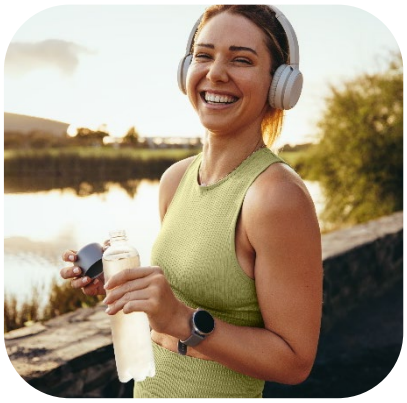

ARHAUS®

2027 ASSOCIATE BENEFITS

Bi-Weekly Pay

Visit ArhausBenefits.com to view information on your benefit package.

Dear Associates,

Arhaus is pleased to offer a comprehensive benefits package that provides quality plans and programs for you and your family. We remain committed to providing you with the best plan options and tools to optimize your health, wellness, and financial security.

Arhaus pays for the majority of the cost of benefits you choose to enroll in, and you pay a small portion for certain benefits. In addition, the company pays the entire cost of Life, AD&D, Short-Term Disability, and Long-Term Disability, on your behalf. If you enroll in the High Deductible Health Plan, the company also makes a contribution to a Health Savings Account for use for eligible health care expenses. We also offer a 401(k) plan, which includes a company match to help you save for retirement. Please read this Benefits Guide carefully so you understand the benefits available to you, as well as how to access coverage. You may also want to share this information with family members.

Arhaus will continue to provide medical plan premium incentives for your participation in our wellness program, allowing you an opportunity to save money by engaging in your health.

Comprehensive information on our plans and partners are available online at www.arhausbenefits.com. Please email Benefits@arhaus.com if you have any questions or need assistance with the enrollment process.

Sincerely,

Arhaus Human Resources

Questions?

Schedule your personalized phone appointment with a Benefits Counselor or Oswald Financial Money Coach

Benefits Questions

Your inbound phone number is 678-280-7805.

Use the phone number to the left to **contact the inbound support line for assistance with benefits questions and enrollment support Monday-Friday, 9am -6pm EST.**

Retirement Plan Questions

Request a 1:1 Session with a Money Coach

OswaldFinancial.com/MoneyCoach >

Register / Watch On-Demand: Webinars & Online Library

OswaldFinancial.com/CoachingCorner >

oswald*financial*

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ELIGIBILITY

We encourage you to read the information in this benefit guide very carefully. This benefit guide provides an overview of the benefits available to you as an eligible Arhaus associate. It is intended only as a general summary of the various options & is not a legal document. Refer to your summary plan description & carrier certificates for final confirmation of coverage.

Associates

Full-Time Associates

Full-time associates who are regularly scheduled to work **at least 30 hours/week** are eligible for Medical, Dental,Vision & Life/AD&D coverage on the 1st of the month following 30 days of employ- ment.

Full-time associates who are regularly scheduled to work **at least 30 hours/week** are eligible for Short-Term & Long-Term Disability coverage on the 1st of the month following 90 days of employment.

Part-Time Associates

Part-time associates who are regularly scheduled to work between 20-40 hours/week are eligible for Dental & Vision coverage on the 1st of the month following 30 days of employment.

Dependents

An eligible dependent may be:

- Your legal spouse

$150/month spousal surcharge may apply if spouse is eligible for benefits elsewhere

- Domestic partners (Domestic Partner Affidavit must be completed)
- A dependent child until the child reaches his or her 26th birthday; includes:
  - Natural biological child, step child or legally adopted child
  - Child for whom the Subscriber or the Subscriber's spouse is a legal guardian or otherwise required by law
  - A child who is considered an alternate recipient under a Qualified Medical Child Support Order
  - Your dependent child who is Disabled either mentally or physically may continue beyond the standard age limit

When Can I Elect or Change my Benefits?

As a New Hire

Associates are eligible for coverage on the 1st of the month following 30 days of employment. You must enroll within 30 days of your eligibility date.

During Annual Open Enrollment

OE takes place each year during the Fall for January 1st. You can make changes to your benefits, enroll in new benefits or drop coverage during this time.

If You Experience a Qualifying Event During the Year

Changes to benefits outside of OE can only be made if you experience a qualified life event, such as a marriage, divorce, birth of a child, adoption or loss of coverage.

You must notify HR within 30 days of a Qualifying Event

MEDICAL

Medical Plan Options

Choose from one of two medical plans to cover yourself and your dependents. Both plans are offered through Anthem Blue Cross & Blue Shield and include prescription coverage. Anthem's network is a national network, providing access to members across the US.

HSA $3,500

Blue Access Health Savings Account (HSA)

With this Consumer-Driven Health Plan:

- Enjoy lower per pay period premiums
- Preventive services are covered at 100%, not subject to Deductible
- Open a Health Savings Account through Anthem with simple, tax-free deposits directly from your paycheck
- Receive a contribution from Arhaus into your Health Savings Account to help pay your medical expenses
- Save for future healthcare expenses tax-free through your HSA!

Core PPO

Blue Access PPO Plan

With this traditional plan:

- Higher per pay period premiums than the HSA plan
- Enjoy the predictability of set copay amounts for office visits, prescriptions & Emergency Room visits
- Lower Deductible
- Preventive services are covered at 100%, not subject to Deductible

By earning wellness credits, associates can save over $600/year for those with Single coverage & over $1,200/year for Families!

MEDICAL

2027 Plan Option:

HSA $3,500

Under this plan option, all services are initially subject to Deductible (both medical & pharmacy). In choosing this plan, you'll also open a Health Savings Account & receive a contribution from Arhaus to help you pay your deductible.

	HSA $3,500	
	In-Network	Out-of-Network
Deductible *(Single/Family)*	$3,500 / $7,000	$7,000 / $14,000
Out-of-Pocket Maximum *(Single/Family)*	$4,000 / $8,000	$8,000 / $16,000
Coinsurance *(what you pay)*	0%	30%
Primary Care Visits	0% after Deductible	30% after Deductible
Preventive Care	Covered in Full	30% after Deductible
Specialist Visits	0% after Deductible	30% after Deductible
Inpatient Hospital Stay	0% after Deductible	30% after Deductible
Outpatient Services	0% after Deductible	30% after Deductible
Emergency Room	0% after Deductible	0% after Deductible
Urgent Care	0% after Deductible	30% after Deductible

*This is a high level summary of benefits. See plan summaries & Certificates for final confirmation of coverage.

MEDICAL

2027 Plan Option:

Core PPO Plan

This plan has an upfront Deductible for inpatient & outpatient procedures. Once that Deductible is met, members will pay coinsurance until the Out-of-Pocket Maximum has been satisfied. Copays apply for Office Visits, ER Visits & Prescriptions. Deductibles, Coinsurance & Copays accumulate towards the OOP Max.

