BRIGHTSPRING® HEALTH SERVICES

2027

Open Enrollment

Navigating Your Total Health Journey

Begins October 28th

Ends November 11th

EFFECTIVE JANUARY 1 – DECEMBER 31, 2027

PART-TIME

BRIGHTSPRING® HEALTH SERVICES

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OPEN ENROLLMENT
October 28 to November 11, 2026

Your Journey Begins Here and Online

Enroll during the first week of Open Enrollment to avoid the wait and to be entered for prize drawings.

Questions?

Call the Benefits Support Center Team at
844-896-0169
Our Benefits Support Center Team is here to help you navigate your benefit options and enrollment experience.

Access & Engage Anywhere, Anytime
Scan the QR code to download the BrightSpringConnect mobile app.



BENEFITS OVERVIEW

Prepare for Your OE Journey

Open Enrollment is your annual opportunity to review your benefit options and choose the coverage that best meets your needs for the year ahead. Take time to explore the coverage options available through BrightSpring's comprehensive benefits program and select the plans that are right for you and your family.

Your journey begins here - scan this QR Code to watch our BrightSpring Open Enrollment Highlights Reel!



What's Changing for 2027?

There are new plans and changes this year including new offerings.

NEW! Enhanced Identity Protection

Your Identity Protection benefit is moving from **Allstate** to **MetLife + Aura**—an all-in-one solution that helps protect you and your family from identity theft, financial fraud, scams, and cybercrime. Enjoy proactive monitoring, online privacy tools, expert fraud resolution, and expanded family protection—all in one easy-to-use app.

NEW! Even Smarter Guidance with Precision Benefits

This year, Precision Benefits is even more personalized. With full healthcare claims integration, you'll receive customized benefit recommendations based on your healthcare history, current needs, and anticipated care—helping you make more informed decisions during Open Enrollment.

Remember: Precision Benefits is designed to guide your journey—not choose it for you. The recommendations are personalized insights, but you remain in complete control of your benefit elections and can choose the coverage that's right for you and your family.

NAVIGATE with Precision Benefits

As a valued BrightSpring team member, you have the opportunity to maximize your benefits enrollment experience by taking advantage of your personalized journey with Precision Benefits.

What is Precision Benefits?

Precision Benefits is a voluntary decision-support tool available through the Enrollment Portal to help you evaluate your benefit options. Using your healthcare utilization and benefit information, the tool provides personalized recommendations to support your enrollment decisions. Utilizing the Precision Benefits tool is completely voluntary, and you remain in full control of your benefit elections at all times.

How to Access the Precision Benefits Tool

Log in to the Enrollment Portal and select 'GET STARTED' to launch Precision Benefits. The tool is available during Open Enrollment and may also be available when making benefit changes following a qualifying life event.

Complete Your Enrollment

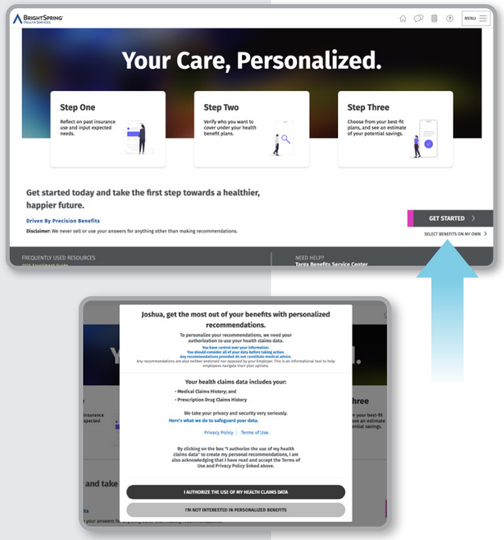
Precision Benefits provides personalized recommendations to help you evaluate your benefit options. After reviewing your recommendations, you'll still need to review your benefit elections and submit your enrollment through the Enrollment Portal.

Be sure to save your enrollment confirmation for your records.

Your Privacy Matters

Your personal health information remains private and confidential. Individual health information and personalized recommendations are not shared with BrightSpring, insurance carriers, or benefits administrators.

If you choose to use Precision Benefits, you'll be asked to authorize the use of certain health information, such as medical claims history and prescription data, to generate your personalized recommendations.



Year-Round Support

Through your BrightSpringConnect Mobile App, you are empowered to make smart healthcare decisions and ensure more financial peace of mind.

On the Right Track: Your Open Enrollment Checklist

1. **Before you enroll, review your current benefit elections and coverage options:** Take time to understand your available plans and determine which options best meet your needs for the coming year.

2. **Re-Elect Your FSA.** Your Flexible Spending Account (FSA) elections do not automatically carry over. If you want to contribute in the upcoming plan year, you must make a new election during Open Enrollment every year.

3. **Verify your personal information is up to date:** Review your address, email, phone number, and beneficiary information. Updates can be made in REACH through Employee Self-Service.

4. **Pay special attention to any benefit changes for the upcoming year:** Review plan updates, contribution changes, and any new programs or offerings before making your elections.

5. **Complete your enrollment by 11:59 pm CT on November 11, 2026.** If no action is required for certain benefits, coverage may default according to plan rules. Review enrollment instructions carefully.

6. **Submit your elections and save your confirmation number.**

Important!

Employees on a leave of absence must still enroll between October 28 – November 11.







Choose Your Route Before You Enroll:

Eligibility

If you are an eligible part-time employee, your BrightSpring benefits are effective on the first day of the month following 30 days of service.

How to Add Your Family to Your Total Health Journey:

To enroll a dependent, be sure to have your dependent's date of birth and Social Security number available when enrolling. If you're adding a new dependent, you will need to verify the dependent status. Your dependent will be placed in a "pending" status until the verification documents are received. Dependent verification documents include marriage and birth certificates.

When Open Enrollment Begins, It's Time to Enroll

1. Log in to the enrollment site using one of the available options.
2. Click Get Started to begin the Precision Benefits decision support journey to make your Open Enrollment choices. Precision Benefits is voluntary — you can choose to skip the recommendations and go straight into your enrollment.
3. Review the benefits available to you, make your elections, add your dependents and beneficiaries (if applicable), and submit your elections.
4. Remember to select Confirm to save your choices.

How to Enroll



Option One:

Use BrightSpringConnect and take advantage of single sign-on. No usernames or passwords to remember.

Log in to the app and look for the Benefit Enrollment Portal link.

From here, you'll be directed to the enrollment site.

