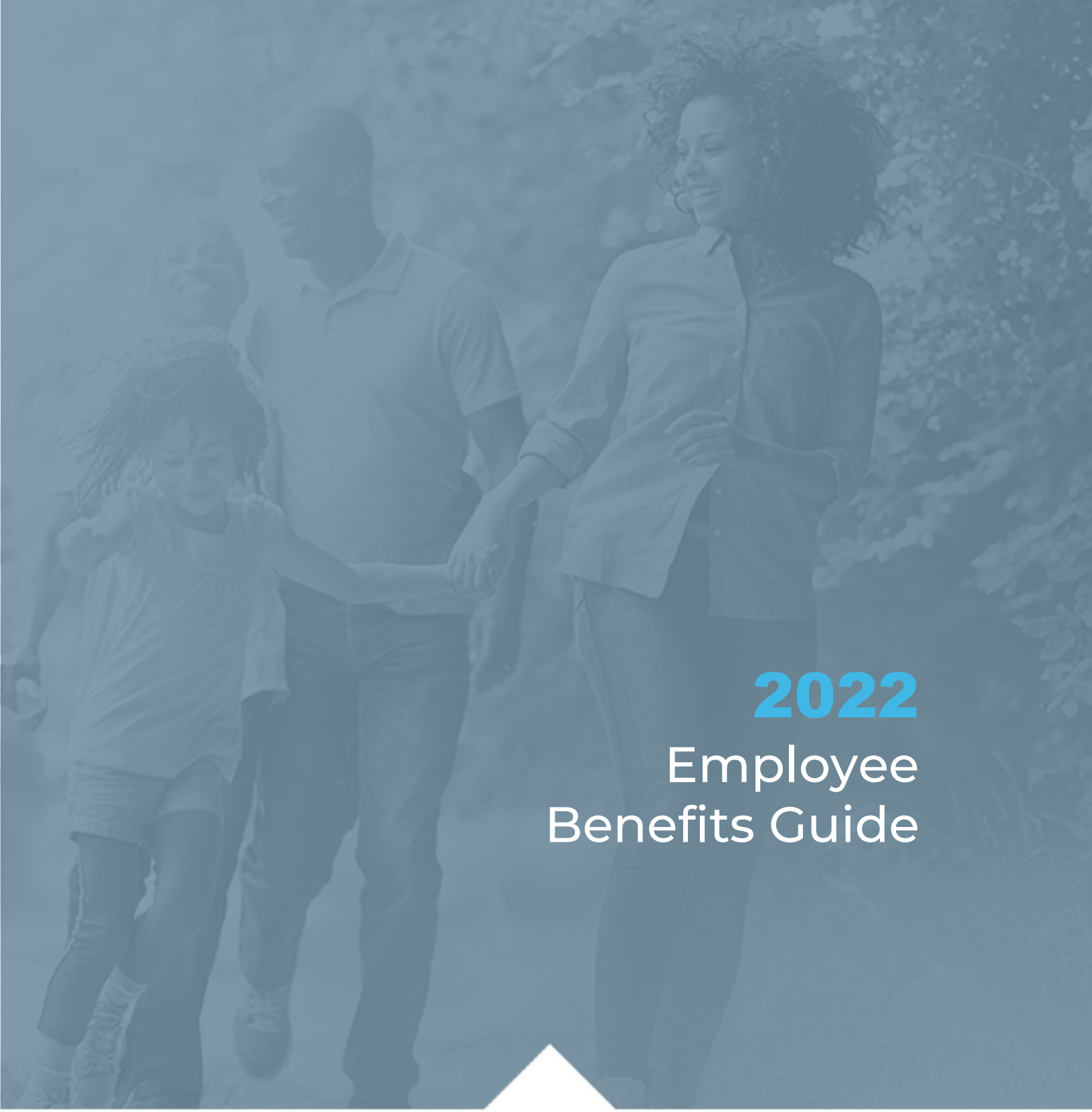

2022
Employee Benefits Guide

Tangram
Reshaping the Idea of Disability

Tangram
Reshaping the Idea of Disability

Welcome to your Benefits

Welcome to the 2022 Tangram Employee Benefits Guide. This guide offers you and your family members a look into your comprehensive benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage options for you and your family. We have included brief descriptions of our benefit offerings and the cost. If you have any questions, please contact the Human Resources Department.

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Welcome

Welcome to Tangram. You are joining a dedicated team committed to shaping our community. At Tangram, we assist people with disabilities to live full, meaningful, and happy lives, at home and as members of their community. We cannot continue to carry out our mission without our employees. Your health, financial well-being and work-life balance are important to us, and our benefit program is designed to meet those needs.

- Tangram believes that your benefits are a significant part of your overall compensation package.
- Tangram strives to lead the market in benefits offerings as a way to reward and retain its talent.
- Tangram continually reviews its benefits offerings to ensure that they meet the diverse needs of our employee population and are cost-effective, given the rising costs of healthcare.

Achieving Financial Well-Being--Unexpected medical expenses or the loss of a paycheck due to death or disability can have a crushing impact on employees and their families. Tax-advantaged funding plans including the Flexible Spending Account (FSA) and the Health Savings Account (HSA) allow employees pay for out-of-pocket healthcare expenses with tax-free money. Life and Accidental Death and Dismemberment (AD&D) insurance provides protection for your family in the event of your death. Disability insurance, both for disabilities of short duration (STD) and long duration (LTD) insure your paycheck, providing ongoing income should you be unable to work as a result of an injury or illness. Accident Insurance and Critical Illness insurance provide payment directly to the insured in the event of certain covered accidents or diagnoses.
Work-Life Balance—Sometimes you just need a little help. Whether you need to find help breaking free of your addictions, or a way to navigate complex relationships, the Employee Assistance Plan (EAP) can refer you to valuable resources to help you achieve greater balance in your life.

Welcome to the Tangram team. We are happy to have you.

Benefits Overview

Benefits Overview
This benefit guide provides an overview of the benefits that Tangram offers.

Tangram offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Who is eligible?
- Full time Non-Exempt employees will become eligible the first of the month following 30 days of employment.
- Full time Exempt employees will become eligible the first of the month following 30 days of employment.

When does coverage become effective?

New employees will become eligible for benefits effective on the first day of the month following 30 days of employment, provided you have completed the enrollment process and all required information and documents.

