUIRED)	A Registered Domestic Partner is either: - A person in a committed relationship with: 1) an employee of the same sex; or 2) an eligible employee of the opposite sex. - A person who an insurance company or claims administrator claims that is it is required to treat as a Registered Domestic Partner under applicable law.	One of the following as proof of domestic partnership: -Registered Domestic Partner (RDP) document with state or local government agency AND One of the following as proof of current residency (each must include your name and your domestic partner's name and be dated within the past 6 months): -Documentation of current joint ownership of residence, or -Documentation of joint tenants on current lease of residence

DEPENDENT TYPE	ELIGIBILITY RULES	DOCUMENTS REQUIRED FOR VERIFICATION
CHILD UP TO AGE 26 (1 TO 2 DOCUMENTS REQUIRED)	Children up to age 26, including birth children, stepchildren, legally adopted children, children placed for adoption, foster children and children for whom legal guardianship has been awarded to you or your Spouse/ registered Domestic Partner.	PROOF OF INITIAL RELATIONSHIP: One of the following as proof of initial relationship: -Official government issued or state, city or country issued Birth certificate* for biological children showing you as the parent, or -Documentation on hospital letterhead indicating birth date of child (for biological children under the age of 6 months) showing you as the parent, or -Court papers for children adopted or placed for adoption, or -Court papers demonstrating legal guardianship or custodianship for court-appointed children, or -Paternity test (must list father), or -Baptismal certificate (must list parents' name), or -Employee's or spouses' current of previous year 1040 federal tax return identifying the child as a dependent AND One of the following as proof of age or proof of relationship (only if proof of initial relationship above doesn't include birth date), such as: -Child's Visa/ Passport, or -Child's Government Records, or -State-issued Birth Registration Card, or -Signed, official notice from the City Clerk's office documenting date of birth (must include city seal) -A copy of the birth certificate or alternative documentation if photocopying is illegal in that state
STEPCHILD UP TO AGE 26 (2 TO 3 DOCUMENTS REQUIRED)		PROOF OF INITIAL RELATIONSHIP: One of the following as proof of initial relationship between your spouse and your stepchild: -Official government issued or state, city or country issued Birth certificate* showing your spouse as the child's parent, or -Paternity test (must list your spouse as parent), or -Baptismal certificate (must list your spouse as parent), or -Employee or spouses' current or previous year 1040 federal tax return identifying the child as a dependent AND One of the following as proof of age (only if proof of initial relationship above doesn't include birth date), such as: -Child's Visa/Passport, or -Child's Government Records, or -Signed, official notice from the City Clerk's office documenting date of birth (must include city seal) AND Proof of your marriage with the child's parent *a copy of the birth certificate or alternative documentation if photocopying is illegal in that state.
CHILD OF DOMESTIC PARTNER UP TO AGE 26 (2 TO 3 DOCUMENTS REQUIRED)		PROOF OF INITIAL RELATIONSHIP: One of the following as proof of initial relationship between your domestic partner and his or her child: -Official government issued or state, city or country issued Birth certificate* showing your domestic partner as the child's parent, or -Paternity test (must list your domestic partner as parent), or -Baptismal certificate (must list your domestic partner as parent), or -Domestic Partner's current or previous year 1040 federal tax return identifying the child as a dependent AND One of the following as proof of age (only if proof of initial relationship, above, doesn't include birth date), such as: -Child's Visa/Passport, or -Child's Government Records, or -State-issued Birth Registration Card, or -Signed, official notice from the City Clerk's office documenting date of birth (must include city seal) AND Proof of your domestic partnership with the child's parent (see Domestic Partner section above) * a copy of the birth certificate or alternative documentation if photocopying is illegal in that state
CHILD 26 AND ABOVE WHO IS INCAPABLE OF SELF-SUSTAINING EMPLOYMENT DUE TO MENTAL RETARDATION OR PHYSICAL HANDICAP AND IS SOLELY DEPENDENT ON YOU FOR SUPPORT AND MAINTENANCE. DISABILITY MUST HAVE OCCURRED PRIOR TO AGE 26 AND WHILE CHILD WAS ENROLLED IN ACE'S MEDICAL PLAN. (2 TO 3 DOCUMENTS REQUIRED)		PROOF OF INITIAL RELATIONSHIP: -Birth certificate for biological children showing you as parent, or -Court papers for children adopted or placed for adoption, or -Court papers demonstrating legal guardianship or custodianship for court-appointed children, AND - FOR MEDICAL, DENTAL, VISION AND OTHER NON-MEDICAL BENEFITS: (Only if documents above don't include birth date) Documented proof of age, such as: -Child's driver's license or other government records, or -Your or your child's federal tax return (first page only) AND Certification of disability must be submitted within thirty-one (31) days of the date the Dependent would no longer be eligible. After the first two(2) years of incapacity and dependency, the Employee may be required to furnish proof once a year regarding the continuation of such condition.

Enroll now. You've got one shot!

What are Qualifying Life Events?

Most people know you can change your benefits when you start a new job or during Annual Enrollment. But did you know that changes in your life may permit you to update your coverage at other points in the year? Qualifying Life Events (QLEs) determined by the IRS could allow you to enroll in health insurance or change your elections outside of the annual enrollment period.

Common QLEs include:

- A change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- A change in your legal marital status (marriage, divorce or legal separation)
- Entitlement to Medicare or Medicaid
- A change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Eligibility for coverage through the Marketplace
- A change in your spouse's employment status (resulting in a loss or gain of coverage)
- Changes in your address or location that may affect the coverage for which you are eligible



Some lesser-known qualifying events are:

- Turning 26 and losing coverage through a parent's plan
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)
- Death in the family (leading to change in dependents or loss of coverage)

When a QLE occurs, you have 31 days to request changes to your coverage and provide supporting documentation. Keep in mind your change in coverage must be consistent with your change in benefit status.

