RIMKUS

2025 BENEFITS GUIDE

IMPORTANT INFORMATION

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, federal law gives you more choices for your prescription drug coverage. Please see page 33 for more details.

Important: This benefits package includes a fixed indemnity policy, which is not health insurance. Please see supplemental benefits on page 30 for more details.

This fixed indemnity policy may pay you a limited dollar amount if you are sick or hospitalized. You are still responsible for paying the cost of your care.

- The payment you get is not based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy is not a substitute for comprehensive health insurance.
- Since this policy is not health insurance, it does not have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

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

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**www.naic.org**) under Insurance Departments.
- If you have this policy through your job, or a family member's job, contact the employer.

WELCOME

This 2025 Rimkus Benefits Guide contains important information about your benefits. Please review it carefully before making enrollment decisions.

Benefits Overview

Rimkus is pleased to continue the following employee benefit offerings this year:

- Medical coverage is offered through **Blue Cross Blue Shield of Texas**. There are two PPO plans and a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA):
  - **Premium Plan** – a $1,000 deductible with 80%/20% coinsurance.
  - **Base Plan** – a $1,500 deductible with 70%/30% coinsurance.
  - **HDHP with HSA Plan** – a $3,450 deductible with 0% coinsurance.
- **HSA Bank** is our Health Savings Account and Flexible Spending Account (FSA) administrator.
- **Prime Therapeutics** is your pharmacy benefit provider. The Prime network includes national chains, local community pharmacies, **Express Scripts** and **Accredo**. See page 16 for additional details.
- If you are taking an eligible medication for the program, **International Rx** will reach out to you to help you enroll and get started.
- Dental and vision coverage are offered through **Guardian**.
- Your Employee Assistance Program is offered through **TELUS Health** at no cost to you.
- **Green Imaging** provides diagnostic imaging services.
- **Sun Life** is our provider for:
  - Life and AD&D insurance
  - Disability insurance
  - Voluntary Accident, Voluntary Critical Illness, and Voluntary Hospital Indemnity (through post-tax payroll deductions)

Rimkus Benefits Assistance

Need help understanding how a claim was paid or have a problem understanding your benefits? The Rimkus Benefits HR Team is available to serve you and your covered dependents and assist with questions you may have about your health and welfare benefits such as:

- Eligibility issues
- Locating a provider
- Claims resolution
- Ordering an ID card

If you have questions regarding your benefits, please contact Human Resources at **713-621-3550**.

The Fine Print

This document is an outline of the coverage proposed by the carriers. It does not include all of the terms, coverages, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The information contained in this summary should in no way be construed as a promise or guarantee of employment or benefits. Rimkus reserves the right to modify, amend, suspend, or terminate any plan at any time for any reason. If there is a conflict between the information in this brochure and the actual plan documents or policies, the documents or policies will always govern. Complete details about the benefits can be obtained by reviewing current plan descriptions, contracts, certificates, policies, and plan documents available from the Benefits Administrator.

The 2025 Benefits Guide is intended to fully comply with the requirements under the Employee Retirement Income Security Act (ERISA) as a Summary of Material Modifications and should be kept with your most recent Summary Plan Description.

TABLE OF CONTENTS

CONTACT INFORMATION

CARRIER	PHONE NUMBER	WEBSITE/EMAIL
MEDICAL		
Blue Cross Blue Shield of Texas	800-521-2227	www.bcbstx.com
PRESCRIPTION DRUGS		
International Rx	877-546-6378	https://internationalrx.com/
DIAGNOSTIC IMAGING SERVICES		
Green Imaging	Text: 713-524-9190 Call: 844-968-4647	www.greenimaging.net
HEALTH SAVINGS ACCOUNT		
HSA Bank	800-357-6246	www.hsabank.com
DENTAL		
Guardian Group No. 00549968	800-541-7846	www.guardiananytime.com
VISION		
Guardian Group No. 00549968	877-814-8970	www.guardiananytime.com
FLEXIBLE SPENDING ACCOUNTS		
HSA Bank	800-357-6246	www.hsabank.com
BASIC LIFE AND AD&D		
Sun Life Group No. 942757	800-247-6875	www.sunlife.com
SUPPLEMENTAL LIFE		
Sun Life Group No. 942757	800-247-6875	www.sunlife.com
LONG TERM DISABILITY		
Sun Life Group No. 942757	800-247-6875	www.sunlife.com
SHORT TERM DISABILITY		
Sun Life Group No. 942757	800-247-6875	www.sunlife.com
EMPLOYEE ASSISTANCE PROGRAM		
TELUS Health	800-433-7916 TTY 800-772-0997	https://login.lifeworks.com/
PET INSURANCE		
ASPCA Pet Health	877-343-5314	www.aspcapetinsurance.com/rimkus
401(k) RETIREMENT SAVINGS PLAN		
Fidelity	800-835-5097	www.netbenefits.com
BENEFITS ADMINISTRATOR		
Human Resources	713-621-3550	benefits@rimkus.com
HEALTH CARE ADVISOR		
Health Advocate	866-695-8622	www.healthadvocate.com/members

EMPLOYEE CONTRIBUTIONS

The chart below specifies the monthly employee contributions for medical, dental, and vision coverage. If you elect medical or dental coverage, you will share the cost with the company. Vision coverage is voluntary and premiums are paid in full by you.

MONTHLY EMPLOYEE CONTRIBUTION			
MEDICAL			
Shared Employer and Employee cost			
	HDHP with HSA Plan	Base PPO Plan	Premium PPO Plan
Employee Only	$55.00	$85.00	$200.00
Employee + Spouse	$350.00	$430.00	$755.00
Employee + Child(ren)	$230.00	$305.00	$485.00
Employee + Family	$480.00	$600.00	$960.00
DENTAL			
Shared Employer and Employee cost			
Employee Only	$20.00		
Employee + Spouse	$40.00		
Employee + Child(ren)	$35.00		
Employee + Family	$60.00		
VISION			
100% Employee Paid			
Employee Only	$6.41		
Employee + Spouse	$12.86		
Employee + Child(ren)	$12.97		
Employee + Family	$20.72		

MONTHLY EMPLOYEE CONTRIBUTION		
CRITICAL ILLNESS		
Rates per $1,000		
Age	Employee and Spouse Non-Tobacco	Employee and Spouse Tobacco
17-24	$0.48	$0.50
25-29	$0.62	$0.68
30-34	$0.62	$0.68
35-39	$1.15	$1.50
40-44	$1.15	$1.50
45-49	$2.40	$3.89
50-54	$2.40	$3.89
55-59	$4.50	$8.44
60-64	$4.50	$8.44
65-74	$8.16	$16.72
Child(ren)		
To age 26	$0.78	
ACCIDENT		
	Low Plan	High Plan
Employee Only	$10.59	$15.30
Employee + Spouse	$18.39	$27.17
Employee + Child(ren)	$19.63	$29.69
Employee + Family	$27.43	$41.56
HOSPITAL INDEMNITY		
	Low Plan	High Plan
Employee Only	$21.93	$40.51
Employee + Spouse	$45.74	$84.80
Employee + Child(ren)	$37.83	$69.69
Employee + Family	$61.64	$113.97

Covering Your Spouse

If your spouse works and has group medical coverage available through his or her employer, you may add your spouse to the Rimkus plan. Because your spouse is eligible for other coverage, a monthly surcharge of $100 will be assessed as long as they are covered under the Rimkus plan. Should your spouse lose access to other coverage, notify Human Resources to have the surcharge removed.

Did You Know?

Your Medical, Dental, and Vision insurance contributions will be handled on a pretax basis, reducing the amount you spend on group insurance premiums by as much as 30%. Contributions for Voluntary Supplemental Life, Voluntary Accident, Voluntary Critical Illness, and Voluntary Hospital Indemnity insurance are withheld post-tax.

ENROLLMENT GUIDELINES

Eligibility

Full-time employees working 30 hours per week or more are eligible to enroll in dental, vision, and most other company-sponsored benefit plans. Benefits begin on your date of hire.

All employees working 30 hours per week may be eligible for medical coverage. Certain part-time employees may be considered full-time under the Affordable Care Act (ACA) and be eligible to enroll in the company's medical plan only. Under these ACA guidelines, part-time employees who work an average of 30 or more hours per week over an annual 11-month measurement period will be eligible for medical benefits during the following year-long stability period. They will remain eligible for medical benefits unless a change in status occurs or are deemed to no longer be considered full-time under the ACA in a subsequent measurement period.