	Core PPO Plan	
	In-Network	Out-of-Network
Deductible *(Single/Family)*	$1,000 / $3,000	$2,000 / $6,000
Out-of-Pocket Maximum *(Single/Family)*	$5,250 / $10,500	$10,500 / $21,000
Coinsurance *(what you pay)*	20%	40%
Primary Care Visits	$30 Copay	40% after Deductible
Preventive Care	Covered in Full	40% after Deductible
Specialist Visits	$60 Copay	40% after Deductible
Inpatient Hospital Stay	20% after Deductible	40% after Deductible
Outpatient Services	20% after Deductible	40% after Deductible
Emergency Room	$350 Copay	$350 Copay
Urgent Care	$75 Copay	40% after Deductible

*This is a high level summary of benefits. See plan summaries & Certificates for final confirmation of coverage.

RX

CVS caremark

Core PPO and HSA $3,500 Rx Plans

Effective January 1, 2027, Arhaus will partner with CVS Caremark to administer prescription drug benefits. To support this transition, members will receive new ID cards that include both Anthem medical and CVS Caremark pharmacy benefit information. Please watch for your new ID cards in the mail as the new plan year approaches and be sure to present the updated card when filling prescriptions on or after January 1, 2027.

	Core PPO Plan	
Prescription Drugs	**Retail**	**Mail Order**
Pharmacy Deductible	$100 / Member	$100 / Member
Generic	$15 Copay after Deductible	$30 Copay after Deductible
Preferred Brand	$50 Copay after Deductible	$125 Copay after Deductible
Non-Preferred Brand	Greater of $75 Copay or 50% ($150 Max) after Deductible	Greater of $75 Copay or 50% ($150 Max) after Deductible
Specialty	25% after Deductible	25% after Deductible

	HSA $3,500	
Prescription Drugs	**Retail**	**Mail Order**
Pharmacy Deductible	Combined with Medical	Combined with Medical
Generic	$10 Copay after Deductible	$10 Copay after Deductible
Preferred Brand	$35 Copay after Deductible	$88 Copay after Deductible
Non-Preferred Brand	$70 Copay after Deductible	$175 Copay after Deductible
Specialty	25% after Deductible ($200 max)	25% after Deductible ($200 max)

*This is a high level summary of Rx Benefits. See plan summaries & Certificates for final confirmation of coverage.

Sign in or Register at Caremark.com or using the QR code.

MEDICAL / RX

Bi-Weekly Premiums (per pay deductions)

Members who certify that they are tobacco/nicotine-free will receive a discounted rate on their insurance premiums. The breakdown of costs is below.

Wellness Credits Earned	Coverage Tier	HSA $3,500 Plan	Core PPO Plan
0 Credits Tobacco/Nicotine-Free	Associate Only	$75.46	$133.32
	Associate + Spouse	$171.04	$332.04
	Associate + Child(ren)	$164.77	$319.85
	Family	$208.78	$440.20
1 Credit Tobacco/Nicotine-Free	Associate Only	$67.46	$125.32
	Associate + Spouse	$155.04	$316.04
	Associate + Child(ren)	$148.77	$303.85
	Family	$192.78	$424.20
2 Credits Tobacco/Nicotine-Free	Associate Only	$59.46	$117.32
	Associate + Spouse	$139.04	$300.04
	Associate + Child(ren)	$132.77	$287.85
	Family	$176.78	$408.20
3 Credits Tobacco/Nicotine-Free	Associate Only	$51.46	$109.32
	Associate + Spouse	$123.04	$284.04
	Associate + Child(ren)	$116.77	$271.85
	Family	$160.78	$392.20
0 Credits	Associate Only	$106.16	$167.19
	Associate + Spouse	$207.00	$376.84
	Associate + Child(ren)	$199.80	$363.74
	Family	$246.81	$490.96
1 Credit	Associate Only	$98.16	$159.19
	Associate + Spouse	$191.00	$360.84
	Associate + Child(ren)	$183.80	$347.74
	Family	$230.81	$474.96
2 Credits	Associate Only	$90.16	$151.19
	Associate + Spouse	$175.00	$344.84
	Associate + Child(ren)	$167.80	$331.74
	Family	$214.81	$458.96
3 Credits	Associate Only	$82.16	$143.19
	Associate + Spouse	$159.00	$328.84
	Associate + Child(ren)	$151.80	$315.74
	Family	$198.81	$442.96

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you may be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact HR for additional information.

HEALTH SAVINGS ACCOUNT

What is an HSA?

Health Savings Accounts (HSA) are a tax-advantaged medical savings account available to those who enroll in the Consumer Driven Health Plan (CDHP). The funds you invest are not subject to most taxes. The growth of the invested amount is not taxed and when the funds are distributed, no tax penalties are incurred when applied to qualifying expenses. The funds you contribute to your HSA are yours to keep and can be used not only for medical expenses, but for retirement expenses as well.

Great Benefits For You

Convenience - Paying for expenses from your HSA is as easy as using a debit card.

Choice - Pay for qualified expenses from your HSA or save your HSA money and pay out-of-pocket.

Control - You decide how the money is spent and you have the freedom to keep it if you change jobs or retire.

Triple-Tax Savings

Tax-Free Deposits - Even if you don't itemize deductions, you don't pay federal income tax on contributions.

Tax-Free Savings - You keep any money you don't spend and it grows tax-free. No use-it-or-lose-it.

Tax-Free Withdrawals - There's never tax on withdraws to pay for qualified expenses.

Contribution Limits	2027
Single	$4,500
Family	$9,000
Catch-up (55+)	$1,000

PLUS an annual contribution from Arhaus up to $750 Single or $1,500 Family

Examples of Qualified Medical Expenses

Acupuncture
Alcoholism treatment
Ambulance
Artificial limbs
Braces
Childbirth preparation classes
Chiropractors
Contact lenses
Crutches
Dental fees
Dentures
Diagnostic fees
Doctor's fees
Drug addiction recovery
Eyeglasses and examination fees
Hearing aid and batteries
Home modifications for handicapped
Insulin
Laboratory fees
Maternity expenses
Nursing homes
Optometrists
Orthodontia
Orthopedic shoes
Oxygen/oxygen equipment
Prescription drugs
Psychiatric care
Therapy treatments (prescribed)
Transportation (for medical care)
Vision correction surgery
Vitamins (if prescribed)
X-rays

The above is a brief summary; refer to IRS Publication 502 for confirmation of eligible expenses

FLEXIBLE SPENDING ACCOUNT

What is an FSA?

Flexible Spending Accounts (FSA) provide you with an important tax advantage that can help you pay health care expenses on a pretax basis. By anticipating your family's health care and dependent care costs, you can actually lower your taxable income and that means you get to keep more of what you earn.

There are two types of FSA's that allow you to make deductions to pay for expenses:

HEALTH CARE FSA/ Limited Purpose FSA

Contributions

You may contribute up to $3,400 per year as a before-tax contribution to your Health Care FSA.

Eligible Dependents

In general, an eligible dependent under the Health Care FSA is anyone you list as a dependent on your federal income tax return. This includes your immediate family members, a close relative or other person whose primary residence is your home and for whom you provide over 50% support.

IMPORTANT REMINDER: Limited purpose FSA funds are for dental and vision expenses when enrolled in a HDHP. Health Care FSA funds are for all eligible medical expenses, but you cannot be enrolled in a HDHP.

