PharmaLogic

2026 New Hire Benefits Guide

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PharmaLogic appreciates your commitment to our success. We're equally committed to providing you with competitive, affordable health and wellness benefits to help you take care of yourself and your family.

Please read this guide carefully. It has a summary of your plan options and helpful tips for getting the most value from your benefit plans.

If you have any questions about your benefits, reach out to your PharmaLogic human resources department. If you'd like to review your plans in more detail, view your summary plan descriptions (SPD) on ADP. To find your SPDs in ADP, click Resources and then go to Forms Library.

ELIGIBILITY

Eligible Employees

You may enroll in the benefits program if you are a regular full-time employee who is actively working a minimum of 30 hours per week. As a benefits-eligible employee, you have the opportunity to enroll in benefit plans during the new hire enrollment period.

Dependent Eligibility

As you become eligible for benefits, so do your eligible dependents. In general, eligible dependents include:

- Your legal spouse or domestic partner.
- Your children up to the age of 26.
  - including biological, adopted, step, foster children, or court-appointed guardianship.
  - disabled children may be covered beyond age 26 with proof of disability and approval.

QUALIFYING LIFE EVENTS

If you have a qualifying life event, it is your responsibility to notify HR within 30 days of the qualifying life event. For newborn or adopted children, coverage will be effective on their date of birth or adoption. For other qualifying life events, coverage will be effective the first of the month following the event.

Here are some examples of qualifying life events:

- Birth, foster, legal adoption or placement for adoption
- Marriage, divorce or legal separation
- Dependent child reaches age 26
- Spouse or dependent loses or gains coverage elsewhere

MEDICAL

Cigna | cigna.com | 888.806.5042

PharmaLogic is committed to helping you and your dependents maintain health and wellness by providing you with access to the highest levels of care. We offer you a choice of three Cigna medical plan options:

- Employer Funded HRA Plan
- HSA Plan
- OAP Plan

Please call Cigna's pre-enrollment line if you have any questions about the plans or network prior to enrolling at **888.806.5042**.

Find an In-Network Provider:

- Go to Cigna.com and click on "Find a Doctor".

ID Cards: Always have your ID card with Cigna's digital ID card. Members can access their digital ID card by following the steps below.

1. Log in or register to myCigna.com or the myCigna app
2. Click or tap "ID Cards"
3. View your card(s) as well as any dependents' cards

PharmaLogic will help you with your medical costs through employer contributions.

- Employer Funded HRA means PharmaLogic will pay the first $3,500 for an individual and $7,000 for a family plan before you start paying your deductible or any coinsurance.
- HSA seed money from PharmaLogic includes $1,500 for an individual and $3,000 for a family.
- You decide when to use your HSA money - either now when you have out of pocket healthcare costs or later when you have future healthcare costs. Balances greater than $2,000 can be invested too.

MEDICAL AND PRESCRIPTION DRUG PLAN SUMMARIES

Medical	Employer Funded HRA		HSA Plan		OAP Plan	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Employer HSA/HRA Contri.	$3,500 / $7,000		$1,500 / $3,000		N/A	
Deductible Employee only / Family	Collective $7,000 / $14,000	Collective $14,000 / $28,000	Non-collective $3,000 /$6,000	Non-collective $6,000 / $12,000	Collective $1,000 / $2,000	Collective $2,000 / $4,000
Coinsurance	70%	50%	80%	50%	80%	50%
Out-of-pocket maximum (includes deductible) Employee only / Family	$8,500 / $17,000	$17,000 / $34,000	$6,000 / $12,000	$12,000 / $24,000	$5,000 / $10,000	$10,000 / $20,000
Preventive care	100%	50%	100%	50%	100%	50%
Office visit PCP Outpatient specialist Telemedicine	Ded, then coins.	50% 50% N/A	Ded, then coins.	50% 50% N/A	$30 copay, no ded $60 copay, no ded	50% 50% N/A
Emergency room	Ded, then coins.		Ded, then coins.		$500 copay, no ded.	
Urgent care	Ded, then coins.	50%	Ded, then coins.	50%	$75 copay, no ded	50%
Ambulance Transport	Ded, then coins.	70%	Ded, then coins.	80%	80%	
Inpatient Facility	Ded, then coins.	50%	Ded, then coins.	50%	$500 copay after ded.	50%
Inpatient Professional Serv.	Ded, then coins.	50%	Ded, then coins.	50%	80% after ded	50%
Outpatient all other serv.	Ded, then coins.	50%	Ded, then coins.	50%	80% after ded	50%
Diagnostic Lab / X-Rays	Ded, then coins.	50%	Ded, then coins.	50%	80%	50%
Advance Radiology Imag.	Ded, then coins.	50%	Ded, then coins.	50%	$300 copay per type per day + 80%	50%
Retail prescription drug (30-day supply)						
Tier 1 — generics	Ded, then coinsurance		Ded, then coinsurance		$10 copay, no ded	
Tier 2 — preferred	Ded, then coinsurance		Ded, then coinsurance		$50 copay, no ded	
Tier 3 — nonpreferred	Ded, then coinsurance		Ded, then coinsurance		$75 copay, no ded	
Mail order prescription drug (90-day supply)						
Tier 1 — generics	Ded, then coinsurance		Ded, then coinsurance		$20 copay, no ded	
Tier 2 — preferred	Ded, then coinsurance		Ded, then coinsurance		$100 copay, no ded	
Tier 3 — nonpreferred	Ded, then coinsurance		Ded, then coinsurance		$150 copay, no ded	