Option Two:

Log in to **www.brightspringbenefits.com.**

If you're a returning user and don't remember your username or password, click on "Did you forget your password" and follow the instructions.

New users should register with their Social Security number and date of birth.

Option Three:

If you prefer to speak with a representative, you can call **844-896-0169.**

Please be aware that call wait times increase during Open Enrollment.

Don't Let Your Benefits Journey Pass You By

Be sure to choose your benefits carefully during the enrollment period since you won't be able to make changes during the year unless you experience a qualified life event (e.g., having a baby or getting married). If you experience such an event, you must go to ***www.brightspringbenefits.com*** *and make any changes within 31 days of the event. Remember, your benefit changes must be related to your life event.*

Open Enrollment

BEGINS

October 28

ENDS

November 11

Access & Engage With Your Benefits Anywhere, Anytime

Download the BrightSpringConnect mobile app to review your current benefits all in one place and explore helpful resources.

You can use single sign-on to complete your enrollment, add dependents, update beneficiaries, and upload any required supporting documents.

Take advantage of single sign-on to many of our vendors, including Fidelity, Imagine360 and MedImpact.



BrightSpringConnect Mobile App

GET IT ON Google Play

Download on the App Store

Scan the QR code to download our app to your smartphone.

Important!

Always be in the know!
Enable your notifications so you know about changes, announcements and key dates.



UHC FlexWork Limited Medical Plan

The FlexWork Limited Medical Plan is a limited medical plan designed for everyday routine healthcare needs. There are no deductibles or coinsurance. The plan provides first-dollar coverage for doctor visits, urgent care, prescription drugs, and other benefits (subject to annual visit limits).

This plan is not comprehensive medical coverage and should be evaluated carefully before selecting.

KEY FEATURES	UHC FLEXWORK PLAN
Annual Deductible	None
Coinsurance	None
Preventive Care	Covered 100%
Out-of-Pocket Limit	Single: $9,200 Family: $18,400
Doctor & Office Visits **6 visits per year limit between PCP and Specialist**	PCP: $25 Specialist: $50
Urgent Care Visits **2 visits per year**	Copay per visit: $100
Outpatient Complex Imaging (CT, PET, MRI)	Not covered
Outpatient Surgery — Facility, Surgical and Physician	Not covered
Emergency Room Visits	Not covered
Inpatient Care	Not covered
PRESCRIPTION DRUG	
Pharmacy	• Tier 1: $15 copay • Tier 2: 40% coinsurance • Tier 3 & 4: 50% coinsurance • Excludes Specialty and Mail Order

Evaluate Carefully!

This plan is not comprehensive medical coverage. Review the plan information online before electing.

United Healthcare

Monthly Medical Rates

COVERAGE LEVEL	COST
Employee Only	$113.71
Employee Plus Spouse	$268.10
Employee Plus Child(ren)	$201.78
Family	$367.04

Map Your Tax Savings with Flexible Spending Accounts

A Flexible Spending Account (FSA) allows you to contribute before-tax dollars throughout the year to pay for eligible healthcare and/or dependent day care expenses that you, your spouse, and your dependents incur. It's important that you understand the differences among the three available FSAs and which expenses are considered eligible before you make your election. Here's how you can spend the money in each account.

FSAs are managed by Fidelity.

HEALTH CARE FSA
Available for Copay Plan Participants

Eligible expenses include:

- Health, vision, and dental expenses not covered by insurance
- Deductibles, copays, and coinsurance
- Prescription drugs
- Medical equipment
- Hearing tests and aids
- Speech and physical therapy
- Over-the-counter drugs
- Feminine care products

You cannot participate in a Health Care FSA if you are enrolled in the HDHP with an HSA.

For 2027, you can contribute a minimum of $100, up to a maximum of $3,400.

DEPENDENT CARE FSA

Eligible expenses include child care and/or adult care while you and your spouse (if married) work or attend college full-time, such as:

- Before- and after-school child care
- Summer day camp
- Elder care

The Dependent Care FSA cannot be used for a dependent's healthcare expenses.

For 2027, you can contribute a minimum of $500, up to a maximum of $7,500 ($3,750 if married and filing a separate tax return).



What else you should know about FSAs:

- Unused FSA funds are generally subject to the 'use it or lose it' rule. However, the plan permits a limited rollover for eligible accounts. Review the plan summary for applicable rollover limits and details.
- Your full balance will be available on your effective date, even before funds are deducted from your salary and deposited into your account. You may draw up to the full value of your annual Health Care FSA contribution when the new benefit year begins.
- You have a reimbursement option. If you decide to pay healthcare and dependent care costs out of your own pocket, you will need to file a claim to be reimbursed from your account(s). Just be sure to submit your claim by the stated deadline.
- For a full list of qualified medical expenses, visit https://www.irs.gov/forms-pubs/about-publication-502.

Keep Your Smile on the Right Path: Your 2027 Dental Benefits

Keeping up with your dental health is vital to your overall health. Studies have shown that good oral health can keep your whole body healthy.

Our dental coverage is provided by Delta Dental. Here are some plan highlights and considerations when choosing a dental plan:

- The Preventive Plan only covers basic services
- The PPO Plus Plan provides coverage for basic and major services as well as child and adult orthodontia
- The PPO Plus Plan has a higher annual maximum benefit and a separate lifetime maximum for orthodontia

Remember, if you need orthodontic services, choose the PPO Plus Plan. And keep in mind, dental expenses are eligible for Health Care FSA.

Good Oral Health

*Adults who visit the dentist annually are **37%** more likely to report good or better oral health.*

Those who report good oral health are almost twice as likely to report good or better overall well-being.

Dental Benefits at a Glance

KEY FEATURES	PREVENTIVE PLAN	PPO PLUS PLAN
Annual Maximum Benefit	$750	$1,500
Individual Deductible	$75	$50
Family Deductible	$225	$150
Preventive Services (exams, cleaning, fluoride, maintenance)	100%	100%
Basic Services	Plan pays 50%	Plan pays 80%
Major Services	Not covered	Plan pays 50%
Orthodontia	Not covered	Plan pays 50%
Orthodontia Lifetime Maximum	Not covered	$1,500

Monthly Dental Rates

COVERAGE LEVEL	PREVENTIVE PLAN	PPO PLUS PLAN
Employee Only	$15.30	$31.58
Employee Plus Spouse	$31.21	$64.42
Employee Plus Child(ren)	$35.96	$74.20
Family	$50.80	$104.83

Visit *www.deltadentalky.com* to search for participating providers.

