2020

ARHAUS®

your home

ASSOCIATE BENEFITS

Arhaus Bi-Weekly Pay

Visit ArhausBenefits.com
to view information on your benefit package

Dear Associates,

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

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

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

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

Sincerely,

Arhaus Human Resources

Schedule your personalized phone appointment with a Benefits Counselor.

678-280-7805

Use the QR Code or link provided below to schedule a call with a Benefits Counselor. They will review your benefits and answer any questions you may have.

Scan Me

Click Here to Schedule Your Phone Appointment

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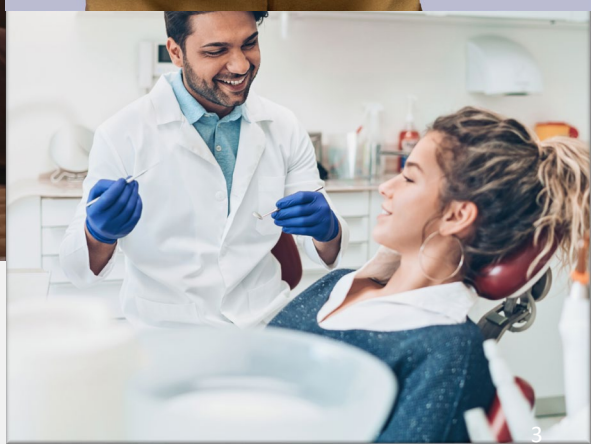

ELIGIBILITY

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

Associates

Full-Time Associates

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

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

Part-Time Associates

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

Dependents

An eligible dependent may be:

- Your legal spouse

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

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

When Can I Elect or Change my Benefits?

As a New Hire

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

During Annual Open Enrollment

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

If You Experience a Qualifying Event During the Year

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

You must notify HR within 30 days of a Qualifying Event

MEDICAL

Medical Plan Options

Choose from one of two medical plans to cover yourself and your dependents. Both plans are offered through Anthem Blue Cross & Blue Shield and include prescription coverage.

HSA $3,300

Blue Access Health Savings Account (HSA)

With this Consumer-Driven Health Plan, you will:

- Enjoy lower per pay period premiums
- Have preventive services covered at 100%
- Be eligible for a Health Savings Account through Anthem with simple, tax-free deposits directly from your paycheck
- Receive Arhaus Furniture's annual contribution to your Health Savings Account
- Save for future healthcare expenses tax free through your HSA!

Core PPO

Blue Access PPO Plan

With this traditional plan, you will:

- Have higher per pay period premiums
- Enjoy the predictability of set copay amounts
- Be subject to a lower deductible
- Have preventive services covered 100%

By earning wellness credits, associates can save over $400/year for those with Single coverage & over $800/year for Families!

MEDICAL/RX

In-Network Benefits	HSA $3,300	Core PPO
Deductible: Single/Family	$3,300 / $6,600	$750 / $2,250
Out-of-Pocket Maximum: Single/Family	$3,650 / $7,300	$5,000 / $10,000
Coinsurance *(You pay after Deductible)*	0%	20%
Primary Care Visits	0% after Deductible	$30 Copay
Preventive Care	Covered in Full	Covered in Full
Specialist Visits	0% after Deductible	$60 Copay
LiveHealth Online Visit	0% after Deductible	$0 Copay ($60 Specialist)
Inpatient Visit	0% after Deductible	20% after Deductible
Outpatient Services	0% after Deductible	20% after Deductible
Emergency Room	0% after Deductible	$250 Copay
Urgent Care	0% after Deductible	$75 Copay
Prescription Drugs		
Pharmacy Deductible	Combined with Medical	$100 per person
Retail Generic (30-day supply)	$10 Copay, after Deductible	$15 Copay
Preferred Brand (30-day supply)	$35 Copay, after Deductible	$50 Copay, after Rx Deductible
Non-Preferred Brand (30-day supply)	$70 Copay, after Deductible	50% ($75 min/$150 max), after Rx Deductible
Specialty (30-day supply)	25% ($250 max), after Deductible	25%, after Rx Deductible

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

Bi-Weekly Premiums (per pay deductions)

Wellness Credits Earned	Coverage Tier	HSA Plan	Core PPO Plan
0 Credits	Associate Only Family	$68.12 $153.73	$111.52 $277.56
1 Credit	Associate Only Family	$60.12 $137.72	$103.52 $261.55
2 Credits	Associate Only Family	$52.12 $121.72	$95.53 $245.55
3 Credits	Associate Only Family	$44.12 $105.72	$87.53 $229.55

HEALTH SAVINGS ACCOUNT

What is an HSA?