Prescription drugs — 100% coverage for preventive generics before the deductible applies. Preventive brand and nonpreferred brand (second- and third-tier) drugs are covered at the plan's coinsurance maximum amounts as outlined in the chart. A deductible does not apply. PharmaLogic utilizes the Cigna National Preferred 4-Tier Prescription Drug List. Visit cigna.com/individuals-families/member-guide/prescription-drug-lists to view covered prescription medications.

Accredo

If you use specialty medications, they must be filled through Accredo, Cigna's specialty pharmacy, to receive coverage. Accredo ships your medication directly to you and provides support from specialty-trained pharmacists and nurses. Cigna will notify you if this requirement applies to you. For the smoothest refill experience, contact Accredo two weeks before your next refill so they can coordinate a new prescription with your doctor. Accredo: 877.826.7657. Learn more at Accredo.

WHERE TO GO FOR CARE

You're feeling 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 prescription, but the pharmacy is closed. Instead of rushing to the emergency room or relying on questionable information from the internet, it's helpful to remember that you have a range of site-of-care options to consider.

Telemedicine

WHEN TO USE
- Minor illnesses and ailments

TYPES OF CARE*
- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

COSTS AND TIME CONSIDERATIONS**
- Copay and/or coinsurance
- Usually immediate access to care

Primary Care Center

WHEN TO USE
- Basic and routine care

TYPES OF CARE*
- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

COSTS AND TIME CONSIDERATIONS**
- Copay and/or coinsurance
- Shorter wait time with appointment

Urgent Care Center

WHEN TO USE
- Non-life threating medical issues that require immediate care

TYPES OF CARE*
- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

COSTS AND TIME CONSIDERATIONS**
- Copay and/or coinsurance
- Walk-in patients welcome, but waiting periods may be longer
- Costs more than office visits

Emergency Room

WHEN TO USE
- Serious, life threatening emergencies

TYPES OF CARE*
- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

COSTS AND TIME CONSIDERATIONS**
- Much higher copay and overall costs
- Open 24/7, but waiting periods may be longer
- Ambulance charges, if applicable, will be separate and may not be in-network

**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.*

MDLIVE TELEMEDICINE

Live video calls (on a phone, tablet or computer) with a doctor or therapist who is available at any time, day or night. It's free to enroll in and available through Cigna.

See a doctor or therapist through 24/7 retail virtual care. MDLive partners with Cigna to bring you quality care from the comfort and convenience of home. Doctors and therapists can diagnose and treat common issues. You can contact MDLive if you have cold & flus, allergies, bronchitis, urinary tract infections, sinus infections, and more.

OMADA COMPLETE

Omada Complete is a dynamic type 2 diabetes and hypertension prevention and support program. All participants receive a curated experience, which could include specialized coaching, tailored curriculum, feedback based on personal health data, and a condition-specific peer group. Visit Omada to apply for the program.

MENTAL HEALTH

Spring Health | springhealth.com | 855.629.0554

Life is easier with the right support

PharmaLogic partners with Spring Health to give you fast, personalized **free** mental health support—no need to wait for a crisis. Spring Health offers:

- **No Cost;** you can get these services at no cost to you or your family!
- **Six free therapy sessions** with a provider of your choice
- **Six free coaching sessions** to help you build habits, reach goals, and stay well
- **Care Navigators** who guide you to the right support and providers
- **Diverse therapists** you can filter by specialty, gender, ethnicity, or language
- **Wellness exercises** to manage stress, sleep better, and improve mindfulness
- **Personalized resources** for legal, financial, child/elder care, pet care, and more

Support for Teens and Children

Your dependent children also have access to Spring Health's resources

- Create an account for each child (ages 0-17) under your profile
- Get help from a Family Care Navigator
- Schedule Therapy for children ages 6+
- Explore on-demand child-friendly videos and tools
- Receive referrals to in-network pediatric providers
- Spring Health makes it easy for your whole family to get the care they need

LEARN MORE AND GET STARTED:

Six free therapy and and coaching sessions are available to PharmaLogic employees. Once those visits are exhausted, members can continue with their therapy/coaching at standard in-network rates.

DIGITAL PHYSICAL THERAPY

Sword Health | swordhealth.com | 888.492.1860

Sword is a digital physical therapy program to help members prevent and treat acute, chronic and post-surgical pain for the lower back, shoulder, neck, hip, knee, elbow, ankle, and wrist. Through guided exercises, one-on-one support, and convenient at-home access, Sword empowers members to manage pain and improve their mobility on their own schedule.

HOW IT WORKS

Your dedicated physical therapist designs an exercise program just for you.

Sword will ship you a tablet and motion sensors to guide you and provide realtime feedback.

Complete your exercise sessions at home when it is convenient for you.

Your physical therapist is there to support you virtually and is available at any time.