Keep Your Vision in Sight: Your 2027 Vision Plan Options

Our vision plan is with Delta Vision and administered by VSP.
You will have the option to choose between two plans — a High Plan and a Low Plan.

Here is what you can expect from the plan:

- **WellVision Exam.** A fully covered exam with a $10 copay.
- **Well-known providers.** An expansive VSP Choice Network with 109,000 access points, including in-network access to Costco, Walmart, and Sam's Club.
- **Frame allowance.*** Buy any frame from your in-network provider up to your frame allowance. Costs over the allowance are discounted.
- **Contact lens benefit.*** You may have coverage for fitting and follow-up visits depending on your plan and lens choice.
- **Lens options.*** Lens options such as UV protection and anti-reflective coating are available at price-protected amounts. Plus, standard scratch coating and polycarbonate lenses for dependent children are available at no cost.
- **Additional pairs of glasses.** Receive a 20% discount on additional pairs of eyeglasses, including prescription sunglasses.

Review schedule of benefits online for details.

Save More

Delta Vision's plans provide special discounts for contact lenses and LASIK vision correction.

You can find more information about discounts and participating providers at www.VSP.com

Vision at a Glance

KEY FEATURES	LOW PLAN In-Network	HIGH PLAN In-Network
Exam (annual)	$10 copay	$10 copay
Lenses	$25 copay	$10 copay
Frames	$130 allowance/once every 24 months	$175 allowance/once every 12 months
Contact Lenses in Lieu of Frames and Lenses	$130 allowance/once every 12 months	$175 allowance/once every 12 months

2027 Monthly Vision Rates

KEY FEATURES	LOW PLAN	HIGH PLAN
Employee Only	$6.08	$8.49
Employee Plus Spouse	$10.63	$14.88
Employee Plus Child(ren)	$11.54	$16.14
Family	$17.60	$24.63

Vision is FSA eligible

Vision Care Provider

DeltaVision®

In partnership with VSP®

In-network with Costco, Walmart/Sam's Club

Plan For The Road Ahead with Income Protection Benefits

Disability and Life Insurance

Part-time employees are eligible for limited short term disability and supplemental life plans for you and your family. Plan rates are based on the options you select. When you enroll, you can compare plans and rates to find the best fit for you.

Explore Additional Benefits Along the Way

BrightSpring offers a variety of voluntary benefits and coverage options to support all areas of your life.

Financial Protection for Life's Unexpected Turns

Accident Insurance (Voya)

Accident Insurance pays you benefits for specific injuries and events resulting from a covered accident. The amount paid depends on the type of injury and care received. Some of the most common treatments and conditions that pay out benefits include Emergency Room, Physical Therapy and follow-up doctor appointments.

Hospital Indemnity Insurance (Voya)

Hospital Indemnity Insurance can help pay for health insurance deductibles and copays related to a hospitalization. It pays a daily cash benefit directly to you, up to the plan maximum, if you or a covered family member is hospitalized.

Critical Illness Insurance (Voya)

Critical Illness Insurance provides coverage for getting your life back on track after a covered illness. This benefit can help with out-of-pocket costs and your family's everyday living expenses.

Health Screening Bonus!

Our 2027 Critical Illness insurance with Voya offers a health screening benefit for completing an annual preventive care screening.

IMPORTANT: Accident Insurance, Hospital Indemnity Insurance and Critical Illness Insurance (Voya) are fixed indemnity policies, NOT health insurance.

These fixed indemnity policies may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much these policies will pay each year.
- These policies aren't a substitute for comprehensive health insurance.
- Since these policies aren't health insurance, they don't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about these policies?

- For questions or complaints about this policy, contact the Benefits Support Center at 844-896-0169.

For more information about your Accident, Hospital Indemnity and Critical Illness benefit options, visit our Voya resource center:

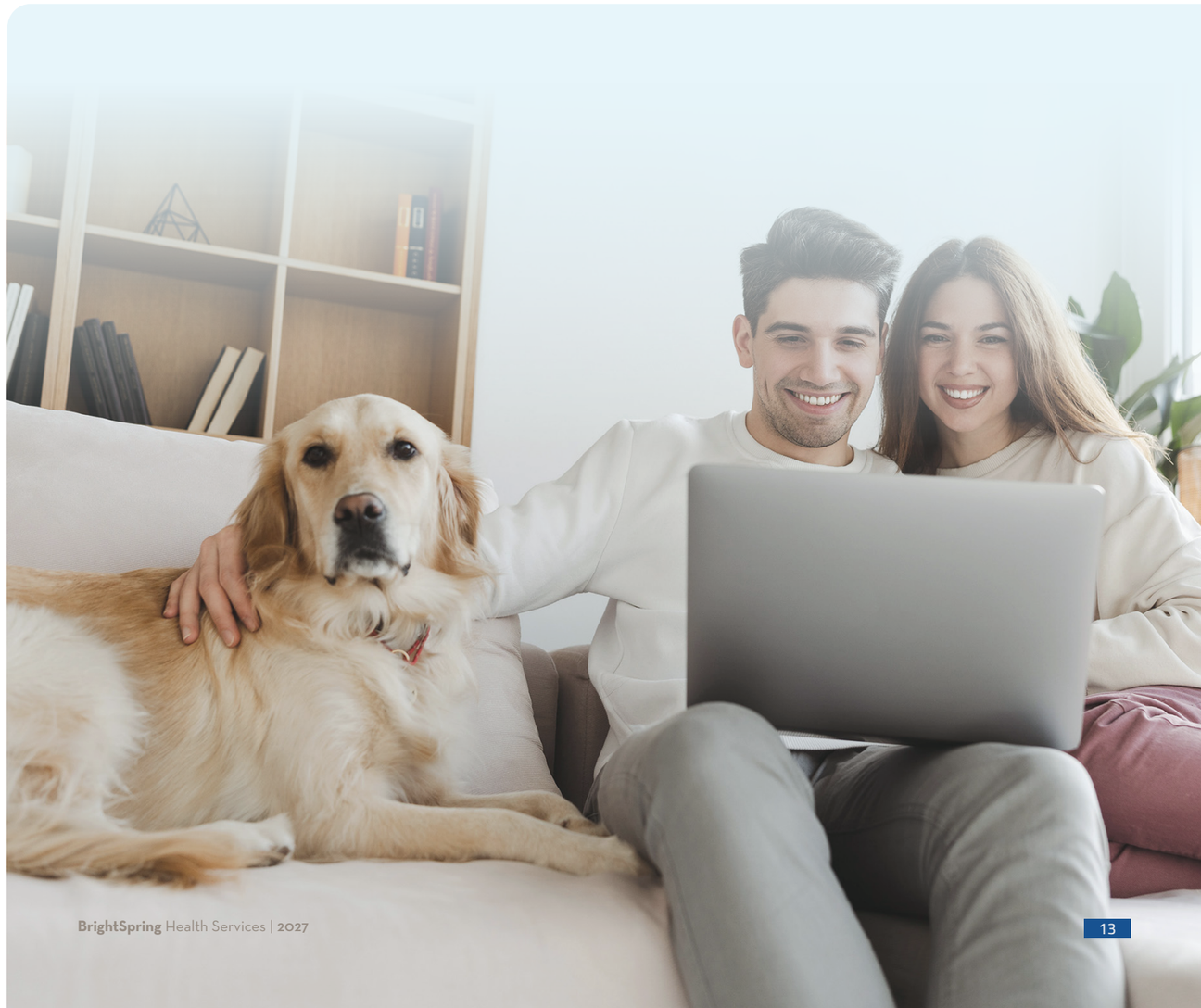
Click here to visit the Voya Resource Center