Dependents

Dependents eligible for benefits include your legal spouse (same or opposite sex) and dependent child(ren). Dependent child(ren) include:

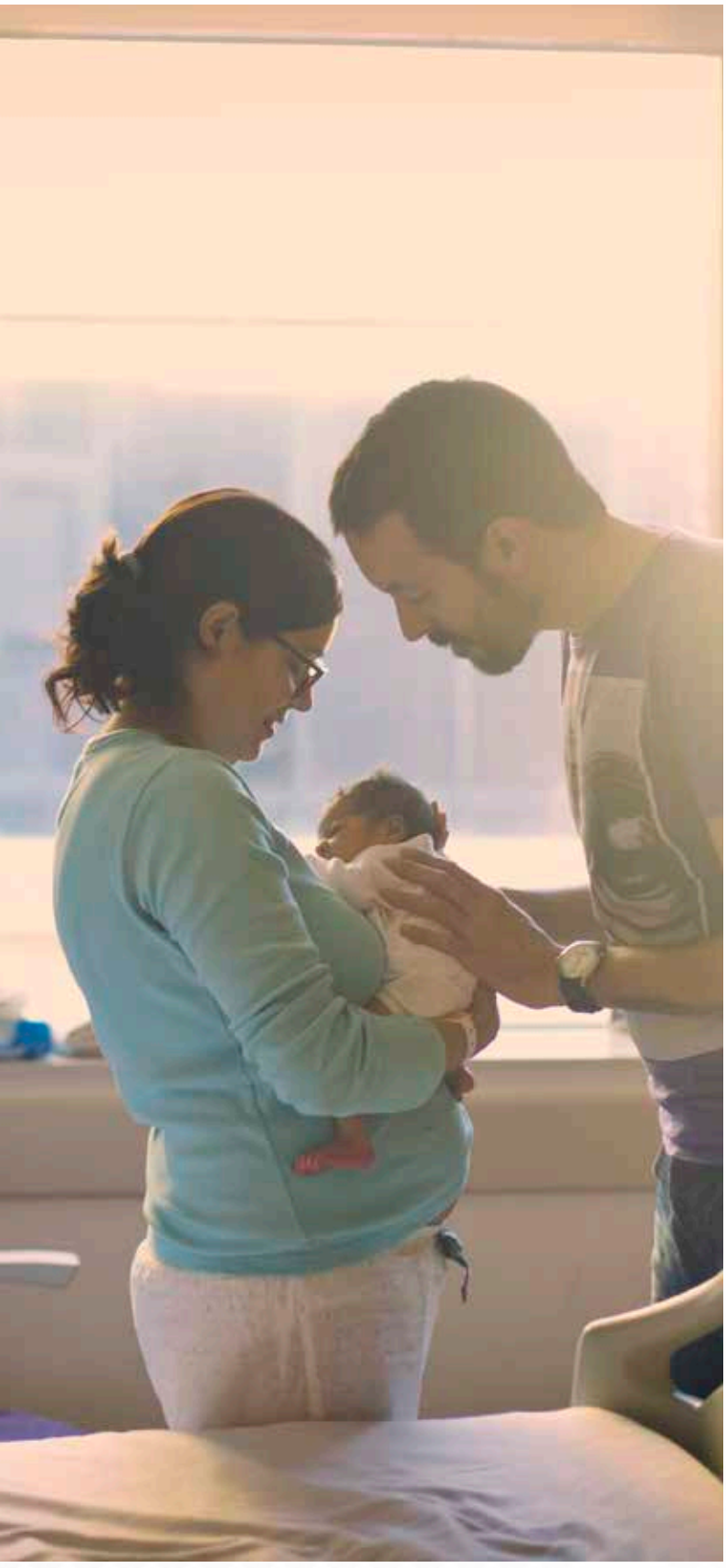
- Natural children
- Legally adopted children or children placed for adoption
- Stepchildren
- Children for whom benefits must be provided through a Qualified Medical Child Support Order
- A child for whom legal guardianship has been awarded to you or your spouse

Children are eligible for medical, dental, and vision coverage from birth to age 26. Unmarried handicapped children are eligible to remain on coverage past age 26 as long as the child's status remains the same and is dependent on you for support.

Dependent/Spouse Clarification

If you are a full time employee legally married to another full time employee, you may not enroll your legally married spouse for benefits as a dependent. Further, if you and your spouse are both employees of the company, your dependent children can only be covered under either your or your spouse's coverage – not under both.

ENROLLMENT GUIDELINES



Making Enrollment Changes During the Year

Midyear changes to your benefit elections must be consistent with a Qualified Change in Status. For example, if you gain a new dependent due to birth, you may only change your benefit elections to add that dependent. In this case, coverage for other dependents cannot be changed.

You have 30 days from the date of a Qualified Change in Status to complete an enrollment change through the **UKG enrollment portal**. Otherwise, you must wait until the next annual enrollment period to make a change to your elections. Your elections become effective the first of the following month, with the exception of a change due to birth or adoption which become effective on the date of the event.

Qualified Change in Status

You may only make changes to your elections during the year if you have a Qualified Change in Status, which includes:

30-Day Notification Timeframe

- Marriage or legal separation
- Birth, adoption, or placement for adoption of an eligible child
- Changes in your spouse's employment that affects benefit eligibility
- Change in residence that affects your eligibility for coverage
- Significant change in benefit plan coverage or cost for you, your spouse, or child
- FMLA leave, COBRA event, court judgment or decree
- Receipt of a Qualified Medical Child Support Order (QMCSO)
- Becoming eligible for Medicare or Medicaid/CHIP

60-Day Notification Timeframe

- Death of a spouse or child
- Divorce
- Change in your child's eligibility for benefits (e.g., reaching the 26 age limit)

MEDICAL BENEFITS

About Your Medical Coverage

Rimkus' medical coverage is offered through **Blue Cross Blue Shield of Texas (BCBSTX)**. You have a choice of three different plans:

- Base PPO
- Premium PPO
- High Deductible Health Plan with Health Savings Account

Preventive care is covered in-network at 100% on all three plan options.

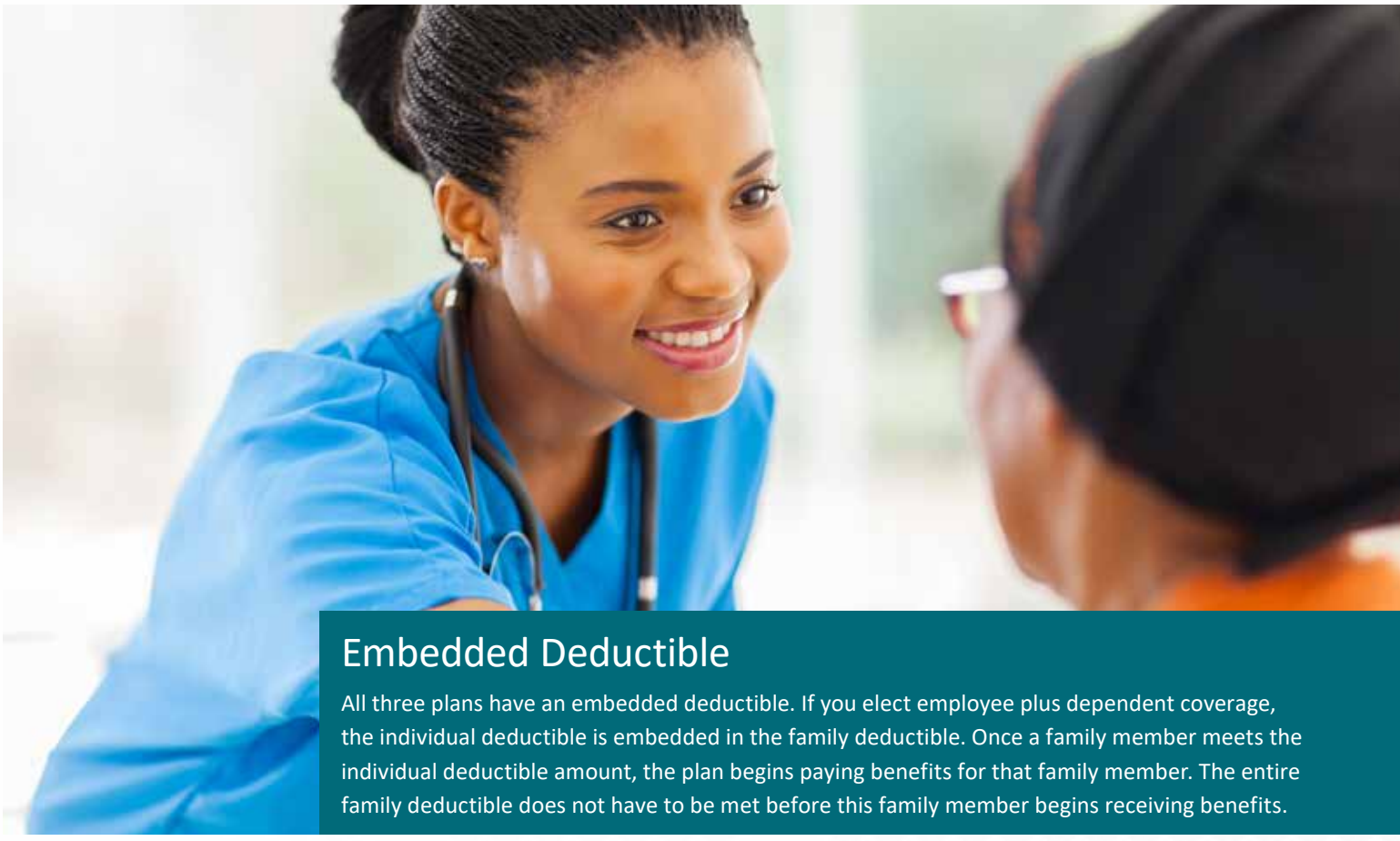
Preferred Provider Organization (PPO) Plans

The Base and Premium PPO plans allow you to choose providers who participate in the Blue Choice PPO network or out-of-network providers. Both plans cover office visits, urgent care, emergency room, and pharmacy services with a copay. All other services apply towards your deductible before the plan pays.

High Deductible Health Plan (HDHP)

The HDHP plan is similar to the PPO plans in that you have the option of choosing your provider when you need care. However, in exchange for a lower monthly premium, you must satisfy a higher deductible that applies to almost all health care expenses. Once your deductible is met, eligible medical and pharmacy expenses are covered at 100% for the remainder of the calendar year.

If you elect to enroll in the HDHP plan, you have the option of opening a Health Savings Account (HSA). An HSA allows you to accumulate tax-free funds to pay for qualified health care expenses. Money accrues interest in your account and the account is owned by you. You will receive a debit card for use with the account. Rimkus will make yearly account contributions of $800 for single coverage or $1,600 for family coverage. One half of the yearly contribution will be made in January; the remaining half will be contributed over the remaining pay periods in the year. Contributions will be prorated for new hires. More HSA information can be found on page 18 of this book.



Embedded Deductible

All three plans have an embedded deductible. If you elect employee plus dependent coverage, the individual deductible is embedded in the family deductible. Once a family member meets the individual deductible amount, the plan begins paying benefits for that family member. The entire family deductible does not have to be met before this family member begins receiving benefits.