Variable Hour Employees
Employees who do not work 30 hours on an ongoing basis are considered Variable Hour Employees (VHEs) and their eligibility will be reviewed during a twelve (12) month measurement period.
- If you DO average at least 30 hours of service during a twelve (12) month initial (or ongoing) measurement period (thereby qualifying you as benefit eligible), you will be considered a benefit eligible employee on the first day of the stability period associated with a twelve (12) month measurement period, and benefits will be effective the first of the month following the end of the stability period. You will be deemed an eligible employee for the duration of a twelve (12) month stability period (regardless of the actual number of hours you work) unless your employment terminates with the company.
- If you DO NOT average at least 30 hours of service during a twelve (12) month initial (or ongoing) measurement period, you will not be considered a full-time eligible employee for the duration of the subsequent stability period associated with that measurement period (regardless of the actual number of hours you work).

Please see your Human Resources department if you have any questions concerning your eligibility for coverage and the measurement method used by the company for your job status.
- If coverage was waived during the initial eligibility period, a full-time employee may apply for coverage during open enrollment.
- No exceptions can be made to the eligibility criteria. The Tangram group benefit plan is a section 125 plan and governed by the Internal Revenue Service (IRS).
- Some premiums are deducted on a pre-tax basis and, as a result, changes can only be made during annual enrollment or if you experience a significant family status change.
- Once you make your elections, they are binding elections and cannot be changed unless there is a significant family status change. For a complete listing of what qualifies as a significant family status change, please refer to the next section of this booklet. You must enroll or make changes by notifying Human Resources within 30 days of a change of family status or you will be required to wait until the next annual enrollment. You may be required to submit proof of your family status change.

Benefits Overview

Significant Family Status Changes

- Involuntary loss of other coverage;
- A change in legal marital status, including marriage, death of the spouse, divorce, legal separation, or annulment;
- A change in the number of dependents (as defined in Code section 152), including birth, adoption, placement for adoption (as defined in the regulations under Code section 9801), or death;
- A change in employment status, termination or commencement of employment by the Participant, the Participant's spouse or a Dependent child, a strike or lockout, commencement of or return from an unpaid leave of absence (including an FMLA leave), or a change in employment status which affects eligibility for coverage, such as switching between hourly and salaried status or a reduction or increase in hours of employment;
- A Dependent satisfying or ceasing to satisfy the requirements for dependent coverage;
- A change in the place of residence or work of the Participant, the Participant's spouse or a Dependent child (which affects health coverage options);
- A HIPAA special enrollment event;
- Entitlement to Medicare or Medicaid or loss of entitlement to Medicare, Medicaid, or CHIP;
- A court order, judgment or decree including a Qualified Medical Child Support Order (QMCSO) requiring the participant or the participant's former spouse to provide health coverage for a Dependent child as long as the coverage is actually added;
- A change in a Dependent's coverage under the plan sponsored by the Dependent's employer that either meets one of the criteria in (2) through (9) above or is made during that plan's open enrollment;
- Special enrollment rights under state Medicaid or state sponsored children health insurance programs (CHIP) where available. (You must request this change within 60 days of losing or gaining coverage). See plan document for guidelines.
- Any other change permitted under IRS rules.

How to Enroll

Look for an email from Paylocity with a registration link. This will be sent to your work email address. Follow the directions to register, verify your personal information and make any necessary changes. You will be able to review your current elections, along with the Benefit Plan information. After you make your elections, you will not be able to change them until the next open enrollment period unless you have a qualified change in status.

Medical Plan

Medical Plan Details

Tangram offers a comprehensive dual choice health plan to all eligible full-time employees.

The PPO and HSA Plans:

- Are administered by Edison Health Solutions and access the **Cigna Network**
- Cover preventive care, such as your annual routine physical and related preventive tests at 100% with no deductible or copayment
- Meet and exceed the minimum coverage requirement under the Affordable Care Act

Edison Health Solutions Benefits Administration Online Services

- Visit www.edisonehs.com
- Select Links and Medical Portal
- Enter your User ID and Password. If you have not yet registered for online services, click “Register New User” and follow the prompts to complete your registration.

Edison Health Solutions online services are fast, easy, and free with convenient access to tools and resources such as:

- Claim status (including copies of Explanations of Benefits - EOBs)
- Status of medical deductibles and out-of-pocket amounts
- Frequently used forms
- Ordering ID cards (duplicates or replacements)
- Health information
- Prescription benefits information

If you have questions or problems, you can contact Edison Health Solutions at 866-386-9779.

Cigna Network

The Tangram Health Plans utilize the Cigna Network. The Cigna Network offers a broad network of physicians and hospitals available. The Cigna Network includes most hospitals within Indiana, as well as a broad national network of providers across the country. It is very likely that your physician already participates in the Cigna Health Network, **but it is recommended that you verify this with your doctor’s office before each visit.**

To find physicians within the PPO network, please visit the Edison Health Solutions portal and click the Cigna Network link.

Medical Plan

Health Plan In-Network Benefits Summary

This brief benefit summary includes in-network benefits only. Edison Health Solutions uses the Cigna network which includes most local physicians and hospitals. As always, please check with your health care provider to verify participation before receiving services.

	High Deductible Health Plan	Traditional PPO Plan
	IN-NETWORK BENEFITS	
Deductible: Individual/Family	$3,000 / $6,000	$3,000 / $6,000
Coinsurance (You Pay)	20%	20%
Out of Pocket Max: Individual/Family	$6,000 / $12,000	$6,000 / $12,000
Preventive Care	100% - No Deductible	100% - No Deductible
Primary Care Provider	Deductible then $25 copay	$25 copay
Specialist	Deductible then $50 copay	$50 copay
Urgent Care	Deductible then $75 copay	$75 copay
Emergency Room	Deductible then coinsurance	Deductible then coinsurance
Prescription Drugs		
Retail (30 day supply)		
Tier 1 **Tier 2** **Tier 3** **Tier 4**	Deductible then $10 Copay Deductible then $25 Copay Deductible then $50 Copay Deductible then 25% to $200 (Over $350 exclude)	$10 Copay $25 Copay $50 Copay 25% to $200 (Over $350 exclude)
Mail Order (90 day supply)		
Tier 1 **Tier 2** **Tier 3**	Deductible then $25 Copay Deductible then $62.50 Copay Deductible then $125 Copay	$25 Copay $62.50 Copay $125 Copay

Medical Plan

Bi-Weekly Employee Contributions (Non-Smoker) PPO Plan		
Tier	**Employees Making Less Than $50,000 Annually**	**Employees Making More Than $50,000 Annually**
Employee Only	$59.14	$66.53
Employee + Spouse	$211.92	$222.51
Employee + Child(ren)	$192.99	$192.99
Employee + Family	$274.36	$288.80