MetLife Legal Plan

MetLife Legal Plan gives you access to expert attorneys who can assist you with a broad range of personal legal needs you might face throughout your life — events that you can plan for in advance as well as those that you don't think about until it's too late.

Services include:

- An experienced service team to help match you with the right attorney
- Experienced legal advice and representation, in person or by phone
- In-court representation for covered legal matters
- No copays, deductibles, or claim forms when using a network attorney for covered matters



ADDITIONAL BENEFITS Continued

Protect Your Digital Journey with MetLife + Aura

Your digital life is an important part of your overall wellbeing. BrightSpring offers **Identity & Fraud Protection through MetLife + Aura,** designed to help protect you and your loved ones from identity theft, financial fraud, scams and cybercrime — all in one easy-to-use experience.

Key features include:

- Identity and financial monitoring.
- Scam and cybercrime prevention to protect you from phishing and block malicious links.
- Privacy and reputation protection to reduce your online exposure.
- A digital vault to securely store important information.

Support for Wherever Life Takes You

Employee Assistance Program (EAP)

The EAP provides confidential counseling and referrals for everything from mental health services to financial and legal advice to daily living services such as child care and home repairs. You and anyone under your roof can take advantage of up to five EAP sessions a year in person at no cost.

To get started, call **833-743-8184**, or visit www.guidanceresources.com and use

Web ID: **BrightSpring.**

Your ComPsych GuidanceResources program offers someone to talk to and resources to consult whenever and wherever you need them. They can answer your questions and, if needed, refer you to a counselor or other resources 24/7.

Pet Insurance

MetLife Pet Insurance can help cover the costs of unexpected accidents or illnesses, provide reimbursements for regular vet visits, and access to 24/7 live vet chat for immediate assistance. Get the coverage that best fits your pet and wallet at **www.metlife.com/getpetquote**

Questions? *Call 1-855-201-2909.*



Save More Along the Way

Employee Discounts

Enjoy exclusive BrightSpring discounts from thousands of vendors, including stores, electronics, travel, tickets, and more through BenefitHub.

Go to brightspring.benefithub.com.
Enter referral code: **QY9EUM.**

Auto and Home Insurance (Farmers GroupSelect)

As a BrightSpring employee, you qualify for an exclusive discount on auto and home insurance from Farmers Insurance. Enroll with Farmers Insurance to:

- Save more with the superior driver discount and multivehicle savings.
- Earn an additional discount when you pay your premium through automatic bank account deduction.
- For a free auto and/or home insurance quote, follow ***this link*** and enter BrightSpring as the employer code.

Purchasing Power

A voluntary benefits program that gives you immediate access to thousands of household products from top brands and allows you to pay over time through your paycheck. This program is a hassle-free alternative to credit cards and high-interest loans.

Navigate Your Retirement Journey with Your 401(k) Plan

The 401(k) retirement plan helps you save for your future.

We offer both traditional and Roth 401(k) plan options so you can save with pre- or post-tax dollars, whichever you choose. All full-time, part-time, and PRN employees are eligible to participate.

Traditional Contributions

Pre-tax contributions are deducted from your pay before income taxes are taken out. This means that you can actually lower the amount of current income taxes you pay each period. It could mean more money in your take-home pay versus saving money in a taxable account.

Roth Contributions

You can elect to make Roth contributions, which are deducted from your pay after taxes but provide for tax-free distributions of earnings, as long as the distributions are qualified.

Investment Options

You have the flexibility to select from investment options that range from more conservative to more aggressive, making it easy for you to develop a well-diversified investment portfolio.

Automatic Annual Increases

Save a little more each year, the easy way — the Annual Increase Program automatically increases your contribution annually.

Download the NetBenefits Mobile App

Easily access all of your Fidelity accounts or use BrightSpringConnect for SSO access — anytime, anywhere. Download from the App Store or Google Play. Or, go to www.Fidelity.com/go/NetBenefitsapp.

- Get messages about timely actions to take within your account.
- View account balance, investments, and personal rate of return.
- Change contributions or investments, and update your profile or beneficiaries.
- See how much you may need in retirement and get your Fidelity Retirement Score.
- Access articles, videos, podcasts, and interactive tools.

Start Saving for Your Retirement Today

Enroll online here or by calling the Fidelity Retirement Service Center at **800-970-2363.**

Take advantage of easy access to your Fidelity 401(k) account via single sign-on (SSO) through your BrightSpringConnect app!

If you haven't already, scan the QR Code to download your app today!

Matching Contribution

BrightSpring may, at its discretion, make employer matching contributions to the 401(k) Plan. Any matching contribution is not guaranteed. You are eligible to receive a matching contribution only if you make employee deferral contributions to the Plan. BrightSpring will communicate directly with eligible employees if a discretionary matching contribution is made for a given Plan Year or pay period. You are not eligible to receive matching contributions for any Plan Year in which you are classified as a Highly Compensated Employee (HCE) under IRS rules.