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

Great Benefits For You

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

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

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

Triple-Tax Savings

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

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

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

Contribution Limits	2025
Single	$4,300*
Family	$8,550*
Catch-up (55+)	$1,000*

PLUS an annual contribution from Arhaus up to $750 Single/$1,500 Family if enrolled in the HDHP and HSA

Examples of Qualified Medical Expenses

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

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

FLEXIBLE SPENDING ACCOUNT

What is an FSA?

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

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

HEALTH CARE FSA

Contributions

You may contribute up to $3,200 per year as a before-tax contribution to your Health Care FSA.

Eligible Dependents

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

IMPORTANT REMINDER: When making your Health Care Flexible Spending Account election, please be aware that over-the-counter medications and menstrual products are eligible for reimbursement.

DEPENDENT CARE FSA

Contributions

In the Dependent Care FSA, you may contribute up to $5,000 per year. The $5,000 annual maximum applies to all contributions made by you and your spouse to a dependent care account. If you are married and filing separately for federal income tax purposes, you may elect to contribute up to $2,500 per year.

Eligible Dependents

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

PAYING YOUR FSA EXPENSES

There are two ways to pay for eligible expenses:

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

DENTAL

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

In-Network Benefits	Low Plan	High Plan	Platinum Plan
Deductible: Single/Family	$50 / $150	$50 / $150	$50 / $150
Annual Maximum Benefit	$1,000	$1,000	$1,500
The *MaxRewards*® program lets you and your covered family members roll a portion of unused dental benefits from one year into the next, so you have extra benefit dollars available when you need them most.			
Preventive Services *Cleanings, Exams, X-Rays*	0%	0%	0%
Basic Services *Fillings, Oral Surgery, Periodontics & Simple Extractions*	20% after Deductible	20% after Deductible	10% after Deductible
Major Services *Crowns, Dentures, Bridges, Root Canals & Surgical Extractions*	Not Covered	50% after Deductible	40% after Deductible
Orthodontia *Dependents and Adults*	Not Covered	Not Covered	50% after Deductible
Lifetime Ortho Maximum	n/a	n/a	$1,000

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

Bi-Weekly Premiums (per pay deductions)

Coverage Tier	Low Plan	High Plan	Platinum Plan
Associate Only	$9.37	$14.63	$17.82
Associate + 1 Dependent	$17.83	$27.33	$33.83
Family	$32.62	$44.11	$56.72

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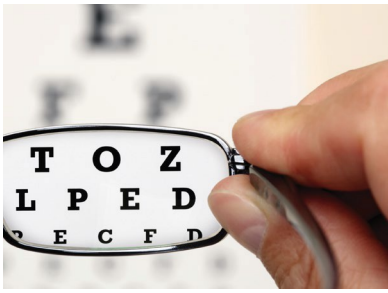
www.lincolnfinancial.com

VISION

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

When you elect Vision coverage you have:

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



Plan Features

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

Bi-Weekly Premiums (per pay deductions)

Coverage Tier	Vision Plan
Associate Only	$2.34
Associate + 1 Dependent	$4.26
Family	$7.38

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DISABILITY & LIFE

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

Short Term Disability (STD)

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

Long Term Disability (LTD)

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

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

Basic Life Insurance

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

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

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

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

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

SUPPLEMENTAL LIFE

Why should I consider Supplemental Coverage?

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

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

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

Premium Illustration is based on age & the amount of coverage elected;
Rate summaries can be found in the LFG Benefit Summary on the benefits website.

CRITICAL ILLNESS

Why do I need a Critical Illness plan?

