Annual Enrollment Notices & Disclosures

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. See Page 43 for the Notice of Creditable Coverage for details.

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Medical Plan Deductibles and Coinsurance:

- PPO Plan: Deductible and coinsurance amounts apply according to the plan's medical and surgical benefit provisions.
- HDHP Plan: Deductible and coinsurance amounts apply according to the plan's medical and surgical benefit provisions.

Please refer to the Medical Benefits section of this guide for the applicable amounts and details.
If you would like more information on WHCRA benefits, please contact your Plan Administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid	ARKANSAS – Medicaid
Website: http://myalhipp.com/ **Phone:** 1-855-692-5447	The AK Health Insurance Premium Payment Program **Website:** http://myakhipp.com/ **Phone:** 1-866-251-4861 **Email:** CustomerService@MyAKHIPP.com **Medicaid Eligibility:** https://health.alaska.gov/dpa/s/default.aspx	**Website:** http://myarhipp.com/ **Phone:** 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health Insurance Premium Payment (HIPP) **Program Website:** https://www.dhcs.ca.gov/services/health-insurance-premium-payment-program-cost-avoidance/ **Phone:** 916-445-8322 **Fax:** 916-440-5676 **Email:** hipp@dhcs.ca.gov	**Health First Colorado Website:** https://www.healthfirstcolorado.com/ **Health First Colorado Member Contact Center:** 1-800-221-3943/State Relay 711 **CHP+:** https://hcpf.colorado.gov/child-health-plan-plus **CHP+ Customer Service:** 1-800-359-1991/State Relay 711 **Health Insurance Buy-In Program (HIBI):** https://www.mycohibi.com/ **HIBI Customer Service:** 1-855-692-6442	**Website:** https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html **Phone:** 1-877-357-3268

GEORGIA – Medicaid	ILLINOIS - Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp **Phone:** 678-564-1162, Press 1 **GA CHIPRA Website:** https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra **Phone:** 678-564-1162, Press 2	**Illinois Medicaid Premium Assistance Information** **Medicaid application website:** https://abe.illinois.gov **HIPP Hotline Number:** 217-524-8268 **HIPP Email:** mhfs.boc.hipp@illinois.gov	Health Insurance Premium Payment Program All other Medicaid **Website:** https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ **Family and Social Services Administration** **Phone:** 1-800-403-0864 **Member Services Phone:** 1-800-457-4584

The Specialty Alliance

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

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid	KENTUCKY – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services **Medicaid Phone:** 1-800-338-8366 **Hawki Website:** https://hhs.iowa.gov/medicaid/plans-programs/hawki **Hawki Phone:** 1-800-257-8563 **HIPP Website:** https://hhs.iowa.gov/medicaid/plans-programs/fee-service/health-insurance-premium-payment-program **HIPP Phone:** 1-888-346-9562	**Website:** https://www.kancare.ks.gov/ **Phone:** 1-800-792-4884 **HIPP Phone:** 1-800-967-4660	**Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:** https://chfs.ky.gov/agencies/dms/member/s/kihipp.aspx **Phone:** 1-855-459-6328 **Email:** KIHIPP.PROGRAM@ky.gov **KCHIP Website:** https://kynect.ky.gov **Phone:** 1-877-524-4718 **Kentucky Medicaid Website:** https://chfs.ky.gov/agencies/dms
LOUISIANA – Medicaid	**MAINE – Medicaid**	**MASSACHUSETTS – Medicaid and CHIP**
Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana **Medicaid Customer Service Line:** 1-888-342-6207 **Louisiana Medicaid email:** healthy@la.gov **Louisiana Health Insurance Premium Program (LaHIPP) Website:** https://www.ldh.la.gov/lahipp **LaHIPP phone:** 1-877-697-6703 **LaHIPP email:** La.HIPP@la.gov **LaHIPP fax:** 1-888-716-9787 **LaHIPP mailing address:** 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084	**Enrollment Website:** https://www.mymaineconnection.gov/benefits/s/?language=en_US **Phone:** 1-800-442-6003 **TTY:** Maine relay 711 **Private Health Insurance Premium Webpage:** https://www.maine.gov/dhhs/ofi/applications-forms **Phone:** 1-800-977-6740 **TTY:** Maine relay 711	**Website:** https://www.mass.gov/masshealth/pa **Phone:** 1-800-862-4840 **TTY:** 711 **Email:** masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**	**MONTANA – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ **Phone:** 1-800-657-3672	**Website:** http://www.dss.mo.gov/mhd/participants/pages/hipp.htm **Phone:** 573-751-2005	**Website:** http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP **Phone:** 1-800-694-3084 **Email:** HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**	**NEW HAMPSHIRE – Medicaid**
Website: http://accessnebraska.ne.gov **Phone:** 1-855-632-7633 **Lincoln:** 402-473-7000 **Omaha:** 402-595-1178	**Medicaid Website:** http://dhcfp.nv.gov **Medicaid Phone:** 1-800-992-0900	**Website:** https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program **Phone:** 603-271-5218 **Toll free number for the HIPP program:** 1-800-852-3345, ext. 15218 **Email:** DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**	**NORTH CAROLINA – Medicaid**
Medicaid Website: https://www.nj.gov/humanservices/dmahs/individuals-families/familycare/ **Phone:** 1-800-356-1561 **CHIP Premium Assistance Phone:** 609-631-2392 **CHIP Website:** http://www.njfamilycare.org/index.html **CHIP Phone:** 1-800-701-0710 (TTY: 711)	**Website:** https://www.health.ny.gov/health_care/medicaid/ **Phone:** 1-800-541-2831	**Website:** https://medicaid.ncdhhs.gov/ **Phone:** 919-855-4100
NORTH DAKOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**	**OREGON – Medicaid and CHIP**
Website: https://www.hhs.nd.gov/healthcare **Phone:** 1-844-854-4825	**Website:** http://www.insureoklahoma.org **Phone:** 1-888-365-3742	**Website:** http://healthcare.oregon.gov/s/index.aspx **Phone:** 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**	**SOUTH CAROLINA – Medicaid**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html **Phone:** 1-800-692-7462 **CHIP Website:** Children's Health Insurance Program (CHIP) (pa.gov) **CHIP Phone:** 1-800-986-KIDS (5437)	**Website:** http://www.eohhs.ri.gov/ **Phone:** 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	**Website:** https://www.scdhhs.gov **Phone:** 1-888-549-0820