Questions regarding specific life events and your ability to request changes should be directed to the Benefits Service Center at 888-488-CLUB (2582), Monday through Friday, 5AM-5PM Pacific Time. Don't miss out on a chance to update your benefits!

Preparing for Annual Enrollment

As a committed partner in your health, AT Collective absorbs a significant amount of your benefit costs. Your contributions for medical, dental and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Please note that employee contributions vary depending on level of coverage. Typically, the more coverage you have, the higher your portion.

Annual Enrollment To-Do

Update your personal information

If you've experienced a Qualifying Life Event in the last year, you may need to change your elections or update your information.

Update your beneficiaries

Take this opportunity to review and update your beneficiaries through the Benefits Service Center.

Review available plans

Take a look at your options and select the option that best suits the needs of you and your family. If you foresee a lot of medical needs next year, you might want a lower deductible. If not, you could switch to a higher deductible and enjoy lower premiums.

Consider your FSA

An FSA can help cover healthcare costs including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help save on tax liabilities.

Check to see if your provider and pharmacy are in-network

Going in-network often saves you money. Check for any plan changes to make sure your preferred provider and pharmacy are still your best option and covered in-network.



How to Enroll

1. Understand Your Choices

This Guide contains useful reference material to help you prepare for New Hire or Annual Enrollment elections. Keep this handy so you can refer to it throughout the year.

2. Review Your Options With Your Family

Make sure you include any other individuals who will be affected by your elections in the decision-making process.

3. Visit www.myclubbenefits.com, or call 888-488-CLUB (2582)

Benefits Service Center Hours: 5AM to 5PM PT Monday – Friday

4. Log In With Your Username and Password

When you log in for the first time, click "New User?" link located under the login box and follow the prompt. If you have previously logged in, you will continue to use your same username and the password you created at the time of enrollment. If you forget your username/password, click the "Forgot User ID or Password?" link located under the login box.

5. Confirm Your Personal and Dependent Information

If you are adding a dependent for the first time, please make sure to have their Social Security number, birth date and other documents to complete their verification. You have sixty (60) days from the date you add a dependent to coverage to submit supporting documentation. For Annual Enrollment, documentation must be submitted by within 60 days.

6. Review Your Benefit Options and Select Any New Coverages

Please remember the IRS requires that you re-elect Flexible Spending Account(s) contributions if you would like to continue them in 2027.

7. Confirm Your Beneficiaries

It is very important to make sure your beneficiary information is current. You will need to indicate their full name, address, Social Security number, relationship to you, date of birth and distribution percentage.

8. Save Your Elections

The benefits enrollment system saves your elections as you go. Please ensure your final elections are confirmed on the final page. Click the "Save Changes" button. Print out your confirmation and keep it for your records.

Medical & Pharmacy Benefits

Medical and pharmacy benefits are provided through HMSA and Kaiser Permanente. Choose the plan that works best for you and your family's needs. Consider your medical and pharmacy needs, premiums and out-of-pocket costs for each plan. Keep in mind your choice is effective for the entire 2027 plan year, unless you have a Qualifying Life Event.

Medical & Pharmacy Contributions

Premium contributions for medical and pharmacy are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your monthly contributions. Please note: the contributions listed below do not include any wellness credit you might receive based on eligibility.

	HMSA CHOICE PLAN (PPO)	HMSA HEALTH PLAN HI PLUS (HMO)	KAISER PERMANENTE HI (HMO)
MONTHLY CONTRIBUTIONS			
EMPLOYEE ONLY	1.5% of monthly pay, capped at $250.53	1.5% of monthly pay, capped at $229.23	1.5% of monthly pay, capped at $116.83
EMPLOYEE + SPOUSE	$604.06	$596.91	$389.67
EMPLOYEE + CHILD(REN)	$548.08	$520.71	$377.08
EMPLOYEE + FAMILY	$931.98	$888.37	$607.50

How to Find a Provider

HMSA: Go to www.hmsa.com/search/providers, select your medical plan (either PPO or HMO) and click search. If you need additional assistance, call 800-776-4672.

Kaiser Permanente: Go to www.kp.org and click Doctors & Locations from the top menu. Enter your location information to find a provider near you. If you need additional assistance, call 800-278-3296.

How to Find a Pharmacy

If you have HMSA coverage, go to www.hmsa.com/search/providers, select Drug PPO or Drug HMO based on your plan, and click search. If you need assistance, call 800-776-4672. If you have Kaiser Permanente coverage, you can pick up prescriptions at any of the Kaiser Permanente pharmacies located in their medical centers and many medical offices. Find a location by visiting www.kp.org/facilities. For assistance, call 866-206-2983.



Medical & Pharmacy Benefits

Medical & Pharmacy Plan Summary

This chart summarizes the 2027 medical plans provided by Kaiser Permanente and HMSA. Your pharmacy benefits are outlined at the bottom of the chart. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations and you could be balance billed.

Prescription Drug Coverage

HMSA and Kaiser Permanente each coordinate their Prescription Drug Program. Information on your benefits coverage and a list of network pharmacies is available online at www.hmsa.com and www.kaiserpermanente.org or by calling the Customer Care number on your ID Card.