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

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

Features & Plan Provisions

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

Covered Conditions:

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

Childhood Conditions:

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

*See LFG summary for full listing of covered conditions

Bi-Weekly Premiums (per pay deductions)

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

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

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

ACCIDENT

Why do I need an Accident plan?

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

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

Bi-Weekly Premiums (per pay deductions)

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

HOSPITAL INDEMNITY NOTICE

IMPORTANT: This is a fixed indemnity policy, NOT health insurance
This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

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

Looking for comprehensive health insurance?

- Visit HealthCare.gov online 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 (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

HOSPITAL INDEMNITY

Why do I need a Hospital Indemnity plan?

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

Features & Plan Provisions

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

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

Bi-Weekly Premiums (per pay deductions)

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

IDENTITY/ FRAUD PROTECTION

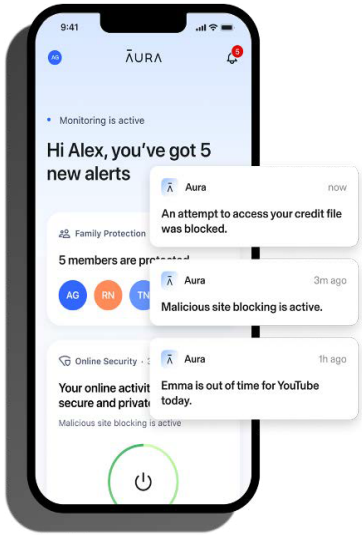
MetLife | Identity & Fraud Protection

Powered by: AURA

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

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

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



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

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

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

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

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

Additional Benefits included in the Protection Plus Plan include:

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

Bi-Weekly Premiums (per pay deductions)

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

PET INSURANCE

MetLife

What is Pet Insurance?

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

What does it cover?

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

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

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

Coverage for unforeseen events and circumstances

Preventive Care

Accident & Illness

Coverage for the unexpected:

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

Wellness

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

How to Enroll?

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

Get a quote or enroll for the 1/1/25 benefit year.

Visit www.metlife.com/getpetquote

Call 1-800-GET-MET8

Scan the QR code

EMPLOYEE ASSISTANCE PROGRAM

We all need a little support now and then.

Lincoln Financial Group® | ComPsych® GuidanceResources® Worldwide

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

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

Emotional Support

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

Wellness Support

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

Work & Lifestyle Support

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

Working Smarter

- Career development
- Effective managing
- Relocation

Legal & Financial

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

COMPLETELY CONFIDENTIAL

888-628-4824

Guidanceresources.com Username: LFGSupport
Password: LFGSupport1
Or download the GuidanceNow App!

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

WELLNESS PROGRAM

Earn Tokens

Join Arhaus' Wellness Program and take charge of your health! You have the opportunity to participate in a variety of health related activities to be entered to win prizes throughout the year. Associates covered on the Arhaus medical plan have the opportunity to earn Tokens, which can reduce your medical insurance premium. For the duration of the 2024-2025 Arhaus wellness program, you have the opportunity to earn Tokens for the following health-focused activities:

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

New this Year

Complete quarterly wellness activities to earn Tokens

- Wellness challenges
- Participating in active minutes challenges
- Healthy Food choices
- Wellness Education
- And more!

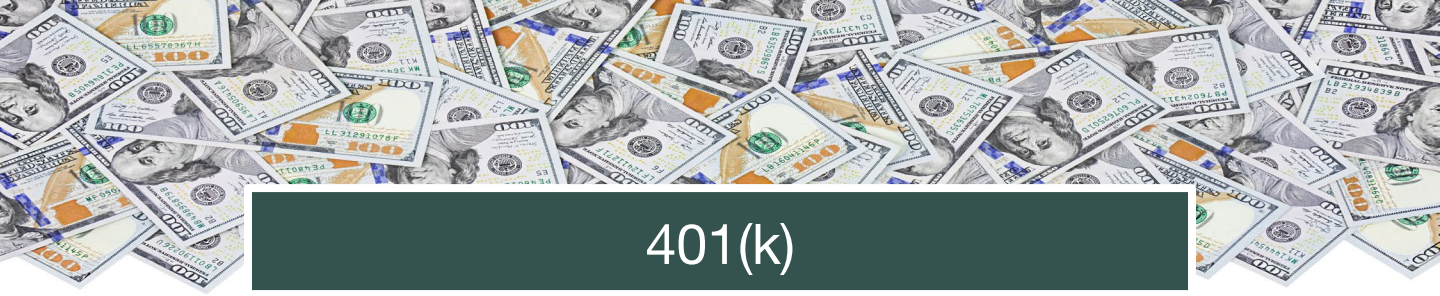
- **10 Tokens Earned** = 1 Wellness Credit
- **20 Tokens Earned** = 2 Wellness Credits
- **30 Tokens Earned** = 3 Wellness Credits