Benefit eligible employees, spouses, and dependents can take advantage of three programs; Thrive, Move, and Bloom. Benefits eligible employees are those full-time employees working more than 30 hours per week. Dependents must be age 13+ for Thrive and Move and 18+ for Bloom to participate.

THRIVE

Digital physical therapy — overcome your pain at home.

Areas Covered:

- Lower Back
- Shoulder
- Neck
- Hip
- Elbow
- Knee
- Ankle
- Wrist

MOVE

Move matches you with a Certified Physical Health Specialist that designs and delivers targeted movement plans tailored to your lifestyle.

BLOOM

Bloom is a digital pelvic therapy solution designed to improve pelvic health from the comfort and privacy of home. It covers all life stages including pregnancy, postpartum, and menopause.

VOLUNTARY SUPPLEMENTAL HEALTH

Cigna | cigna.com | 800.754.3207

You have access to three supplemental health plans through Cigna. All these plans are voluntary, meaning the employee pays the full cost of the premium. These plans pay a lump sum cash benefit to you, based on the coverage you elect.

Critical Illness

Critical illness insurance offers you support in the instance you or a covered dependent become seriously ill with a covered condition.

Critical Illness	
Employee	Options of $5,000 to $30,000, in increments of $5,000
Spouse	Options of $5,000 to $30,000, in increments of $5,000
Child(ren)	100% of issued employee benefit amount

Accident

The Accident plan gives you additional financial resources to help with medical costs or ongoing living expenses. There is no limit on the number of claims a covered person can file. The below chart highlights some of the benefits of the accident plan.

Accident	
Emergency Care Treatment	$200
Physician Office Visit	$125
Diagnostic Exam	$150
Ground or Water Ambulance/Air Ambulance	$400/$1,500

Hospital Indemnity

Hospital Indemnity is insurance that pays a set amount per day if you are confined to a hospital.

Hospital Indemnity		
	Base Plan	High Plan
Initial Hospital Admission	$1,000	$2,000
Daily Benefit for hospital confinement for up to 30 days	$100 per day	$100 per day
ICU confinement for up to 30 days Day 1 (Additional ICU Admission + Per Day) Day 2-30 (Per Day)	$1,200 one time $200 per day	$2,200 one time $200 per day

LEGAL AND IDENTITY THEFT

MetLife | metlife.com | 800.438.6388

The legal plan, offered through MetLife, allows you access to attorneys and identity theft services for a small premium. The legal plan includes services such as assistance with legal documentation review, will preparation, motor vehicle services, IRS audit services and trial defense. The identity theft plan provides credit report services, credit score analysis, continuous credit score monitoring and identity restoration services.

DENTAL

Delta Dental | deltadentalins.com | 800.521.2651

PharmaLogic partners with Delta Dental for dental coverage. Through Delta, you will have access to a strong, experienced, national dental insurance provider.

	Core Plan	Buy-up Plan
Deductible (individual/family)	$50/$150	$25/$75
Annual Maximum (per person)	$1,200 calendar year max	$2,000 calendar year max
Preventive Services	100% no deductible	100% no deductible
Basic Services	80%	90%
Major Services	50%	60%
Orthodontia (dep. children up to age 26)	Not covered	50% no deductible, $2,000 lifetime max

VISION

VSP | vsp.com | 800.877.7195

PharmaLogic partners with VSP to provide vision benefits. VSP offers a strong network of eyecare providers, discounts on national brands, and support for your overall eye health. PharmaLogic offers coverage for an annual retinal screening at a $0 copay for all members.

	In-Network Benefit
Eye exam with dilation as necessary (once per calendar year)	$10 copay
Retinal screening during eye exam	$0
Frames (once per 24 months)	$130 allowance ($180 allowance for featured frame brands)
Standard plastic lenses (once per calendar year)	
Single, Bifocal, Trifocal, Lenticular	$25 copay
Contact lenses (once per calendar year)	
Elective contact lenses in lieu of glasses	$130 allowance

ID Cards

- Delta Dental - you will receive a printed ID card in the mail.
- VSP - no ID cards needed. Let your provider know you have VSP and they will verify eligibility.

Finding an In-Network Provider

Choose a network dentist to maximize your savings. Find a network provider by following the instructions below.

Delta Dental:

- Visit deltadentalins.com
- Navigate to "Find a Dentist" and select Delta Dental Premier network.

VSP:

- Visit vsp.com
- Navigate to "Find a Doctor"

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Our HRA is an account funded by PharmaLogic that works in tandem with the HRA medical plan. Your HRA is administered by Cigna and will be automatically applied by Cigna to your eligible medical expenses.

HRA employer contribution

PharmaLogic will contribute the following amounts to your HRA. You will have access to the full contributions once your benefits are effective and you have completed enrollment.

PharmaLogic HRA Contribution	
Individual Coverage	$3,500
Family Coverage	$7,000

HRA FAQs

Contribution Proration

Employer contributions to the HRA are prorated based on your benefits effective date. The employer contribution decreases by:

- $350 per month Employee Only
- $700 per month Family

For example:

- *July 1 effective date = $2,100 Employee Only / $4,200 Family*
- *December 1 effective date = $350 Employee Only / $700 Family*

Discover how you're reimbursed.