	HMSA CHOICE PLAN (PPO)		HMSA HEALTH PLAN HI PLUS (HMO)	KAISER PERMANENTE HI (HMO)
CALENDAR YEAR DEDUCTIBLE				
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY	IN-NETWORK ONLY
INDIVIDUAL	N/A	$100	N/A	N/A
FAMILY	N/A	$300	N/A	N/A
COINSURANCE (PLAN PAYS)	80%	70%	80%	80%
CALENDAR YEAR OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE AND MEDICAL AND RX COPAYS)				
INDIVIDUAL	$2,500		$2,500	$2,500
FAMILY	$7,500		$7,500	$7,500
COPAYS/COINSURANCE (YOU PAY)				
PREVENTIVE CARE	No Charge	30%*	No Charge	No Charge
PRIMARY CARE	$12	30%**	$20	$15
SPECIALIST SERVICES	$12	30%**	$20	$15
URGENT CARE	$17	30%**	$20	$15
DIAGNOSTIC CARE	20%	30%**	20%	20%
EMERGENCY ROOM	20%	20%	$100	20%
RX CALENDAR YEAR OUT-OF-POCKET MAXIMUM				
INDIVIDUAL	$5,000		$5,000	Included with Medical
FAMILY	$7,500		$7,500	Included with Medical
RETAIL PRESCRIPTION DRUG COVERAGE (30-DAY SUPPLY)* **				
GENERIC	$7	$7 copay; 20% coinsurance	$7****	$10
PREFERRED	$30	$30 copay; 20% coinsurance	$30****	$45
NON-PREFERRED	$30	$30 copay; 20% coinsurance	$30****	$45

*After Deductible
**After deductible and subject to out-of-network reimbursement limitations
***90-day supply through mail order is available
****Out-of-Network Coverage for prescriptions offered at applicable tier copay and 20% coinsurance

Use In-Network Providers

Your employer-provided health plan uses networks of high-quality doctors, hospitals and other healthcare providers to help hold down healthcare costs. Here is how using an in-network healthcare provider can help you and your employer-provided health plan financially.

IN-NETWORK	OUT-OF-NETWORK
▶ Doctors, hospitals and other healthcare providers agree to let the plan adjust their billed charge to a lower amount negotiated in advance with the network. ▶ The in-network healthcare provider typically is not permitted to send you a bill for the difference between its billed charge and what the plan pays, except for what you might owe because of your deductible or coinsurance (the portion of a covered medical claim that you are required to pay) or for services not covered by the plan.	▶ HMO plans do not have out-of-network options. ▶ Healthcare providers can bill you whatever they want. ▶ If the service is covered by the health plan, the plan will typically pay a smaller percentage of the bill than it would pay an in-network provider. ▶ The out-of-network provider can then bill you for the entire amount left unpaid by the health plan, even after you've met your deductible.

Follow this road map to financial savings:

- Check to see if your healthcare provider is in-network; the health plan has a directory of in-network providers you can use.
- Ask your doctor, when he or she refers you to another doctor, outpatient center, or hospital, whether the provider is in-network and then double-check with your health plan. Many patients end up paying more because their specialist or facility is out-of-network.
- Ask the doctors who treat you at an in-network facility, like a hospital, whether they are in-network (sometimes they won't be), and let the facility know you want to only be seen by in-network doctors and other providers.
- Be wary of promises by out-of-network healthcare providers that you'll never have to pay more than you would if they were in-network. The health plan might adjust the claim, reducing it by the amount of the provider's fee forgiveness.



Out-of-Pocket Costs

Know Before You Go: Paying for Services

Deductible

The amount you must pay for covered services before your insurance starts paying its portion.



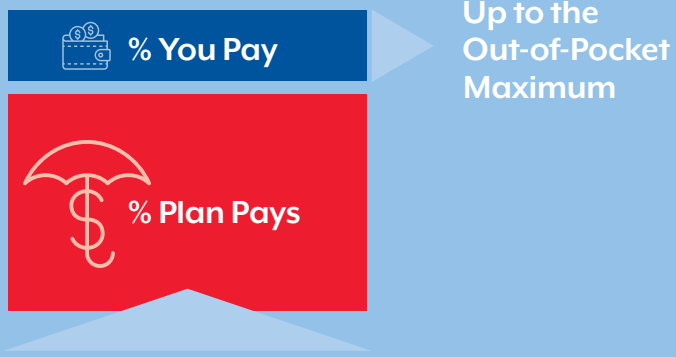
Copay

The fixed amount you pay for healthcare services at the time you receive them.



Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.



Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount. All copays, coinsurance and deductibles you pay during the calendar year contribute to the out-of-pocket maximum.



Healthcare Cost Transparency

With options like Flexible Spending Accounts, your healthcare spending is in your control. But with so many providers and varying costs for services, how do you decide where to go? Healthcare cost transparency tools are online services available through most health insurance carriers that allow consumers to compare costs for medical services, from prescriptions to major surgeries, to make choices easier. To learn more, visit www.hmsa.com or www.kaiserpermanente.org.

Rising Costs of Healthcare

The cost of healthcare in the U.S. has been steadily growing each year. Why? Some of the factors include an aging population, increased demand for care (resulting in higher prices for premiums and prescription drugs), and an increase in chronic illnesses. **AT Collective wants to help keep you healthy, so we do what we can to keep your healthcare costs reasonable.** Make sure you're informed about your options so you can make the best healthcare choices for you and your family. Placing an importance on preventive care, making healthy choices, and managing costs will help keep your health — and wallet — in control in the long run.

Generic Drugs

Looking to save money on medication costs? You've most likely heard that generic prescription drugs are a more affordable option: generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety and strength. Because they are the same medicine, generic drugs are just as effective as brand-name drugs and undergo the same rigid FDA standards. But on average, **a generic version costs 80% to 85% less than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Thoughts & Tips: The cost of an MRI can vary between $300 and $3,000 — even within your area.

How to Pick a Plan

Which plan is right for you? When deciding, consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

How does a PPO (Preferred Provider Organization) work?

You'll pay more in premiums out of your paycheck, but perhaps less at the time of service.

You're able to choose from a network of providers who offer a fixed copay for services.

If you expect to need more medical care this year or you have a chronic illness, the PPO plan may be the right choice for you to ensure your healthcare needs are covered.

How does a HMO (Health Maintenance Organization) work?

You'll pay higher premiums and the majority of services have a set copay. (Think less out-of-pocket at time of service.)

HMOs do not offer coverage for Out-of-Network Providers.

Your Primary Care Physician coordinates all of your healthcare services. In order to see a specialist you will need a referral.

If you want lower medical expenses at the cost of plan flexibility, the HMO plan may be for you.

Preventive Care

Most health plans are required to cover a set of preventive services — at no cost to you!