DEPENDENT CARE FSA

Contributions

In the Dependent Care FSA, you may contribute up to $7,500 per year. The $7,500 annual maximum applies to all contributions made by you and your spouse to a dependent care account. If you are married and filing separately for federal income tax purposes, you may elect to contribute up to $3,750 per year.

Eligible Dependents

You can be reimbursed for day care expenses you have in a plan year, if the expenses are necessary to allow you and your spouse—if you're married— to work. These services may be provided inside or outside your home by babysitters, companions or eligible day care centers. Services may not, however, be provided by someone you claim as a dependent on your tax return.

PAYING YOUR FSA EXPENSES

There are two ways to pay for eligible expenses:

- FSA Claim Form – You pay your health care providers directly and then file a claim for reimbursement. Simply file a claim online or through the WEX mobile app. Claims payment can be made via direct deposit or paper checks (note a fee will apply for paper checks)
- Debit Card – You can use this card to pay for eligible health care expenses at any health care provider or approved merchant. With the Debit Card, participants have instant access to the money in their FSA, which is automatically drawn from their account as purchases are made.

DENTAL

With dental insurance, routine preventive care can lead to better overall health. And you'll be able to save money if any extensive dental work is needed.

In-Network Benefits	Low Plan	High Plan	Platinum Plan
Deductible: Single/Family	$50 / $150	$50 / $150	$50 / $150
Annual Maximum Benefit	$1,000	$1,000	$1,500
Preventive Services *Cleanings, Exams, X-Rays*	0%	0%	0%
Basic Services *Fillings, Oral Surgery, Periodontics & Simple Extractions*	20% after Deductible	20% after Deductible	10% after Deductible
Major Services *Crowns, Dentures, Bridges, Root Canals & Surgical Extractions*	Not Covered	50% after Deductible	40% after Deductible
Orthodontia *Dependents and Adults*	Not Covered	Not Covered	50% after Deductible
Lifetime Ortho Maximum	n/a	n/a	$1,000

*Illustration of in-network benefits only; the plan does provide benefits for non-network providers. See plan summaries & Certificates for final confirmation of coverage.

Bi-Weekly Premiums (per pay deductions)

Coverage Tier	Low Plan	High Plan	Platinum Plan
Associate Only	$10.12	$15.80	$19.25
Associate + 1 Dependent	$19.26	$29.52	$36.54
Family	$35.23	$47.64	$61.26

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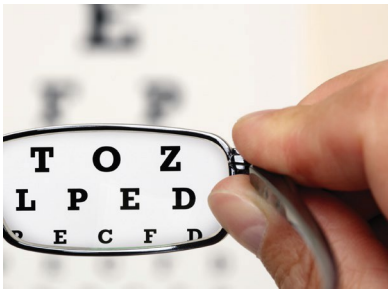
Find a Provider
www.lincolnfinancial.com

VISION

Even if you have perfect eyesight, it's important to have regular eye exams to make sure you're still seeing clearly. Most of us may eventually need vision correction, which is why we offer vision insurance to cover some of the costs.

When you elect Vision coverage you have:

- Access to one of the largest panels of eye care professionals
- $10 copay for in-network routine evaluation
- $130 allowance for frames, plus 30% off any remaining balance
- $10 copay for lenses; single vision, Bifocal, Trifocal or Lenticular
- $125 allowance for contact lenses



Plan Features

- Lincoln VisionConnect members are supported through the Spectera Vision network. When you visit your eye care provider, let them know you're a Spectera customer to maximize your in-network provider benefits.
- *Lincoln VisionConnect* gives you the option to choose contact lenses instead of eyeglass lenses.
- *Lincoln VisionConnect* features a covered contact lens selection benefit.

Bi-Weekly Premiums (per pay deductions)

Coverage Tier	Vision Plan
Associate Only	$2.03
Associate + 1 Dependent	$3.70
Family	$6.42

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DISABILITY & LIFE

All Full-time Associates are provided a base level of disability protection, both short-term and long-term, effective the 1st of the month after 90 days of employment, paid for by Arhaus.

Short Term Disability (STD)

Full-Time Associates will be eligible for up to 90 days of short-term disability benefits conditioned upon written medical certification that the associate is unable to perform his/her job due to a medical condition. STD benefits will not commence until the paperwork has been approved & the associate has been off work, due to medical reasons, for 14 consecutive work days. 100% paid leave for 30 days, then 70% for up to 11 weeks.

Long Term Disability (LTD)

This coverage can help replace a portion of your income in the event you are unable to work due to a covered disability that is non-work related & continues for at least 90 days. The long-term disability plan replaces 60% of your monthly income loss up to a maximum of $5,000 per month.

Don't forget to designate a beneficiary for associate life insurance.

Basic Life Insurance

We know you want to protect your loved ones in case of life's uncertainties. We provide Basic Life and Accidental Death & Dismemberment coverage at no cost to all Full-time Associates. Accidental Death & Dismemberment provides your family additional money in the event of accidental death. You are automatically enrolled for this coverage. Your coverage will be effective the 1st of the month following 30 days of employment. Please ensure your beneficiary designation is up to date in UKG.

You may purchase additional, supplement coverage to increase your coverage amounts.

At no cost to you, Basic Term Life Insurance gives you:

- Coverage of $50,000
- AD&D coverage as part of your life insurance
- The ability to convert to an individual policy if you leave
- Possible waiver of premiums if you become disabled
- Possible accelerated death benefit if you are diagnosed with a terminal disease

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Protection from life's unexpected, provided by Arhaus at no cost to you

LEAVE OF ABSENCE

Family Medical Leave

FMLA provides unpaid, job protection for up to 12 weeks in a rolling 12-month period. FMLA can be taken for certain serious health conditions.

Eligibility: Must have worked at least 1,250 hours within previous 12 months

Child Bonding Leave

Full-time associates who are not the birthing parent are eligible for Child Bonding Leave. Child Bonding Leave provides 100% paid leave for up to 5 weeks, for the birth or adoption of a child.

Eligibility: 1st of the month following 90 days

Birthing Parent Leave

Full-time associates who are the birthing parent are eligible for Birthing Parent and Child Bonding Leave. Birthing Parent Leave provides 100% paid leave for up to 5 weeks, for the birth or adoption of a child.

If you are utilizing Birthing Parent Leave, Child Bonding Leave will begin once Birthing Parent Leave has exhausted.

Eligibility: 1st of the month following 90 days

Contact Benefits@Arhaus.com to initiate a leave of absence or for any questions

SUPPLEMENTAL LIFE

Why should I consider Supplemental Coverage?

Supplemental Life Insurance is an optional coverage that you can elect as an extra layer of protection, in addition to the coverage that Arhaus already provides

If you purchase Supplemental Life Insurance for yourself, your spouse and dependents:

- You can elect up to:
    - $500,000 coverage for yourself ($300,000 Guarantee Issue)
    - $250,000 on your Spouse ($50,000 Guarantee Issue)
    - $10,000 on your Children ($10,000 Guarantee Issue)
- Guarantee Issue only applies when you initially become eligible for coverage
- To elect Supplemental Spouse or Child coverage, you must elect coverage for yourself
- If you do not enroll in coverage for yourself or your dependents within 31 days of your first day of employment, you may enroll at a later date; however, coverage is medically underwritten & subject to proof of insurability
- To elect Supplemental Spousal or Child coverage, you must also elect Associate coverage

CRITICAL ILLNESS

Why do I need a Critical Illness plan?