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

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

To see if any other states have added a premium assistance program since July 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137

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The Specialty Alliance

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HIPAA Notice Of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

The Specialty Alliance is committed to the privacy of your health information. The administrators of The Specialty Alliance Health and Welfare Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Benefits Administrator.
The notice also is available online in your benefits microsite.

HIPAA Special Enrollment Rights

The Specialty Alliance Health and Welfare Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in The Specailty Alliance Health and Welfare Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program)

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage).

However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage.
However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption

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

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program

If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.
To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact GIA Benefits at giabenefits@gialliance. com.

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Notice Of Creditable Coverage

Important Notice from The Specialty Alliance Management, LLC About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it.

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

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

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

When Can You Join a Medicare Drug Plan?

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

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

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current The Specialty Alliance Management, LLC coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current The Specialty Alliance Management, LLC coverage, be aware that you and your dependents will be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

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

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

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For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through The Specialty Alliance changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

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

For more information about Medicare prescription drug coverage:

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

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

Remember: Keep this Creditable Coverage Notice.

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

Date
10/01/2026

Nameof Entity/Sender
The Specialty Alliance

Contact—Position/Office
Benefits Department

Office Address
950 E.State Highway 114,
Suite 200
Southlake,TX 76092

Phone Number
817-402-7618
817-402-7589

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USERRA Notice

Your Rights Under USERRA

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of theuniformed services, and applicants to the uniformed services.

B. Reemployment

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to Be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service; then an employer may not deny you
  - Initial employment;
  - Reemployment;
  - Retention in employment;
  - Promotion; or
  - Any benefit of employment because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifyingor making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employerbased health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., preexisting condition exclusions) except for serviceconnected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 18664USADOL or visit its Web site at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS and may be viewed on the Internet at this address: http://www.dol.gov/vets/programs/userra/poster.htm. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees. U.S. Department of Labor, Veterans' Employment and Training Service, 866.487.2365.

Essential Health Benefits Comparisons

The state of Illinois mandates that employers must make additional health plan disclosures to their Illinois employees under a new state law (Pub. Act 1020630, SB 1905). An employer that offers group health coverage must provide a comparison of the plan's covered benefits against the essential health benefits (EHBs) that stateregulated individual health insurance policies must provide.