BCBSTX PROGRAMS

BCBSTX Website Information

Visit **www.bcbstx.com** for valuable information and resources associated with your BCBSTX medical plan. Use the member and group numbers on your ID card to help you register.

- Click *Sign Up* or *Log in*
- Next to *New User*, click on *Register Now*.

After selecting a username and password, you can access the following features:

- Search for providers and hospitals in your area
- Monitor your personal claims
- Order mail order prescriptions
- Access health information and participate in web events
- Order additional ID cards
- Verify your deductible and out-of-pocket accumulations
- Check your Health Savings Account balance

BCBSTX Mobile App

For convenience, you can also download the BCBSTX app to your mobile device. The app can help you stay organized and in control of your health — anytime, anywhere. Download and log in to:

- Track your account balances and deductibles
- View, fax, or email ID card information
- Find doctors and pharmacies
- Refill your BCBSTX home delivery prescriptions and view order history
- View medication costs based on your plan and search for lower, cost-saving alternatives

To get the BCBSTX app, text **BCBSTXAPP** to **33633** or visit your device's app store.

Blue365℠
Because health is a big deal℠

Blue365 can help you save money on health and wellness products and services not covered by insurance. There are no claims to file and you do not need a referral or preauthorization. Sign up for Blue365 at **www.blue365deals.com/bcbstx** to receive weekly Featured Deals by email. Discounts include:

- EyeMed I Davis Vision | LasikPlus – eyewear and LASIK
- TruHearing | Beltone – hearing aids and tests
- Dental Solutions – dental discount card
- Nutrisytem | Sunbasket – weight loss and nutrition
- Reebok | SKECHERS – work footwear
- Livekick – Private fitness
- eMindful – 50% discount on any live streaming
- Fitbit – Customize your workout routine
- InVite Health – Vitamins and supplements

HEALTH CARE OPTIONS

Becoming familiar with your options for medical care can save you time and money.

HEALTH CARE PROVIDER		SYMPTOMS	AVERAGE COST	AVERAGE WAIT
NON-EMERGENCY CARE				
 **VIRTUAL VISITS/ TELEMEDICINE**	Access to care via phone, online video or mobile app whether you are home, work or traveling; medications can be prescribed **24 hours a day, 7 days a week**	▪ Allergies ▪ Cough/cold/flu ▪ Rash ▪ Stomachache	$	**2-5 minutes**
 **DOCTOR'S OFFICE**	Generally, the best place for routine preventive care; established relationship; able to treat based on medical history **Office hours vary**	▪ Infections ▪ Sore and strep throat ▪ Vaccinations ▪ Minor injuries, sprains and strains	$	**15-20 minutes**
 **RETAIL CLINIC**	Usually lower out-of-pocket cost than urgent care; when you can't see your doctor; located in stores and pharmacies **Hours vary based on store hours**	▪ Common infections ▪ Minor injuries ▪ Pregnancy tests ▪ Vaccinations	$	**15 minutes**
 **URGENT CARE**	When you need immediate attention; walk-in basis is usually accepted **Generally includes evening, weekend and holiday hours**	▪ Sprains and strains ▪ Minor broken bones ▪ Small cuts that may require stitches ▪ Minor burns and infections	$$	**15-30 minutes**
EMERGENCY CARE				
 **HOSPITAL ER**	Life-threatening or critical conditions; trauma treatment; multiple bills for doctor and facility **24 hours a day, 7 days a week**	▪ Chest pain ▪ Difficulty breathing ▪ Severe bleeding ▪ Blurred or sudden loss of vision ▪ Major broken bones	$$$$	**4+ hours**
 **FREESTANDING ER**	Services do not include trauma care; can look similar to an urgent care center, but medical bills may be 10 times higher **24 hours a day, 7 days a week**	▪ Most major injuries except trauma ▪ Severe pain	$$$$$$	**Minimal**

Note: Examples of symptoms are not inclusive of all health issues. Wait times described are only estimates. This information is not intended as medical advice. If you have questions, please call the phone number on the back of your medical ID card.

HEALTH ADVOCATE

Health Advocate is your independent, personal health care advisor. The experts at Health Advocate can answer questions and take on virtually any health care issue so you and your family get the right care at the right time at no cost to you.

Expert Health Care Help

Personal Health Advocates can answer questions about your health plan, explain your insurance benefits, and help you understand your coverage, locate doctors, and support all medical and insurance issues, no matter how complex.

They can:

- Support medical issues, from common to complex
- Answer questions about diagnoses and treatments
- Research the latest treatment options
- Coordinate services related to all aspects of your care
- Find the right in-network doctors and make appointments
- Coordinate second opinions and transfer medical records
- Research and locate eldercare services
- Resolve insurance claims and medical billing issues

Mobile App

Download the Health Advocate mobile app to your mobile device for quick, convenient access to health care help.

ALTERNATIVE CARE

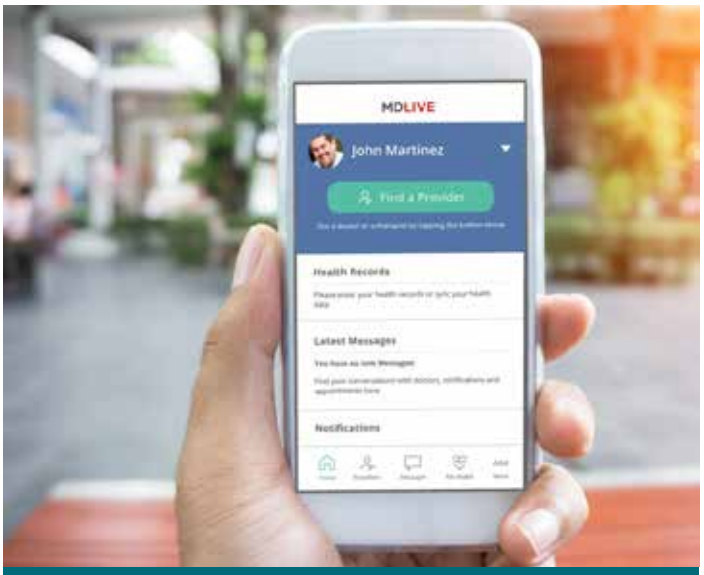
MDLIVE

MDLIVE provides access to telemedicine services as part of your BCBSTX medical plan and can be a cost-effective alternative to visiting your primary care provider, urgent care center, or emergency room.

You can connect with a board-certified doctor via secure video chat or phone without leaving your home or office. Your cost is often the same or less than a visit to your primary care provider. Care is available 24/7/365, including holidays.

Telemedicine services should only be used for minor, nonlife-threatening conditions such as:

- Sore throat
- Headache
- Stomachache
- Cold and flu
- Allergies
- Fever
- UTIs
- Bladder infections



Register for MDLIVE

Register for MDLIVE so you are ready to use this telemedicine service when and where you need it.

- Visit **www.mdlive.com/bcbstx** or call **888-680-8646** to register. You will need your first and last name, date of birth, and your BCBSTX ID number.
- Once registered, call or go online to visit with a doctor or health service specialist.
- You can also download the MDLIVE app to your mobile device.

DIAGNOSTIC IMAGING SERVICES

$0 COST X-RAY AND IMAGING SERVICES

Green Imaging provides diagnostic imaging services to you for FREE—no prior authorization is required. If your doctor prescribes a diagnostic imaging service (e.g., X-ray, CT scan, MRI, etc.), ask Green Imaging to schedule the procedure. If you need X-rays or imaging, you may choose to use either Green Imaging or the diagnostic benefits that come with your medical plan.

Green Imaging Services

- MRI
- CT scan
- PET
- Ultrasound
- Nuclear medicine
- Mammography
- DXA
- X-ray
- Arthrogram
- Echocardiogram

How Green Imaging Works

1. Ask your doctor to fax the medical request to **866-653-0882**.
2. Then, contact Green Imaging to schedule an appointment and request a voucher. You will need to provide some personal information, your physician's order (a photo of it if texting) and your Group Name.
3. Green Imaging will schedule your appointment and send you a voucher to bring to your appointment.
4. Green Imaging will then take your X-rays or images and send the medical report to your Green Imaging account and to your doctor.

Contact Green Imaging

- Text – **713-524-9190**
- Chat – **www.greenimaging.net**
- Call – **844-968-4647**

MEDICAL BENEFITS SUMMARY

	BASE PPO PLAN		PREMIUM PPO PLAN		HDHP WITH HSA PLAN	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Lifetime Maximum	Unlimited		Unlimited		Unlimited	
Coinsurance	70% [1,2]	50% [1,2]	80% [1,2]	60% [1,2]	0%	50% [1]
	You Pay		You Pay		You Pay	
Calendar Year Deductible ▪ Individual ▪ Family	 $1,500 $3,000	 $3,000 $6,000	 $1,000 $2,000	 $1,500 $3,000	 $3,450 $6,900	 $4,000 $8,000
Out-of-Pocket Maximum Includes deductible ▪ Individual ▪ Family	 $4,500 $9,000	 $6,000 $12,000	 $3,000 $6,000	 $7,500 $15,000	 $3,450 $6,900	 $8,000 $16,000
Preventive Care Routine physical exams; routine gynecological exams, including Pap test; mammograms, as required; well child and immunizations	$0	50% [2]	$0	40% [2]	$0	50% [2]
Virtual Visit	$20 copay	Not covered	$20 copay	Not covered	$0 [2]	50% [2]
Primary Care Physician Office Visit	$30 copay	50% [2]	$30 copay	40% [2]	$0 [2]	50% [2]
Specialist Office Visit	$40 copay	50% [2]	$40 copay	N/A	$0 [2]	N/A
Chiropractic Visit 20 visits per calendar year	$70 copay	50% [2]	$70 copay	40% [2]	$0 [2]	50% [2]
Routine Lab and X-ray	$0	50% [2]	$0	40% [2]	$0 [2]	50% [2]
Green Imaging	$0	$0	$0	40% [2]	$0	50% [2]
Emergency Room Facility Services	$250 copay + 30% [3]		$250 copay + 20% [3]		$0 [2]	
Emergency Room Other Services	30% [2]		20% [2]		$0 [2]	
Urgent Care Center	$75 copay	50% [2]	$75 copay	40% [2]	$0 [2]	50% [2]
Ambulance	30% [2]	30% [4]	20% [2]	20% [4]	$0 [2]	$0 [4]
Hospital Expenses Inpatient and Outpatient	30% [2]	50% [2]	20% [2]	40% [2]	$0 [2]	50% [2]
Durable Medical Equipment Precertification may be required	30% [2]	50% [2]	20% [2]	40% [2]	$0 [2]	50% [2]
Skilled Nursing Facility Care Limit 60 days per calendar year	$0	50% [2]	$0	40% [2]	$0 [2]	50% [2]
Home Health Care Limit 60 visits per calendar year	$0	50% [2]	$0	40% [2]	$0 [2]	50% [2]
Mental Health/ Substance Abuse Care ▪ Inpatient ▪ Outpatient	 30% [2] $30 copay	 50% [2] 50% [2]	 20% [2] $30 copay	 40% [2] 40% [2]	 $0 [2] $0 [2]	 50% [2] 50% [2]

[1] Until the out-of-pocket maximum is met.