Your Benefits Compass: Important Benefits Contacts

PROGRAM	CARRIER	PHONE	WEBSITE
Benefits Support Center	BrightSpring	844-896-0169	www.brightspringbenefits.com
Flexible Spending Account	Fidelity	833-299-5089 (FSA)	www.NetBenefits.com
Dental Plan	Delta Dental of KY	800-955-2030	www.deltadentalky.com
Vision Plan	VSP	800-877-7195	www.vsp.com
Accident Insurance	Voya	877-236-7564	presents.voya.com/EBRC/Brightspring-healthservices
Hospital Indemnity Insurance	Voya	877-236-7564	presents.voya.com/EBRC/Brightspring-healthservices
Critical Illness Insurance	Voya	877-236-7564	presents.voya.com/EBRC/Brightspring-healthservices
Group Legal	MetLife Legal Plan	800-821-6400	mybenefits.metlife.com
Identity & Fraud Protection	MetLife + Aura	844-931-2872	www.my.aura.com/sign-in
Auto and Home Insurance	Farmers Insurance	800-438-6381	www.myautohome.farmers.com
Employee Discounts	BenefitHub	866-664-4621	www.benefithub.com Referral code: QY9EUM
401(k) Retirement Plan	Fidelity	800-970-2363	www.NetBenefits.com
Employee Assistance Program	ComPsych	833-743-8184	www.guidanceresources.com Web ID: BrightSpring

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice.

To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

BRIGHTSPRING® HEALTH SERVICES

ABOUT THIS GUIDE

This guide highlights your benefits. Official plan and insurance documents govern your rights and benefits under each plan. For more details about your benefits, including covered expenses, exclusions, and limitations, please refer to the individual Summary Plan Descriptions (SPDs), plan document, or certificate of coverage for each plan. If any discrepancy exists between this guide and the official documents, the official documents will prevail. BrightSpring reserves the right to make changes at any time to the benefits, costs, and other provisions related to benefits.

This guide includes a description of changes to your benefits as described in your current SPD and updates information in your SPD, effective as of January 1, 2027, and applies to the BrightSpring Health Services Welfare Benefit Plan ("Plan"). This guide is considered a Summary Material Modification (SMM). Please keep this SMM with your SPD so you understand your current Plan rules. As explained in your SPD, BrightSpring Health Services reserves the right to amend or terminate any of its plans or policies at any time with or without notice or cause, subject to applicable law.



BRIGHTSPRING REQUIRED NOTICES

Res-Care, Inc. d/b/a BrightSpring Health Services reserves the right to change, amend, or terminate any benefit plan at any time for any reason. Participation in a benefit plan is not a promise or guarantee of future employment. Receipt of benefit documents does not constitute eligibility.

SUMMARY OF BENEFITS COVERAGE

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health plan is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at www.brightspringbenefits.com or by accessing the BrightSpringConnect app. A paper copy is also available, free of charge, by calling the Benefits Support Center at (844) 896-0169 or emailing BrightSpringBenefits@BrightSpringHealth.com.

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides employees additional opportunities, outside of open enrollment, to enroll in a group health plan if they experience a loss of other coverage or for certain life events. If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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.

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state Children's Health Insurance Program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state Children's Health Insurance Program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request HIPAA special enrollment or obtain more information, contact the BrightSpring Benefits Support Center at (844) 896-0169.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the BrightSpring group health plan. If you would like more information on WHCRA benefits, call the Benefits Support Center at (844) 896-0169.

BRIGHTSPRING HIPAA PRIVACY NOTICE

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 applies to all self-funded group health benefits (referred to as the "Plan") sponsored by Res-Care, Inc. d/b/a BrightSpring Health Services (the "Plan Sponsor") and is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. The purpose of this Notice is to inform you of the Plan's privacy practices.

In connection with providing health benefits to you, the Plan receives and maintains medical and other information about you. The Plan is sponsored by Res-Care, Inc. d/b/a BrightSpring Health Services (the "Plan Sponsor"). The Plan Sponsor has hired Imagine 360 and Coupe to process claims and otherwise assist with Plan operations. The Plan Sponsor may also hire other service providers to assist with Plan operations. These service providers are called "business associates" of the Plan, and the Plan Sponsor requires that they agree to comply with the privacy laws regarding your protected health information. The Plan Sponsor or your employer may also assist with Plan operations as described below, and the Plan Sponsor and your employer will comply with the privacy laws with respect to your protected health information if they maintain or receive any such information.

HIPAA does not apply to information maintained by your employer other than in connection with the Plan. Information provided to your employer by you or from another source that is in connection with sick or disability pay, a leave of absence, or a benefit plan that is not a health plan is not subject to these rules.

The Plan's Obligations.

The Health Plan is required by law to:

- Make certain that your protected health information (PHI) is safeguarded and used or disclosed only in accordance with HIPAA and the provisions of this notice;
- Give you this notice of your legal rights with respect to your PHI, and the Plan's legal duties and privacy practices with respect to health information about you;
- Notify you following a breach of your unsecured PHI; and
- Follow the terms of the notice that are in effect.

How the Plan Uses Your Protected Health Information.

The Plan may use and disclose your protected health information for the following purposes:

Claims Payment. The Plan may use or disclose your protected health information to process and pay a claim for services or supplies covered by the Plan. The Plan may also provide eligibility information to your doctor or another provider who requests the information in connection with your treatment.

Operation of the Plan. The Plan may use or disclose your medical information in connection with its normal operations and management, such as conducting quality assessment and improvement activities, underwriting or other activities relating to insurance in connection with the Plan, care coordination or case management, customer service, and fraud detection. However, genetic information cannot be used for underwriting purposes.

Treatment Purposes. The Plan may disclose your medical information to your doctor, at the doctor's request, in connection with your treatment. The Plan may also use your medical information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure Required by Law. The Plan must disclose protected health information to the U.S. Department of

Health and Human Services in connection with an audit. The Plan may also disclose your medical information as required to comply with workers' compensation laws, or as required by a legal proceeding, such as a court or administrative order or subpoena.

To Your Employer. The Plan may disclose to your employer summary claims and other similar information if information that could be used to identify individuals has been removed. Such summary information does not disclose your name or other distinguishing characteristics. The Plan may also disclose to your employer whether you are enrolled in the Plan. The Plan may disclose your protected health information to the Plan Sponsor or to your employer for Plan administrative functions as long as the Plan Sponsor or your employer (as the case may be) has certified that it will ensure the continuing confidentiality and security of your protected health information and that it will not use or disclose your medical information for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor or employer. The Plan Sponsor has amended the Plan to specifically allow this use for Plan purposes by the Plan Sponsor or your employer.

To Family Members. The Plan may generally disclose protected health information to a spouse or parent in connection with inquiries about plan benefits and claims payment. An individual (but not an unemancipated minor) may ask that no such disclosure be made to family members, and the Plan will honor the request. The Plan may require a written authorization before making disclosures to a family member. A Plan may disclose protected health information to a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you are not able to give or withhold consent for the Plan to do this.