Screening tests and routine checkups are considered preventive, which means they're often paid at 100%. Keep up to date with your primary care physician to save time and money and keep yourself healthier in the long run. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

- Wellness visits, physicals and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity and diabetes
- Pediatric screenings for hearing, vision, obesity and developmental disorders
- Anemia screenings, breastfeeding support and pumps for pregnant and nursing women
- Preventive drugs including contraception.



Take advantage of these covered services. However, remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. This means if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

Where to Go for Care

You think you may be sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new medication, but the pharmacy is closed. Instead of immediately choosing an expensive trip to the emergency room or relying on questionable information from the internet, take a look below at various care centers and resources and the types of care they provide.

PRIMARY CARE CENTER $$

When would I use this?
You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

What type of care would they provide?*
- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

What are the costs and time considerations?**
- Requires a copay on any of the AT Collective plans.
- Normally requires an appointment.
- Usually little wait time with scheduled appointment.

VIRTUAL VISIT $

When would I use this?
You need care for minor illnesses and ailments, but would prefer not to leave home. These services are available by phone and online (via webcam).

What type of care would they provide?*
- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

What are the costs and time considerations?**
- May require a copay on any of the AT Collective plans.
- Access to care is usually immediate.
- Some states may not allow for prescriptions through telemedicine or virtual visits.
- Find more information about the virtual visit benefit on the next page.

URGENT CARE CENTER $$$

When would I use this?
You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

What type of care would they provide?*
- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

What are the costs and time considerations?**
- Requires a copay on any of the AT Collective plans.
- Walk-in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first.

DO YOUR HOMEWORK

The $ symbol for each category represents that certain places have higher costs. What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

EMERGENCY ROOM $$$

When would I use this?
You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

What type of care would they provide?*
- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

What are the costs and time considerations?**
- The PPO plan requires coinsurance, and the HMO plan requires a copay.
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first.

*This is a sample list of services and may not be all-inclusive.

**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Virtual Visits

When you're sick, the last thing you want to do is leave the comfort of your home. Or sometimes you're just too on the go to pop in for a visit. Virtual visits are a convenient and easy way to talk to a doctor fast.

AT Collective provides a virtual visit benefit through each of the medical plans to enrolled employees and dependents. Virtual visits offer on-demand access to board-certified doctors through phone or online video, and appointments typically take about 15 minutes. Virtual visits are useful for after-hours non-emergency care, when your primary care doctor is unavailable, if you need prescriptions or refills, or if you're traveling. Please note that some states do not allow physicians to prescribe medications via virtual visits.

Choose the medical plan you are enrolled in and follow the steps on the right to activate your account or schedule a virtual visit. Make sure you have your medical ID card available to register.

Examples of conditions that can be treated through virtual visits:

- Allergies
- Asthma
- Behavioral Health
- Cold/flu
- Ear Infections
- Fever
- Nausea
- Pink Eye
- Rash
- Sinus Infections

HMSA:

- Go to www.hmsaonlinecare.com to register or sign in using the information on your HMSA membership card. Choose the type of visit you are looking for and select a provider.
- Download the HMSA Online Care app from Apple's App Store or Google Play. Sign up using the information on your HMSA membership card. Choose the type of visit you are looking for and select a provider.

Kaiser Permanente:

- Go to www.kp.com/videovisit to register or sign in. Go to the Appointment Center and select the Upcoming Appointments tab. Click Join Appointment and wait for your doctor to join.
- Download the Kaiser Permanente app from Apple's App Store or Google Play. Select the Appointments tab and find your scheduled appointment. Under Appointment Details, select Join Now and wait for your doctor to join.



Flexible Spending Accounts

Flex your spending power! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses. The FSA benefit is provided through HealthEquity.

Healthcare Flexible Spending Account

You can contribute up to $3,400 annually for qualified medical expenses (deductibles, copays, coinsurance, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.



Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $7,500 ($3,750 if married and filing jointly) to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent daycare expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or daycare provider
- Before- and after-school care
- Day camp
- In-house dependent daycare

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.



Using the Account

HealthEquity will issue you an FSA debit card. Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact HealthEquity with reimbursement questions. If you need to submit a receipt, HealthEquity will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges in case you need to prove an expense was eligible. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2027 plan year.
- Funds cannot be transferred between FSAs.
- You are not permitted to claim the same expenses on both your federal income taxes and Dependent Care FSA.
- You must "use it or lose it" — any unused funds will be forfeited.
- Up to $680 may be rolled over to the next plan year at the end of 2027 for Healthcare FSAs.
- You cannot change your FSA election in the middle of the plan year without a Qualifying Life Event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (gross earnings were $160,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

Grace Period

- Our Company offers a grace period for Dependent Care FSA spending. You have 2½ months after the plan year ends on December 31, 2027, to incur additional expenses and submit them for reimbursement. Therefore, any remaining balance in the previous plan year that ended December 31, 2027, will be used to pay that grace period expense even though the service was provided in the NEW plan year.
- The grace period applies to only the Dependent Care FSA.

Thoughts & Tips: **Your FSA money can cover the cost of going to a chiropractor or acupuncturist, if your insurance doesn't already cover it.**

FSA Highlights

OWNERSHIP	Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.
ELIGIBILITY & ENROLLMENT	You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event.
TAXATION	FSA contributions are tax-free* via payroll deduction. Funds are spent tax-free when used for qualified expenses.
CONTRIBUTIONS	You can contribute up to $3,400 in 2027 to an FSA. This amount may be increased annually.
PAYMENT	Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.
ROLLOVER OR GRACE PERIOD	You must use the money in the account by the end of the plan year. The Dependent Care FSA includes a 2.5-month grace period after the end of the plan year for any expenses to be incurred and reimbursed. For the Healthcare FSA, you may roll over up to $680 of unused funds to the next plan year.
QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.
OTHER TYPES	Dependent Care FSA (pre-tax dollars can be used for elder or child dependent care) and Limited Use FSA (Offered in conjunction with an HSA and used to pay for eligible dental and vision expenses).