This is 1st dollar coverage; Cigna will automatically process eligible expenses against the employer contribution.

HRA enrollees are able to participate in the FSA amount.

You may enroll in an FSA and make tax-free contributions to pay for eligible expenses that are NOT covered by your employer-sponsored HRA.

Identify what happens to your HRA if you leave the company.

The HRA remains with the company. It does not go with you and is not portable.

Track your HRA Balance. Go to my.cigna.com.

STEP 1
PharmaLogic provides up to 50% of the deductible immediately for employee use.

STEP 2
Employee goes to healthcare provider or pharmacy.

STEP 3
Healthcare provider submits services to CIGNA.

STEP 4
CIGNA pays claim utilizing the HRA funds first.

Typical HRA eligible expenses

Eligible expenses for reimbursement are those you pay out-of-pocket for healthcare that is provided to you, your spouse, or your eligible dependents.

- Medical expenses: coinsurance and deductibles
- Professional services: physical therapy, chiropractic and acupuncture services
- Prescription drugs and insulin

HRA deductible expenses are paid only to applicable medical/Rx providers.

HEALTH SAVINGS ACCOUNT (HSA)

WEX | wexinc.com | 866.451.3399

2026 HSA Contributions	
Single/Family Contribution Limits	$2,100/$4,200
Catch-up Contribution Limit (ages 55+)	$3,000/$5,100
PharmaLogic Contributes	$1,500/$3,000

An HSA is a personal healthcare bank account you can use to pay out-of-pocket medical expenses with pre-tax dollars. You own your HSA. You determine how much you contribute to your account, up to the annual maximum limits when to use your money to pay for qualified medical expenses, and when to reimburse yourself. Remember, this is a bank account; you must have money in the account before you can spend it. The maximum amount you can contribute to your HSA through payroll is prorated based on your benefits effective date through December 31. In addition, PharmaLogic will be contributing funds to eligible employees' HSAs, and that employer contribution counts toward the annual IRS HSA limit.

HSA Highlights

Tax savings:

- Contributions are tax-free
- Investments grow tax-free
- Qualified withdrawals are tax-free

Reduced out-of-pocket costs:

- You can use the money in your HSA to pay for eligible medical, dental and vision expenses and prescriptions. The HSA funds you use can help you meet your plan's annual deductible by applying funds towards eligible expenses.

Contribution Proration

Employer contributions to the HSA are prorated based on your benefits effective date. The employer contribution decreases by:

- $150 per month Employee Only
- $300 per month Family

For example:

- *July 1 effective date = $900 Employee Only / $1,600 Family*
- *December 1 effective date = $150 Employee Only / $300 Family*

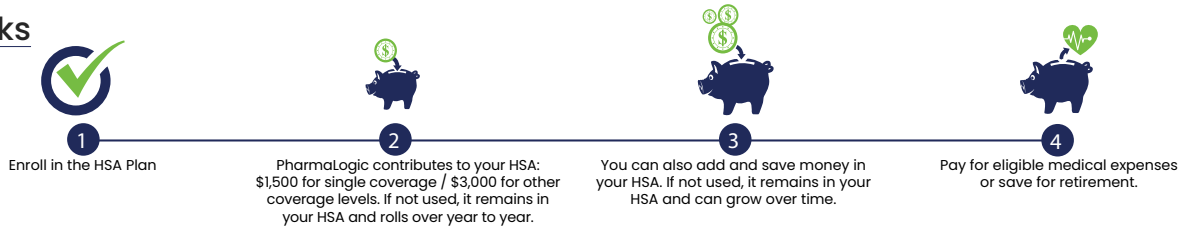
Beyond PharmaLogic:

- Your HSA funds are always yours
- Money rolls over each year
- You can invest your HSA to grow even more, but you must have $2,000 minimum in your account before you can begin to invest your funds.
- Funds are available for future healthcare costs, even in retirement

Important HSA Eligibility

- You, your spouse, and dependent children. Even if they're not covered by your health plan. Dependents are eligible as long as they are a tax dependent.
- Once enrolled in any part of Medicare, you can no longer contribute to an HSA, but you may still use existing funds. Contact HR for details.

How an HSA works



FLEXIBLE SPENDING ACCOUNT (FSA)

WEX | wexinc.com | 866.451.3399

PharmaLogic offers three flexible spending account (FSA) options—the healthcare, limited-purpose, and dependent care —which allow you to pay for eligible expenses with pre-tax dollars. The FSAs are administered by WEX. Log into your account at wexinc.com to view your account balance(s), calculate tax savings, view eligible expenses, download forms, view transaction history, and more.

ELIGIBILITY

If you enroll in the Employer Funded HRA Plan or OAP Plan, you are eligible for the Healthcare FSA and DCFSA. If you enroll in the HSA Plan, you are eligible for the LPFSA and DCFSA.

	Annual contribution limits	Carryover benefit
Healthcare flexible spending account	$2,800 per household	$680
Limited-purpose flexible spending account	$2,800 per household	$680
Dependent care flexible spending account	$6,250 filed jointly, $3,125 filed individually	N/A

Contributions will be prorated based on your benefits effective date through December 31.