Employer Name:	**The Specialty Alliance / Alliance Physician Services**
Employer State of Situs:	**TX / PA**
Name of Issuer:	**BCBSTX**
Plan Marketing Name:	**PPO, HDHP 1, HDHP 2**
Plan Year:	**2027**

Ten (10) Essential Health Benefit (EHB) Categories:

- **Ambulatory patient services (outpatient care you get without being admitted to a hospital)**
- **Emergency services**
- **Hospitalization (like surgery and overnight stays)**
- **Laboratory services**
- **Mental health and substance use disorder (MH/SUD) services, including behavioral health treatment (this includes counseling and psychotherapy)**
- **Pediatric services, including oral and vision care (but adult dental and vision coverage aren't essential health benefits)**
- **Pregnancy, maternity, and newborn care (both before and after birth)**
- **Prescription drugs**
- **Preventive and wellness services and chronic disease management**
- **Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)**

2020-2026 Illinois Essential Health Benefit (EHB) Listing (P.A. 102-0630)

	EHB Benefit	EHB Category	Benchmark Page # Reference	Employer Plan Covered Benefit? Plan Covered Benefit?		
				PPO	HDHP 1	HDHP 2
1	Accidental Injury -- Dental	Ambulatory	Pgs. 10 & 17	Covered	Covered	Covered
2	Allergy Injections and Testing	Ambulatory	Pg. 11	Covered	Covered	Covered
3	Bone anchored hearing aids	Ambulatory	Pgs. 17 & 35	Covered	Covered	Covered
4	Durable Medical Equipment	Ambulatory	Pg. 13	Covered	Covered	Covered
5	Hospice	Ambulatory	Pg. 28	Covered	Covered	Covered
6	Infertility (Fertility) Treatment	Ambulatory	Pgs. 23 - 24	Not Covered	Not Covered	Not Covered
7	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Ambulatory	Pg. 21	Covered	Covered	Covered
8	Outpatient Surgery Physician/Surgical Services (Ambulatory Patient Services)	Ambulatory	Pgs. 15 - 16	Covered	Covered	Covered
9	Private-Duty Nursing	Ambulatory	Pgs. 17 & 34	Covered	Covered	Covered
10	Prosthetics/Orthotics	Ambulatory	Pg. 13	Covered	Covered	Covered
11	Sterilization (vasectomy men)	Ambulatory	Pg. 10	Covered	Covered	Covered
12	Temporomandibular Joint Disorder (TMJ)	Ambulatory	Pgs. 13 & 24	Not Covered	Not Covered	Not Covered
13	Emergency Room Services (Includes MH/SUD Emergency)	Emergency services	Pg. 7	Covered	Covered	Covered
14	Emergency Transportation/ Ambulance	Emergency services	Pgs. 4 & 17	Covered	Covered	Covered
15	Bariatric Surgery (Obesity)	Hospitalization	Pg. 21	Not Covered	Not Covered	Not Covered
16	Breast Reconstruction After Mastectomy	Hospitalization	Pgs. 24 - 25	Covered	Covered	Covered
17	Reconstructive Surgery	Hospitalization	Pgs. 25 - 26, & 35	Not Covered	Not Covered	Not Covered
18	Inpatient Hospital Services (e.g., Hospital Stay)	Hospitalization	Pg. 15	Covered	Covered	Covered
19	Skilled Nursing Facility	Hospitalization	Pg. 21	Covered	Covered	Covered
20	Transplants - Human Organ Transplants (Including transportation & lodging)	Hospitalization	Pgs. 18 & 31	Covered	Covered	Covered
21	Diagnostic Services	Laboratory services	Pgs. 6 & 12	Covered	Covered	Covered
22	Intranasal opioid reversal agent associated with opioid prescriptions	MH/SUD	Pg. 32	Covered	Covered	Covered
23	Mental (Behavioral) Health Treatment (Including Inpatient Treatment)	MH/SUD	Pgs. 8 -9, 21	Covered	Covered	Covered
24	Opioid Medically Assisted Treatment (MAT)	MH/SUD	Pg. 21	Covered	Covered	Covered
25	Substance Use Disorders (Including Inpatient Treatment)	MH/SUD	Pgs. 9 & 21	Covered	Covered	Covered
26	Tele-Psychiatry	MH/SUD	Pg. 11	Covered	Covered	Covered
27	Topical Anti-Inflammatory acute and chronic pain medication	MH/SUD	Pg. 32	Covered	Covered	Covered
28	Pediatric Dental Care	Pediatric Oral and Vision Care	See AllKids Pediatric Dental Document	Not Covered	Not Covered	Not Covered
29	Pediatric Vision Coverage	Pediatric Oral and Vision Care	Pgs. 26 - 27	Not Covered	Not Covered	Not Covered
30	Maternity Service	Pregnancy, Maternity, and Newborn Care	Pgs. 8 & 22	Covered	Covered	Covered
31	Outpatient Prescription Drugs	Prescription drugs	Pgs. 29 - 34	Covered	Covered	Covered
32	Colorectal Cancer Examination and Screening	Preventive and Wellness Services	Pgs. 12 & 16	Covered	Covered	Covered
33	Contraceptive/Birth Control Services	Preventive and Wellness Services	Pgs. 13 & 16	Covered	Covered	Covered
34	Diabetes Self-Management Training and Education	Preventive and Wellness Services	Pgs. 11 & 35	Covered	Covered	Covered
35	Diabetic Supplies for Treatment of Diabetes	Preventive and Wellness Services	Pgs. 31 - 32	Covered	Covered	Covered
36	Mammography - Screening	Preventive and Wellness Services	Pgs. 12, 15, & 24	Covered	Covered	Covered
37	Osteoporosis - Bone Mass Measurement	Preventive and Wellness Services	Pgs. 12 & 16	Covered	Covered	Covered
38	Pap Tests/ Prostate- Specific Antigen Tests/ Ovarian Cancer Surveillance Test	Preventive and Wellness Services	Pg. 16	Covered	Covered	Covered
39	Preventive Care Services	Preventive and Wellness Services	Pg. 18	Covered	Covered	Covered
40	Sterilization (women)	Preventive and Wellness Services	Pgs. 10 & 19	Covered	Covered	Covered
41	Chiropractic & Osteopathic Manipulation	Rehabilitative and Habilitative Services and Devices	Pgs. 12 - 13	Covered	Covered	Covered
42	Habilitative and Rehabilitative Services	Rehabilitative and Habilitative Services and Devices	Pgs. 8, 9, 11, 12, 22, & 35	Covered	Covered	Covered