*FSAs are tax-exempt for federal income tax purposes only; please refer to your state taxing office for state income tax applicability. Please refer to your summary plan description or plan certificate for your plan's specific FSA benefits.

Dental Benefits

Brushing your teeth and flossing are great, but don't forget to visit the dentist too! AT Collective offers three affordable plan options for routine care and beyond. ACE offers two DPPO plans that allow for in-network and out-of-network coverage and one DHMO plan that allows for in-network only coverage.

Network Dentists

If you use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Maximum Allowable Charge (MAC) and could be balance billed. To find a Cigna network dentist, visit www.cigna.com, click Find a Doctor, Dentist or Facility. You may log in or click Plans Through Your Employer or School. Under Dental Plans, select either the Total DPPO or Access Plus DHMO depending on which dental plan you elect.

Dental Contributions

Premium contributions for dental are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your monthly contribution.

Dental Plan Summary

This chart summarizes the 2027 dental coverage provided by Cigna. Please review the dental plans below carefully to ensure you select the plan that best fits the needs of you and your family.

	CIGNA BASE (NO ORTHODONTIA)		CIGNA BUY UP (WITH ORTHODONTIA)		CIGNA DENTAL DHMO PLAN
MONTHLY CONTRIBUTIONS					
EMPLOYEE ONLY	$7.17		$15.33		$4.00
EMPLOYEE + SPOUSE	$30.12		$49.63		$14.00
EMPLOYEE + CHILD(REN)	$25.82		$41.66		$12.00
EMPLOYEE + FAMILY	$41.60		$70.73		$22.00
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK ONLY
CALENDAR YEAR DEDUCTIBLE					
INDIVIDUAL	$50	$50	$50	$50	$0
FAMILY	$150	$150	$150	$150	$0
CALENDAR YEAR MAXIMUM					
PER PERSON	$1,500		$1,500		N/A
COVERED SERVICES (YOU PAY)					
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Complete X-rays, Panoramic X-rays, Fluoride Applications, Sealants	Covered in full	10%	Covered in full	10%	Examples of copays include: Cleaning – $5 copay Sealant – Non Molars $5 copay Root Canal – Anterior $50 copay Orthodontic – Child $1,512 24-month treatment fee Orthodontic – Adult $1,992 24-month treatment fee
BASIC SERVICES Fillings, Root Canal Therapy, Surgery, Periodontal Scaling and Root Planing, Denture Adjustments, Routine Extractions, Space Maintainers	50%*	50%*	20%*	30%*	
MAJOR SERVICES Crowns, Removable Appliances, Fixed Appliances, Prosthesis Over Implant	50%*	50%*	50%*	50%*	
ORTHODONTICS Applies to all Adult and Child members	Not covered		50%		
ORTHODONTIC LIFETIME MAXIMUM	Not applicable		$2,000		

*After Deductible
The Calendar Year Deductible is not applicable for Preventive Care.

Vision Benefits

Don't wear glasses? Even you shouldn't skip an annual eye exam! AT Collective provides you and your family access to quality vision care with a comprehensive vision benefit through VSP.

Vision Contributions

Premium contributions for vision are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your monthly contribution.

Vision Plan Summary

This chart summarizes the 2027 vision coverage options provided by VSP.

	VSP BASIC PLAN	VSP PREMIER PLAN
MONTHLY CONTRIBUTIONS		
EMPLOYEE ONLY	$5.19	$9.68
EMPLOYEE + SPOUSE	$10.90	$20.33
EMPLOYEE + CHILD(REN)	$9.34	$17.40
EMPLOYEE + FAMILY	$15.04	$28.04
EXAMS		
COPAY	$10	$10
FREQUENCY	1 every 12 months	1 every 12 months
LENSES		
SINGLE VISION	$15 copay	$10 copay
BIFOCAL	$15 copay	$10 copay
TRIFOCAL	$15 copay	$10 copay
LENTICULAR	$15 copay	$10 copay
FREQUENCY	1 every 12 months	1 every 12 months
CONTACTS (IN LIEU OF LENSES AND FRAMES)		
FITTING AND EVALUATION*	15% discount; $60 copay max	15% discount; $60 copay max
ELECTIVE	$130 allowance for materials only	$175 allowance for materials only
MEDICALLY NECESSARY	Covered in full after copay	Covered in full after copay
FRAMES		
ALLOWANCE	$130; 20% off amount over allowance	$175; 20% off amount over allowance
FREQUENCY	1 every 24 months	1 every 12 months

*Fitting and Evaluation fee applied to contact lens allowance.

Thoughts & Tips: More than 150 million Americans use corrective eyewear to compensate for refractive errors.

Survivor Benefits

It's difficult to think about what would happen if something ever happened to you, but it's important to have a plan in place to make sure your family is provided for. Survivor benefits provide financial protection and security in the event of an absence or unexpected event. Securing life insurance now ensures your family will be protected for the future.

Basic Life Insurance

AT Collective provides employees with Basic Life insurance as part of your basic coverage through Voya, which guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an employee's benefits after death.

Your Basic Life insurance benefit is 1x your Base Salary, rounded to the next $1,000. Employees may elect a flat amount of $50,000 to avoid being taxed on the higher amount. Benefits are reduced to 75% for ages 65-69; 65% for ages 70-74; and 50% for ages 75 and above.

Voluntary Life and AD&D Insurance

Employees may purchase Voluntary Life and AD&D insurance for themselves and their families. Benefits are reduced to 75% for ages 65-69; 65% for ages 70-74; and 50% for ages 75 and above. The chart on the next page outlines your options. **During each annual enrollment, you will be able to increase your current election one benefit level, up to 3x your Base Salary, without being subject to Evidence of Insurability (EOI). EOI will apply to any election of more than 3x Base Salary or if over the $700,000 Guaranteed Issue amount.**





What's a beneficiary?