Business Associates. The Plan may disclose your protected health information to third parties with whom it contracts to perform services on its behalf. If the Plan discloses your information to these entities, it will have an agreement with them to safeguard your information. Examples of these third parties include third-party administrators and auditors.

Communications with You. The Plan, or its business associates, may contact you via telephone, email, or text message about your treatment, care, or payment related activities. As an example, the Plan may remind you that you have an appointment for medical care and provide information about treatment. The Plan or its business associate may also use your protected health information to communicate with you about health-related benefits or services that may be of interest to you, such as available immunizations.

Legal Proceedings, Lawsuits and Other Legal Actions. The Plan may disclose protected health information about you to courts, attorneys, court employees, and others when we receive a court order, administrative subpoena, warrant, or other lawful instructions. The Plan also may disclose protected health information about you to those working on the Plan's behalf in a lawsuit or action involving the Plan. The Plan may also disclose information for law enforcement purposes as required by law or in response to a valid administrative subpoena, court order, or similar process.

Substance use disorder treatment records received from programs subject to 42 CFR part 2, or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on written consent, or a court order after notice and an opportunity to be heard is provided to you or the holder of the record. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Other Uses. The Plan may also use and disclose your medical information as follows:

- The Plan may disclose protected health information to the extent required by law, to law enforcement officials, the U.S. Armed Forces, for research, for national security, or for public health activities as permitted by the privacy laws.
- The Plan may disclose protected health information about a deceased person to a coroner, medical examiner, or funeral director.
- The Plan may disclose protected health information in the event of a serious threat to your health or safety or the health or safety of others.
- If the Plan reasonably believes that you are a victim of abuse, neglect or domestic violence, the Plan may disclose PHI about you to a government authority, including a social services or protective services agency, authorized by law to receive such reports.
- If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- To workers' compensation agencies for workers' compensation benefit determination.
- To another health plan maintained by the Plan Sponsor for purposes of facilitating claims payments under that plan.

Substance Use Disorder Treatment Records. Federal regulations known as the Part 2 regulations require special privacy protections for substance use disorder records held by certain treatment programs ("Part 2 Programs"). If you give a Part 2 Program a general consent to use and disclose your Part 2 Program records for purposes of treatment, payment, or health care operations, and if the Plan receives some or all of your Part 2 Program records as a result of that consent, the Plan may use and disclose those records for treatment, payment, and health care operations purposes as described in this notice.

If the Plan receives or maintains Part 2 Program records about you through specific consent you provide to the Plan or another third party, the Plan will use and disclose your Part 2 Program records only as described in the consent you provided.

The Plan will not use or disclose a Part 2 Program record about you, or testimony that describes the information contained in a Part 2 Program record about you, in any civil, criminal, administrative, or legislative proceedings against you, unless authorized by your written consent or a court order that is issued after you are given notice and an opportunity to be heard as provided for in the Part 2 regulations. If the use or disclosure is appropriately authorized by a court order, the Plan will not use or disclose the Part 2 Program record, or testimony about such record, unless the court order authorizing use or disclosure is accompanied by a subpoena or other legal requirement compelling disclosure. You can provide a single consent for all future uses and disclosures of Part 2 Program records for purposes of treatment, payment, and health care operations that do not permit use for civil, criminal, administrative, or legislative proceedings.

Although the Plan does not anticipate using any Part 2 Program records for fundraising purposes, you will be given an opportunity to opt out of receiving any fundraising communications from the Plan before the Plan will use your Part 2 Program records for fundraising purposes.

Other Restrictions on the Use and Disclosure of PHI

Certain other federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information. If a use or disclosure of PHI described above in this notice is prohibited or materially limited by other laws that apply to the Plan, the Plan intends to meet the requirements of the more stringent law.

You Must Authorize Other Uses. The Plan (including business associates providing services to the Plan and your employer) will not use or disclose your protected health information from the Plan for any purpose other than those described in this Notice unless you give the Plan written authorization to do so. With limited exceptions, the Plan must obtain your authorization for uses or disclosures of psychotherapy notes, protected health information used for marketing purposes, and sales of protected health information. If you give written authorization, it must state the specific use you are authorizing, and in most cases, you may revoke your authorization in writing at any time. Your revocation will not be effective to the extent that the Plan has already taken action in reliance on your authorization. The Plan

is prohibited from using or disclosing any of your PHI that is genetic information for underwriting purposes.

Individual Rights to Inspect, Copy, and Amend and Other Rights Regarding Health Information.

The law gives you certain rights regarding your protected health information used or maintained by the Plan, as follows:

- You have the right to see and get copies of your protected health information, with limited exceptions. The Plan reserves the right to impose a reasonable charge for paper copies, repeat disclosures or numerous disclosure requests within one year.
- You have the right to ask that the Plan communicate with you in another way to keep your protected health information confidential. You can ask the Plan to communicate by a different means or at a different location than the Plan normally uses. The Plan does not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow the Plan to collect premiums and pay claims.
- You may request additional restrictions on the Plan's use and disclosure of your medical information. The Plan does not have to agree to your request. However, the Plan must comply with your request not to disclose information about any medical expense for which you paid in full for the services.
- You have the right to notice in the event of an unauthorized disclosure of your health information where there is a significant risk your information has been compromised.
- You may request a correction to your protected health information. The Plan will determine whether it is appropriate to correct your information in a particular circumstance.
- You may request an accounting of disclosures of your medical information by the Plan for the last 6 years. This accounting will not include disclosures for treatment, payment or Plan operations, disclosures to you, disclosures pursuant to your authorization, or disclosures for disaster relief, national security, or intelligence purposes.
- You may request a paper copy of this notice if you received this notice by e -mail or on the internet.
- You have the right to choose someone to act on your behalf (i.e., designation of a healthcare power of attorney or personal representative) by exercising your rights and making decisions about your health information.

If you want to exercise any of the above rights, contact the Privacy Official of the Plan as described below.

State Privacy Rights. You may have additional health information privacy rights under state laws, including rights in connection with mental health and psychotherapy reports, pregnancy, HIV/AIDS-related illnesses, and the health treatment of minors.

Complaints. You have the right to complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services if you believe that your rights regarding the privacy of your protected health information have been violated. You may file a complaint with the Plan's Information and Complaint Official (identified below). You will not be retaliated against if you choose to file a complaint with the Plan or with the U.S. Department of Health and Human Services.