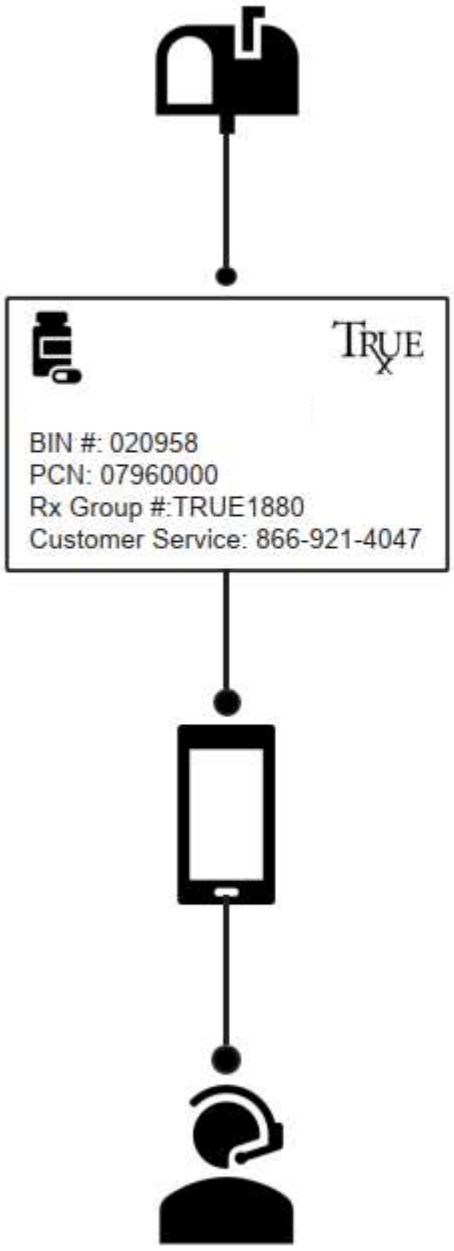
Bi-Weekly Employee Contributions (Smoker) PPO Plan		
Tier	**Employees Making Less Than $50,000 Annually**	**Employees Making More Than $50,000 Annually**
Employee Only	$78.99	$86.38
Employee + Spouse	$231.76	$242.36
Employee + Child(ren)	$212.84	$212.84
Employee + Family	$294.20	$308.64

Bi-Weekly Employee Contributions (Non-Smoker) HDHP Plan		
Tier	**Employees Making Less Than $50,000 Annually**	**Employees Making More Than $50,000 Annually**
Employee Only	$49.71	$53.31
Employee + Spouse	$190.29	$197.52
Employee + Child(ren)	$169.31	$175.80
Employee + Family	$242.53	$251.53

Bi-Weekly Employee Contributions (Smoker) HDHP Plan		
Tier	**Employees Making Less Than $50,000 Annually**	**Employees Making More Than $50,000 Annually**
Employee Only	$69.56	$73.16
Employee + Spouse	$210.14	$217.37
Employee + Child(ren)	$189.15	$195.64
Employee + Family	$262.37	$271.38

Pharmacy Plan

True Rx has partnered with your employer to provide you with pharmacy insurance benefits. In order to activate your benefits, please take these three steps.



1. FIND YOUR NEW CARD IN THE MAIL.

You will receive a new insurance card **from Edison Health Solutions.**

This card ensures the amount you pay for your medications at the pharmacy is accurate with your insurance plan.

2. TAKE YOUR NEW CARD TO THE PHARMACY.

If you need to fill a prescription and do not have your new insurance card, please bring this document to the pharmacy.

3. UPDATE YOUR MAIL ORDER PRESCRIPTION.

If your plan allows for mail order service and you would like to continue to receive medications mailed to you, please contact Postal Prescription Services. You can complete this process online at www.ppsrx.com or call PPS at 800-552-6694.

YOUR SECURE INFORMATION IS AVAILABLE 24/7.

Sign into the secure portal at www.truerx.com or download the app.

- View your ID card
- Find your member ID number
- Locate pharmacies in your network
- See current prescriptions
- Compare medication pricing

YOU HAVE A PRESCRIPTION PLAN EXPERT TO CALL.

You have a team of experts in prescription benefit plans ready to help.

- Call True Rx at 866-921-4047
- Monday – Friday
- 8:00am – 6:00pm EDT

On behalf of all of us at True Rx, we look forward to taking care of your pharmacy insurance needs.

866-921-4047 | www.truerx.com

Pharmacy Plan

SHARx Prescription Assistance

What is SHARx Prescription Assistance?

SHARx is a pharmacy advocacy solution offered by your employer. This program was created to extend advocacy program benefits to employees like you. Their role is to help facilitate the advocacy onboarding process for each eligible member of the health plan and provide access for all specialty medications.

This program is scheduled to start on January 1, 2022. Because it can take a few weeks to get set up, now is the time to begin the process.

Who is eligible?

Tangram is making this program available to members enrolled in the health plan. If you are currently on a specialty medication, you will want to follow the steps for potential cost savings to you.

What are the costs?

There are no costs to you to participate in the SHARx program. Tangram has paid 100% of the cost of this service for you and your family as long as you are enrolled in the health plan. Prescriptions obtained through this service could be free for you and your family. Sometimes a co-pay or out of pocket amount will be required, but this out of pocket may be substantially less than what you are paying now.

Visit SHARXPLAN.COM or Call (314) 451-3555 to start the process today!

What is considered a Specialty Prescription?

Any medication that is high cost, high complexity, or high touch is included under the specialty medication designation. These would include Actemra, Atripla, Avastin, Betaseron, Botox, capecitabine, Cellcept, Copaxone, Cosentyx, Enbrel, Entyvio, Forteo, Gammagard, Genvoya, Gilenya, Glatopa, Harvoni, HP Acthar, Hizentra, Humatrope, Humira, In lectra, Lupron Depot, Orencia, Otezla, Prolia, Remicade, Revlimid, Sprycel, Stelara, Stribild, Taltz, Tecfidera, Truvada, Xeljanz, and MANY, MANY More!!

What happens if I don't enroll in the SHARx program?

Your specialty medications will no longer be covered by your employer pharmacy benefit plan. Certain manufacturers will require additional information to verify your income. Please respond right away to these requests for additional information to ensure there is no delay with your advocacy. Our goal is for everyone to receive the medications they need as quick as possible at the lowest price, and this is only accomplished with your help.