Your beneficiary is the person you designate to receive your life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by AT Collective.

Name a primary and contingent beneficiary to make your intentions clear. Make sure to indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. If you need assistance, contact the Benefits Service Center or your own legal counsel.

Voluntary Life and AD&D Insurance

Life and Accidental Death & Dismemberment (AD&D) benefits are an important part of your family's financial security. The basic benefits provided to you by AT Collective may not be enough to cover expenses in a time of need. Therefore, extra coverage is available to protect you and your family. Eligible employees may purchase Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions on an after-tax basis.

BASIC EMPLOYEE LIFE	
COVERAGE AMOUNT	1x Base Salary, rounded to next $1,000. Employees may elect a flat $50,000 to avoid being taxed on the higher amount
WHO PAYS	AT Collective
BENEFITS PAYABLE	Upon Employee's death
MAXIMUM BENEFIT	$500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No, upon initial enrollment
VOLUNTARY EMPLOYEE LIFE & AD&D	
COVERAGE AMOUNT	1-4x Base Salary, rounded to next $1,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon Employee's death
MAXIMUM BENEFIT	$1,000,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	New Hire: Any election of more than 3x Base Salary or if over the $700,000 Guaranteed Issue amount Existing Enrollees: You may increase one benefit level during Annual Enrollment; any additional amount is subject to EOI. EOI will apply to any elections of more than 3x Base Salary or if over the $700,000 Guaranteed Issue amount.
VOLUNTARY SPOUSE LIFE & AD&D	
COVERAGE AMOUNT	$50,000 or 0.5-3x Covered Employee's Base Salary, rounded to next $1,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon Spouse's death
MAXIMUM BENEFIT	$350,000, may not exceed 100% of Employee's Basic and Voluntary Life insurance
EVIDENCE OF INSURABILITY (EOI) REQUIRED	New Hire: $50,000 Existing Enrollees: You may increase $50,000 or one benefit level during Annual Enrollment; any additional amount is subject to EOI
VOLUNTARY CHILD LIFE & AD&D	
COVERAGE AMOUNT	Option 1: $5,000; Option 2: $10,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon Child's death
MAXIMUM BENEFIT	$10,000

The amount of Life Insurance applicable to the Covered Person's class of benefits will reduce once the employee attains age 65 or older as follows:

- Ages 65-69: to 75%
- Ages 70-74: to 65%
- Ages 75 and up: to 50%

Survivor Benefits

VOLUNTARY LIFE INSURANCE					
RATES/$1,000 (MONTHLY)					
AGE*	EMPLOYEE	AGE*	SPOUSE	AGE*	OPTIONAL EMPLOYEE/ SPOUSE LIFE SMOKER RATES
<25	$0.05	<25	$0.05	<25	$0.08
25-29	$0.06	25-29	$0.06	25-29	$0.08
30-34	$0.08	30-34	$0.08	30-34	$0.09
35-39	$0.09	35-39	$0.09	35-39	$0.11
40-44	$0.10	40-44	$0.10	40-44	$0.17
45-49	$0.15	45-49	$0.15	45-49	$0.28
50-54	$0.24	50-54	$0.24	50-54	$0.47
55-59	$0.43	55-59	$0.43	55-59	$0.74
60-64	$0.69	60-64	$0.69	60-64	$1.16
65-69	$1.27	65-69	$1.27	65-69	$2.09
70-79	$2.06	70-74	$2.06	70-74	$3.75

VOLUNTARY CHILD LIFE INSURANCE
MONTHLY PREMIUM RATES PER $1,000 COVERAGE
$0.080

VOLUNTARY EMPLOYEE, SPOUSE OR CHILD AD&D INSURANCE
MONTHLY PREMIUM RATES PER $1,000 COVERAGE
$0.016

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE OR AD&D COVERAGE WILL COST:				
$	÷ 1,000	$	x Applicable Rate =	$
Benefit Elected				Monthly Premium

*Rates change the first of the month following the date the next age band is reached. Notification of changes will not be sent out during the year when your rate increases and/or decreases based on changes made due to salary changes or age band.

Income Protection

Maintaining your quality of life counts on your income. AT Collective offers you the option to elect disability coverage through Reliance Matrix to protect you financially in the event you cannot work as a result of a qualifying disability. A portion of your income is protected until you can return to work or until you reach retirement age.

Long-Term Disability Insurance

AT Collective offers you the option to purchase Long-Term Disability (LTD) on a voluntary basis. This benefit replaces 50% of the first $18,000 of your pre-disability income if you become partially or totally disabled for an extended time. During annual enrollment, you will be able to elect the Voluntary LTD coverage without Evidence of Insurability. Certain exclusions, including pre-existing condition limitations, may apply. See your plan documents or contact the Benefits Service Center for details.

MONTHLY MAXIMUM BENEFIT	$9,000
ELIMINATION PERIOD	26 weeks
MAXIMUM BENEFIT PERIOD	Payments will last until the later of your Social Security Normal Retirement Age or the period shown in the chart.

VOLUNTARY DISABILITY INSURANCE	
RATES/$1,000 (MONTHLY)	
AGE*	EMPLOYEE
<25	$0.042
25-29	$0.053
30-34	$0.084
35-39	$0.127
40-44	$0.200
45-49	$0.295
50-54	$0.380
55-59	$0.443
60-64	$0.475
65+	$0.548

AGE ON DATE OF YOUR DISABILITY	BENEFIT PERIOD
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

TO CALCULATE HOW MUCH YOUR LTD COVERAGE WILL COST:

$	÷ 12	$	x Rate	$	÷ $100 =	$	
Annual Salary		Monthly Covered Payroll		Amount		Monthly Premium	

Employee Resources

We care about you and want you to succeed in all aspects of life, so we offer a variety of additional benefits to help make your day-to-day easier.