[2] After deductible.

[3] Copay waived if admitted.

[4] After in-network deductible.

PRESCRIPTION DRUGS

The Rimkus prescription drug program has a tiered structure:

- **Tier 1** – Lowest copay
- **Tier 2 (formulary drugs)** –Higher copay
- **Tier 3 (non-formulary drugs)** – Highest copay

The Preferred Drug List is updated quarterly to ensure that newer, more effective drugs are included. To get the most updated list, visit **www.bcbstx.com**.

	BASE PPO PLAN	PREMIUM PPO PLAN	HDHP WITH HSA PLAN
RETAIL COPAY [1]			
	Up to 31 Days	Up to 31 Days	Up to 31 Days
Tier 1 Generic drugs	$15 copay	$15 copay	$0 after deductible
Tier 2 Formulary drugs	$30 copay	$30 copay	$0 after deductible
Tier 3 Non-formulary drugs	$65 copay	$65 copay	$0 after deductible
Tier 4 Specialty drugs	$100 copay	$100 copay	$0 after deductible
MAIL ORDER COPAY [2]			
	Up to 90 Days	Up to 90 Days	Up to 90 Days
Tier 1 Generic drugs	$37.50 copay	$37.50 copay	$0 after deductible
Tier 2 Formulary drugs	$75 copay	$75 copay	$0 after deductible
Tier 3 Non-formulary drugs	$162.50 copay	$162.50 copay	$0 after deductible

[1] In-network only.

[2] When using mail order, you will save $7.50 for Tier 1, $15 for Tier 2, and $32.50 for Tier 3 medications.

Preventive Drug Benefit Program

BCBSTX administers an expanded preventive drug benefit for the High Deductible Health Plan (HDHP). The preventive drug benefit includes prescription drugs often used for preventive purposes.

If your doctor prescribes a listed preventive medication, the plan may pay for the prescription before you meet your HDHP deductible. If your doctor prescribes a listed drug for treatment purposes (and not preventive purposes), then your plan does not provide coverage for that drug until your HDHP deductible is satisfied. Refer to the HDHP-HSA Common Preventive Drug List Guide posted on the Rimkus intranet site.

Fertility / Infertility Prescriptions

This plan covers $5,000 per member per lifetime toward the cost of fertility / infertility prescriptions. This does not apply to medical procedures.

Pay $4 for Prescriptions

Did you know that Walmart offers more than 500 different generic drugs that range between $4 to $38 depending on medication and dosage quantity per prescription fill or refill (up to a 30-day supply or 60 pill maximum)? The store also offers a $10 Prescription Program that includes generic medications for up to a 90-day supply for maintenance medications. The program is available at all Walmart, and Neighborhood Market pharmacies. A similar program is also offered through Target, HEB, Randall's, Walgreen's, and CVS.

Important Tips

- You do not need a membership at Sam's Club or Costco to use the pharmacy.
- The list of eligible drugs on Walmart or similar programs is subject to change.
- When using a pharmacy's special generic drug program like the Walmart $4 program, you do not have to show your BCBSTX ID card.

PRESCRIPTION DRUGS

Mail Order Prescriptions

Express Scripts delivers your long-term (or maintenance) medicines to the address of your choice.

New Prescriptions

- Mail your prescription to Express Scripts or have your doctor fax or e-prescribe.
- Ask your doctor to write a prescription for a 90-day supply of each of your long-term medicines. Or, ask your doctor to fax or e-prescribe your order.
- To print a new prescription order form, go to **www.express-scripts.com/rx** or call **833-715-0942**.
- Mail your prescription, completed form, and payment to Express Scripts.

Medicines take about five days to deliver after receipt of your order.

Refill or Transfer Prescriptions

- **Online** – Visit **www.express-scripts.com/rx** to register and create a profile or log in to www.myprime.com and follow the links to Express Scripts Pharmacy.
- **Phone** – Call **833-715-0942** and have your member ID card and your doctor's and Rx information ready.
- **Mail** – Log in to **www.bcbstx.com**, complete the mail order form, and send it with your Rx and payment to Express Scripts.
- **Doctor** – Ask your doctor to fax, call, or email your Rx to Express Scripts for you.
- **Questions?** – Visit **www.bcbstx.com** or call the number on your member ID card.

Important

The member advocacy team is available 24/7 with live-answer access. Call **877-546-6378** to learn more about the program.

Specialty Medications

If you need specialty drugs to treat complex or chronic conditions, use **Accredo** for new or transfer orders. Call **833-721-1619** to speak to a representative and place your order. Certain exclusions and limitations apply, so visit **www.accredo.com** for details.

International Prescription Drug Option

International Rx mail order program offers savings on certain specialty prescription drugs such as Humira, Ozempic, Tremfya, Simponi, and others. You pay a **$0 copay** for all medications on the formulary. International Rx also shares in any pharmacy rebate for the plan's first 12 months of enrollment. Follow the below steps to begin using the program.

1. Fill your prescription through the BCBS pharmacy program as you do today
2. International Rx will call you to start the process
3. International Rx will work with you and your physician on your prescription
4. Your member advocate will reach out to you prior to the shipping of your medication to verify all details along with tracking numbers
5. Prescriptions are shipped to you from Canada, United Kingdom, or Australia in a specialized shipping container which contains GPS tracking
6. Once your medication is received, the advocacy team will confirm receipt and schedule the pick-up of the shipping container
7. Your rebate check is mailed

HEALTH SAVINGS ACCOUNT

When you enroll in a High Deductible Health Plan (HDHP), you are eligible to open a Health Savings Account (HSA) through **HSA Bank**. An HSA is a personal savings account you can use to pay qualified out-of-pocket medical, pharmacy, dental, and vision expenses with pretax dollars. You — not the Company — own and control the money in your HSA. The money you deposit is not taxed and you can invest it in stocks, bonds, and mutual funds. The money in this account (including interest and investment earnings) grows tax-free, and as long as the funds are used to pay for qualified health care expenses, they continue to be tax-free.

Unlike a Flexible Spending Account, there is no "use it or lose it" rule — you do not lose your money if you do not spend it in the plan year — and there are no vesting requirements or forfeiture provisions. The account will automatically roll over year after year. Since it is an individual account, if you change health plans or jobs, the account is yours to keep.

For access to your account information, visit **www.hsabank.com**.

HSA Eligibility

You are eligible to open and contribute to an HSA if you:

- Are enrolled in an HSA-eligible HDHP (the HDHP with HSA plan)
- Are not covered by other non-high deductible health plans, such as your spouse's health plan or a Health Care Flexible Spending Account
- Are not eligible to be claimed as a dependent on someone else's tax return
- Are not enrolled in Medicare, Medicaid, or TRICARE
- Have not received Veterans Administration benefits

You can use the money in your HSA to pay for qualified medical expenses now or in the future. Your HSA can be used for your expenses and those of your spouse and dependents*, even if they are not covered by the HDHP.

If you open an HSA, you may also contribute to a Limited Purpose Health Care FSA, which you can use to pay for qualified dental and vision expenses. See page 18 for more information.

* To age 19 or 24, if a full-time student.

Maximum Contributions

You may contribute to the HSA with pretax dollars through payroll deduction. Rimkus will also make a matching contribution to your account. For calendar year 2025, total contributions into an HSA cannot exceed $4,300 if you have single coverage or $8,550 if you have any form of family coverage (spouse, child, or full family).

MAXIMUM HSA CONTRIBUTIONS		
Individual	Individual	Family
Total	$4,300	$8,550
Less Rimkus	$800	$1,600
Your Maximum	$3,500	$6,950
Age 55+ Catch-Up Contribution		Additional $1,000

Note: Some states do not allow HSA contributions to be deducted on a pretax basis for state income tax purposes. Keep in mind:

- Rimkus also makes a contribution to your HSA: $800 for single coverage and $1,600 for family coverage.
- One half of your company contributions ($400 individual / $800 family) will be made in January while the other half will be contributed over your remaining pay periods. These company contributions will be prorated for new hires.
- You must contribute in order to receive the company contribution.
- You can only use the money in your HSA to pay for medical, pharmacy, dental, or vision expenses that are qualified by the IRS. If you use your HSA for any expenses other than health care, you must pay taxes on the excess amount as well as a 20% penalty.
- The HSA does not work like a Flexible Spending Account, where your annual allocation is available to you on the first day of the plan year. With an HSA, you can only spend money for eligible health care expenses that have been deposited in your account.

HEALTH SAVINGS ACCOUNT

Frequently Asked Questions

Can I participate in both the Health Care Flexible Spending Account (FSA) and the HSA?