Edison Health

Our health plan has partnered with Edison Healthcare to provide preferred access to some of the nation's leading Smart Care Medical Centers **at no cost to you**. These centers feature integrated care teams who meet specific criteria for ethics, quality, safety and effectiveness, and who have an established track record for successfully treating patients with complex conditions. **For spine, back and shoulder procedures, you will experience world-class service and save money through Edison Healthcare.**

Edison Healthcare is an added benefit to you and your family when facing one or more of the following:

- Spine Surgery
- Hepatitis-C Treatment
- Orthopedic Surgery
- Transplant Surgery
- Heart Surgery
- Stem-Cell Therapy
- Valve Replacement Surgery
- Cancer Diagnosis

Beginning 1/1/2022, if you need care for back, shoulder or spine procedures, please use Edison Healthcare Smart Care Centers

- We have partnered with Edison Healthcare to provide a second opinion for members in need of a surgery, to determine appropriateness of care and provide direct access to some of the highest quality healthcare facilities in the country.
- Their concierge service manages the entire process from the initial contact, to booking any travel and accommodations, patient care and treatment follow up.
- **Conservatively, over 20% of surgeries are misdiagnosed and 40% of surgeries have wrong treatment plans.** Partnering with Edison Healthcare provides Tangram employees and family members peace of mind that they are getting the best care possible.

World Class Health Systems who are part of the Edison Healthcare Smart Care Network are:

- Mayo Clinic (Minnesota, Florida, and Arizona)
- Cleveland Clinic (Cleveland, Ohio)
- Mercy Hospital (Springfield, Missouri)
- Oschner Health System (New Orleans, Louisiana)
- Boston Children's Hospital (Boston, Massachusetts)

To learn more visit us at www.EdisonHealthcare.com.

Health Savings Account

How do I access my HSA funds?

The bank will provide you with a debit card and check book (if requested). Remember, in the event of an IRS audit, you are responsible for providing your receipts for services and other items purchased with money from your HSA.

What if I don't have enough money in my HSA account to pay for my medical expenses during the year which apply toward my deductible and coinsurance out-of-pocket?

The good thing about an HSA is that it is flexible and allows you to add additional money (up to the maximum below) if your medical claims are more than you had anticipated. You can either request a change in the amount of your pre-tax payroll deduction during the year, or you can deposit after-tax money and generally take a deduction when you file your taxes. Talk to your tax advisor about this option.

How much can I contribute to an HSA?

The annual HSA contribution limits for 2022 are:

- $3,650 for individual coverage and $7,300 for family coverage
- Individuals age 55 or older may be eligible to make a catch-up contribution of $1,000.

What if I enroll in an HSA in the middle of the year?

Your HSA contributions are generally determined on a monthly basis. However, if you enroll in an HSA mid-year, you are allowed to make a full year's contribution, provided you are eligible on Dec. 1 of that year and you remain eligible for HSA contributions for at least the 12-month period following that year.

Who is eligible to use my HSA funds?

You can use your HSA funds to reimburse Qualified Medical Expenses incurred by you, your spouse,

and your tax dependents, as long as the expenses are incurred after the date that your HSA is established.

What happens to my HSA funds if I leave?

You take your HSA account and funds with you because it's your personal bank account. Remaining HSA funds may continue to be spent on qualified out-of-pocket medical, dental, and vision expenses.

For further information and a list of HSA qualified medical expenses, please visit https://www.irs.gov/pub/irs-pdf/p502.pdf

Coming in February 2022!

HealthJoy is your easy-to-use, chat-based app that gives you access to board-certified doctors, personal Healthcare concierges, and your company's Benefit Wallet.

Download the mobile app at http://Downoad.HealthJoy.com

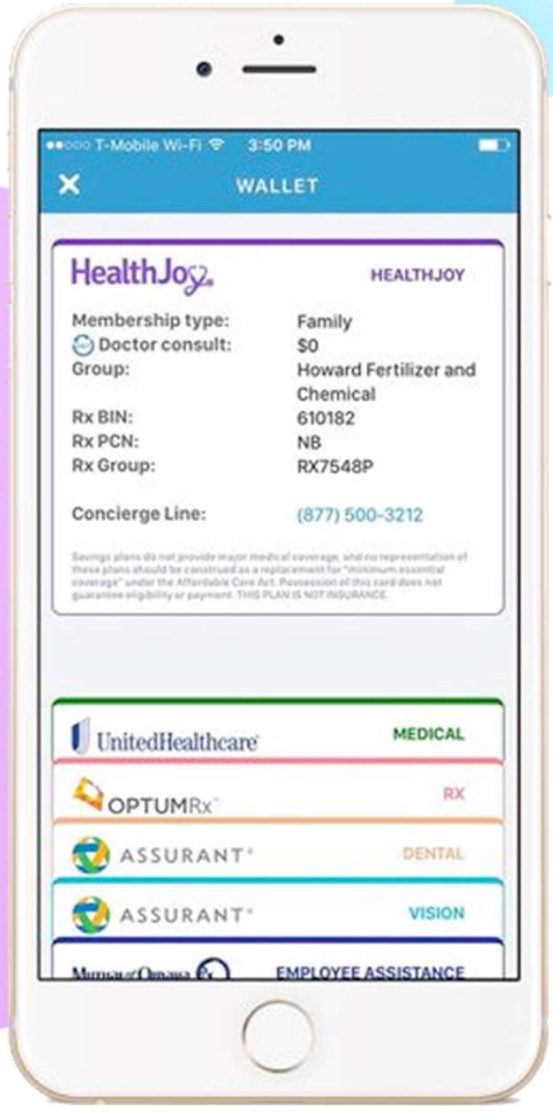
Through this app you will have access to a board-certified physician similar to what was offered with LiveHealthOnline.

Your Healthcare Concierge will assist you by clarifying your benefits, finding providers, Care Coordination and more!

You will have access to a benefits wallet on the app that will have your membership card for all your benefits virtually.

No Smartphone? No Worries! You can get the same services if you call HealthJoy at 877.500.3212 or email at groups@healthjoy.com.

Please stay tuned for more information on this exciting new resource!!



Dental Insurance

MetLife Dental Plan

You have the option to enroll in a comprehensive dental insurance plan, administered by MetLife. You do not need to be enrolled in the health insurance plan to enroll in dental insurance. You can find in-network providers at www.metlife.com/dental

Type of Service	Low Plan In-Network	High Plan In-Network
Calendar Year Deductible Single Family	 $50 $150	 $50 $150
Annual Dental Maximum per Person	$1,250	$1,250
Preventive Services Oral Exams & Cleanings, Bitewing X-rays & Fluoride Treatments	100%	100%
Basic Services Fillings, Simple Extractions, X-rays, Periodontics	50%	80%
Major Services Major Restorative Services, Crowns, Bridges, Dentures	25%	50%
Orthodontia for Children to Age 19 Coinsurance Lifetime Max per Individual	N/A	 50% $1,000

This is a partial listing of benefits and services only. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of the Dental Certificate.