Tokens will add cumulatively throughout the program and will be applicable to your premium incentive discount and will be applied to the upcoming plan year.

Activate your PeopleOne Health Portal:

1. Go to portal.peopleonehealth.com
2. On the right-hand side, under 'Create Account', click 'Create your account with Member ID or SSN, Name and Birthday instead.'
3. Enter your last name, date of birth and last 6 digits of your Social Security number, check 'I'm not a robot' and then click 'Create Account'
4. You're all set! When logging in, in the future after your account has been created, you will go to portal.peopleonehealth.com and enter your email address and password under 'Sign-in'

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



401(k)

EASY

Your savings are made by automatic deductions from your pay.
You can contribute up to $23,000 in 2024.
50+ can contribute an additional catch-up amount of $7,500

FREE MONEY

We will match your contribution!
100% of the first 4% of earnings that you contribute to the plan.

TAX BENEFITS

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

ENROLLMENT

Associates are eligible to participate the 1st of the month following six months of employment.

GENEROUS

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

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

oswaldfinancial

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

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

833-224-5660 info@oswaldfinancial.com

charles SCHWAB

Your MAIN platform for your retirement plan

Some Services Include:

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

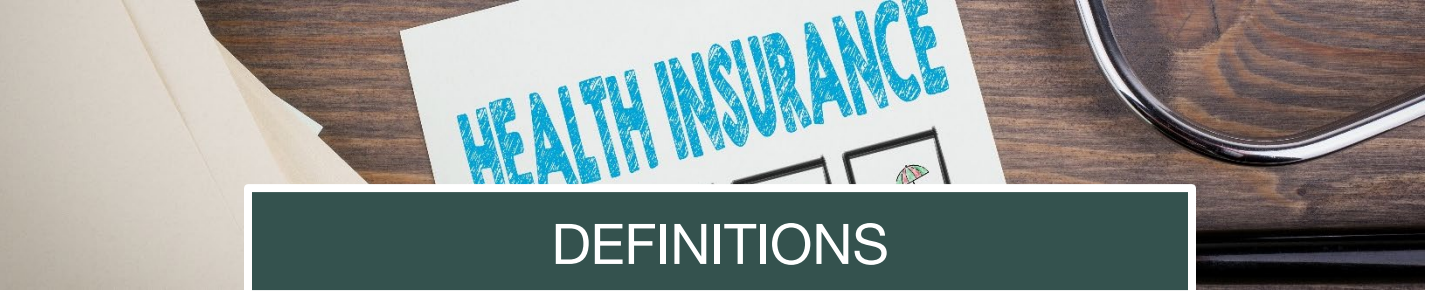
800-724-7526 workplace.schwab.com

CONTACTS

Benefit	Administrator	Contact Information
Human Resources Information System (HRIS) Benefits, Payroll, etc.	UKG	https://ew42.ultipro.com/ email: ultipro@arhaus.com
Medical/Rx	Anthem Policy #W43278	www.anthem.com (833) 639-1634
Health Savings Account (HSA)	Anthem Spending Account	www.anthem.com (833) 639-1634
Flexible Spending Account (FSA)	WEX	customerservice@wexhealth.com www.wexinc.com (866) 451-3399
Life Insurance Short/Long-Term Disability Supplemental Life	Lincoln Policy ID: 09-LF1596	www.lincolnfinancial.com (800) 423-2765
Accident Critical Illness Hospital Dental Vision	ACC-0001200064 CI-0001200062 HI-0001200063 00001D043699-00000 000400284812-00000	www.lincolnfinancial.com (800) 423-2765
Employee Assistance Program	ComPsych (EAP)	http://www.guidanceresources.com/ Web ID: LFGSupport Password: LFGSupport1
Pet Insurance ID Theft	MetLife	https://www.metlife.com/ (833)-552-2123
401k	Schwab	workplace.schwab.com (800) 724-7526