No one is ever really prepared for a life-altering critical illness diagnosis. The whirlwind of appointments, tests, treatments and medications can add to your stress levels. Critical Illness coverage helps provide financial support if you are diagnosed with a covered critical illness.

Provides a large, lump sum benefit to help you bounce back when you suffer a major health event. The Critical Illness benefit pays cash, on top of any other medical or disability plan.

Features & Plan Provisions

- Coverage is available to all family members: spouses up to 100% of the face amount elected by the associate; children up to 50%
- Elect $10,000 up to $30,000 in coverage
- Guarantee Issue $30,000 (no medical questions asked) when initially eligible for coverage
- Includes an annual Wellness benefit that pays you $50 per person per year for many common preventive screenings

Covered Conditions:

Heart Attack (Myocardial Infarction)
Stroke
Cancer
Major Organ Transplant
Renal Failure
Carcinoma in Situ
Coronary Artery Bypass Surgery
Alzheimer's Disease
Multiple Sclerosis
Parkinson's Disease

Childhood Conditions:

Cerebral Palsy
Cleft Lip/Palate
Club Foot
Cystic Fibrosis
Down's Syndrome
Muscular Dystrophy
Spina Bifida
Type I Diabetes

*See LFG summary for full listing of covered conditions

Bi-Weekly Premiums (per pay deductions)

Coverage	<30	30-39	40-49	50-59	60-69	70+
$10,000	$1.40	$2.31	$4.67	$8.99	$16.17	$35.34
$20,000	$2.80	$4.62	$9.34	$17.98	$32.34	$70.68
$30,000	$4.20	$6.93	$14.01	$26.97	$48.51	$106.02

Rates are illustrative for Associate only coverage. Spouse rates can be found on the benefit summary

*Spouse coverage premium is based on Associate age; Child cost is included with associate election

ACCIDENT

Why do I need an Accident plan?

When you, your spouse or child has a covered off-the-job accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs. While health plans may cover direct costs associated with an accident, you can use accident benefits to help cover related expenses like lost income, childcare, deductibles and copays…or any way you see fit.

Injury	Cash Payment
Accidental Death	Associate: $50,000 Spouse: $25,000 Child: $12,500
Hospital Admission	$1,000 / $2,000 ICU
Hospital Confinement	$450/day
Fracture	Schedule up to $2,500
Ambulance	Ground: $100 / Air: $500
Emergency Room	$200
Dislocations	Schedule up to $2,000
Coma	$10,000
Concussion	$200

Bi-Weekly Premiums (per pay deductions)

Coverage Tier	Accident Plan
Associate Only	$4.26
Associate + Spouse	$7.10
Associate + Child(ren)	$7.95
Family	$10.73

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HOSPITAL INDEMNITY

Why do I need a Hospital Indemnity plan?

Hospital indemnity insurance can cover some of the cost associated with a hospital stay, letting you focus on your recovery. If you become seriously ill or injured, it's likely you will have a hospital stay. It may be a little scary, as well as expensive. While medical insurance may cover the hospital bills, there can also be non-medical expenses such as transportation to medical treatment or additional child care which could be considerable. If you became hospitalized, could you manage all of these expenses from your savings?

Features & Plan Provisions

- Coverage is available to you, your spouse & your dependent children
- Coverage is portable (take it with you if you change jobs)
- No pre-existing condition limitation
- Receive $500 per admission (limited to 1 admissions per insured)
- Receive $250 per day you're confined to the hospital, limited to 30 days per insured

Lincoln Financial Group helps protect you and your family from unexpected expenses

- Lincoln Financial Group Hospital Indemnity Insurance supplements your medical plan — no matter what type of other coverage you have.
- You receive cash benefits based on your covered sickness or injury, treatments and services.
- The cash benefits are paid directly to you and can be used for any purpose — from covering medical copays and deductibles to paying for everyday expenses such as the mortgage, groceries and utilities, — and you decide how to use them

Bi-Weekly Premiums (per pay deductions)

Coverage Tier	Hospital Indemnity Plan
Associate Only	$5.42
Associate + Spouse	$10.93
Associate + Child(ren)	$9.08
Family	$14.59

Lincoln Financial Group®

IDENTITY/ FRAUD PROTECTION

MetLife | Identity & Fraud Protection

Powered by: AURA

We do more online than ever—from banking, shopping and even socializing—making personal information more vulnerable to cyber threats. Aura helps ensure your personal information is not anywhere it shouldn't be by protecting the things you care about most: identity, money and assets, family and privacy.

All-in-one digital safety for the whole family, available on every device.

Aura offers smart, proactive protection to help you get ahead of online threats. It's easy to use, simple to set up, and all in one place.

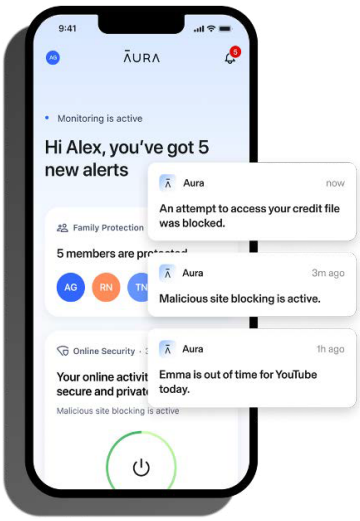
Identity Theft Protection - We alert you if we detect threats to your identity, registered online accounts, and passwords.

Financial Fraud Protection - Stay a step ahead of threats with credit and bank account monitoring, and financial tools to help keep your assets safe.

Privacy & Device Protection - Connect online more securely and privately with intelligent safety tools that help protect your passwords, devices, and WIFI connection from hackers.

Family Safety - Aura makes it easy for parents and caregivers to protect vulnerable loved ones online with fully integrated family digital safety tools.

Service and Support - 100% U.S.-based Customer Care available 24/7. Plus, victims of ID theft get white glove fraud resolution services.



Additional Benefits included in the Protection Plus Plan include:

- Payday/Specialty Loans Block
- Experian Credit Lock
- Credit Score Simulator
- Social Media Account Monitoring and Takeover alerts
- Gamertag Monitoring
- Social Media Privacy Checkup
- Credit Monitoring and Alerts (3 Bureau)
- Annual Credit Report (3 Bureau)
- WIFI Security/VPN (Unlimited Devices)
- Antivirus (Unlimited Devices)

Bi-Weekly Premiums (per pay deductions)

Coverage Tier	Protection Plan	Protection Plus Plan
Associate Only	$3.21	$4.13
Family	$5.52	$6.90

PET INSURANCE

What is Pet Insurance?

Pet insurance can help reimburse you for covered unexpected veterinary expenses for your pet.