No. If you enroll in the HDHP, you will need to choose the HSA. You may, however, participate in a Limited Purpose Health Care FSA. If you are changing from the PPO plan and you have an FSA balance, you must exhaust the FSA balance or roll it into a Limited Purpose Health Care FSA before you can contribute to an HSA.

How much can I contribute to the HSA?

The 2025 maximum HSA contributions are:

- Employee Only – $4,300
- Employee and Dependent(s) – $8,550
- $1,000 catch-up if age 55 or older

May I change my contribution amount during the year?

You may change your HSA contribution amounts on January 1 and July 1.

Is there an employer contribution?

Yes. Annual contributions are $800 (single coverage) and $1,600 (family coverage).

What expenses may I pay for from my HSA?

Refer to IRS *Publication 502 Medical and Dental Expenses* at **www.irs.gov** for a complete description of eligible medical and dental expenses (see page 25 for an abbreviated list). In addition to the listed expenses, you may use the money for Long Term Care and COBRA premiums in the event you lose your coverage.

Is there a penalty for paying for non-qualified medical expenses from my HSA?

Yes, you will be subject to your regular income tax rate and a 20% penalty, unless you are over age 65. If you are over age 65, withdrawal is treated as retirement income and only subject to your regular income tax rate.

Do I have to prove my HSA reimbursements are qualified medical expenses?

You are responsible for keeping receipts in the event of an IRS audit.

If I do not spend all of the money in my HSA, do I lose it?

No, you own the HSA. Any unused funds are yours and roll over each year.

If I leave Rimkus, do I lose the money in my HSA?

No, you own your HSA and the money is yours.

Do I have to make a contribution to the health savings account to receive the company contribution?

Yes, you are required to make a contribution of your own funds to the account to receive the company contribution.

Designating a Beneficiary

A beneficiary is a person or entity you elect to receive the death benefits of your Health Savings Account with HSA Bank. You can name more than one beneficiary and change beneficiaries at anytime. Visit **www.hsabank.com** and go to Settings>Profile> Edit to designate your beneficiaries.

Why it's important to designate a beneficiary

- By having a designated beneficiary in place at the time of your death, the assets of your HSA can be distributed according to the designation.

Review your beneficiary designations

- By periodically reviewing your beneficiary designations for your HSA, you can rest assured that your assets will be distributed according to your wishes.

Circumstances for which a review is recommended

- You experience a major life event such as a birth, marriage, dissolution of marriage or domestic partnership, or death in the family.

CHOOSE A MEDICAL PLAN

If you already have a good idea of the right coverage for you, the examples below should help confirm your choice of medical coverage.

- **Example 1** – What if I am a healthy, single person with minimal expenses?
  - Monthly allergy formulary brand-name prescription drug ($70 retail value)
  - One office visit ($100 retail value)

	BASE PPO PLAN	PREMIUM PPO PLAN	HDHP WITH HSA PLAN
Annual Premium	$1,020	$2,400	$660
Primary Care Office One visit	$30	$30	$100
Allergy Medications 12 30-day prescriptions	$360	$360	$840
Total Cost **Premium cost plus out-of-pocket cost**	**$1,410**	**$2,790**	**$1,600 - $800 employer contribution = $800**

- **Example 2** – What if I cover my family and one person incurs $5,000 in expenses?

	BASE PPO PLAN	PREMIUM PPO PLAN	HDHP WITH HSA PLAN
Annual Premium	$7,200	$11,520	$5,760
Specialist Office Visit Five visits	$200	$200	$500
Deductible	$1,500	$1,000	$2,950
Coinsurance	$1,050	$800	$0
Total Cost **Premium cost plus out-of-pocket cost**	**$9,950**	**$13,520**	**$9,210 - $1,600 employer contribution = $7,610**

- **Example 3** – What if I cover my family and two individuals have serious health conditions (over $100,000 in expenses)?

	BASE PPO PLAN	PREMIUM PPO PLAN	HDHP WITH HSA PLAN
Annual Premium	$7,200	$11,520	$5,760
Specialist Office Visit 15 visits	$600	$600	$1,500
Deductible	$3,000	$2,000	$5,350
Coinsurance	$5,400	$3,400	$0
Total Cost **Premium cost plus out-of-pocket cost**	**$16,200**	**$17,520**	**$12,610 - $1,600 employer contribution = $11,010**

ADDITIONAL BENEFITS

Employee Assistance Program

Rimkus offers the **Telus Health** Employee Assistance Plan (EAP). This plan helps you and your family members cope with life — from the everyday to the unexpected. Your EAP is a confidential counseling service to help address any personal issues you face. This service, staffed by experienced clinicians, is available by calling **800-433-7916**, 24/7 or going online to **https://login.lifeworks.com**. **A Guidance Consultant will refer you to a local counselor or to resources in your community for up to five face-to-face sessions per year.**

Call anytime with personal concerns, including:

- Relationships
- Problems with your children
- Stress, anxiety, or depression
- Job pressures
- Marital conflicts
- Grief and loss
- Substance abuse
- Empty-nesting

Whether you are a new parent, a caregiver for a dependent elder, sending a child off to college, buying a car, or doing home repairs, you are bound to have questions or need resource referrals. The EAP specialists will help you sort out the issues and provide you with information based on your specific criteria, including:

- Finding child or eldercare
- Planning for college
- Relocating to a new city
- Finding pet care
- Purchasing a car
- Home repair
- Adopting a child
- Planning a vacation

Download the App

Download the Telus Health One app to your mobile device for access anytime you need assistance.

Emergency Travel Aid

Travel assistance is provided through Sun Life with **Assist America**. The travel aid program is available when traveling 100 miles or more from your primary home for 90 days or less. It provides a variety of services 24/7 through friendly, multilingual professionals who can advise you in a medical emergency. Services include:

- English-speaking doctors, hospitals, pharmacies, and dentists anywhere in the world
- Medical consultation, evaluation, and referral
- Hospital admission guarantee
- Emergency medical evacuation
- Lost prescription assistance
- Legal and interpreter services

Contact Assist America

- Call within the U.S. – **800-872-1414**
- Call outside the U.S. – **609-986-1234**
- Email – **medservices@assistamerica.com**

Use reference number 01-AA-SUL-100101.

DENTAL BENEFITS

Good oral hygiene can contribute to your overall health. That is why it is important to get regular dental checkups. Rimkus offers a dental plan through **Guardian** using the DentalGuard Preferred Network. The plan offers reimbursement for both in-network and out-of-network services. If you visit a dentist in the Guardian network, you will receive the most savings. If you use an out-of-network dentist, the out-of-network payments are based on usual and customary charges.

Dental Benefits Summary

	NAP PLAN
Annual Maximum Benefit Per covered person[1]	$2,000
	You Pay
Calendar Year Deductible[2] ▪ Single ▪ Family	$50 $150
Type A – Preventive Services Oral Exams and Evaluation, Cleanings, Fluoride Treatment, Bitewing Series, Full Mouth X-ray, Sealants, Space Maintainers	0%
Type B – Basic Restorative Fillings, Simple Extractions	20%
Type C – Major Restorative Inlays and Crowns, Implants, Bridgework, Endodontic Treatment, Periodontal Surgery, Oral Surgery, General Anesthesia	50%
Type D – Orthodontia Adult and Child	50%[3]

[1] Type A, B, and C services only.

[2] Calendar Year Deductible waived for Type A services.

[3] $2,000 lifetime maximum.

Guardian Maximum Rollover Program

As a dental plan member, you are automatically enrolled in the Guardian Maximum Rollover Program. When you have regular dental checkups and your annual claims are below $800, a portion of your unused annual maximum is rolled over into a personal Maximum Rollover Account (MRA). If you leave Rimkus, any funds in your MRA are forfeited. Your MRA can be used in future years if you reach the plan's annual maximum. An annual maximum of $400 can be rolled into your account. Leftover balances carry over to the next benefit period. Once your account reaches $1,500, no additional funds will be added. You and your insured dependents maintain separate accounts based on individual claim activity.

VISION BENEFITS

Guardian also provides our vision coverage. You may see any vision provider you choose. However, if you use a VSP vision provider, you will have access to discounted charges and, in most instances, you pay only a copay.

Periodic eye examinations are an important part of routine preventive health care. Early diagnosis and treatment are important for maintaining good vision and preventing permanent vision loss. Eye exams can detect symptoms of diseases such as diabetes, hypertension, multiple sclerosis, brain tumors, osteoporosis, and rheumatoid arthritis.

This is only a brief summary of benefits. Please see your Vision plan document for complete details.

Vision Benefits Summary

GUARDIAN VISION		
	In-Network You Pay	**Out-of-Network Reimbursement**
Vision Exam Once every 12 months	$10 copay	Up to $39
Lenses Once every 12 months ▪ Single Vision ▪ Bifocal ▪ Trifocal ▪ Lenticular	 $25 copay* $25 copay* $25 copay* $25 copay*	 Up to $23 Up to $37 Up to $49 Up to $64
Frames Once every 12 months	$150 allowance after copay	Up to $46
Elective Contact Lenses Professional Fees and Materials In lieu of spectacle lenses and a frame – once every 12 months	Up to $150 allowance	Up to $100

* The copay covers the base lens. All additional services added to the lens are provided at a discounted fee when using in-network providers.

FLEXIBLE SPENDING ACCOUNTS

A great way to plan ahead and save money over the course of a year is to participate in our Flexible Spending Account (FSA) programs. These accounts allow you to put a portion of your salary, on a pretax basis, into reimbursement accounts. Pretax means the dollars you use for eligible expenses are not subject to Social Security tax, federal income tax, and, in most cases, state and local income taxes. When you enroll, you must decide how much to set aside from your paycheck for each account. Be sure to estimate your expenses conservatively, as the IRS requires that you use the money in your account during the plan year (January 1 – December 31, 2025). **HSA Bank** is our FSA administrator.