CONTACTS

Benefit	Administrator	Contact Information
Wellness Program	PeopleOne Health	https://peopleonehealth.com/
COBRA	WEX	www.marketplace.wexhealth.com
Leave of Absence	Lincoln Policy #09-LF1596ARH	www.lincolnfinancial.com (800) 423-2765
Arhaus Benefits Team		
Benefits Team		benefits@arhaus.com
Kathryn Walko	Sr. Benefits Specialist	kwalko@arhaus.com (440) 439-7700 x3070



DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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

Notice of Creditable Coverage

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

Why This is Important

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

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

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

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

When May You Join A Medicare Drug Plan?

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

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

If you decide to join a Medicare drug plan, your current Arhaus Furniture coverage may or may not be affected as well as dependent coverage. Additional guidance is available at https://www.cms.gov/medicare/prescription-drug-coverage/creditablecoverage?redirect=/creditablecoverage/ which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

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

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

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

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

For more information about Medicare prescription drug coverage:

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

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

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

HIPAA Notice of Privacy Practices

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

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

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

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

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

Uses and Disclosures of Protected Health Information (PHI)

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

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

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

Health Care Operations. The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and

improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

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

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

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

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

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

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

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

An Individual's Rights Regarding PHI

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

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

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

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

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

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

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

Optional if covered entity engages in underwriting **Genetic Information** An individual's genetic information will not be used for under writing except for long term care plans.

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

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

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

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

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

Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 2020

HIPAA Plan Special Enrollment Notice

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

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

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

Genetics Information Notice

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

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

Mental Health/Substance Use Disorder Parity

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

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

health conditions and substance use disorder conditions in your benefit plan may be reduced.

Newborns' and New Mothers Care Disclosure

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

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

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

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.
If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272). If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility.

ALABAMA - Medicaid	Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA - Medicaid	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS - Medicaid	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
COLORADO - Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health- insurance-buy-program 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	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
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
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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
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.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740 TTY: Maine relay 711
MASSACHUSETTS - Medicaid and CHIP	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840

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: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
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/oii/hipp.htm Phone: 603-271-5218Toll 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: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON - Medicaid	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA - Medicaid	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA - Medicaid	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS - Medicaid	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH - Medicaid and CHIP	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669Phone: 1-877-543-7669
VERMONT – Medicaid	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA - Medicaid and CHIP	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WEST VIRGINIA - Medicaid	Website: http://mywvhipp.com/ 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~~

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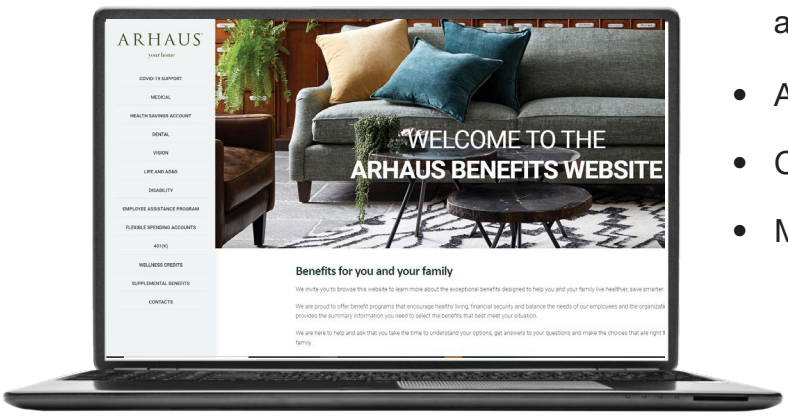

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