What does it cover?

- Accidental injuries
- Illnesses
- Exam fees
- Surgeries
- Medications
- Ultrasounds
- Hospital stays
- X-rays and diagnostic tests

Coverage is flexible and customizable so that you can choose the plan that works for you. Options include:

- Levels of coverage from $500 – Unlimited
- $0-$2,500 deductible options
- Reimbursement percentages from 50%-100%
- Every pet and individual have unique needs, which is why MetLife provides the ability to customize your coverage
- Payment will be through direct bill

Coverage for unforeseen events and circumstances

Preventive Care

Accident & Illness

Coverage for the unexpected:

- Accidental injuries such as broken bones, foreign object ingestion
- Illness such as allergies, ear infections, masses, cancer, hip dysplasia

Wellness

- Optional coverage with additional charge
- For wellness visits (preventive care, vaccinations etc.)

How to Enroll?

Visit the link below, and select “Arhaus, LLC” as your employer to get started or call the phone number below for a quote!

MetLife

Get a quote or enroll for the 1/1/27 benefit year.

Visit www.metlife.com/getpetquote

Call 1-800-GET-MET8

Scan the QR code

EMPLOYEE ASSISTANCE

We all need a little support now and then.

Lincoln Financial Group® | ComPsych® GuidanceResources® Worldwide

The employee assistance program provides guidance for personal issues that you might be facing and information about other concerns that affect your life, whether it's a life event or on a day- to-day basis.

- 5 face-to-face or virtual sessions per person, per issue, per year
- In-person consultations with network lawyers
- State-of-the-art website featuring helpful articles on topics like wellness, training courses, and a legal and financial center

Emotional Support

- Marital, relationship or family issues
- Stress, anxiety, or depression
- Grief and loss
- Job pressures and substance disorders

Wellness Support

- Tobacco and nicotine cessation
- Weight management and Sleep improvement
- Diabetes prevention

Work & Lifestyle Support

- Adoption assistance
- Before/after school programs
- Elder care

Working Smarter

- Career development
- Effective managing
- Relocation

Legal & Financial

- Basic tax planning
- Credit & collections
- Debt counseling
- Home buying

COMPLETELY CONFIDENTIAL

888-628-4824

Guidanceresources.com

New Users Select Register (webID: LFGSupport)

Follow the prompts to create your username and password.

Or download the GuidanceNow App!

The team is available 24 hours a day, 7 days a week

WELLNESS PROGRAM

We are pleased to announce the enhanced Arhaus Wellness Program! This program is being offered through Integrated Health 21/HealthWorks and is designed to support and encourage you to take charge of your health while offering various opportunities to maintain and improve your health throughout the year. You can also reduce your medical insurance premiums by participating!

Through the HealthWorks portal you can easily navigate the program steps and requirements, track your progress toward program completion, participate in wellness challenges and access health-related content.

You may earn points by completing activities by December 18, 2027. Points earned will convert to Wellness Credits.

INTEGRATED HEALTH 21 | HealthWorks Central Region

For the Duration of the 2027 Arhaus Wellness Program, you have the opportunity to earn Points for the following Health-Focused Activities:

- Preventive Care Visit & Preventive Care Sign-Off
- Age and Gender Appropriate Screenings
- Tobacco/Nicotine Waiver

You can complete additional wellness activities to earn points as well!

$ 10 Points Earned = 1 Wellness Credit

$$ 20 Points Earned = 2 Wellness Credits

$$$ 30 Points Earned = 3 Wellness Credits

Points will add cumulatively throughout the program and will be applicable to your premium incentive discount and will be applied to the upcoming plan year, January 1, 2028 – December 31, 2028.

TO SIGN IN FOR THE FIRST TIME:

- Go to myHealthWorksportal.com
- **Username:** the email your company has on file for you
- **Create Password:**
  - Click the "Forgot Password" link
  - Check your email & follow prompts to create a unique password
- **Login with username and new password**

NEW HIRES:

Start dates after 3/1/2027:

- Go to myHealthWorksportal.com
- Click **'Sign up now'** & create an account
- Input your name as it appears on your insurance card
- A verification code will be sent to the email you provide
- After your account has been verified, you will be prompted to enter your company's ACCESS CODE: WHR4A

Associates who are NOT covered on an Arhaus medical plan may still participate in programming with the opportunity to earn raffle entries for fun prizes!

401(k)

Eligibility

Employees who are age 21+ and have completed a waiting period of 6 months are eligible to enter the plan the first of the following month.

Annual Contribution Limits

You can contribute up to $24,500 in 2026.
50+ can contribute an additional catch-up amount of $8,000.
60, 61, 62, 63 you can contribute a catch-up amount of $11,250.

Employer Contributions

Arhaus will match 100% on your contribution up to 4% of your salary.

Pre-tax vs. Roth Contributions

Contributions that are made with traditional pre-tax dollars lowers your taxable income now, but you'll pay taxes later in retirement. Roth contributions are taxed now but you won't pay taxes when you withdraw in retirement.

Vesting

100% fully vested upon enrollment for your contributions as well as company matching contributions.

DID YOU KNOW OSWALD FINANCIAL IS YOUR FINANCIAL ADVISOR, BUT THAT'S NOT THE SAME AS YOUR PLAN RECORD KEEPER?

charles SCHWAB

Your MAIN platform for your retirement plan

Some Services Include:

- Providing account statements to associates (paper or paperless)
- Aiding in fund allocation & deferral changes
- Assisting with loan questions/requests
- And much more

800-724-7526 workplace.schwab.com

oswaldfinancial

Oswald focuses on retirement readiness, and tailors their strategy to meet your needs. Their money coaches sit down with you one-on-one to get the full picture of your situation and goals, so they can guide you through every stage of life's journey.

- Understand your goals
- Gather information about your situation
- Evaluate your situation
- Discuss options
- Create/implement your plan
- Monitor your plan
- Discuss updates and observations

833-224-5660 info@oswaldfinancial.com

SUNLIFE HEALTH NAVIGATOR

Your organization offers Health Navigator as a complimentary benefit to assist you with any medical concerns. This valuable resource provides professional advice and helps you navigate the complexities of healthcare system.

What is Health Navigator?

Health Navigator, powered by PinnacleCare, is a service that guides you to appropriate care and connects you with specialists for expert opinions on any health-related need. Our Care Advisors and Medical Director team is an unbiased resource to help you navigate health issues, confirm diagnoses, and explore treatment options.

How can I access Health Navigator?

- Call 888-352-4969 to speak with a Care Advisor (Monday - Friday, 8:00 a.m. - 6:00 p.m. ET)
- Visit http://sunlife.com/healthnav
- Use Sun Life Health 360 to access support for your health and wellbeing

How does Health Navigator differ from my doctor and health plan?

Health Navigator works solely on your behalf to navigate your specific care or treatment as well as the healthcare system.