Privacy Official and Information and Complaint Official. For more information about the Plan's privacy practices or to take advantage of your rights as described in this Notice, contact:

Privacy Officer
BrightSpring Health Services
805 N Whittington Parkway
Louisville, KY 40222

To file a complaint with the plan, contact:

Privacy Officer
BrightSpring Health Services
805 N Whittington Parkway
Louisville, KY 40222
502-394-2100

To file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:
200 Independence Avenue, S.W.
Washington, D.C. 20201

Effective Date of This Notice. This Notice is effective as of October 1, 2026. The Plan must comply with the provisions in this Notice until it is changed. The Plan reserves the right to change the provisions of this Notice at any time. If the Plan makes changes to this Notice, the Plan will send the changed Notice to all participants covered by the Plan at that time. The Plan may make the changes that apply to all protected health information it maintains, even information obtained before the effective date of the new Notice.

Interpretation. This notice is intended to comply with the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA). It is not intended to give individuals any greater rights than they have under HIPAA and it is not intended to give the Plan, employers or business associates any greater obligations than they have under HIPAA, and it shall be interpreted accordingly. However, state laws may provide additional protections, in which case those additional protections will apply.

CREDITABLE COVERAGE DISCLOSURE NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with BrightSpring and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1) Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2) BrightSpring has determined that the prescription drug coverage options listed below are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

- Imagine360 $900 Plan with Co-Pay
- Imagine360 $2,000 HDHP
- Imagine360 $2,800 Plan with Co-Pay
- Imagine360 $4,000 HDHP
- HMSA PPO (Hawaii)
- Kaiser Colorado $1,500 HMO
- Kaiser Colorado $3,500 HDHP
- Kaiser California $1,500 HMO
- Kaiser California $3,500 HDHP
- Kaiser Washington $1,500 HMO
- Kaiser Washington $2,500 HDHP
- Kaiser Northwest $1,500 HMO
- Kaiser Northwest $3,500 HDHP
- Coupe
- BCBS PPO
- BCBS HDHP

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

Your BrightSpring coverage pays for other medical expenses in addition to prescription drugs. If you or your covered family member for whom Medicare pays second enrolls in a Medicare drug plan, your BrightSpring medical and prescription drug coverage will not be impacted, and the Medicare drug benefits will be coordinated with your BrightSpring prescription drug plan coverage. Medicare drug coverage will be secondary for you or the covered family member who chooses to enroll in a Medicare drug plan. However, you will have to pay a Medicare Part D premium, which BrightSpring will not reimburse.

Because your existing coverage is considered Creditable Coverage, you have several options. Your options include the following:

- Maintain your current benefits with BrightSpring and delay enrollment in Medicare prescription drug coverage.
- Keep your current benefits with BrightSpring and enroll in Medicare prescription drug coverage (in addition to prescription drugs, your current coverage includes medical benefits through the plan options listed above and you will be eligible to receive all of your current medical benefits even if you choose to enroll in a Medicare prescription drug plan).
- Enroll in a Medicare prescription drug plan and drop current benefits with BrightSpring. Note that you will lose your BrightSpring medical coverage as well as prescription drug coverage if you elect this option.

If you have both Medicare and BrightSpring prescription drug coverage, the amounts covered by BrightSpring prescription drug coverage will delay, and may prevent, you from reaching this limit. So, before you enroll in a Medicare drug plan, you should consider whether it will provide you with additional value.

If you do decide to join a Medicare drug plan and drop your current BrightSpring coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period or if you experience a qualifying life event that allows for a mid-year election.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

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

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

For More Information About This Notice Or Your Current Prescription Drug Coverage: Contact the BrightSpring Benefits Support Center at (844) 896-0169. 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 the BrightSpring changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage: More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date of this notice: October 1, 2026

BrightSpring Health Services
Benefits Department
805 N. Whittington Parkway
Louisville, KY 40222

NON-CREDITABLE COVERAGE DISCLOSURE NOTICE

IMPORTANT NOTICE FROM BRIGHTSPRING HEALTH SERVICES 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 BrightSpring Health Services and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. BrightSpring Health Services has determined that the prescription drug coverage offered by the **UHC FlexWork Plan** is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the **UHC FlexWork Plan**. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can elect to keep coverage from the **UHC FlexWork Plan**. However, because this coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a Medicare drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you decide to drop your current coverage with BrightSpring Health Services, since it is employer-sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under the **UHC FlexWork Plan**.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under the **UHC FlexWork Plan**, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

If you decide to join a Medicare drug plan, your current BrightSpring coverage will not be affected, and the Medicare drug benefits will be coordinated with your BrightSpring coverage. As an active employee, Medicare drug coverage will pay secondary for you or your spouse who chooses to enroll in a Medicare drug plan.

However, you likely will have to pay a Medicare Part D premium, which BrightSpring will not reimburse. Your options include the following:

- Keep your current benefits with BrightSpring Health Services and enroll in Medicare prescription drug coverage (in addition to prescription drugs, your current coverage includes medical benefits through the plans listed above and you will be eligible to receive all of your current medical benefits even if you choose to enroll in a Medicare prescription drug plan).
- Enroll in a Medicare prescription drug plan and drop current benefits with BrightSpring Health Services. Note that you will lose your BrightSpring medical coverage as well as prescription drug coverage if you elect this option.

If you do decide to join a Medicare drug plan and drop your current BrightSpring Health Services coverage, be aware that you and your dependents may not be able to get this coverage back until the next open enrollment period or you experience a qualified life event that allows for a mid-year enrollment.

For More Information About This Notice Or Your Current Prescription Drug Coverage: Contact the BrightSpring Benefits Support Center at (844) 896-0169. 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 BrightSpring Health Services changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage: More detailed information about Medicare plans that offer prescription drug coverage can be found 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).