Healthcare FSA

The healthcare FSA allows you to pay for eligible out of-pocket expenses, such as deductibles, copays, and other health-related expenses, that are not paid by the medical, dental, or vision plans. Any unused funds exceeding the carryover amount at the end of the year will be forfeited.

Limited-Purpose FSA (LPFSA)

If you are enrolled in the HSA medical plan you are eligible to enroll in the LPFSA. IRS rules state that you cannot have both an HSA and healthcare FSA since both apply funds toward your medical expenses. A LPFSA is much like a healthcare FSA but the LPFSA is set up to reimburse only eligible dental and vision expenses. Any unused funds exceeding the carryover amount at the end of the year will be forfeited.

For a list of IRS allowable expenses, visit irs.gov.

Carryover Benefit

The maximum contribution in 2026 for the healthcare and limited-purpose flexible spending accounts is $2,800 per household. Our plan has a carryover feature that allows up to $680 of your unused funds to be carried forward to the following plan year. These carryover dollars can be used for expenses incurred at any point within the new plan year. Any unused amount over $680 will be lost.

Dependent Care FSA (DCFSA)

DCFSAs allow you to set aside money pre-tax to pay eligible out-of-pocket day care expenses so that you or your spouse can work or attend school full-time. You must contribute money through payroll deduction to your DCFSA before you can spend it.

COMPARING TAX SAVER ACCOUNTS

	Healthcare FSA	Limited-Purpose FSA	Dependent Care FSA	HSA	Employer Funded HRA
	WEX				Cigna
Eligibility	Only available with the OAP and Employer Funded HRA plans	Only available with the HSA plan	Available with all plans for eligible dependent care expenses	Only available with the HSA plan	Only available with the HRA plan
Funding	Employee-funded	Employee-funded	Employee-funded	Employee- and employer-funded	Employee- and employer-funded
Funds rollover	Limited to $680	Limited to $680	✗	✓	✗
Portability	✗	✗	✗	✓	✗
Contribution changes	Enrollment or a Life Event	Enrollment or a Life Event	Enrollment or a Life Event	Anytime	✗
Investment options	✗	✗	✗	✓ $2,000 minimum	✗
Out-of-pocket use	Medical, dental, vision expenses	Dental, vision expenses	Childcare, preschool, day camps, elder care	Medical, dental, vision expenses, Medicare/COBRA premiums	Medical expenses
Tax treatment	Pre-tax contributions	Pre-tax contributions	Pre-tax contributions	Triple tax advantaged for federal and some states	N/A

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Unum | portal.unum.com | 866.868.6737

PharmaLogic's comprehensive benefits package includes financial protection for you and your family in the event of an accident or death. Basic life and AD&D coverage are provided automatically at no cost to you upon employment. In the event of your death, the life insurance policy provides a benefit to the beneficiary you designate. If your death is the result of an accident or if an accident leaves you with a covered debilitating injury, you are covered under the AD&D insurance for the same amount.

Coverage	Benefit amount
Life Benefit	1 x annual salary to a maximum of $50,000
Accidental Death and Dismemberment	1 x annual salary to a maximum of $50,000

AGE REDUCTION SCHEDULE

Life and AD&D Insurance will be reduced as follows:

- At age 65, benefits will reduce to 65%.
- At age 70, reduces to 40%
- At age 75, reduces to 25%
- At age 80, reduces to 10%

Ensure you elect a beneficiary in ADP when making your benefit elections.

VOLUNTARY LIFE AND AD&D

Voluntary Life and AD&D insurance is available for employees, with the option to add coverage for a spouse and/or dependent children. Your cost is based on the coverage amount you choose and your age. To cover a spouse or child(ren), employee coverage must be elected as well. When enrolling during your initial enrollment period, you can elect coverage up to the guaranteed issue amount (no health questions). If you enroll later or request coverage above the guaranteed issue amount, Evidence of Insurability (EOI) may be required. EOI is a short health questionnaire (and, in some cases, additional information) used by the insurance carrier to determine approval for coverage.

Coverage	Available benefit	Guaranteed amount at initial enrollment
Employee	$10,000 to $300,000, in increments of $10,000, not to exceed 5 times your annual earnings	5 times your annual earnings or $150,000
Spouse	$5,000 to $150,000, in increments of $5,000, not to exceed 50% of employee's amount of life insurance	$30,000 (not to exceed 50% of employee coverage)
Dependent child(ren)	Live birth to 14 days: $1,000 14 days to 6 months: $1,000 6 months to age 26: a minimum of $5,000 to a maximum of $10,000 in $5,000 increments, not to exceed 50% of employee's amount of life insurance	$10,000 ($250 for age 14 days to 6 months)

SHORT- AND LONG-TERM DISABILITY

Unum | portal.unum.com | 866.868.6737

PharmaLogic offers employer-paid Short-term disability and Long-term disability through Unum to provide financial assistance in case you become disabled and unable to work.

Short-term disability (STD) plan

STD benefits are designed to replace a portion of your income for a non-work-related short-term injury or illness. STD benefits are paid at 60% of your eligible weekly base pay, up to $2,000 weekly, during the first 12 weeks of injury or illness.