Your dedicated Health Navigator team will:

- Guide you through what can be a stressful, confusing, and time-consuming process
- Determine if your diagnosis is correct
- Connect you with specialists about treatment options
- Collaborate with your doctor and health plan as needed

A healthcare challenge can happen at any time, from a need for routine care to a serious diagnosis. When faced with medical concerns, Health Navigator is ready to assist you with a wide range of health needs, including:

Understanding your diagnosis

- Confirming your diagnosis
- Getting second opinions from expert doctors (online or in-person)

Planning your care

- Exploring the best treatment options
- Connecting you with the right doctors

Preventive care

- Creating a preventive care plan tailored to your needs

Choosing a doctor

- Finding doctors who are a good match for what you need
- Making sure your current doctors are the right ones for your health issues

Administrative assistance

- Setting up appointments
- Collecting and sending your medical records where needed

Health information and education

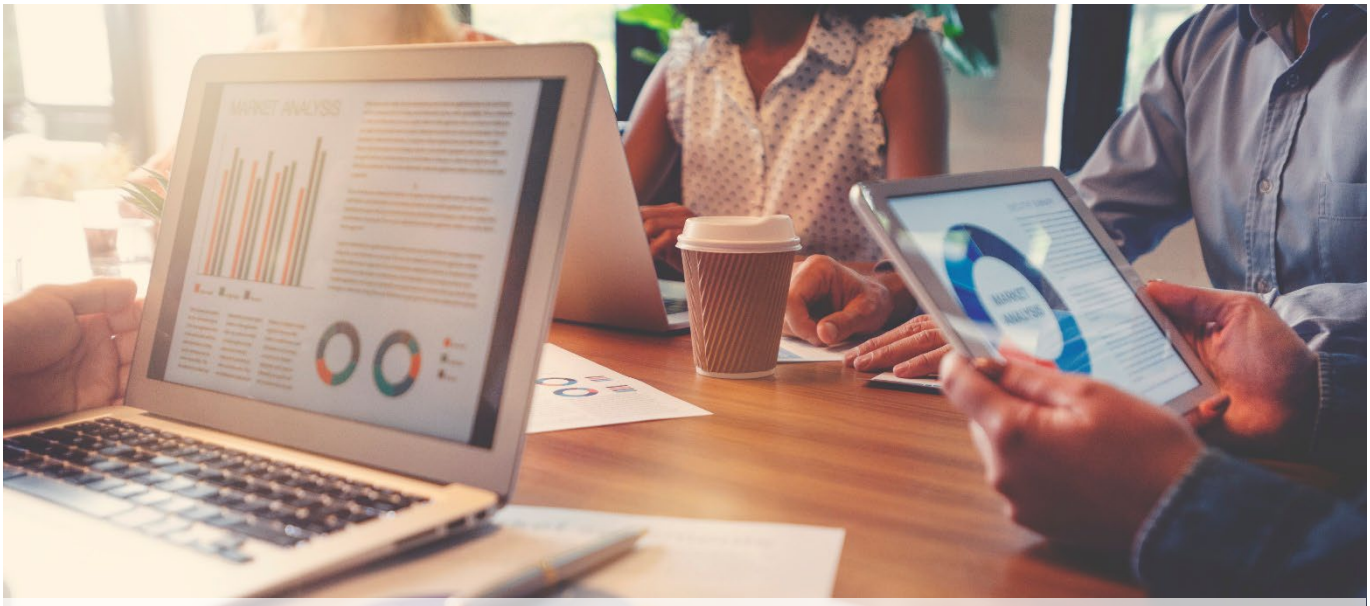
- Researching your health condition
- Answering your questions about your medical concerns

This resource is available to Associates and their dependents who are covered on the Arhaus Medical Plan.

CONTACTS

Benefit	Administrator	Contact Info
HR Information Systems (Benefits / Payroll)	UKG	https://ew42.ultipro.com/ ultipro@arhaus.com
Medical	Anthem Policy #W43278	www.anthem.com (833) 639-1634
Rx	CVS Caremark RXGRP: RX26DN	Caremark.com 888-595-5273
Health Savings Account (HSA)	Anthem	www.anthem.com (833) 639-1634
Flexible Spending Account (FSA)	WEX	customerservice@wexhealth.com www.wexinc.com (866) 451-3399
Dental / Vision Life Insurance Short / Long-Term Disability Leave of Absence	Lincoln	www.lincolnfinancial.com (800) 423-2765
Accident, Critical Illness, Hospital Indemnity	Lincoln	www.lincolnfinancial.com (800) 423-2765
Employee Assistance Program	ComPsych	http://www.guidanceresources.com/ Web ID: LFGSupport Create your username and password
Pet Insurance, ID Theft	MetLife	https://www.metlife.com/ (833)-552-2123
COBRA	WEX	www.marketplace.wexhealth.com
Wellness Program	HealthWorks	myHealthWorksportal.com
401(k)	Schwab	https://workplace.schwab.com (800) 724-7526
SunLife Health Navigator	SunLife	http://sunlife.com/healthnav (888)-352-4969
Benefits Counselor	Prepare Benefits	(678)-280-7805

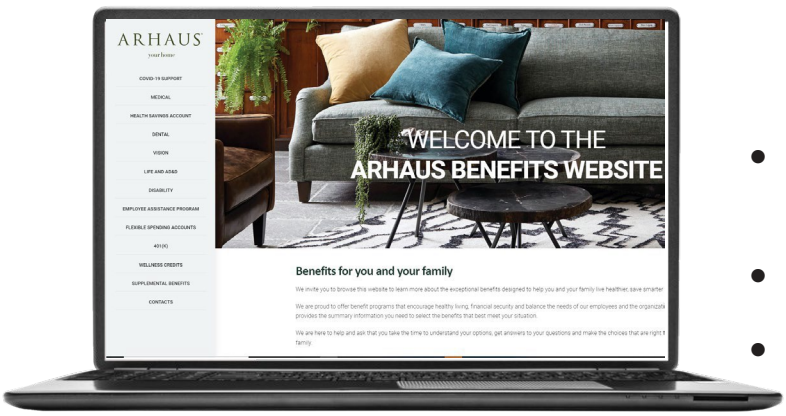
Arhaus Benefits Team		
General Questions		benefits@arhaus.com
Kathryn Walko, Sr. Benefits Specialist	(440) 439-7700 x3070	kwalko@arhaus.com
Brianna DeNigris, Benefits Specialist	(440)-439-7700 x3024	bdenigris@arhaus.com



STAY CONNECTED.

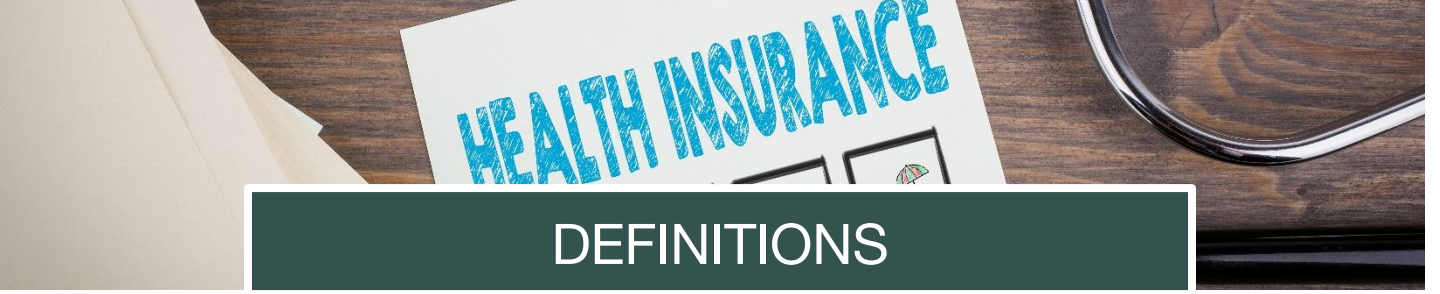
www.arhausbenefits.com

Don’t forget about your benefits website



Your benefit information at your fingertips!