Inflection

Inflection is a resource that guides you and your household through life's most challenging moments – when clarity, action, and the right support can transform your life. Inflection's digital education platform delivers expert-led, on-demand guidance from the world's leading voices across topics like elder- and end-of-life care, divorce, menopause, fertility, and workplace sensitivity. At the heart of Inflection's offering is unparalleled guidance from more than 250 of the world's leading experts.

Across the suite of Inflection Points – ElderCareIQ, EndofLifeIQ, DivorceIQ, MenopauseIQ, and FertilityIQ, they deliver more than 300 hours of deeply researched, expert-led courses designed to meet people at the moments that matter most.

Adjacent to the courses, they also offer Personal Navigation from Inflection experts, to get people to the right information faster.

Employee Assistance Program

We know life is complicated, and sometimes we all just need a little help. Our Employee Assistance Program (EAP), coordinated through ComPsych Guidance Resources, helps manage your and your family's total health, including mental, emotional and physical. This benefit is offered at no cost to you.

Through this program, you and the members of your household have access to mental health assistance and legal and financial help from a number of professionals. You have 24-hour access to helpful resources by phone, and the EAP benefit includes six face-to-face visits per issue with a licensed professional. The program provides referrals to help with:

- Emotional Health and Well-Being
- Alcohol or Drug Dependency
- Marriage or Family Relationship Problems
- Job Pressures
- Stress, Anxiety, Depression
- Grief and Loss
- Financial or Legal Advice

All services provided are confidential and will not be shared with ACE. You may access information, benefits, educational materials and more either by phone at 855-741-2582 or online at www.guidanceresources.com; Organization Web ID: ACEEAP.



Glossary

Annual Enrollment – The period set by the employer during which employees and dependents may enroll for coverage, make changes or decline coverage.

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount, as determined by your insurance plan, you pay for healthcare services received.

Deductible – The amount you owe for healthcare services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," meaning that funds not used by the end of the Plan Year will be lost. Some FSAs do allow for a grace period or a rollover into the next Plan Year.

- **Dependent Care FSA** – A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.



Network – A group of physicians, hospitals and other healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network** – Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network** – Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.
- **Non-Participating** – Providers that have declined entering into a contract with your insurance provider. They may not accept any insurance and you could pay for all costs out of pocket.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

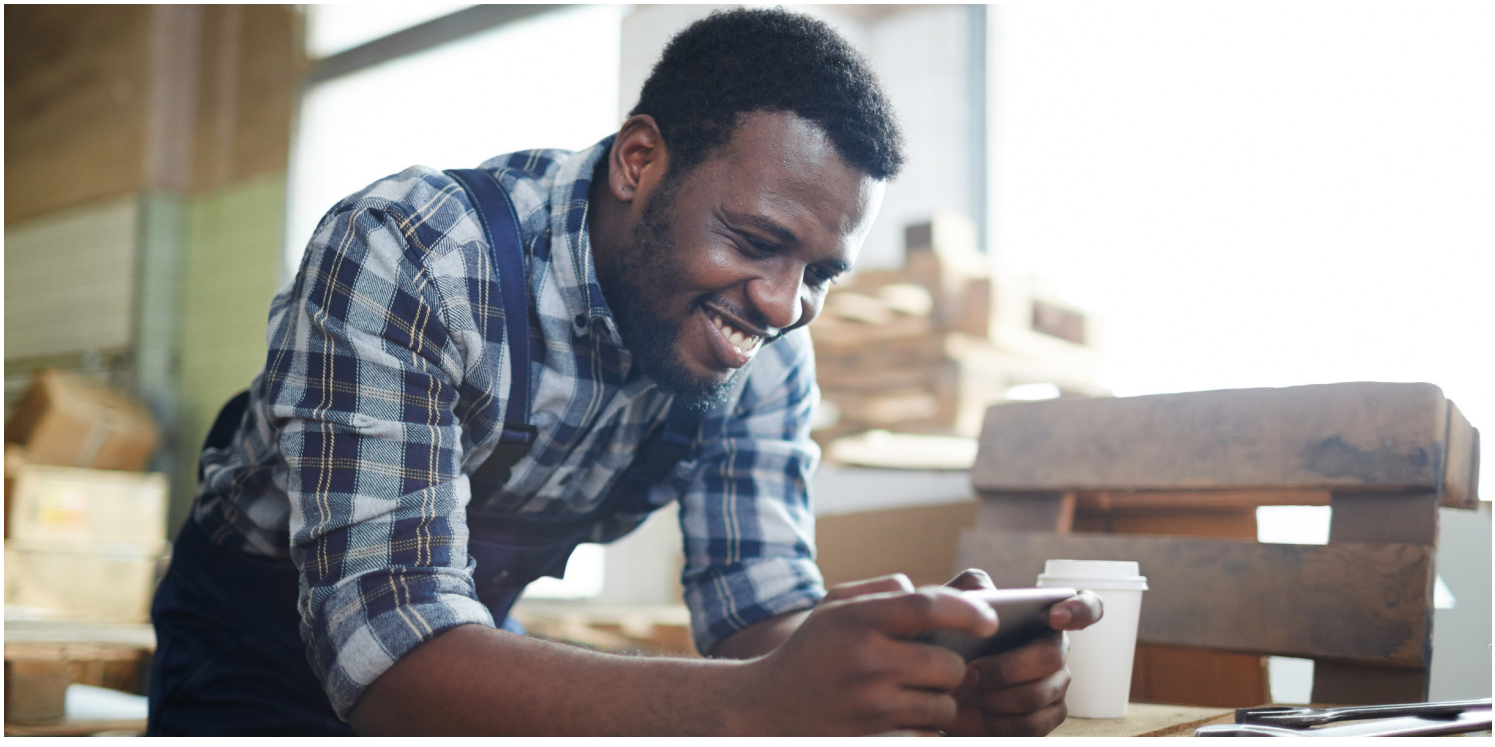
Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty.

- **Generic Drugs** – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs** – Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs** – Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs** – Prescription medications used to treat complex, chronic and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.