Short-term disability eligibility — full-time employees	100% paid by the employer
Weekly benefit amount	60% of your weekly wages
Weekly benefit maximum	$2,000 per week
Benefits begin	After the 7th day of an accident or illness.
Benefits duration	12 weeks

The STD benefit is paid for by PharmaLogic; there is no cost to you. However, any income replacement benefits received are taxable.

COORDINATION OF DISABILITY BENEFITS

Your benefit may be reduced if you receive disability benefits from retirement, Social Security, workers' compensation, state disability insurance, no-fault benefits or return-to-work earnings. Contact HR for more information.

Long-term disability (LTD) plan

After STD benefits are exhausted, LTD coverage helps continue a portion of your income if you are unable to work for an extended period. In addition, the value of this benefit is taxed to employees, which means that any LTD payments you receive from a future claim will be tax-free, giving you greater financial security during a difficult time. This benefit offers financial protection to you when you need it most — if you become disabled and can no longer work.

Long-term disability eligibility — full-time employees	100% paid by the employer
Monthly benefit amount	60% of your monthly earnings
Monthly benefit maximum	$10,000 per month
Benefits begin	After the 90th day of disability
Benefits duration	Later of age 65 or social security normal retirement age

The LTD benefit is also paid for by PharmaLogic. If you become totally disabled, you will receive 60% of your base salary—up to a maximum of $10,000 per month—after satisfying the 90-day waiting period. And because taxes are paid on the value of this employer-provided coverage, any LTD benefit you receive will be non-taxable, allowing you to keep more of your benefit when you need it most. This benefit is paid directly from Unum.

401(K) RETIREMENT SAVINGS PLAN

Fidelity Investments | www.401k.com | 800.343.3548

Take control of your future and start planning today for retirement!

Retirement saving is one of the most powerful benefits you have—and PharmaLogic helps you build momentum fast. The PharmaLogic 401(k) Retirement Savings Plan, administered by Fidelity Investments, lets you save through payroll and invest for the future. PharmaLogic helps grow your savings with a dollar-for-dollar match up to 4% of eligible pay. Contribute 4%, and PharmaLogic contributes 4%—doubling of your savings right away. Your contributions and the company match are 100% vested immediately, which means the money is yours from day one. All employees are eligible to participate. After your first paycheck processes, log in to Fidelity and set your 401(k) deferral election (how much you want to contribute each paycheck).

You can contribute either way:

- Pre-tax 401(k): Contributions are made before federal income taxes (and state income taxes in most states). Taxes are generally paid later when you take distributions in retirement.
- Roth 401(k): Contributions are made after taxes are withheld. Qualified distributions are generally tax-free under current tax law.

You choose how much to save for retirement and can select from a number of investment funds, including a Target Date Fund that will make the investment choices based on your expected retirement date. You can update your deferral at any time. In addition to your regular 401(k) contribution election, you may choose to make a separate deferral election specifically for any bonus you receive and get dollar for dollar up to 4% company match on your contribution. This allows you to decide how much of your bonus—if any—you would like to contribute to your 401(k) plan, independent of your ongoing paycheck contributions.

SECURE 2.0 Highlights Roth Catch-Up Requirement

If your prior-year FICA wages exceeded $150,000, any age 50+ catch-up contributions must be made as Roth. If you're eligible for catch-up contributions, the plan will automatically switch your contributions to Roth catch-up after you reach the standard 401(k) annual limit. If you do not wish to make catch-up contributions, adjust your contribution election so that your total annual deferrals do not exceed the standard IRS limit.

IMPORTANT: Ensure you elect a beneficiary in Fidelity when making your benefit elections. Log onto www.401k.com, click on the link under "your profile," and then click on the "Beneficiaries" link.

Contribution Type	Employee Deferral	Total Employee Max (deferral + catch-up)
401(k) Electve Deferral Limit	$24,500	$24,500
Catch-up Contribution (age 50+)	$8,000	$32,500
Super Catch-up (age 60-63)	$11,250	$35,750

TIME OFF AND LEAVES

Paid Time Off

At PharmaLogic, we're excited to offer a comprehensive Paid Time Off (PTO) program designed to help you recharge, enjoy personal time, or sick time. PTO is accrued each pay period and grows with your years of service. We've redesigned our plan to allow you more time sooner and incorporated the floating holidays into your PTO bank. We hope you make the most of this benefit all year long. Enjoy your time!

PTO Accrual by Years of Service

- 0-1 Years: 18 days
- 1-3 Years: 20 days
- 3-7 Years: 25 days
- 7+ years: 30 days

Paid Caregiver Leave

Paid Caregiver Leave is designed to support you when life happens. From the birth of a child to the caring of a parent, we want to support you during these moments that matter.

We recognize there are times when carrying for a newborn or taking care of a family member is your main focus. Caregiver Leave provides you up to 4 weeks of full pay to attend to your family.

Use this time in the way that works for you — either all at once or intermittently. Paid Caregiver Leave will run concurrently with FMLA and applicable state leave programs.

COMPANY HOLIDAY SCHEDULE

PharmaLogic has 7 paid holidays per year. To ensure patients receive the care they need, you may be required on a company holiday. If you must work during one of the holidays, you will be compensated for your hours worked.