- Complete benefit overviews and summaries
- Access to online enrollment
- Carrier contacts
- Mobile-friendly



DEFINITIONS

Coinsurance After you meet the deductible amount, you and the plan share the cost of covered expenses. Coinsurance is always a percentage totaling 100%. For example, if your plan pays 70% coinsurance, you pay the remaining coinsurance share, 30% of the cost.

Copayment or Copay A form of medical cost-sharing whereby a member pays at time of service (or purchase for prescription drugs) a fixed dollar amount, regardless of whether you have met your deductible for the year.

Deductible The fixed amount of cost-sharing you are responsible for during the benefit period before the plan will pay. The
deductible typically does not apply to preventive care and certain other services.

Evidence of Insurability (EOI) / Statement of Health A medical questionnaire used to determine whether an applicant will be approved or declined for coverage. This may be required for certain types of insurance coverage.

Explanation of Benefits (EOB) The statement made available to a member by their carrier after services have been received and the claim has been processed, which lists the services received, amount paid by the plan, and the amount to be paid by the member.

Flexible Spending Accounts Health or Dependent Care (HCFSA or DCFSA): An account you put money into that you use to pay for certain out-of-pocket health or childcare costs with pre-tax dollars. This means you'll save an amount equal to the taxes you would have paid on the money you set aside. Funds deposited into a health FSA will be forfeited if you do not use them by the IRS deadline.

Formulary A list of prescription drugs covered by the plan that will be used to determine the coverage for the drug based on the tier the drug is listed.

Generic Drugs Medications that have the same active ingredients, dosage, and strength as their brand-name counterparts. Generic drugs generally have the same efficacy as their brand name counterparts at a much lower cost for you and your employer.

Guaranteed Issue When an insurance policy is offered to any eligible applicant without regard to the health status of the individual that applies. Typically, no health questionnaires (EOI) or exams are required.

In-network Doctors, clinics, hospitals and other providers with whom the plan has an agreement to care for its members. Plans cover a greater share of the cost for in-network providers than for providers who are out-of-network, and the member pays a lower amount for those services.

Non-Preferred Brands These medications generally have generic alternative and/or one or more preferred brand options within the same drug class which causes these drugs to cost more. You and your employers usually pay more for non-preferred brand medications. Also known as non-formulary brands.

Out-of-Network A physician, healthcare professional, facility or pharmacy that doesn't participate in the plan's network and doesn't provide services at a discounted rate. Using an out-of-network healthcare professional or facility will cost you more.

DEFINITIONS

Out-of-Pocket Maximum The maximum dollar amount a member is required to pay out of pocket for allowable covered expenses under a plan during a benefit period before the plan will pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or services your plan doesn't cover. Some plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Preferred Drug A list of prescription medicines that are preferred based on an evaluation of effectiveness and cost. Another name for this list is a "formulary" or "formulary brand." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs not on the preferred drug list may not be covered.

Payroll Deduction The amount you pay out of your paycheck in order to be enrolled in the medical, dental and/or vision insurance plans and other offered benefits.

Prior Authorization/Pre-Service Notification The decision by the plan that a service, treatment plan, prescription drug, medical equipment, or other services defined in the certificate of coverage and/or Summary Plan Description (SPD), is medically necessary. The plan may require preauthorization for certain services before receiving them, in order for the service to be covered.

Provider A physician (medical, dental or vision), healthcare professional or health care facility licensed, certified or accredited as required by state law recognized for payment by the plan.

Qualifying Event An occurrence defined by IRS Rules such as marriage/divorce, death, termination of employment, childbirth/ adoption, involuntary loss of coverage, etc. which triggers an employee's ability to make changes to their benefit elections at the time the qualifying event occurs outside of open enrollment.

Arhaus Furniture

2027 OPEN ENROLLMENT & PLAN PARTICIPANT NOTICE

Notice Regarding Wellness Program

If a Constituent Benefit Program listed is a voluntary wellness program available to all employees, it is intended to be administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program, depending upon that program, it may include a voluntary health risk assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include blood tests or other diagnostic tests. Please note that this is voluntary, and you are not required to participate in these evaluations or examinations.

In certain wellness programs, employees who choose to participate in the wellness program will receive an incentive that is disclosed to you in the open enrollment information for the Constituent Benefit Program. Although you are not required to complete the assessments or participate in the biometric screening, only employees who do so will receive the incentive. Additional incentives up to the maximums permitted by law, may be available for employees who participate in certain health-related activities or those who achieve certain health outcomes. If so, these will be described in your program materials or otherwise communicated to you.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Plan Administrator listed in your Summary Plan Description. The information from any assessment and any results from your examinations or screenings will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Consistent with the disclosures in this Notice regarding the protection of your health and personally identifiable health information, any information gathered in the Constituent Benefit Program that is a wellness program, will be confidential. The wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, but it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Also, your health information will not be sold, exchanged, transferred, or otherwise disclosed (except as permitted or required by law) to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving any incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a wellness program nurse, or physician or other health coach staff for purposes of the wellness program. You may inquire about who specifically has access to your information in this regard.

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. Precautions deemed appropriate 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. Finally, 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. Any questions should be directed to the Plan Administrator as listed in your Summary Plan Document.

Anthem Blue Cross Blue Shield

ARE YOU, OR A FAMILY MEMBER, MEDICARE ELIGIBLE (OR ABOUT TO BECOME MEDICARE ELIGIBLE)? IF SO, PLEASE READ AND KEEP FOR YOUR RECORDS!

Your prescription drug coverage provided under The Arhaus Furniture Health & Welfare plan is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage".

This information is to help you decide whether or not you want to join a Medicare drug plan. It is important for those eligible for both Medicare and a group health plan to look ahead and weigh the costs, benefits, and participation terms of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

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. Arhaus Furniture has determined that the prescription drug coverage offered by the Anthem Blue Cross Blue Shield Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When May You Join A Medicare Drug Plan?

Eligible individuals may join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable 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 Arhaus Furniture coverage may or may not be affected as well as dependent coverage. Additional guidance is available at https://www.cms.gov/medicare/prescription-drug-coverage/creditablecoverage?redirect=/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.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage
Contact the person listed below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Arhaus Furniture changes. You also may request a copy of this notice at any time.