Reasonable and Customary Allowance (R&C) – Also known as the UCR (Usual, Customary, and Reasonable) amount. The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.



Required Notices

Important Notice From Automobile Club of Southern California About Your Prescription Drug Coverage and Medicare Under the Hawaii HMSA and Kaiser Permanente Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Automobile Club of Southern California and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Automobile Club of Southern California has determined that the prescription drug coverage offered by the Hawaii HMSA and Kaiser Permanente plan(s) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Automobile Club of Southern California coverage may 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 herein.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Automobile Club of Southern California and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

Contact the person listed at the end of these notices for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Automobile Club of Southern California changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2027
Name of Entity/Sender:	Automobile Club of Southern California
Contact—Position/Office:	Employee Benefits Department
Address:	3333 Fairview Road Costa Mesa, CA 92626
Phone Number:	714-850-8284

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Employee Benefits Department at 714-850-8284.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Employee Benefits Department at 714-850-8284.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to 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 towards 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 employee, 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 31 days after your or your dependent's(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 the 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 towards 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 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Employee Benefits Department at 714-850-8284.

Important Contacts

BENEFITS SERVICE CENTER
888-488-2582
www.myclubbenefits.com

MEDICAL & PHARMACY
HMSA
800-776-4672
www.hmsa.com

Kaiser Permanente
800-278-3296
www.kp.org

DENTAL
Cigna
800-997-1654
www.cigna.com

VISION
VSP
800-877-7195
www.vsp.com

FLEXIBLE SPENDING ACCOUNTS
HealthEquity
877-924-3967
www.healthequity.com

LIFE AND AD&D
Voya
800-955-7736
https://presents.voya.com/ACE

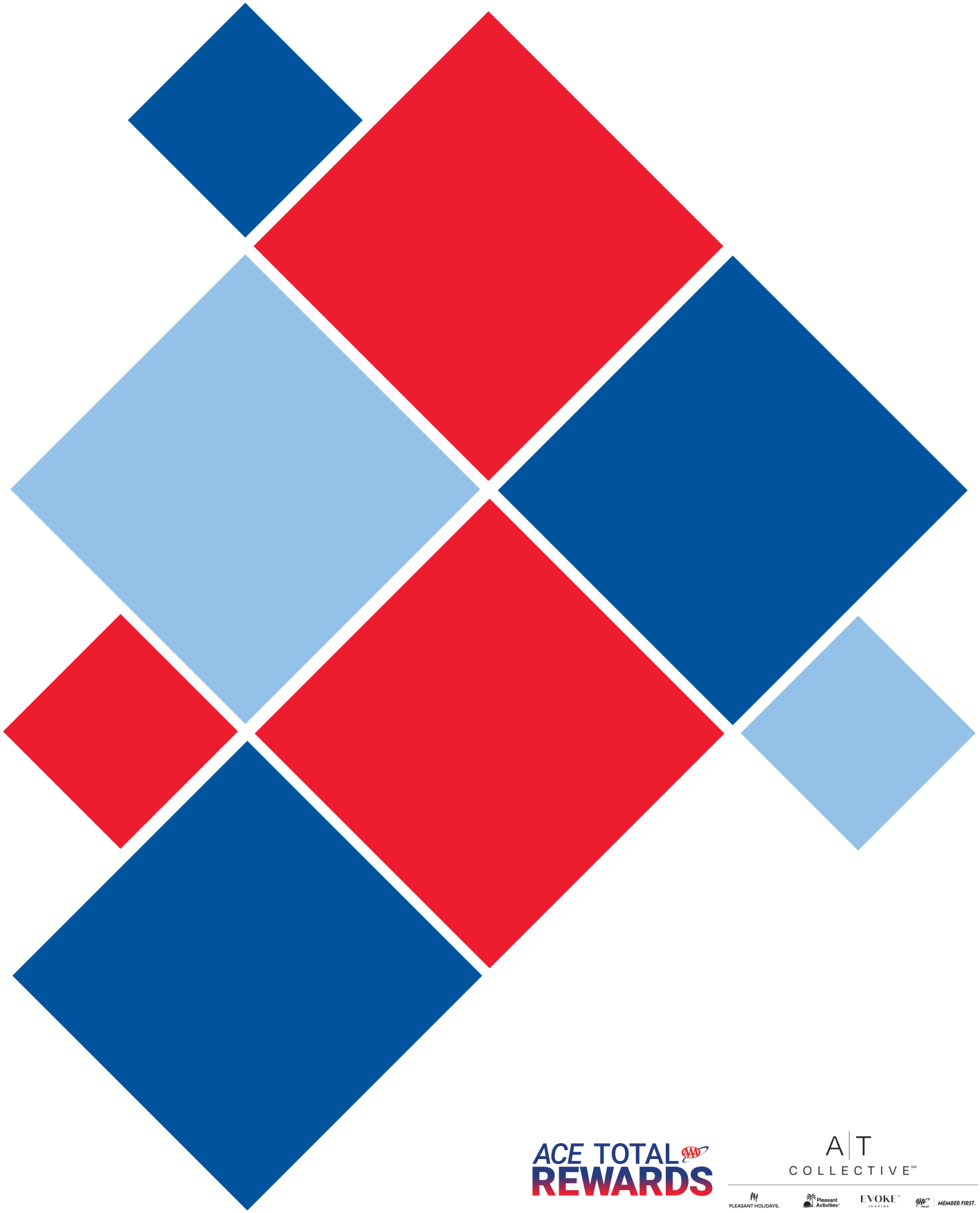
LONG-TERM DISABILITY
Reliance Standard Life Insurance
800-351-7500
www.rsli.com

EMPLOYEE ASSISTANCE PROGRAM
ComPsych Guidance Resources
855-741-2582
www.guidanceresources.com
Login ID: ACEEAP

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ACE TOTAL REWARDS

A|T COLLECTIVE℠

PLEASANT HOLIDAYS. Pleasant Activities® EVOKE™ INSPIRE AAA Travel MEMBER FIRST.