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving
- Christmas Day

Part-time employees receive holiday pay based on their recent hours worked. We use a calculation that takes your average hours from the past 4 weeks.

If you have questions or want help planning your leave, contact Human Resources.

CONTRIBUTION RATES

MEDICAL	Employer Funded HRA Plan		HSA Plan		OAP Plan	
	Bi-weekly	Weekly	Bi-weekly	Weekly	Bi-weekly	Weekly
Employee	$20.00	$10.00	$30.00	$15.00	$115.00	$57.50
Employee + spouse	$90.00	$45.00	$130.00	$65.00	$300.00	$150.00
Employee + child(ren)	$50.00	$25.00	$72.00	$36.00	$250.00	$125.00
Family	$150.00	$75.00	$175.00	$87.50	$425.00	$212.50

DENTAL	Core Plan		Buy-Up Plan	
	Bi-weekly	Weekly	Bi-weekly	Weekly
Employee	$3.00	$1.50	$6.50	$3.25
Employee + spouse	$7.50	$3.75	$14.75	$7.38
Employee + child(ren)	$7.25	$3.63	$17.00	$8.50
Family	$11.00	$5.50	$27.00	$13.50

VISION	Bi-weekly	Weekly
Employee	$0.50	$0.25
Employee + spouse	$0.85	$0.43
Employee + child(ren)	$0.80	$0.40
Family	$1.25	$0.63

HOSPITAL INDEMNITY	Monthly Rates		ACCIDENT INSURANCE	Monthly Rates
	Base Plan	High Plan		
Employee	$14.97	$23.87	Employee	$8.91
Employee + spouse	$29.94	$47.74	Employee + spouse	$14.97
Employee + child(ren)	$24.47	$38.38	Employee + child(ren)	$19.85
Family	$39.44	$62.25	Family	$25.91

LEGAL AND ID THEFT	Bi-weekly Rates
Legal	
Employee	$9.12
ID Theft	
Employee	$3.67
Family	$6.44

CONTACTS

PharmaLogic Human Resources Department

Email: HR@radiopharmacy.com

Medical & Rx Plan

CIGNA

Pre-enrollment: 888.806.5042
Customer service: 800.997.1654
Website: cigna.com

Virtual Care

MDLIVE

Customer service: 888.726.3171
Website: myCigna.com

Mental Health

SPRING HEALTH

Customer service: 855.629.0554
Website: pharmalogic.springhealth.com

Digital Physical Therapy

SWORD HEALTH

Customer service: 888.492.1860
Website: swordhealth.com
Email: help@swordhealth.com

Supplemental Health

CIGNA

Customer service: 800.754.3207
Website: cigna.com

Legal and Identity Theft

METLIFE

Customer service: 800.GET.MET8
Website: MetLife.com

Dental

DELTA DENTAL

Customer service: 800.521.2651
Website: deltadentalins.com

Vision

VSP

Customer service: 800.877.7195
Website: vsp.com

HRA

CIGNA

Customer service: 800.997.1654
Website: Cigna.com

HSA

WEX

Customer service: 866.451.3399
Website: wexinc.com

FSA

WEX

Customer service: 866.451.3399
Website: wexinc.com

Life and AD&D

UNUM

Customer service: 866.868.6737
Website: portal.unum.com

Short- and Long-Term Disability

UNUM

Customer service: 866.868.6737
Website: portal.unum.com

401(k)

FIDELITY

Customer service: 800.343.3548
Website: www.401k.com

GLOSSARY

AGE REDUCTION: The basic life and AD&D insurance coverage are subject to a reduction in benefit amount as you age.

COINSURANCE: Your share of the costs of a covered healthcare service, calculated as a percentage (for example, 20%) of the allowed amount for the service. Your coinsurance will begin after you have met your deductible. For example, your medical plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The medical plan pays the rest of the allowed amount.

COPAY: A fixed dollar amount you pay for a healthcare service. The amount can vary by the type of service. Your copays will not count toward your deductible, but will count toward your out-of-pocket maximum.

DEDUCTIBLE: The amount you owe for covered healthcare services before your plan begins to pay benefits. For example, if your deductible is $3,000, your plan won't pay anything until you've met your $3,000 deductible for covered healthcare services that are subject to the deductible. In-network preventive care is not subject to the deductible, as it is covered 100% by the medical plan options.

COLLECTIVE DEDUCTIBLE: If you have family coverage, your OAP or HRA Plan has a collective deductible. That means there is one single deductible that applies to the entire family. All family members' medical expenses contribute toward one shared deductible. The plan doesn't start paying until the full family deductible is met - regardless of how much any one person has incurred.

NON-COLLECTIVE DEDUCTIBLE: If you have family medical coverage, your HSA Plan has a non-collective deductible. That means if one family member reaches the individual deductible, they will begin to share in the cost of care through coinsurance—they do not need to reach the family deductible before coinsurance begins. Once the expenses for all other family members reach the family deductible, coinsurance will begin.

EXPLANATION OF BENEFITS (EOB): A statement from the insurance company showing how claims were processed. The EOB tells you what portion of the claim was paid to the healthcare provider and what portion of the payment, if any, you are responsible for.