2022 Bi-Weekly Dental Payroll Deductions	Low Plan	High Plan
Employee Only	$10.13	$13.59
Employee + Spouse	$21.62	$29.00
Employee + Children	$29.79	$39.97
Employee + Family	$40.64	$54.53

Vision Insurance

MetLife Vision Plan

Tangram's Vision benefits are provided by MetLife using the Davis network. The network directory can be found at www.metlife.com/vision. The plan offers out-of-network reimbursements, but you will get the greatest benefit by staying In-Network

Benefits When Using a Participating Network Provider		Copay
Well Vision Exam	• Focuses on your eyes and overall wellness • One every 12 months	$10
Frame	• $120 allowance for a wide selection of frames • 20% off amount over your allowance • One every 24 months	Copays may apply
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • One every 12 months	$20
Contacts (in lieu of glasses)	• $120 allowance for contacts • Contact lens exam (fitting and evaluation) • One every 12 months	Copays may apply

2022 Bi-Weekly Vision Payroll Deductions	Vision Plan
Employee Only	$2.22
Employee + Spouse	$4.43
Employee + Children	$4.65
Employee + Family	$6.48

Flexible Spending Account (FSA)

Flexible Spending Accounts (FSA) For PPO Medical Plan Participants

In an effort to keep your medical benefit and dependent care costs as affordable as possible, a Flexible Benefits Plan is being sponsored by Tangram. The Plan provides each eligible employee with the opportunity to set aside part of their pay on a *pre-tax* basis to provide for reimbursement of unreimbursed medical and dependent care expenses. These are two separate accounts as noted below. You save Social Security and income taxes on the amount of your salary reduction used to pay for these expenses. Your annual election should consider only expenses that you will incur from your effective date through December of the current year.

How It Works:

As a qualified employee, there is no enrollment cost. Through the Flexible Benefit Plan, you will have the opportunity to set up two types of reimbursement accounts, similar to checking accounts. At the beginning of the Plan Year, you will estimate your annual out-of-pocket medical and dependent care expenses. Not sure what is eligible for reimbursement? IRS publication 502 has an extensive list of eligible items and can be found at www.irs.gov/publications/p502. Your annual election will be divided by the number of pay periods for the year and be deducted from your paycheck each pay period…**before taxes are taken out!**

Beneflex Convenience Card:

Once enrolled you will be issued a Beneflex Convenience Card, which is a special purpose MasterCard that stores the value of your account contributions. Each time you make a purchase for a qualified expense by swiping the Beneflex Convenience Card, your purchase will be deducted from the appropriate account automatically. If your purchase does not comply with IRS "auto- adjudication" guidelines, you may be required to forward transaction receipts to Beneflex.

Deadline for Reimbursement: You have until March 31st of the following year to claim expenses incurred in the prior year. Amounts allocated to one account cannot be used to pay for expenses for another account.

Health Care Flexible Spending Account (HCFSA):

In determining an amount of your salary to defer into a health care flexible spending account, you should consider your health insurance deductibles and co-payments, as well as uninsured medical and dental expense, vision care and hearing care. Generally, the expenses covered must be "medically necessary" as determined by a doctor.

The 2022 Federal contribution limit for HCFSAs is $2,850.

Dependent Care Flexible Spending Account (DCFSA):

If you pay a person (provider cannot be your spouse or person you list as your dependent on income taxes) to care for your dependent child (under age 13), or a disabled dependent, while you work, you may allocate money to the dependent care account. These eligible expenses will be reimbursed to you with pre-tax dollars.

The 2022 Federal contribution limit for DCFSAs is $5,000 ($2,500 if married and filing separately). However, the amount pledged by you cannot exceed the lower of you or your spouse's annual salary.

You cannot claim dependent care expenses which you submitted to your dependent care account for reimbursement on your tax return. It is encouraged that employees contact a professional tax consultant to determine if it would be more advantageous to
claim the tax credits on your tax return.

Wellness Program

Wellness Program

Here at Tangram, we value our employees and take your health and wellness seriously. A strong company cannot exist without healthy employees. The everyday choices we make can help us live healthier, happier, and more fulfilling lives-both at home and at work.

Preventive Healthcare

Do you have your own physician or family doctor? It is important to be involved in your own health care no matter the condition you have. Speak up for yourself and tell your health care provider about current symptoms, past illnesses and operations. Bring a list of all treatments and medicines you are using, including prescriptions, over-the-counter drugs and supplements. Make sure you find out the facts. Before you and your provider decide on a medication, learn as much as you can. Research the brand and generic names, uses, warnings, drug interactions, adverse effects and directions. Be sure to consider the benefits and risks—your health is worth the effort!

Routine Preventive Care Services are paid at 100% In-Network if you are enrolled in the medical plans. We encourage you to obtain Preventive Care Services and Health Screenings, as appropriate for your age, to help maintain or improve your health and achieve your health and wellness goals. Regular preventive care visits and health screenings may help to identify potential health risks for early diagnosis and treatment. Please refer to our plan documents for your specific coverage.

Routine Preventive Care Services are age-based and can include:

- Child wellness exams and immunizations
- Mammograms and pelvic exams
- Cervical cancer screening
- Blood pressure
- Cholesterol
- Obesity screening
- Colorectal cancer testing
- Counseling for cancer prevention strategies for women at high risk for breast cancer
- Influenza shots, HPV, MMR, chicken pox, and tetanus shots
- Diabetes and osteoporosis screening for certain populations
- Prostate cancer screening
- Human immunodeficiency virus (HIV) screening and counseling

If you have more questions on eligible preventive healthcare benefits, please contact Human Resources

Life and AD&D Insurance

Basic Life / AD&D

Tangram provides benefit-eligible employees (effective after meeting eligibility requirements) with Basic Life and Accidental Death & Dismemberment Insurance equal to one times (1x) your annual earnings to a maximum of $150,000. **This benefit is provided at no cost to you.**

Voluntary Life

Employees who want to supplement their group life insurance benefits may purchase additional coverage. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through bi-weekly payroll deductions. You can purchase coverage on yourself and your spouse in $5,000 increments. Minimum coverage is $10,000 and maximum coverage is $500,000 or 5 x your annual earnings, whichever is less. Newly eligible employees can elect coverage up to $100,000 for themselves and $25,000 for their spouse without providing proof of good health. Late enrollment or enrollment for amounts over the guaranteed issue amount will be subject to medical underwriting.