Contact--Position/Office: Arhaus Human Resources
Address: 51 E. Hines Hills, Boston Heights, OH 44236
Phone Number: 440-439-7700

For More Information Regarding 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:

1. Visit www.medicare.gov
2. 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
3. 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).

HIPAA Notice of Privacy Practices

You are receiving this Privacy Notice because you are eligible to participate in an employer sponsored group health plans. The Health Plans are committed to protecting the confidentiality of any health information collected about an individual. This Notice describes how the Health Plan may use and disclose, "protected health information" (PHI). For information to be considered "PHI", it must meet three conditions:

Information is created or received by a health care provider, health plan, employer, or health care clearinghouse; Information relates past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and the information either identifies the individual or provides a reasonable basis for believing that it can be used to identify the individual.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to an individual. Additionally, the Health Plan is required by law to:

Maintain the privacy of an individual's "protected health information" (PHI) and provide you with the Privacy Notice of its legal duties and privacy practices with respect to an individual's PHI and follow the terms of its Privacy Notice that is currently in effect.

Employees of the plan sponsor who administer and manage this Health Plan may use PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These individuals must comply with the same requirements that apply to the Health Plan to protect the confidentiality of PHI.

Dependent Coverage

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Plan. Individuals may request enrollment for such children for 30 days from the date of notice. Effective first day of the Plan Year that began on or after Septmebr 23, 2010.

Lifetime Limitations

The lifetime limit on the dollar value of benefits under the Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the Plan Administrator.

Rescission

A rescission of your coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide you with coverage, just as if you never had coverage under the Plan. Your coverage can only be rescinded if you (or a person seeking coverage on your behalf), performs an act, practice, or omission that constitutes fraud, or unless you (or a person seeking coverage on your behalf) makes an intentional misrepresentation of material fact, as prohibited by the terms of your Plan. You will be provided with thirty (30) calendar days' advance notice before your coverage is rescinded. You have the right to request an internal appeal of a rescission of your coverage. Once the internal appeal process is exhausted, you have the additional right to request an independent external review. See the Claims Procedure Section under the Plan for more information.

Uses and Disclosures of Protected Health Information (PHI)

The following categories describe the ways that the Health Plan may use and disclose protected health information. For each category of uses and disclosures, examples will be provided. Not every use or disclosure in a category will be listed. However, all the ways the Health Plan is permitted to use and disclose information will fall within one of these categories.

Treatment Purposes. The Health Plan may disclose PHI to a health care provider for the health care provider's treatment purposes. For example, if an individual's Primary Care Physician (PCP) or treating medical provider refers the individual to a specialist for treatment, the Health Plan can disclose the individual's PHI to the specialist to whom they have been referred so (s)he can become familiar with the individual's medical condition, prior diagnoses and treatment, and prognosis.

Payment Purposes. The Health Plan may use or disclose health information for payment purposes; such as, determining eligibility for plan benefits, obtaining premiums, facilitating payment for the treatment and services an individual receives from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans. Examples of payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a specific treatment is covered under the plan

Health Care Operations. The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

To a Business Associate of the Health Plan. The Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, provided a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so or provides services to the Health Plan such as legal, actuarial, accounting, consulting, or administrative services. Examples of Business Associates include the Health Plan's Third-Party Administrators (TPAs), Actuary, and Broker.

To the Health Plan Sponsor. The Health Plan may disclose PHI to the Plan Sponsor as long as the sponsor has amended its plan documents, provided a certification to the Health Plan, established certain safeguards and firewalls to limit the classes of employees who will have access to PHI, and to limit the use of PHI to plan purposes and not for non-permissible purposes, as required by the Privacy Rule. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Some examples may include: disclosure for claims appeals to the Plan's Benefits Committee, for case management purposes, or to perform plan administration functions.

The Health Plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "Summary Health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

Required by Law or Requested as Part of a Regulatory or Legal Proceeding. The Health Plan may use and disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, the Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

There are limits on the Plan's use and disclosure of PHI in regard to disclosures related to Reproductive Health Care. In regard to such requests, if a request may impact Reproductive Health Care, as defined in the Policy and the HIPAA Regulations, the Plan must obtain an Attestation to verify that the requested use or disclosure if not for a Prohibited Purpose, as defined by Regulations. Prohibited Purposes in this regard include the following; 1)to conduct criminal, civil or administrative investigation into any person for the mere fact of seeking, obtaining, providing or facilitating lawful reproductive healthcare; 2)to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, provoking , or facilitating lawful reproductive health care; and/or 3) to identify any person for purposes of items (1) and (2). Certain types of requests automatically require Attestation.

In Addition, when substance use disorder treatment related to PHI is requested, there are limits on permitted disclosures related to civil, criminal, administrative, or legislative proceedings against the individual, unless based on written consent, or a court order after notice an opportunity to be had is provided to the individual 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 PHI can be used or disclosed.

Public Health Activities or to Avert a Serious Threat to Health or Safety. The Health Plan may disclose PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Law Enforcement or Specific Government Functions. The Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with an individual's written authorization or that of their legal representative, and the individual may revoke such authorization as provided by section 164.508(b) (5) of the Privacy Rule. Any disclosures that were made when the individual's Authorization was in effect will not be retracted.

An Individual's Rights Regarding PHI

An individual has the following rights with respect to their PHI:

Right to Inspect and Copy PHI. An individual has the right to inspect and copy health information about them that may be used to make decisions about plan benefits. If they request a copy of the information, a reasonable fee to cover expenses associated with their request may be charged.

Right to Request Restrictions). An individual has the right to request restrictions on certain uses and disclosures of their PHI (although the Health Plan is not required to agree to a requested restriction).

Right to Receive Confidential Communications of PHI). An individual has the right to receive their PHI through a reasonable alternative means or at an alternative location if they believe the Health Plan's usual method of communicating PHI may endanger them.

Right to Request an Amendment. An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI but is required to provide the individual with a response in either case.

Right to Accounting of Disclosures. An individual has the right to receive a list or "accounting of disclosures" of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual's Authorization, or to the individual. An individual's request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12-month period.

Breach Notification. An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so, required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Genetic Information If the covered entity under the Plan engages in underwriting an individual's genetic information will not be used for underwriting except for long term care plans.

Right to Paper Copy. An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

The Health Plan's Responsibilities Regarding an Individual's PHI

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI. The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to all actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice.

The complaint will be investigated, and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20210

HIPAA Plan Special Enrollment Notice

If you are declining your enrollment under the Plan, or declining coverage for your spouse or one of your dependents, because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing toward such other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends, or after the period for which the employer ceased contributing toward such other coverage if such payment applied to your circumstances.

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

To request special enrollment or obtain more information, please contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for furtherinformation.

Genetics Information Notice

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Mental Health/Substance Use Disorder Parity

Effective for Plan Years on and after July 1, 2010, benefits under Plans that provide Mental Health Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Newborns and New Mothers Care Disclosure

This Plan generally does not, consistent with applicable 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, consistent with that same Federal law, this Plan 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, this Plan does not, in accordance with 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).

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual and Regular Notice

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, notwithstanding anything herein to the contrary, the Plan provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for further information.

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, 2026. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (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	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com

MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, 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