Health Care FSA

The Health Care FSA enables you to take control of your out-of-pocket health care spending by contributing pretax money to your account to pay for everyday eligible expenses. The result can be substantial savings on products and services not covered by your plan such as copays, coinsurance, deductibles, prescription expenses, lab exams and tests, contact lenses, eyeglasses, and more. A complete list of qualified expenses can be found in publication 502 on the IRS website. When you incur the expense, you will be reimbursed the full amount at that time. You can contribute up to $3,300 to the Health Care FSA for the 2025 plan year.

Limited Purpose Health Care FSA

A Limited Purpose Health Care FSA is available if you are enrolled in the HDHP and contribute to an HSA. You can use a Limited Purpose Health Care FSA to pay for eligible out-of-pocket dental and vision expenses only, such as:

- Dental and orthodontia care (e.g., fillings, X-rays, and braces)
- Vision care (e.g., eyeglasses, contact lenses, and LASIK surgery)

You can contribute up to $3,300 to the Limited Purpose FSA for the 2025 plan year.

Dependent Care FSA

The Dependent Care FSA helps pay for dependent/eldercare expenses associated with caring for elder or child dependents in order for you or your spouse to work or attend school full-time. The dependent child must be under age 13 and claimed as a dependent on your federal income tax return, or a disabled dependent of any age incapable of caring for himself or herself and who spends at least eight hours a day in your home. You can contribute up to $5,000 to the Dependent Care FSA for the 2025 plan year.

How the Dependent Care FSA Works

Unlike the Health Care FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is deposited in your account at that time. In order to be reimbursed, you must provide the tax identification number or Social Security number of the party providing care and that provider cannot be anyone considered your dependent for income tax purposes.

Commuter FSAs

Commuter FSAs enable you to pay certain workplace transit and parking expenses on a tax-free basis through payroll deductions. Commuter benefits are not tied to a benefit year, so the funds remain in your account until exhausted. Election changes are not limited by a plan year and can be updated or stopped as your needs change. You must submit all claims within 180 days of receiving the service for reimbursement.

Note: Toll fees are not eligible.

Eligible Commuter Expenses

- Parking
- Transit
- Carpool
- Vanpool

Using Your Commuter FSA

Using your Commuter FSA is easy with the FSA debit card, HSA Bank mobile app, and website. The maximum is $325 per month for transit and $325 per month for parking.

- **Debit Card** – Use your FSA debit card to pay commuter expenses and U.S. terminal charges for transit and parking plans.
- **Online** – Visit **www.hsabank.com** to submit claims for cash reimbursement.
- **App** – Download the HSA Bank app to your mobile device for on-the-go access to your account.
- **Smart Commute** – Directly load funds for passes and fare fees.

FLEXIBLE SPENDING ACCOUNTS

How to Use the Debit Card

The FSA debit card allows you to pay for eligible health care expenses at the point of service and deducts funds directly from your Health Care Spending Account. This allows you to avoid waiting for reimbursement. You may use your FSA debit card at locations such as doctor and dentist offices, pharmacies, and vision service providers. The card cannot be used at locations that do not offer health-related services under the plan, unless the provider has complied with IRS regulations. Should you attempt to use the card at an ineligible location, the swipe transaction will be denied. Should you need to submit a receipt for substantiation, you will receive a written request.

Once you are enrolled, you will receive a debit card from HSA Bank for managing your FSA account reimbursements. To view your account information, go to **www.hsabank.com**.

For convenient, real-time access to your account, download the HSA Bank app on your mobile device. Use the app to view statements and see account activity, receive notifications on claim status, reset login credentials, report a card lost or stolen, sign up for text alerts, and much more.

Remember: Your debit card cannot be used for dependent care expenses.

Rollover Rule

The IRS has amended the "use it or lose it" rule to allow you to carry over up to **$660** from 2025 into the 2026 plan year. The carry-over rule does not apply to your Dependent Care FSA.

Over-the-Counter Item Rule Reminder

Health care reform legislation requires that certain over-the-counter (OTC) items have a prescription in order to be considered an eligible Health Care FSA expense. You will only need to obtain a one-time prescription per OTC item for the 2025 plan year.

Keep Your Receipts!

You are responsible for maintaining all records and receipts to substantiate debit card transactions and FSA reimbursements in the event of a substantiation request.

FLEXIBLE SPENDING ACCOUNTS			
Account Type	**Eligible Expenses**	**Annual Contribution Limits**	**Benefit**
Health Care FSA	Most medical, dental, and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses, and doctor-prescribed over-the-counter medications)	$3,300	Saves on eligible expenses not covered by insurance, reduces your taxable income
Limited Purpose Health Care FSA	Dental and vision care expenses that are not covered by your plan (such as eyeglasses, contacts, LASIK eye surgery, fillings, X-rays, and braces)	$3,300	Saves on eligible expenses not covered by insurance, reduces your taxable income
Dependent Care FSA	Dependent care expenses (such as daycare, after-school programs, or eldercare programs) so you and your spouse can work or attend school full-time	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns)	Reduces your taxable income
Commuter FSA	Parking and commuter expenses, including mass transit and van pooling	$325 for transit and $325 for parking expenses	Reduces your taxable income

FLEXIBLE SPENDING ACCOUNTS

FSA, LPFSA* and HSA Eligible Expenses

Your Health Care FSA, Limited Purpose FSA* or HSA dollars can be used for a variety of out-of-pocket health care expenses. The following is based on a list of eligible expenses created by the IRS. It is not all-inclusive, but provides many examples of eligible expenses, some of which may require a Note of Medical Necessity from your health care provider to qualify for reimbursement.

Dental*

- Dental X-rays
- Dentures and bridges
- Exams and teeth cleaning
- Extractions and fillings
- Oral surgery
- Orthodontia
- Periodontal services

Eyes*

- Eye exams
- Eyeglasses and contact lenses
- Laser eye surgeries
- Prescription sunglasses
- Radial keratotomy

Hearing

- Hearing aids and batteries
- Hearing exams

Lab Exams/Tests

- Blood and metabolism tests
- Body scans
- Cardiograms
- Laboratory fees
- X-rays

Medications

- Insulin
- Prescription drugs

Medical Equipment and Supplies

- Air purification equipment
- Arches and orthotic inserts
- Contraceptive devices
- Crutches, walkers, wheelchairs
- Exercise equipment
- Hospital beds
- Mattresses
- Medic alert bracelet or necklace
- Nebulizers
- Orthopedic shoes
- Oxygen
- Post-mastectomy clothing
- Prosthetics
- Syringes

Medical Procedures and Services

- Acupuncture
- Alcohol and drug/substance abuse
- Ambulance
- Fertility enhancement and treatment
- Hair loss treatment
- Hospital services
- Immunization
- In vitro fertilization
- Physical examination
- Service animals
- Sterilization/sterilization reversal
- Transplants (to include donor)
- Transportation

Obstetrics

- Lamaze class
- OB/GYN exams
- OB/GYN maternity fees
- Prenatal and postnatal

Practitioners

- Allergist
- Chiropractor
- Christian Science practitioner
- Dermatologist
- Homeopath
- Naturopath
- Optometrist
- Osteopath
- Physician
- Psychiatrist or psychologist

Therapy

- Alcohol and drug addiction
- Counseling
- Exercise programs
- Hypnosis
- Massage (medically necessary)
- Occupational
- Physical
- Smoking cessation programs
- Speech

Weight Loss Programs

How FSAs Work

Estimate the amount you will need for eligible out-of-pocket health care and/or dependent care expenses for the calendar year or portion thereof, depending upon your effective date of coverage. Estimate carefully and contribute only as much as you think you will need, subject to the plan limit.

Divide your total estimated expenses by the number of paychecks you receive yearly, or portion thereof, depending on your effective date of coverage. This is the amount that will be deducted from each paycheck and deposited into your non-interest-bearing account(s).

LIFE AND AD&D INSURANCE

Sun Life administers our Life and Accidental Death & Dismemberment (AD&D) coverages.

With Sun Life Group Term Life and AD&D insurance, your family will be protected with benefits and a variety of support services designed for coping with both emotional and financial issues after the loss of a family member. It can help you preserve your dream of a secure lifestyle for your family even if you cannot be there.

Life and AD&D Insurance paid for by Rimkus Consulting Group. Eligible full-time employees automatically receive Basic Life and AD&D insurance equal to two (2) times their base salary rounded to the next higher $1,000 capped at $700,000.

BASIC LIFE AND AD&D*	
Benefit Amount	Two times annual earnings
Maximum Benefit	$700,000*
Benefits Reduce By	35% of original amount at age 70 50% of original amount at age 75

* Imputed Income – Federal taxes will be assessed at the appropriate federally mandated rates for employer-paid Life insurance for a benefit amount over $50,000.

Conversion – Portability – Waiver of Premium

Upon termination of employment, you have the option to continue your company paid and/or Supplemental Life and AD&D insurance and pay premiums directly to SunLife. Your company paid Life and AD&D insurance may be converted to an individual policy. Portability is available if you are enrolled in Supplemental Life and AD&D coverage. If you are disabled at the time your employment is terminated, you may be eligible for a Waiver of Premium while you are disabled. Contact HR for a Conversion, Portability, or Waiver of Premium application.

Beneficiary Designation

It is very important that you keep your beneficiary designation current. Your beneficiary is the person or persons you name to receive benefits should you die while covered by a plan. When you enroll in Life insurance, you must designate a beneficiary. Examples of situations that may require a beneficiary change include: marriage, birth, adoption, and divorce.

Supplemental Life Insurance Paid for by You

In addition to the Basic Life insurance provided by Rimkus, you have the option to purchase additional Life insurance coverage for yourself and your eligible dependents. You may purchase additional coverage up to the guarantee issue amount.