Special Note: Under Pub. Act 102-0104, eff. July 22, 2021, any EHBs listed above that are clinically appropriate and medically necessary to deliver via telehealth services must be covered in the same manner as when those EHBs are delivered in person.

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COBRA

Continuation Coverage Rights Under

The following is important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

If you are an employee of The Specialty Alliance, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If your spouse is an employee of The Specialty Alliance, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parentemployee dies;
- The parentemployee's hours of employment are reduced;
- The parentemployee's employment ends for any reason other than his or her gross misconduct;
- The parentemployee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

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COBRA

When is COBRA continuation coverage available?

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

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

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

The Specialty Alliance
950 E. State Highway 114, Suite 200
Southlake, TX 76092

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18month period of COBRA continuation coverage

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

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

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COBRA

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollmentpenalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll inthe other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicareandyou.

If you have any questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)
For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

The Specialty Alliance
950 E. State Highway 114, Suite 200
Southlake, TX 76092

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Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 10.22% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 10.22% of the employee's household income.2

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

1 Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

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

The Specialty Alliance

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

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.
Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage.
Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact giabenefits@gialliance.com.

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

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PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name A. The Specialty Alliance Management B. Alliance Physician Services, PC		4. Employer Identification Number (EIN) A. 83-2074098 B. 47-4352018
5. Employer address A. 950 E. State Highway 114, Suite 200 B. 140 W. Germantown Ave, Ste 200		6. Employer phone number A. 817.402.7618 B. 817.402.7589
7. City: A. Southlake B. Plymouth Meeting	8. State: A. TX B. PA	9. ZIP Code: A. 76092 B. 19462
10. Who can we contact about employee health coverage at this job? Benefits Department		
11. Phone number (if different from above):	12. Email address: giabenefits@gialliance.com	

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

- As your employer, we offer a health plan to:
  - ☒ All employees. Eligible employees are: Employees who work on average 30+ hours per week
  - ☐ Some employees. Eligible employees are:
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are: spouse and dependent children up to age 26
  - ☐ We do not offer coverage.
  - ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**
    - ☒ **Yes** (Continue)
      - 13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
    - ☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
    ☒ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (do not include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
    a. How much would the employee have to pay in premiums for this plan? Refer to the online enrollment system or the Rates Appendix for employee premium amounts.
    b. How often? ☒ Weekly ☒ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

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16. What change will the employer make for the new plan year?_____
    - ☐ Employer won't offer health coverage
    - ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

    a. How much would the employee have to pay in premiums for this plan? $_____
    b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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Notes

Visit Your Benefits Microsite to find your Summary of Benefits and Coverage and more deatils about your benefits

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‘This enrollment guide describes The Specialty Alliance Group Benefits program as the company currently intends to offer it. The company reserves the right, however, at any time and for any reason, to amend the terms of the program or to terminate any of the benefits offered under it. The complete provisions of the plans are in the official plan documents. If there is any difference between this guide and the official plan documents, the plan documents will govern.



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