IN-NETWORK VS. OUT-OF-NETWORK: A network is composed of all contracted providers. Networks request providers to participate in their network, and in return, providers agree to offer discounted services to their patients. If you pick an out-of-network provider, your costs will be higher because you will not receive the discounts the in-network providers offer.

OUT-OF-POCKET MAXIMUM: The out-of-pocket maximum is designed to protect you if you have a catastrophic illness or injury. Your out-of-pocket maximum includes your deductible, coinsurance and copays that come out of your pocket. After you have reached the annual out-of-pocket maximum, the plan pays the remaining covered services at 100%.

PORTABILITY AND CONVERSION: Portability and conversion are available if your employment with PharmaLogic ends. Portability allows you to continue your term life coverage, while the conversion option allows you to convert your term life policy into an individual whole life policy.

PREVENTIVE CARE: Routine healthcare services can minimize the risk of certain illnesses or chronic conditions. Examples of preventive care services include physical exams, mammograms, flu vaccines, prostate tests and smoking cessation.

REASONABLE AND CUSTOMARY: The amount of money a medical plan determines is the normal or acceptable range of charges for a specific health-related service or medical procedure. If your healthcare provider submits higher charges than what the health plan considers reasonable and customary, you may have to pay the difference.

PREVENTIVE MEDICATION: Preventive medications are prescription drugs that are used to prevent the occurrence or recurrence of a disease or condition. They are not used to treat an existing illness or injury.

RETAIL PHARMACIES: Retail pharmacies dispense medications and healthcare products to the public. They also offer services, like health screenings, immunizations, and personalized counseling on medication use.

GENERIC DRUGS: A generic drug has the same active-ingredient formula as a brand-name drug, but usually costs less. The FDA rates these drugs to be as safe and effective as brand-name drugs.

SPECIALTY PHARMACIES AND SPECIALTY DRUGS: A specialty pharmacy solely or largely provides drugs for people living with serious health conditions, requiring complex therapies. Specialty drugs are higher-cost prescription drugs used to treat rare, complex, and chronic conditions such as cancer, diabetes, hemophilia, infertility, hepatitis, kidney disease, rheumatoid or psoriatic arthritis, multiple sclerosis, Crohn's disease, and psoriasis.

MAIL-ORDER PHARMACY: A mail-order pharmacy, also known as an online pharmacy or internet pharmacy, is a pharmacy that sends orders to customers by mail or through an online portal. You'll typically pay less for maintenance drugs filled through a mail-order pharmacy than a retail pharmacy.

NOTICES

PharmaLogic

HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE
This packet of notices related to our health care 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 Notice From PharmaLogic About Your Prescription Drug Coverage and Medicare."

MEDICARE PART D CREDITABLE COVERAGE NOTICE

IMPORTANT NOTICE FROM PHARMALOGIC 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 PharmaLogic 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. PharmaLogic has determined that the prescription drug coverage offered by the PharmaLogic 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 PharmaLogic 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 PharmaLogic Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the PharmaLogic 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 PharmaLogic 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 978-621-2658. **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 PharmaLogic 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:	October 15, 2025
Name of Entity/Sender:	Michelle Prisco
Contact—Position/Office:	HR Benefits Management Specialist
Address:	5301 N Federal Highway Suite 280 Boca Raton, Florida 33487
Phone Number:	561-532-4198

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

PHARMALOGIC
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:

***PharmaLogic Medical Plan**

PharmaLogic Dental Care Plan

PharmaLogic Vision Plan

PharmaLogic Flexible Benefits Plan

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

For the remainder of this notice, PharmaLogic is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities;
- When required for judicial or administrative proceedings;
- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its

representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to

the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 23).

21. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

22. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

23. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official

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

Michelle Prisco
HR Benefits Management Specialist
561-532-4198

Effective Date

The effective date of this notice is: March 1, 2026

NOTICE OF SPECIAL ENROLLMENT RIGHTS

PHARMALOGIC 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 (e.g., 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 eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 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 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:

Michelle Prisco
HR Benefits Management Specialist
561-532-4198

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

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want 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:

Michelle Prisco
HR Benefits Management Specialist
5301 N Federal Highway Suite 280
Boca Raton, Florida 33487
561-532-4198

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

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

PharmaLogic Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan issuer.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from PharmaLogic Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the PharmaLogic Employee Health Care Plan at:

Michelle Prisco
HR Benefits Management Specialist
561-532-4198

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

PharmaLogic Employee Health Care 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.

The PharmaLogic Employee Health Care 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.
If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Michelle Prisco
HR Benefits Management Specialist
561-532-4198

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 Michelle Prisco, HR Benefits Management Specialist, 561-532-4198.

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, 2025. Contact your State for more information on eligibility –

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

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

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

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

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

This guide provides highlights of the current policies and benefits at PharmaLogic as they apply to eligible employees. Complete details of the plan can be found in the legal documents. If there is any difference in the information in this document and the legal plan documents, the legal plan documents govern. PharmaLogic reserves the right to terminate, suspend, withdraw, amend or modify any of the plans or policies at any time for any reason.