Spouse rates match the employee rates. Rates by age band are shown in the chart on the next page. Premiums will be deducted from your paycheck on an after-tax basis beginning January, 2025.

SUPPLEMENTAL LIFE		
	Employee	**Spouse**
Benefit Amount	Increments of $5,000	Increments of $5,000
Maximum Benefit	Five times annual salary up to $500,000	100% of employee's elected amount, not to exceed $500,000
Guarantee Issue	Lesser of five times annual salary or $200,000 (new hires only)	$50,000 New hires only
Child		
Children Live Birth to age 26	$10,000	

Employee	• Current enrolled = increase by $5,000 no EOI • Enrolling for the first time = $5,000 no EOI up to the guarantee issue for both of these
Spouse	• Increase = Need EOI • Enrolling for the first time - $5,000 no EOI up to guarantee issue
Child	• No EOI required

LIFE AND AD&D INSURANCE

SUPPLEMENTAL LIFE MONTHLY RATES*		
Age	**Employee Rate per $10,000**	**Spouse Rate per $5,000**
Under 34	$0.60	$0.30
34-39	$0.90	$0.45
40-44	$1.40	$0.70
45-49	$2.20	$1.10
50-54	$3.30	$1.15
55-59	$4.90	$2.45
60-64	$8.10	$4.05
65-69	$14.60	$7.30
70-74	$20.70	$10.35
75 & Over	$44.50	$22.25

*Based on employee's age for employee and spouse.

Age Reduction(s)

When you attain age 70, the amount of Supplemental Life insurance for you and your spouse will be reduced by 35%. At age 75, a 50% benefit reduction of the original amount will occur.

Calculate Your Monthly Supplemental Life Insurance Cost

- Find your (employee) age group in this table.
- Multiply the rate by the number of coverage units you want (units are per $10,000 of coverage).
- Calculate the cost of coverage for your spouse (units are per $5,000 of coverage) using your age, then calculate the cost of coverage for your children.
- Add the premiums for you, your spouse, and your children to get your monthly cost.

Employee

_____ units × $_____ per unit = $_____

Spouse

_____ units × $_____ per unit = $_____

Children

$2.00 for $10,000 coverage

DISABILITY INSURANCE

Short Term Disability

Short Term Disability (STD) insurance is paid for by Rimkus Consulting Group. Eligible full-time employees are provided STD insurance coverage through **Sun Life**. You are eligible for STD benefits the first of the month following 30 days of active employment. If you become disabled according to the policy's definition, you will be eligible to receive a weekly benefit based on a percentage of your weekly income. Your benefits begin after 7 days following the onset of an accident or illness. Benefits are paid as long as you are out on disability for up to 12 weeks. Your benefit is paid at 60% of your base weekly earnings to a maximum of $4,000 a week. Benefits are paid for qualifying non-occupational disabilities. Coverage is provided to you without having to answer any medical questions.

Uses for STD Insurance Examples

- Maternity leave
- Recovery from surgery

Please see the plan document for more details.

New York Residents

The company-paid Short Term Disability plan coordinates with any state-mandated disability program. For employees in the state of New York, coverage will also be administered by Sun Life. The elimination period on this program is seven days and the benefits are paid up to 25 weeks. Disability must be a non-work-related illness or injury.

NEW YORK SHORT TERM DISABILITY	
Benefit	50% of your weekly earnings
Maximum Benefit	$170 per week
Elimination Period	7 days
Benefit Duration	Up to 25 weeks

Long Term Disability

Long Term Disability (LTD) insurance is paid for by Rimkus Consulting Group. Full-time eligible employees are provided LTD insurance coverage through **Sun Life**. You are eligible for LTD benefits the first of the month following 30 days of active employment. Rimkus will automatically enroll you into the LTD plan. Should you ever become disabled and unable to work, the LTD monthly benefit pays you a percentage of your basic monthly earnings.* LTD payments may be reduced by deductible sources of income and other disability earnings. Benefits begin after a 90-day elimination period and are subject to a pre-existing conditions exclusion. Please see the plan document for more details.

*Monthly maximum dollar amount, benefit percentage, and duration will vary. Please contact HR for further information.

LEGAL SHIELD

LegalShield is offered at an affordable cost for personal legal needs and allows you to talk to an attorney about any personal legal issue. Whether the issue is big, small, or somewhere in between, your LegalShield provider law firm can offer advice or assistance on a variety of personal legal issues, including*:

- Personal legal advice on unlimited issues
- Letters and calls made on your behalf
- Contracts and documents reviewed (up to 15 pages)
- Residential loan document assistance
- Lawyer prepared will, living will, and health care power of attorney
- Moving traffic violations (available 15 days after enrollment)
- IRS audit assistance
- Trial defense (if named defendant or respondent in a covered civil action suit)
- Uncontested divorce, separation, adoption, and/or name change representation (available 90 days after enrollment)*
- 24/7 emergency access for covered situations
- 25% preferred member discount for legal situations that fall outside of those fully covered (bankruptcy, criminal charges, DUI, contested divorce, and more).

Always refer to your LegalShield contract for specific state details.

*You must enroll for family coverage to seek services for family-related issues.

MemberPerks

Save money at both local and national companies on everyday purchases such as tickets, electronics, apparel, travel, and more.

To get started, go to **https://legalshield.perkspot.com/login** and click on the Resources tab, then click on MEMBERPERKS. If you do not already have an account, follow the simple onscreen instructions to start an account with your personal or work email and your LegalShield membership number.

SUPPLEMENTAL INSURANCE

Rimkus provides additional benefit options for you and your family through **Sun Life**.

Hospital Indemnity, Accident, and Critical Illness benefit plans enhance your current coverage so you may avoid dipping into your savings to cover medical expenses. Sun Life pays in addition to your Rimkus sponsored health plan to cover costs with childcare, transportation, and other day-to-day expenses associated with medical issues. Specific dollar amounts and coverage information are available in the benefit summaries of each plan.

Critical Illness Insurance

Critical Illness insurance pays a fixed benefit if you are diagnosed with a covered critical illness. It helps cover the costs associated with a critical illness such as lost income, childcare, travel to and from treatment, high deductibles and copays, plus out-of-network and alternative treatments. Benefits are paid in a lump sum and can be paid directly to you or to a hospital or physician when you or a covered family member is diagnosed with conditions such as:

- Cancer
- Heart attack
- Stroke
- Major organ transplant
- Kidney failure
- Benign brain tumor

Coverage is available to you and your spouse. You can elect up to the Guaranteed Issue amount of $40,000 for yourself and up to $40,000 for your spouse in $10,000 increments. Children are covered at 50% of the primary insurance benefit.

Accident Insurance

Accident insurance benefits are paid directly to you based on a fixed schedule that includes benefits for hospitalization, fractures, dislocations, emergency room visits, major diagnostic exams, physical therapy, and more. You may enroll yourself and other family members.

Hospital Indemnity Insurance

Hospital Indemnity coverage provides you with payments when you are admitted and confined to a hospital due to a covered accident or illness. Typically, a flat amount is paid for admission and a daily amount is paid for each day of a hospital stay. You may enroll yourself and your eligible family members.

SUPPLEMENTAL INSURANCE [1]

CRITICAL ILLNESS INSURANCE [2]

Diagnosis	Benefit
Cancer	100%
Heart Attack	100%
Stroke	100%
End Stage Renal (Kidney) Failure	100%
Major Organ Transplant or Failure	100%
Non-invasive Cancer	25%
Wellness Benefit	$50

ACCIDENT INSURANCE

Diagnosis	Benefit	
Ambulance ▪ Air ▪ Ground	 $1,000 $300	 $2,000 $400
Blood/Plasma/Platelets	$100	$200
Burns	Up to $10,000	Up to $20,000
Coma At least 14 consecutive days	$5,000	$10,000
Dislocation	Up to $2,000	Up to $4,000
Emergency Dental Work	Up to $100	Up to $200
Eye Injury	$125	$250
Fracture	Up to $3,000	Up to $6,000
Hospital Admission	$1,500	$2,000
Hospital Confinement Up to 365 days	$300 per day	$400 per day
Laceration	Up to $250	Up to $500
Prosthetic Device	Up to $500	Up to $1,000
Rehabilitation 15 days per covered incident	$50	$100
Surgery	Up to $625	Up to $1,250
Transportation	$250	$500
X-Ray	$50	$100
Wellness Benefit	$50	

HOSPITAL INSURANCE

	Benefit	
Hospital/ICU Admission	$1,000	$2,000
Hospital/ICU Confinement Up to 15 days	$100 per day	$200 per day
Wellness Benefit	$50	

[1] Refer to the plan documents for a complete list of coverage and benefits.

[2] Benefits may not be paid for any condition treated within 12 months prior to your effective date until you have been covered under this plan for 12 months.

PET INSURANCE

Rimkus offers the opportunity to purchase pet insurance. **ASPCA Pet Health** Insurance provides benefits for veterinary treatments related to accidents and illnesses, including cancer. You can choose the care you want when your pet is hurt or sick and take comfort in knowing you have coverage. Customize your coverage for accidents, illnesses, cancer, dental disease, hereditary conditions, or behavioral issues. You can pick the following:

- **Annual Limit** – Up to $10,000
- **Deductible** – $100, $250, or $500 to be satisfied once during a 12-month period
- **Reimbursement Levels** – Choose a plan with a 70%, 80%, or 90% reimbursement level
- **Add Preventive Care** – Reimbursement for vaccines, dental cleanings, and screenings
- **Select Accident Only Coverage** – Care due to accidents only

Plans are simple to use. You just pay your vet bill, submit your claim, and get reimbursed. You can visit the vet, specialist, or emergency care clinic of your choice. You can also choose to receive reimbursement via mail or direct deposit.

To get a customized quote and to enroll, call **877-343-5314** or go to **www.aspcapetinsurance.com/rimkus**. Use priority code **EB21Rimkus**.