Date of this notice: October 1, 2026

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, you can contact your state Medicaid or CHIP office or dial 1-877-KIDS-NOW (1-877-543-7669) or visit 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 U.S. Department of Labor's Employee Benefits Security Administration 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, 2026. Contact your State for more information on eligibility:

ALABAMA – Medicaid

Website: http://myalhipp.com/

Phone: 1-855-692-5447

ALASKA – Medicaid

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

Website: http://myarhipp.com/

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program
Website: www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/

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+)

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

FLORIDA – Medicaid

Website:

https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

Phone: 1-877-357-3268

GEORGIA – 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

Illinois – Medicaid

Medicaid application website: https://abe.illinois.gov

HIPP Hotline Number: 217-524-8268

HIPP Email: mhfs.boc.hipp@illinois.gov

INDIANA – Medicaid

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)

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

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

KENTUCKY – 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

LOUISIANA – Medicaid

Louisiana Medicaid website:
https://www.ldh.la.gov/healthy-louisiana

Medicaid Customer Service Line: 1-888-342-6207

Medicaid email: healthy@la.gov

LaHIPP website: https://www.ldh.la.gov/lahipp

LaHIPP phone: 1-877-697-6703

LaHIPP email: La.HIPP@la.gov

LaHIPP fax: 1-888-716-9787

LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084

MAINE – Medicaid

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa

Phone: 1-800-862-4840

TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website:

https://mn.gov/dhs/health-care-coverage/

Phone: 1-800-657-3672

MISSOURI – Medicaid

Website:

http://www.dss.mo.gov/mhd/participants/pages/hipp.htm

Phone: 573-751-2005

MONTANA – Medicaid

Website:

http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP

Phone: 1-800-694-3084

Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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

Medicaid Website:
https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/

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)

NEW YORK – Medicaid

Website:
https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON – Medicaid

Website:
http://healthcare.oregon.gov/Pages/index.aspx

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website:
https://www.pa.gov/en/services/dhs/applyformedicaid-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)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/

Phone: 1-855-697-4347, or

401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov

Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov

Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP)

Program | Texas Health and Human Services

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

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

Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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

Website: https://www.hca.wa.gov/

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: https://bms.wv.gov/

Medicaid Phone: 304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm

Phone: 1-800-362-3002

WYOMING – Medicaid

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

OMB Control Number 1210-0137 (expires 5/31/2029)

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 05/31/2029)

Wellness Notice

BrightSpring offers voluntary wellness benefits, available on a nondiscriminatory basis to BrightSpring employees enrolled in the BrightSpring medical plan. Our program is administered according to federal laws, which permit employers to sponsor wellness programs that seek to improve employee health or prevent disease. These federal laws include, but are not limited to:

• The Americans with Disabilities Act of 1990;

• The Genetic Information Nondiscrimination Act of 2008; and

• The Health Insurance Portability and Accountability Act.

Our wellness benefits include the ability to forgo a $50 per month per tobacco user medical premium surcharge. If you do not complete the annual tobacco attestation form or you indicate that you and/or your spouse are tobacco users, you can avoid the tobacco surcharge by completing a free tobacco cessation program. Even if you don't complete the tobacco cessation program you may still be entitled to a reasonable accommodation or an alternative standard, which if approved and completed will also result in you avoiding the tobacco surcharge. To request a reasonable accommodation or an alternative standard you can contact BrightSpringBenefits@BrightSpringHealth.com. Completing the tobacco cessation program or an agreed-upon alternative will result in the full waiver of the surcharge (retroactively, back to the start of the applicable calendar year).

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. BrightSpring uses the Healthy Guidance Tobacco Cessation Program through GuidanceResources, which may aggregate information; however, GuidanceResources will never disclose any of your personal information either publicly or to BrightSpring, except as necessary to respond to a request from you for a reasonable accommodation or alternative standard, to access or process BrightSpring wellness benefits, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with wellness benefits will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to wellness benefits, and you will not be asked or required to waive the confidentiality of your health information as a condition of receiving a benefit. Anyone who receives your information for purposes of providing you wellness benefits or services will abide by the same confidentiality requirements.

In addition, all medical information obtained to administer our wellness benefits will be kept separate from your personnel records, all relevant information stored electronically will be encrypted, and no information you provide will be used in making any employment decision. BrightSpring maintains specific safeguards to protect the privacy and security of this information, in compliance with the Health Insurance Portability and Accountability Act. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide, we will notify you promptly.

BrightSpring will not discriminate against you because of the medical information you provide (if any) to access wellness benefits and will not retaliate against you if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact BrightSpringBenefits@BrightSpringHealth.com.

Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under the BrightSpring Health Services Welfare Benefit 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 monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

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

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

• Your hours of employment are reduced, or

• Your employment ends for any reason other than your gross misconduct.

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

• Your spouse dies;

• Your spouse's hours of employment are reduced;

• Your spouse's employment ends for any reason other than his or her gross misconduct;

• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

• You become divorced or legally separated from your spouse.

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

• The parent-employee dies;

• The parent-employee's hours of employment are reduced;

• The parent-employee's employment ends for any reason other than his or her gross misconduct;

• The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

• The parents become divorced or legally separated; or

• The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

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

• The end of employment or reduction of hours of employment;

• Death of the employee; or

• The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. For divorce, legal separation, or a dependent child's loss of eligibility, you or another qualified beneficiary must notify the BrightSpring Benefits Support Center within 60 days after the qualifying event. Notice should be sent to the BrightSpring Benefits Support Center, PO Box 2948, Bellaire, TX 77402. The notice must include sufficient information to identify the employee and affected qualified beneficiaries, the type and date of the qualifying event, and any supporting documentation requested by the Plan.

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period 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

BrightSpring Benefits Support Center

844-896-0169

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

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 10.22% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest cost.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special

Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage under an employment-based health plan, such as an employer-sponsored health plan, you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact BrightSpring Benefits Support Center at 844.896.0169.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Res-Care, Inc. d/b/a BrightSpring Health Services

4. Employer Identification Number (EIN): 610875373

5. Employer address: 805 N. Whittington Pkwy

6. Employer phone number: 502.394.2100

7. City: Louisville

8. State: KY

9. ZIP: 40222

10. Who can we contact about employee health coverage at this job? BrightSpring Benefits Support Center

11. Phone number (if different from above): 844.896.0169

12. Email address: BrightSpringBenefits@BrightSpringHealth.com

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

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

☐ All employees.

☒ Some employees. Eligible employees are: Full-time employees scheduled to work 30 or more hours per week and eligible part-time employees who average 30 or more hours per week over the measurement period.

• With respect to dependents:

☒ We do offer coverage. Eligible dependents are: Legally married spouse, domestic partner, dependents under the age of 26 and disabled dependents over the age of 26 who became disabled prior to attaining age 26.

☐ We do not offer coverage.

Does the employer offer a health plan that meets the minimum value standard*?

☒ Yes ☐ No

The coverage your employer offers to eligible employees meets the minimum value standard, and the cost of this coverage is intended to be affordable, based on the employee wages.

Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, www.healthcare.gov will guide you through the process. Here's the employer information you'll enter when you visit www.healthcare.gov to find out if you can get a tax credit to lower your monthly premiums.