Who Can Enroll	Benefit Amounts	Maximum Amount
EMPLOYEE	$10,000 minimum	$500,000
SPOUSE	$10,000 minimum	$100,000
CHILDREN	$1,000 minimum	$10,000

Bi-Weekly Cost For Each $1,000 of Employee & Spouse Supplemental Life Insurance Coverage										
AGE	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
LIFE	$.046	$.046	$.065	$.12	$.185	$.27	$.415	$.683	$1.14	$1.86
DEPENDENT CHILDREN	$1,000 - $0.22/month $2,000 - $0.44/month Cost covers all eligible dependent children.			$4,000 - $0.88/month $5,000 - $1.10/month				$10,000 - $2.21/month		

It is important to review your beneficiary designation at least once a year. Please contact HR to update your beneficiary information.

Life and AD&D Insurance

Voluntary Life / AD&D (continued)

Voluntary Life Calculator	
1. Enter amount of Voluntary Life coverage desired……	$_____
2. Divide Line 1 by 1,000……..	_____
3. Select your rate from the table above……	_____
4. Multiply Line 2 by Line 3 for est. bi-weekly premium.....	_____

Disability Insurance

Voluntary Disability Insurance (Income Protection)

Disability insurance coverage is offered through The Hartford. Disability insurance pays you a benefit when, because of an accident or illness, you are unable to work. Short term disability pays for qualified non-work-related disabilities which last longer than a week, but less than 12 weeks. Long term disability pays for qualified disabilities that last longer than 90 days.

	Voluntary Short-term Disability	Voluntary Long-term Disability
Benefits Begin	On the 8+ day of disability for accidents and illness	On the 90+ day of continuous disability
Benefits Payable	12 weeks of disability	To age 65
Percentage of Income Replaced	60% of pre-disability basic weekly earnings	60% of pre-disability basic monthly income
Maximum Benefit	$500 per week	$6,000 per month

Disability insurance is voluntary, and all premiums are paid by the employee. Premium is paid on a post-tax basis, making the benefits tax free.

Age	Short-term Disability Monthly Rate per $10 Weekly Benefit	Long-term Disability Monthly Rate per $100 of Covered Salary
<25	$1.40	$0.52
25-29	$1.08	$0.67
30-34	$1.04	$0.87
35-39	$0.81	$1.06
40-44	$0.70	$1.60
45-49	$0.79	$2.29
50-54	$1.01	$3.21
55-59	$1.11	$3.82
60-64	$1.22	$4.24
65-69	$1.34	$3.38
70-74	$1.34	N/A

Short Term Disability Calculator

$_____ / 52 = $_____ * .60 = _____ / 10 * $_____ = $_____ * 12 / 26 = $_____

Your Salary | Weekly Income | Weekly STD Benefit | Age Banded Rate | Premium Per Month | Premium Per Pay

Long Term Disability Calculator

$_____ / 12 = $_____ / 100 * $_____ = $_____ * 12 / 26 = $_____

Your Salary | Monthly Salary | Age Banded Rate | Premium Per Month | Premium Per Pay

Voluntary Insurance

Voluntary Accident Insurance

Guardian

Accident insurance is offered through Guardian. Personal Accident coverage pays you directly for diagnoses and treatment associated with accidents. Coverage is voluntary. You have the option of electing one of two plans, the Value Plan and the Advantage Plan, both of which are described below.

Benefit	Value Plan	Advantage Plan
Accidental Death and Dismemberment		
Death Benefit	Employee: $10,000 Spouse: $5,000 Child: $5,000	Employee: $25,000 Spouse: $12,500 Child: $5,000
Catastrophic Loss	--Quadriplegia: 100% of AD&D --Loss of speech and hearing (both ears): 100% of AD&D --Loss of cognitive function: 100% AD&D --Hemiplegia: 50% of AD&D	--Quadriplegia: 100% of AD&D --Loss of speech and hearing (both ears): 100% of AD&D --Loss of cognitive function: 100% AD&D --Hemiplegia: 50% of AD&D
Common Cancer	200% of AD&D	200% of AD&D
Common Disaster	200% of spouse AD&D	200% of spouse AD&D
Dismemberment		
Hand, Foot, Sight	Single: 50% of AD&D Multiple: 100% of AD&D	Single: 50% of AD&D Multiple: 100% of AD&D
Thumb/Index Finger Hand, Four Fingers Same Hand, All Toes Same Foot	25% AD&D	25% AD&D
Seatbelts and Airbags	Seatbelts: $10,000 Airbags: $15,000	Seatbelts: $10,000 Airbags: $15,000
Reasonable Accommodation to Home or Vehicle	$2,500	$2,500
Wellness Benefit	Provides a $50/year benefit for completing certain routine wellness screenings or procedures (refer to plan highlights section for example procedures)	Provides a $50/year benefit for completing certain routine wellness screenings or procedures (refer to plan highlights section for example procedures)
Portability	Included without evidence	Not Applicable
Child(ren) Age Limits	Birth to 26 years subject to state limitations	Birth to 26 years subject to state limitations

Voluntary Insurance

Guardian

Voluntary Accident Insurance (continued)

Benefit	Value Plan	Advantage Plan
Accident Follow-up Visit with Doctor	$25 up to 6 treatments	$50 up to 6 treatments
Air Ambulance	$500	$1,000
Ambulance	$100	$150
Appliance	$100	$125
Blood/Plasma/Platelets	$300	$300
Burns (2nd and 3rd degree)	9 SQ inches to 18 SQ inches: $0/$2,000; 18 SQ inches to 35 SQ inches: $1,000/$4,000; Over 35 SQ inches: $3,000/$12,000	9 SQ inches to 18 SQ inches: $0/$2,000; 18 SQ inches to 35 SQ inches: $1,000/$4,000; Over 35 SQ inches: $3,000/$12,000
Burn-skin Graft	50% of bum benefit	50% of bum benefit
Child Organized Sport	20% increase to child benefits	20% increase to child benefits
Chiropractic Benefit	No Benefits	$25 per visit up to 6 visits
Coma	$7,500	$10,000
Concussions	$50	$75
Dislocations	Schedule up to $3,600	Schedule up to $4,400
Diagnostic Exam (Major)	$100	$150
Emergency Dental Work	$200/crown; $50/extraction	$300/crown; $75/extraction
Epidural Pain Management	$100 2 times per accident	$100 2 times per accident
Eye Injury	$200	$300
Family Care	$20/day up to 30 days	$20/day up to 30 days
Fracture	Schedule up to $4,500	Schedule up to $5,500
Hospital Admission	$750	$1,000
Hospital Confinement	$175/day up to 1 year	$225/day up to 1 year
Hospital ICU Admission	$1,500	$2,000
Hospital ICU Confinement	$350/day up to 15 days	$450/day up to 15 days
Initial Physician's Office/Urgent Care Facility Treatment	$50	$75
Knee Cartilage	$500	$500
Joint Replacement (Hip/Knee/Shoulder)	$1,500/$750/$750	$2,500/$1,250/$1,250
Laceration	Schedule up to $300	Schedule up to $400