401(K) RETIREMENT SAVINGS PLAN

In 2025, Rimkus is partnering with **Fidelity** to offer you an enhanced retirement plan experience and 401(k) benefit. Through Fidelity, you will have access to improved tools, services, and personalized support while maintaining the great benefits you already enjoy. You will be able to access your account at **www.netbenefits.com**.

Eligibility and Entry Date

All employees who are at least 21 years old and have completed one month of service are eligible for the plan.

You may enter the plan on the first day of the month after you have met the eligibility requirements.

Your Contributions

You have the option to save for retirement on a pre-tax and/or Roth basis. If you do not make your own election or opt out of the plan upon your eligibility, you will be automatically enrolled in the plan at 3% pre-tax.

You can enroll or change your contribution by logging into your Fidelity account at **www.netbenefits.com**. Your change will occur within 1-2 pay periods.

For 2025, the IRS Deferral Limit is $23,500. If you are over age 50, you can do an additional catch-up contribution up to $7,500. Participants who are ages 60-63 are eligible for a higher catch up limit, and can contribute up to $11,250.

You can roll over contributions from other retirement plans including 401(k) plans, traditional IRAs, 403(b) plans, and 457 plans.

Safe Harbor Match

In 2025, Rimkus will provide a Safe Harbor Match of 100% of your deferrals on the first 3% of compensation deferred plus 50% of your deferrals on the next 2% of compensation deferred. The match, will be calculated on a per pay-period basis. Note, in order to receive the full 4% match you will need to contribute at least 5% on each pay period for the entire year.

Access Your Account

Visit **www.netbenefits.com** anytime or call **800-835-5095** Monday through Friday from 7:30 a.m. – 7:00 p.m. CST.

Vesting Schedule

You are always 100% vested in your own 401(k) contributions as well as the Safe Harbor Match. Prior company match contributions remain subject to a four-year vesting schedule.

Your 401(k) Retirement Plan Online

Enrollment

To enroll at Fidelity go to **www.netbenefits.com** and click on *Register Now*.

Fidelity's website is designed to help guide you through the enrollment process. If you need additional assistance, you can call a Fidelity Retirement Plan Representative at **1-800-835-5097** between 8:30 a.m. and 8:00 p.m. EST Monday-Friday.

Once you set up your account, you can log in at anytime to view your account balance, adjust your contribution amount, change your investment allocation, and/or utilize the tools and resources available to you.

Your Professionally Managed Account

Through Fidelity, you have access to "Personalized Planning & Advice", a fee based managed account service. If you choose to utilize this service, you will receive personalized guidance and advice on your account.

Making Changes

You may change your salary deferral amount at anytime by logging into your Fidelity NetBenefits account at **www.netbenefits.com**. Your changes are automatically uploaded into our payroll system and will be reflected on the first administratively feasible payroll check after the update is made in the Fidelity NetBenefits portal. You can stop making salary deferral contributions at anytime.

- Choose from pre-selected investment plan options or customize your own.
- Receive detailed statements.
- Withdrawal options are available for financial hardships, including college tuition, purchase of a primary residence, prevention of eviction or foreclosure, burial, and unreimbursed medical expenses.
- Loan options allow you to borrow up to 50% of your vested account balance or $50,000, whichever is less (special rules apply).

REQUIRED NOTICES

Women's Health and Cancer Rights Act of 1998

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully.

As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a mastectomy is also entitled to the following benefits:

- 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; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

Health plans must determine the manner of coverage in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and coinsurance amounts that are consistent with those that apply to other benefits under the plan.

Special Enrollment Rights

This notice is being provided to ensure that you understand your right to apply for group health insurance coverage. You should read this notice even if you plan to waive coverage at this time.

Loss of Other Coverage or Becoming Eligible for Medicaid or a state Children's Health Insurance Program (CHIP)

If you are declining coverage for yourself or your dependents because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must enroll within 31 days after your or your dependents' other coverage ends (or after the employer that sponsors that coverage stops contributing toward the other coverage).

If you or your dependents lose eligibility under a Medicaid plan or CHIP, or if you or your dependents become eligible for a subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents in this plan. You must provide notification within 60 days after you or your dependent is terminated from, or determined to be eligible for, such assistance.

Marriage, Birth or Adoption

If you have a new dependent as a result of a marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must enroll within 31 days after the marriage, birth, or placement for adoption.

For More Information or Assistance

To request special enrollment or obtain more information, contact:

Rimkus Consulting Group, Inc.
Benefits Administration
12140 Wickchester Lane Suite 300
Houston, TX 77079
713-621-3550

Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Rimkus Consulting Group, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to enroll in a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or the dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that offers prescription drug coverage. All Medicare prescription 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. Rimkus Consulting Group, Inc. has determined that the prescription drug coverage offered by the Rimkus Consulting Group, Inc. medical plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage. The HSA plan is considered Creditable Coverage.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare prescription drug plan, as long as you later enroll within specific time periods.

You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare. If you decide to wait to enroll in a Medicare prescription drug plan, you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7 but as a general rule, if you delay your enrollment in Medicare Part D after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

You should compare your current coverage, including which drugs are covered at what cost, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting Rimkus Consulting Group, Inc. at the phone number or address listed at the end of this section.

If you choose to enroll in a Medicare prescription drug plan and cancel your current Rimkus Consulting Group, Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

If you cancel or lose your current coverage and do not have prescription drug coverage for 63 days or longer prior to enrolling in the Medicare prescription drug coverage, your monthly premium will be at least 1% per month greater for every month that you did not have coverage for as long as you have Medicare prescription drug coverage. For example, if nineteen months lapse without coverage, your premium will always be at least 19% higher than it would have been without the lapse in coverage.

For more information about this notice or your current prescription drug coverage:

Contact the Human Resources Department at **713-621-3550**.

NOTE: You will receive this notice annually and at other times in the future, such as before the next period you can enroll in Medicare prescription drug coverage and if this coverage changes. You may also request a copy.

REQUIRED NOTICES

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 will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription 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 **877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at **800-772-1213**. TTY users should call **800-325-0778**.

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

January 1, 2025
Rimkus Consulting Group, Inc.
Benefits Administration
12140 Wickchester Lane Suite 300
Houston, TX 77079
713-621-3550

Notice of HIPAA Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective Date of Notice: September 23, 2013

Rimkus Consulting Group, Inc.'s Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1 – Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

1. For treatment, payment and health care operations.
2. Enrollment information can be provided to the Trustees.
3. Summary health information can be provided to the Trustees for the purposes designated above.
4. When required by law.
5. When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

REQUIRED NOTICES

6. When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In which case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
7. The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
8. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
9. When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.
10. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
11. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Section 2 – Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right. Such requests should be made to the Plan's Privacy Official.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.

Protected Health Information (PHI)

Includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

Designated Record Set

Includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

REQUIRED NOTICES

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan's Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice. Such requests should be made to the Plan's Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3 – The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted, you will also receive a copy of the Notice or information about any material change and how to receive a copy of the Notice in the Plan's next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan's policies regarding the uses or disclosures of PHI, the individual's privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants' PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4 – Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201. The Plan will not retaliate against you for filing a complaint.

Section 5 – Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at:

Rimkus Consulting Group, Inc.
Benefits Administration
12140 Wickchester Lane Suite 300
Houston, TX 77079
713-621-3550

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.

REQUIRED 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, 2024. Contact your State for more information on eligibility.

ALABAMA – MEDICAID

Website: http://www.myalhipp.com/
Phone: 1-855-692-5447

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – MEDICAID

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA– MEDICAID

Health Insurance Premium Payment (HIPP) Program Website: 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) AND CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – MEDICAID

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – MEDICAID

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

INDIANA – MEDICAID

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: https://www.in.gov/medicaid/
Phone 1-800-457-4584

IOWA – MEDICAID AND CHIP (HAWKI)

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
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – MEDICAID

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

REQUIRED NOTICES

LOUISIANA – 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)

MAINE – MEDICAID

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine Relay 711

MASSACHUSETTS – MEDICAID AND CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – MEDICAID

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – MEDICAID

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – MEDICAID

Website: https://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – MEDICAID

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – MEDICAID

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – MEDICAID

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345 ext.5218

NEW JERSEY – MEDICAID AND CHIP

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

NEW YORK – MEDICAID

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – MEDICAID

Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – MEDICAID

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – MEDICAID AND CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – MEDICAID

Website: https://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – MEDICAID AND CHIP

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – MEDICAID AND CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – MEDICAID

Website: https://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – MEDICAID

Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – MEDICAID AND CHIP

Medicaid Website: https://medicaid.utah.gov
CHIP Website: https://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– MEDICAID

Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – MEDICAID AND CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

REQUIRED NOTICES

WASHINGTON – MEDICAID
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – MEDICAID AND CHIP
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
Website: https://www.dhs.wisconsin.gov/ badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – MEDICAID
Website: https://health.wyo.gov/healthcarefin/medicaid/ programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other States have added a premium assistance program since **January 31, 2024**, or for more information on special enrollment rights, you can 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

Continuation of Coverage Rights Under COBRA

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), if you are covered under the Company group health plan you and your eligible dependents may be entitled to continue your group health benefits coverage under the Company plan after you have left employment with the company. If you wish to elect COBRA coverage, contact your Human Resources Department for the applicable deadlines to elect coverage and pay the initial premium.

Plan Contact Information

Rimkus Consulting Group, Inc.
Benefits Administration
12140 Wickchester Lane Suite 300
Houston, TX 77079
713-621-3550

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

- Emergency services – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.
- Certain services at an in-network hospital or ambulatory surgical center – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed, you may contact your insurance provider. Visit **www.cms.gov/nosurprises** for more information about your rights under federal law.

Higginbotham™

This brochure highlights the main features of the Rimkus Employee Benefits Program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Rimkus reserves the right to change or discontinue its employee benefits plans at anytime.