Voluntary Insurance

Voluntary Accident Insurance (continued)

Benefit	Value Plan	Advantage Plan
Occupational or Physical Therapy	$25/day up to 10 days	$25/day up to 10 days
Prosthetic Device/Artificial Limb	1: $500; 2 or more: $1,000	1: $500; 2 or more: $1,000
Rehabilitation Unit Confinement	$150/day up to 15 days	$150/day up to 15 days
Ruptured Disc W/ Surgical Repair	$500	$500
Surgery (Cranial, Open Abdominal, Thoracic)	Schedule up to $1,000 Hernia: $125	Schedule up to $1,000 Hernia: $125
Surgery (Exploratory or Athroscopic)	$150	$250
Tendon/Ligment/Rotator Cuff	1: $250; 2 or more: $500	1: $500; 2 or more: $1,000
Transportation	$400—3 times per accident	$500—3 times per accident
X-Ray	$20	$30
Personal Accident Premiums Per Pay Period		
Employee	$6.49	$8.43
Employee/Spouse	$11.09	$14.24
Employee/Child(ren)	$11.65	$14.68
Employee/Family	$16.24	$20.48

Voluntary Insurance

Voluntary Critical Illness Insurance

Critical Illness coverage is offered through Guardian. You may select coverage for yourself in the amount of $5,000 or $15,000. If you select coverage for yourself, you may also select coverage for your spouse and/or dependent children. Spousal and Dependent Child(ren) coverage is available for half of the policy amount of the employee election.

If you are newly eligible for this coverage, you can elect $5,000 guarantee issued. If you are a late entrant, or you wish to increase your current amount, you will need to provide Evidence of Insurability.

	Percentage of Lump Sum	
Condition	1st Occurrence	2nd Occurrence
Cancer Type 1 (Invasive)	100%	50%
Heart Attack	100%	50%
Kidney Failure	100%	50%
Stroke	100%	50%
Cancer Type 2 (Non-Invasive)	25%	0%
Coronary Artery Bypass Graph	25%	0%

Voluntary Insurance

Voluntary Critical Illness Insurance (continued)

Guardian

	<20	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Employee $5,000 Benefit											
Non-Tobacco	$.16	$.28	$.49	$.81	$1.36	$2.31	$3.69	$5.47	$7.85	$11.49	$16.55
Tobacco	$.19	$.30	$.55	$.97	$1.73	$3.05	$5.49	$8.82	$13.71	$21.49	$32.31
Spouse $2,500 Benefit											
Non-Tobacco	$.08	$.14	$.25	$.41	$.68	$1.15	$1.85	$2.74	$3.92	$5.75	$8.28
Tobacco	$.09	$.15	$.28	$.49	$.87	$1.52	$2.75	$4.41	$6.85	$10.75	$16.15
Child(ren) Benefit $2,500											
Children	$.13	$.13	$.13	$.13	$.13	$.13	$.13	$.13	$.13	$.13	$.13
Employee Benefit $15,000											
Non-Tobacco	$.49	$.83	$1.45	$2.42	$4.09	$6.92	$11.08	$16.41	$23.54	$34.48	$49.64
Tobacco	$.55	$.90	$1.66	$2.91	$5.19	$9.14	$16.48	$26.45	$41.12	$64.45	$96.92
Spouse Benefit $7,500											
Non-Tobacco	$.25	$.42	$.73	$1.21	$2.05	$3.46	$5.54	$8.20	$11.77	$17.24	$24.82
Tobacco	$.28	$.45	$.83	$1.45	$2.60	$4.57	$8.24	$13.22	$20.56	$32.23	$48.46
Child(ren) Benefit $7,500											
Children	$.38	$.38	$.38	$.38	$.38	$.38	$.38	$.38	$.38	$.38	$.38

Voluntary Critical Illness Calculator	
1. Enter amount of Voluntary Life coverage desired.....	$_____
2. Divide Line 1 by 1,000.....	_____
3. Select your rate from the table above.....	_____
4. Multiply Line 2 by Line 3 for your estimated monthly premium.....	_____

CENTERSTONE
SOLUTIONS

Employee Assistance Program

When life throws you challenges, you don't have to deal with them alone

Finding Solutions to Life's Challenges

Balancing the demands of work and home can be challenging. Sometimes additional support is needed to help us meet our personal and professional goals.

Taking a Proactive & Preventative Approach

When you don't feel like you are functioning at your best or just don't feel like yourself, the EAP can help you identify and address concerns to help improve your overall health and well-being.

Contacting the EAP is a Positive First Step

Utilizing the EAP is time for you to focus on your needs and goals. Common reasons people call include stress, anxiety, depression, workplace concerns, loss/grief, relational (couples, families), child /adolescent, substance use, finding a balance, reaching a goal, and other stressors (health/financial/legal).

Your EAP

As a valued employee, your well-being is important. The EAP is available to employees and their household members to develop strategies that will have the biggest impact in the shortest amount of time. The EAP is a confidential service offered to you at no cost.

Learn More

800-766-0068

centerstonesolutions.org

facebook.com/CenterstoneSolutions

Benefits Contact Information

Medical & Pharmacy

Edison Healthcare / Cigna
Medical, 2nd Opinion, Centers of Excellence
Group Number - Tangram
Phone: 1-888-47EDISON
memberservices@edisonehs.com
Website: www.edisonehs.com

True Rx – Prescription Drugs
RxBIN: 020958
RxGRP: TRUE1552
RxPCN: 07960000
Rx Member Service: 1-866-921-4047
Website: www.truerx.com

Dental

MetLife
Group Number - 5392953
Phone: 1-800-275-4638
Website: www.metlife.com/dental

Vision

MetLife (Davis Vision network)
Group Number - 5392953
Phone: 1-800-877-7195
Website: www.metlife.com/vision

Flexible Savings Accounts

Clarity Benefits
Phone: 1-888-423-6359
Website: www.flexaccount.com

Health Savings Account

The HSA Authority / Old National Bank
Group Number: H880025
Phone: 1-800-843-6705
Website: www.gpatpa.com

Life and AD&D

MetLife
Group Number - 5392953
Phone: 1-800-275-4638
Website: www.metlife.com

Short Term Disability

The Hartford
Group Number: 864348
Phone: 1-800-752-9713
Website: www.hartfordlife.com

Long Term Disability

The Hartford
Group Number: 864348
Phone: 1-800-752-9713
Website: www.hartfordlife.com

Personal Accident Insurance

Guardian
Group Number: G-433317
Phone: 1-888-600-1600
Website: www.guardiananytime.com

Critical Illness Insurance

Guardian
Group Number: G-433317
Phone: 1-888-600-1600
Website: www.guardiananytime.com

Employee Assistance Program

Centerstone Solutions
Phone: 1-800-386-7055
Website: www.centerstonesolutions.org

Tangram Human Resources

Ponda Sullivan
Phone: 317-968-9036
Email: psullivan@thetangramway.org

Compliance Notices

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days [or insert any longer period that applies under the plan] 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 [or insert any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

If you are declining enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) 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' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

Notice of Patient Protection

If your health plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. Until you make this designation, the health plan generally may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact [your plan administrator or your Human Resources Department].

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

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;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, contact [the Plan Administrator].

Newborns' and Mothers' Health Protection Act Notice

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn

earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Michelle's Law Notice

Michelle's Law was signed into law effective January 1, 2010. This law generally allows seriously ill or injured fulltime college students, who are covered under their parent's health insurance plan, to take up to one year of medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

*Under the Patient Protection and Affordable Care Act, group health plans are required to offer coverage to dependent children up to age 26, regardless of student status.

Important Notice from Tangram Inc. About Your Prescription Drug Coverage and Medicare (CREDITABLE)

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with

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

2. Tangram Inc. has determined that the prescription drug coverage offered by the HDHP and PPO Group Health Plans 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.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Tangram Inc. coverage will not be affected. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Tangram Inc. coverage, be aware that you and your dependents will be able to get this coverage back.

Compliance Notices

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 Tangram Inc and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact Member Services at the number on your Medical plan ID card for more information. **Note:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Tangram Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription

drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

Date: 1/01/2022

Name of Entity/Sender: Tangram Inc

Contact--Position/Office: Ponda Sullivan, HR Director

Address: 5155 Pennwood Drive, Indianapolis, IN 46205

Phone Number: 219-210-9844

Compliance Notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility.

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711

ALASKA – Medicaid	FLORIDA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268

Compliance Notices

ARKANSAS – Medicaid	GEORGIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

Compliance Notices

KENTUCKY – Medicaid	NEVADA – 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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218

MAINE – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

Compliance Notices

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427

Compliance Notices

PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, 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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Tangram Human Resources.

HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect. Participants in insured group health plans may also receive a notice of privacy practices from those plans. You may request a copy of the current Privacy Practices, explaining how medical information about you may be used and disclosed and how you can get access to this information.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law. You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (“GINA”) prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any the benefits under included benefit plans. GINA generally:

- Prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;
- Prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;
- Allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and
- Prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual’s enrollment.

Qualified Medical Child Support Order Notice

A Qualified Medical Child Support Order (QMCSO) is a court order, or an order issued by a state administrative agency in accordance with federal and state laws that requires an alternate beneficiary (for example, a child or stepchild) to be covered by a plan participant’s group health plan. The Plan honors QMCSOs that meet the legal requirements for such orders. It is important to note that a QMCSO cannot require a plan to provide a type or form of benefit, or an option, that is not currently available from the plan to which the order is directed, unless receiving this benefit or option is necessary to meet the requirements of the Social Security Act, which relates to the enforcement of state child support laws and reimbursement of Medicaid. A QMCSO must be provided to the Plan Administrator to determine if it meets the legal requirements for a QMCSO. If it does, the alternate beneficiary is considered a beneficiary for the purposes of ERISA and

is enrolled as a dependent of the employee participant. If the Plan Administrator receives a medical child support order that relates to you, you will be notified and then informed of the decision as to whether the order is qualified.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If you take leave under USERRA, to the extent required by USERRA, your Employer may continue to maintain your benefits on the same terms and conditions as if you were still an active employee.

Employees going into or returning from service in the uniformed services may have Plan rights mandated by USERRA. These rights apply only to employees and their dependents covered under the Plan before the employee left for military service. To be entitled to USERRA rights, the employee must give the employer advanced notice of the employee's absence from employment for uniformed service, unless precluded by military necessity or if it is otherwise impossible or unreasonable under all the circumstances. Additionally, subject to certain exceptions, the employee's absence from work may not exceed five years.

USERRA rights include up to 24 months of continued health care coverage. For periods of leave less than 31 days, the employee only needs to pay his or her normal portion of the premium. For periods of leave 31 days or more, coverage will only be extended upon payment of the entire cost of coverage plus a reasonable administrative fee.

If you comply with USERRA upon returning to active employment after military service, you may re-enroll yourself and your eligible dependents in health coverage immediately upon returning to active employment, even if you and your eligible dependents did not elect USERRA continuation coverage during your military service. Reinstatement will occur without any waiting periods or pre-existing condition exclusions, except for illnesses or injuries connected to the military service.

USERRA rights terminate if the employee's discharge from the uniformed service was a result of "dishonorable" or other undesirable conduct, the employee fails to report back to work or apply for reemployment within the time period required under USERRA, or if the employee fails to pay coverage premiums.

The time periods within which to elect and pay for USERRA continuation of coverage shall be the same time periods within which to elect and pay for COBRA coverage under the Plan. If both USERRA and COBRA apply, an election for continuation coverage will be an election to take concurrent COBRA/USERRA coverage. Note also that state law may provide continuation and/or conversion coverage.

Mental Health Parity Act Notice

The Mental Health Parity Act ("MHPA") requires that the annual or lifetime dollar limits on mental health benefits may not be lower than any such dollar limits for health and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan. The lifetime limit ceased to apply effective January 1, 2011, and the annual limit ceased to apply effective January 1, 2014. Beginning with the 2010 plan year, federal law also will require that plans providing both health/surgical and mental health benefits may not impose more restrictive financial requirements (such as deductibles and copayments) and treatment limitations (such as limits on days of coverage) on mental health benefits than are imposed on health/surgical benefits.

Compliance Notices

Model General Notice of COBRA Continuation Coverage Rights (For use by single-employer group health plans)

Continuation Coverage Rights Under COBRA - Introduction. You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

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

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Tangram Inc, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

- The end of employment or reduction of hours of employment;
- Death of the employee;
- or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Tangram Human Resources

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.

What if I 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.

Compliance Notices

Family and Medical Leave Act (FMLA) Leave Entitlements. Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within one year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse,child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness. An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

Benefits and Protections. While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave. Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions. An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

Eligibility Requirements. An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite. *Special "hours of service" requirements apply to airline flight crew employees.

Requesting Leave. Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures. Employees do not have to share a medical diagnosis but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified. Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Employer Responsibilities. Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility. Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Enforcement. Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

Notes

https://www.thetangramway.org/

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Reshaping the
Idea of Disability